Saiz-Ruiz J, Moral L (1988) Delirium induced by association of propranolol and maprotiline. *J Clin Psychopharmacol* 8:77–78.
Shalev A, Munitz H (1986) The neuroleptic malignant syndrome: Agent and host interaction. *Acta Psychiatr Scand* 73:337–347.
Silver JM, Yudofsky SC, Kogan M, Katz BL (1986) Elevation of thioridazine plasma levels by propranolol. *Am J Psychiatry* 143:1290–1292.
Tollefson G, Lesar T (1984) Effect of propranolol on maprotiline clearance. *Am J Psychiatry* 1:148–149.
Uldry PA, Regli F, Naegeli C (1989) Quelques encéphalopathies d'origine médicamenteuse. *Schweiz Rundsch Med Prax* 78:658–662.

Peter H. Vetter, M.D.
Center of Nervous and Mental Diseases
Department of Psychiatry
Dietfrid G. Proppe, M.D.
1st Medical Clinic
Department of Internal Medicine
Christian Albrecht University
D-2300 Kiel
Germany

Interactional Pattern in Sleep Deprivation Therapy: An Empirical Study

This paper reports an attempt to identify possible therapeutic effects of those interactional (or interpersonal) aspects of biological treatment procedures that are often ignored in medicine. It utilizes a central principle of an Ericksonian-based brief therapy developed at the Mental Research Institute in Palo Alto, CA (Fisch et al., 1982; Priebe, 1989; Watzlawick et al., 1974) to suggest problem solutions that are opposite to those previously recommended by the patient's significant others.

Specifically, we investigated the possible contributions of this approach to the reported antidepressant effect of sleep deprivation therapy (Elsenga and van den Hoofdakker, 1987; Gerner et al., 1979). Biological explanations for this therapeutic effect have been suggested (Wu and Bunney, 1990), but the underlying mechanisms are not yet understood (Bonhuys et al., 1989). Moreover, it is not possible to predict consistently those patients who will respond, and, in any event, the antidepressant effect usually persists for only 1 or 2 days.

The therapeutic procedure begins with a request from the psychiatrist (an authoritative figure upon whom the patient must depend) to participate in the treatment. The patient is then asked to do something that is effortful even for a healthy person, *i.e.*, to overcome fatigue and remain awake for an entire night, which can be perceived as a request for stressful activity. According to our principle, depressives who have been asked by their significant others to rest, refrain from activity, and avoid significant effort should particularly benefit. Conversely, sleep deprivation should be less effective for those patients already pressed by significant others to cope with their depression by active exertion.

Method

Total sleep deprivation was studied in 40 inpatients (23 women, 17 men), ranging in age from 25 to 75 years (50.5 ± 13.3). All met Research Diagnostic Criteria for major depressive disorder (Spitzer et al., 1978) and were free of medication for a minimum of 3 days before sleep deprivation. No fixed program of activities was offered, but patients were attended by a nurse during the night.

TABLE 1
Association of Response to Sleep Deprivation and Significant Others' Interaction with the Patient[a]

	Significant Others Asked the Patient to	
	Refrain from activity	Cope by active exertion
Nonresponder	4	17
Responder	9	10

[a] $\chi^2 = 3{,}65$, $df = 1$, $p = .056$ (two-tailed test).

To assess the interaction between patients and significant others, an interviewer not otherwise involved in treatment asked the patients the following question on the morning before sleep deprivation: "When you are depressed, do your significant others encourage you to be active, or do they ask you to refrain from any activity?" The patients decided which of the two alternatives was correct without any further explanation.

Response was self-rated on the morning after sleep deprivation. Patients were asked whether they felt improvement (responders) or no improvement (nonresponders; Haug and Fahndrich, 1986).

Results

Thirteen patients reported that their significant others had asked them to refrain from activity, while 27 said they had been encouraged to be active. These statements were not related to gender or age. On the morning after sleep deprivation, 19 patients reported improvement and 21 did not. Table 1 shows the relationships between patients' statements about their interaction with significant others and their response to sleep deprivation.

Nine of 13 patients who had been asked to refrain from demanding activities by their significant others reported improvement, but only 10 of the 27 patients asked to cope with their depression by means of activity and exertion felt such improvement. This difference just fails to reach statistical significance in a two-tailed chi-square test, but it is significant in a one-way analysis.

Discussion and Conclusion

Our procedure is subject to a variety of methodological criticisms, and the data are not conclusive. Nonetheless, they offer preliminary evidence in favor of the hypothesis. The possible influence of interactional factors in this instance is regarded as complementary to, rather than competitive with, other explanations of the therapeutic effect of sleep deprivation.

References

Bonhuys AL, Beersma DGM, van den Hoofdakker FH (1989) Observed behavior as a predictor of the response to sleep deprivation in depressed patients. *Psychiatry Res* 28:47–61.
Elsenga S, van den Hoofdakker RH (1987) Response to total sleep deprivation in endogenous depression. *Psychiatry Res* 21:157–161.
Fisch R, Weakland J, Segal L (1982) *The tactics of change.* San Francisco: Jossey-Bass.
Gerner RH, Post RM, Gillin JC, et al (1979) Biological and behavioral

effects of one night's sleep deprivation in depressed patients and normals. *J Psychiatr Res* 15:21–40.
Haug HG, Fahndrich E (1986) Problems in defining response in therapy studies. *Pharmacopsychiatry* 19:170–171.
Priebe S (1989) Can patients' view of a therapeutic system predict outcome? An empirical study with depressive patients. *Fam Process* 28:349–355.
Spitzer RL, Endicott J, Robins E (1978) Research Diagnostic Criteria: Rationale and reliability. *Arch Gen Psychiatry* 35:773–782.
Watzlawick P, Weakland J, Fisch R (1974) *Change: Principles of problem formation and problem solution.* New York: W. W. Norton.
Wu JC, Bunney WE (1990) The biological basis of an antidepressant response to sleep deprivation and relapse. Review and hypothesis. *Am J Psychiatry* 147:14–21.

Stefan Priebe, M.D.
Freie Universitat Berlin, Germany
Hans-Joachim Haug, M.D.
Universitat Basel, Switzerland

Psychotic Episodes and Nightmares: A Case Study

Nightmares may occur during transition to psychosis (Detre and Jarecki, 1971; Mack, 1970) and have even been considered a diagnostic factor in schizophrenic breakdown (Detre and Jarecki 1971). We present here a case clinically demonstrating a transition from nightmares to a brief psychotic episode associated in terms of time and content of the dream.

A 78-year-old man was admitted to our emergency unit following a serious suicide attempt. On admission, 3 hours after the attempt, he appeared frightened but fully oriented. He had begun to suffer from nightmares 3 years earlier, with recurring content: A man wielding an axe and accompanied by big dogs was chasing him. The nightmare was sufficiently frightening that he developed sleep avoidance. During the 2 weeks prior to admission, he had awakened from sleep experiencing auditory and visual hallucinations involving the man and his dogs. In the course of one episode, he attempted suicide using an axe "to complete the work for this man."

Two more episodes were observed during his 10-day stay in the ward, each occurring when he awakened from sleep (once in the daytime). Throughout each of the attacks, which lasted 1 to 2 hours, the patient hallucinated and thought the ward staff were enemies coming to kill him. Repeated examinations between attacks revealed no psychopathology and no deficits in cognitive functions. Previous psychiatric history was unremarkable, and physical and neurological examinations, EEG, x-ray of cranium, and CT scan were within normal limits. A sleep laboratory study performed between attacks revealed that he fell into superficial sleep after 3½ hours (stage 2, 87%, REM = 12%; stages 3–4, 1%, 50 to 60 breath interruptions). Blood chemistries were normal. After seven medication-free days, Halcion (triazolam) (.25 mg/day) and oxazepam (10 mg twice daily) were initiated. No recurrence of nightmares or psychotic episodes was reported at 6-month follow-up.

Nightmares may afford us an approach to understanding psychotic experience, at least to some extent. Our patient demonstrated a transition through nightmares from normality to psychosis that has not previously been reported in the literature, although it supports the hypothesis of Hartmann et al. (1978, 1987) and Mack (1970). The case also demonstrates the importance and usefulness of treating such nightmares, especially in the elderly.

References

Detre TR, Jarecki HG (1971) *Modern psychiatric treatment.* New York: J. B. Lippincott.
Hartmann E, Russ D, Oldfield U, et al (1987) Who has nightmares: The personality of the lifelong nightmare sufferer. *Arch Gen Psychiatry* 44:49–56.
Hartmann E, Skoff B, Russ D, Oldfield U (1978) The biochemistry of nightmare: Possible involvement of dopamine. *Sleep Res* 7:188.
Mack JE (1970) *Nightmares and human conflict.* Boston: Little Brown.

S. Fennig, M.D.
E. Salganik, M.D.
M. Chayat, M.D.
Shalvata Mental Health Centre
Hod Hasharon, Israel

Books

GOSHEN-GOTTSTEIN, ESTHER (with a foreword by Oliver Sacks). *Recalled to Life: The Story of a Coma.* New Haven, CT: Yale University Press, 1990. xiv + 208 pp. $25.00.

It is rare that a book is simultaneously of profound interest to clinicians, medical scientists, and lay people. *Recalled to Life* is such a book. It is the fascinating and clinically important story of an eminent 59-year-old Israeli philologist who went into a coma following coronary bypass surgery and remained in a persistent vegetative state for 15 weeks before making an almost complete recovery. The story is told by his dedicated and talented wife, who presents an almost unheard from and desperately needed lay, familial perspective on the care of patients in a vegetative state. Herself a clinical psychologist, she is remarkably perceptive and contributes great insight into both her husband's recovery from a coma and the clinical caregivers' shortcomings.

The book presents a dramatic chronicling of the despair of the family, the callous and clumsy treatment by physicians and nurses, and the ecstatic joy of the unexpected, but painfully slow, recovery.

Even though Goshen-Gottstein writes quite explicitly in the Jewish tradition, she manages to remain realistic about her husband's developments, clearly grasping the scientific possibility of low probability events while the physicians spoke incorrectly of both "hopelessness" and "miraculous recovery."

The appendices include a fascinating exploration of the recapitulation of child development of those recovering from coma, advice to those in similar situations, and a helpful timeline of the events leading to the patient's recovery, as well as a brief account by Rodney H. Falk, neighbor, friend, and family physician. He manages to manifest a paternalism regarding the "duty of every physician to make . . . decisions" to terminate life support (p. 200) that is rapidly becoming