term has come to be; his concrete achievement is as evanescent as his steamship line. "You have been preying upon the gullibility of your own people," a judge told Garvey. "You should have taken this $600,000 and built a hospital for colored people in this city instead of purchasing a few old boats. There is a form of paranoia which manifests itself in believing oneself to be a great man."

Honky baiting, a favored tactic of black demagogues from Garvey to Jeremiah Wright, is a sorry substitute for reform. Equally barren is the assertion that Garvey, however demented, deserves praise for detesting the detestable. Such symbolic triumphs have so long been offered to black Americans that too many have substituted shadow for act (these days it is called "representation") in a state of almost conscious denial. As the black scholar Kelly Miller said in the last century, "The Negro pays for what he wants and begs for what he needs."

Michael Anderson is writing a biography of the playwright Lorraine Hansberry.

Waking Nightmare

Reviewed by D. T. Max

Pity the poor sleep researcher. There he (and it is usually a "he") is at a sleep convention, and along comes Gayle Greene, a professor of literature with chronic insomnia who has made a specialty of trying to cure herself. The researcher is pumped up on recent successes in the field: the growth of apnea treatments or the development of a pill that quiets restless legs syndrome. The "sleep switch," a central trigger in the brain that divides sleeping from waking, has been located. Then Greene, who teaches at Scripps College in Claremont, California, starts her rat-a-tat of questions. What do we know about how our diet affects sleep? she might ask the researcher. Er, nothing. Do our parents' sleep habits affect our own? Er, we don't really know. Well, surely you can tell me how the best-known sleeping pills work? No, actually, Professor Greene, we can't. They just sort of seem to help.

Insomniac is an odd kind of book: It's not a whodunit but a why-don't-they-do-it. It asks questions, then asks why no one really qualified is exploring them. Greene wants answers, and, unfortunately, there are few in the world of sleep research. Those we have are bought and paid for by Big Pharma, with a predictable distorting effect. For instance, we know a lot about how breathing affects sleep patterns, but next to nothing about how menstruation affects sleep patterns. That's because there's money to be made in treating breathing problems. Insurance companies will cover the costs of the things sleep clinics can sell you to ease your apnea. Not so if your insomnia is linked—as Greene suspects hers is—to hormonal fluctuations.

INSOMNIAC.

By Gayle Greene. Univ. of California Press. 503 pp. $29.95

Insomniac is, along the way, an alarming, uncomfortable portrayal of how researchers in the field fail the sufferers they are supposed to treat. Desperate for funds, bent over by insurance companies, whiplashed by the National Institutes of Health, researchers do not treat insomnia as it is actually experienced. If you cannot cure me, Greene seems to be saying, at least hear me. Don't tell me how insomnia ought to be, but let me tell you how it really is. "What is missing from everything I read about insomnia is—the insomniacs," she writes. And earlier she confides, "No doctor I ever saw showed the slightest curiosity about the cocktail of hormones, estrogen, progesterone, thyroid, that I ingest daily." "This is a somewhat cranky book," she writes. Indeed it is.

And with reason, as Greene makes clear. Certainly insomnia came early to her and has stayed for a long time. Greene was born wide awake. "There is no sleep in that baby," her mother wrote to

***Night* (1963), by George Tooker**

her father in 1944, in a letter Greene unearthed many years later. With puberty her insomnia really blossomed, and by graduate school it had become a permanent companion. Her only break was during pregnancy (whence her theory that hormones can play a significant role in insomnia).

But if there was never any sleep in Greene, there was always a lot of fight. She came of age in a generation that believed that problems could be cured, an optimistic postwar time. There is no station of the insomniac cross she has not visited in the last 65 years. "I've tried (nearly) everything anyone has ever told me worked for them," she writes, "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." On the pharmaceutical front she's been equally active, sampling "valerian, kava kava, chamomile, skullcap, passionflower, homeopathic concoctions, L-tryptophan, 5-HTP, GABA, melatonin, Elavil, Zoloft, trazodone, tricyclics." Add to this the benzodiazepines, "Librium, Valium, Xanax, Dalmane, Klonopin, Restoril, Halcion, and more Ativan than I care to remember or probably can remember, since the drug erodes memory." Throw in Ambien and Sonata, and "in the bad old days" sedatives such as Nembutal, Seconal, and Miltown. Plus the over-the-counter remedies: Sominex, Nytol, Sleep-Eze. Not to mention other treatments, including meditation, acupuncture, and biofeedback. And on and on, poor soul. Nothing ever quieted her chattering brain.

The tone of much of this book is high dudgeon. If she were Dante, Greene would put the drug companies in the last circle of hell and arrogant, prescription-scrib-

bling "sleep specialists" one circle away. But she reserves gentler criticism for the sleep therapists who treat patients with cognitive behavioral therapy. CBT is, in theory, exactly where Greene wishes the field would head. "The best drug is no drug, as far as I'm concerned," she writes. Instead of treating insomniacs with pills, CBT counsels small changes in behavior that will lead to more soporific outcomes, changes that are sometimes grouped under the rubrics "sleep hygiene" and "sleep restriction." For instance, use blackout drapes, CBT advises. Do nothing in your bed besides sleep (or make love, Greene gamely adds); if you can't sleep, get out of bed and do something else. When you're sleepy, come back and try again. And no, we repeat, no caffeine.

The only problem with CBT, Greene learns, is that it doesn't really work. She cites studies showing that CBT rarely increases sleep time significantly and that the work involved in participating in it often leaves insomniacs more dispirited than before they started. One 1999 review of 50 CBT studies Greene mentions found that sleep was only increased by 30 minutes. Sufferers probably spent that much time filling out their sleep diaries.

So with the virtuous pagan of CBT fallen, what are we left with? What hope does Greene hold out for herself? For the reader? For the researcher who deigns to pick up a book written by a non-specialist? Greene embraces some commonsense proposals for the near-term future: (1) Stop blaming the victim. Failure to sleep is not a character flaw, nor is complaining about tiredness a sign of weakness. (It is not true that "the best don't rest.") (2) Insomnia is not a psychological condition but the result of a combination of genetic and physiological problems with a possible psychiatric component. For instance, contrary to long-standing assumptions, there is no proof that insomnia is a byproduct of depression; indeed, depression is likely a byproduct of insomnia. (3) Sleep is a feminist issue, or should be. Researchers should look a lot harder at women, who report sleep problems in disproportionate numbers. (4) And they have to push back against the pharmaceutical industry, which trumpets one miracle cure after another without testing them widely enough or on a diverse enough group of subjects. "Most medications on the market today," Greene writes, "are a parody of what we need, dumbing us down and increasing the risk of falls." (5) Sleep researchers must be wary of their own success—if "success" is the vast increase in sleep clinics in this country. Those clinics are good at treating pulmonary problems but all but useless for true insomnia. (6) A child of the '60s, Greene's final call is to organize. Follow the model of AIDS or restless legs syndrome sufferers. Arise, insomniacs, you have nothing to lose but the bags under your eyes.

Insomniac is a wild ride, and its wildness is part of its pleasure. You get to know Greene in these pages: bright, jagged, exhausted, funny, wistful. "Hast thou not poured me out as milk, and curdled me like cheese?" she might say with Job. If *The Anatomy of Melancholy* is the textual analogue of bipolar syndrome, *Insomniac* is the textual equivalent of sleeplessness. It's jazzed. It's disorganized. It's in a hurry. It forgets its hat.

But when all is said and done, you emerge with a great sense of frustration on behalf of the author and a lively appreciation for what she has been through. You certainly do wonder about the mystery of sleep, how we can know so little about a physiological state so central to our experience. "If sleep does not serve an absolutely vital function," the sleep researcher Allan Rechtschaffen famously observed, "then it is the biggest mistake the evolutionary process ever made." And after reading Greene's plaint, you'd add that if nature was going to go to all this trouble, this vast mechanism for restoration that leaves us inert and unprotected for a third of our lives, it might at least have done a better job.

D. T. Max is the author of *The Family That Couldn't Sleep* (2006), a cultural and scientific study of fatal familial insomnia.