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Qual Health Res 2000 10: 84

DOI: 10.1177/104973200129118264

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Coming Out of Intensive Care Crazy: Dreams of Affliction

Joel Richman

The impetus for this article was the author's experience of illness, necessitating 5 months of hospitalization, 7 weeks of which were spent in a coma in an intensive care unit (ICU). The origins and general characteristics of ICUs are noted. A pastiche of illness narrative is constructed to allow for the author's own comment on his experience. The intensive care syndrome (ICS), a permeable category, continuing the aftermath of surgery and the social, psychological, mechanical, and pharmaceutical effects of the unit itself, is discussed. Dreams of affliction, a component of the ICS, are explored; the prior sociological history of the neglect of dreams, an essential universal, is also pointed out. The author's dream forms and their shamanistic parallels are explored. In Foucauldian language, they are considered a product of the fragmentation of the cosmological spirit, whereas the author was a medical object and mechanical appendage. Nursing is in a strategic position to make patients' dream narratives their own as an aid for understanding illness.

Like any one else, sociologists fall ill. Some go on to be what Frank (1995) has called the "wounded storyteller," a role traced back to the ancient Greeks. The seriousness of the infirmity often legitimates the accuracy of the unfolding narrative. Medical sociology has its own heroic lineage of wounded storytellers. Frank himself is one. In 1988, he suffered a heart attack, which was followed shortly by a seminoma tumor (for which he ceased treatment). The late Irving Zola is another fine exemplar. In his teens, he experienced polio in the pre-Salk days, and later, a car crash. Their stories gave their lives a purposeful destination, testimonies to the will and newly recovered emergent self. Illness was also the impetus for generating academic pathways, especially advancing the conceptualization of the body. Zola's (1982) biography, *Missing Pieces*, is aptly named. Others regard illness as integral to the private self.

My own illness was the product of a ruptured gall bladder (quite unusual) while on the National Health Service elastic waiting list, resulting in peritonitis and septicaemia (a deadly combination). I was rushed into the hospital as an emergency at the end of December 1995, a festivity time for the staff. My only memory is of being triaged in Accident and Emergency in extreme agony. After two operations, I was in a coma for 7 weeks in the intensive care unit (ICU), about which I remember

AUTHOR'S NOTE: Many thanks are due to Val Wilkes for processing this article and to Ann Wakefield for doing library research while the author was hospitalized and for patiently listening to the author's dreams, as did Jim Lord and Eileen Fairhurst. Not the least of which, the author would like to thank his wife, Rosalie, and his children, without whose continuous vigil, he would not have survived. Thanks are due to the author's former teacher, Professor Ronnie Frankenberg, who encouraged the author to write this article and gave helpful comments. Any errors, of course, belong to the author.



QUALITATIVE HEALTH RESEARCH, Vol. 10 No. 1, January 2000 84-102
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nothing. It took a long time to piece together my clinical history, which included renal and liver failure, and at one time, the possibility of blindness.

I am writing this article in an attempt to rescue my lost self. An ICU was never on my research agenda before the illness; I was mainly involved in forensic psychiatry.

This personal odyssey has two voices: my own voice, full of fear and despair, especially when initially immobile and unable to speak during retreat from the coma; and the voice of the professional literature, especially the literature dealing with the ICU, of which I have no direct memories. These two voices are at times resonant, often colliding. From the professional discourse, I learned that I had experienced the intensive care syndrome (ICS), emerging crazy into the routine of a high-dependency ward. I traced the long history of the syndrome, culminating in the rise of the ICU setting. The latter has an extensive literature (not presented here), which discusses how Forssman, in the 1930s, a recent graduate from the Berlin Medical School, catheterized his own heart to produce a continuous reading; Drinker's development of the iron lung; the transference of skills from the Post Anaesthetic Recovery Room (PAR); and so on. Baltimore Hospital, under Peter Safar, an anesthesiologist, claims to have had the world's first ICU in 1958 (so does Sweden) (Safar & Grenvick, 1997).

For convenience, the data are presented in three sections. First, a brief location of my illness narrative, among others, is presented. I have eschewed the opportunity of presenting a complete paternoster of my symptoms, each of which would demand its own social and clinical etiology. They are still too painful to recount. Second, the clinical behavior that generates the ICS is examined; it is too simplistic to accept the residual explanation of narcosis for it. Third, some dreams experienced as part of the syndrome are explored. Reasons for sociology's scant attention to dreams are noted. Peters (1990) reminds us that "dreams are active communication" (p. 1); while comatose, they were my only world. To make sense of them, I treated them as ethnographic events, providing entree into my lost self.

ILLNESS NARRATIVES

Under the influence of discourse theories, clinical hermeneutics, and the patient as text (Daniel, 1986), illness narratives, of which there are many forms, are increasing. I have fabricated a heuristic composition, allowing me to describe my own illness dilemmas succinctly.

Serious illness forces the sufferer into deep inner contemplation, especially during long sleepless nights in a busy high-dependence ward. I made a contract with myself to adopt a more sensible lifestyle after recovery, to enjoy myself more. Much of what I formerly found serious and urgent would now become trivial (see Frank, 1993, p. 39; Toombs, Barnard, & Carson, 1995). Reaching full consciousness and piecing together my medical history by comparing trusted friends' accounts with relatives' accounts, I realized that I was fortunate to be alive (see Frank, 1993, p. 40). It was no consolation to hear others say, "I had been lucky," or "God did not want me." I relapsed repeatedly into the survivor syndrome and was heavily depressed. The initial dissemination of my illness story was located in terms of how the medical culture required patient conformity in its regime (see Early, 1982, p. 1492). To gain

audience support for my illness dilemmas, especially the horrendous dreams, I found good listeners to be essential for sustaining my shattered existence (see Kleinman, 1988, p. 52). My talk was heavily laced with moral-philosophical terms about how all are vulnerable to the unexpected (see Kleinman, 1988, p. 53), although my concept of self, modified in tandem with the illness progression, the final identity berth, could not be assumed with certainty (see Hyden, 1995, pp. 67, 72; Somers, 1994, p. 630). I conceived a range of possible plans for the future, hoping that at least some would be completed. Making sense of illness entails making endless constructions of the history of the illness trajectory during the many periods of illness solitude (see Churchill & Churchill, 1982, p. 73; Zola, 1991, p. 3).

Although the repeated retelling of an illness narrative attracts confirmation from others, some may challenge the inconsistency of detail (e.g., temporal sequence), especially if the listener was there on a given occasion (see Churchill & Churchill, 1982, p. 74; Ochs, Taylor, & Rudolph, 1992, p. 44). However, this challenge does provide an opportunity to test further my gathered interpretation of strategic events. In addition, others can take over your story for further retelling, sometimes in your presence, relieving you of the effort of interaction with unwelcome newcomers who want to know all (see Good & Good, 1994, p. 837). This surrogate retelling frequently contains aspects of the narrative with some logical inconsistencies; the narrator then attempts his or her own reconciliation of the misplaced explanation on your behalf. Repairing your narrative offers a valuable gift exchange. Justifications include the oft-made comment that "anyone would be confused" in similar, arduous illness happenings. Illness narratives reference heroic elements, by doctors or self, in experiencing the unendurable; survival becomes reduced to chance or mystical causation. The latter leads the self and others to promise a similar miraculous outcome of full recovery and a restoration of former roles and network (see Good & Good, 1994, p. 838).

ICS REVISITED

The United Kingdom (UK) Intensive Care Society defines *intensive care*

as a service for patients with potentially recoverable conditions who can benefit from more detailed observation and treatment than is generally available in the standard wards and departments. Intensive Care should be differentiated from High Dependency care although there is some overlap. (Report from the King's Fund Panel, 1989, p. 4)

Most units in my regional health authority have less than 7 beds; however, mine was large, with 12 beds. They are costly (about £250,000 per annum) and in short supply, and under pressure from an increasing elderly population and from more new, complex surgery. Unpredicted demands from, for example, Accident and Emergency could mean that a patient might be shunted to another hospital (Wells, 1995) (in a manner of the poor, between parishes, in Elizabethan England) if the immediate ICU is full. A national register of ICU beds is now set up.

ICUs are frequently prefaced as places of critical choices (Raffin, Shurkin, & Wharton, 1988). Nurses' judgments are more valued here by doctors than elsewhere. The U.S. Office of Technology and Assessment notes that ICUs make up 28%

to 34% of total hospital costs. The American Task on Guidelines of Society of Critical Care Medicine recommends 12 beds as an ideal size (Safar, 1984).

I was a privileged patient. An ICU bed was reserved for me after a lifesaving operation. Family and colleagues own this sequence. They spoke to me, often loudly, and were encouraged by the nursing staff that was attempting to arouse me from my coma. My daughter read accounts of Manchester United games to me, and I was told that a colleague from a nearby university discussed his department's audit report. Friends took it in relay to visit me. Prayers were said for me at Mecca and at numerous churches of different denominations. The rabbi gave me the last rites at my bedside.

Becoming conscious in a high-dependency ward, I was crazy; the Chinese term *dian kuang* was apt. Later I recognized that I experienced what McKegney (1966) refers to as ICS. He calls it the "new disease of medical progress" (p. 633). Nahum (1965), in the same vein, refers to it as the "new madness of medical progress" (p. 771). I displayed psychotic and paranoiac symptoms. I believed firmly that the reason for my hospitalization was that I was shot in the university car park. Furthermore, I believed that the \$5 million I carried for a foreign agency was stolen and that their agents were set on assassinating me. I told my youngest son to camp out on the flat roof of the hospital building overlooking my window at the ward, with strict instructions that if anyone came on the roof carrying a holdall, which could contain a gun, he was not to ask questions but throw that person off the roof. (John le Carré has much to answer for!) Another feature of my condition was a change of taste. Everything tasted of aluminum; I refused to eat and had to be coaxed to take liquid supplements. Tracheotomy, often a standard procedure in ICUs, eliminates the sense of smell. Extubation also affects the sense of taste. The fear of being poisoned is a first-rank symptom of schizophrenia. More disturbing were horrifying dreams that I can only describe as animistic; anything was capable of being transformed into dangerous and unpredictable life-forms. Dream themes are further examined below.

ICS is not recognized in the *International Classification of Disease* (World Health Organization, 1996). It has a large family of resemblance: postoperative confusion; postcardiotomy delirium; black-patch delirium (after eye operations); turbulent delirium (a progression from disorientation of time, place, and person); ICU delirium; digitalis delirium; hallucinatory syndrome; transient paranoia; febrile delirium; postoperative melancholy; and acute, organic brain syndrome. To date, there are 30 conditions allied to ICS.

The first detailed account of this postoperative psychiatric disorder was noted by Dupuytren of Paris in his 1834 clinical lectures (Knox, 1963). Discussing nervous delirium (*delirium nervosum*), he described its characteristics as incoherent speech, often singing, followed by patients pulling off dressings and attempting to walk on recently operated limbs without apparently feeling pain. It was George H. Savage's (1887) paper at the Fifty-fifth Annual Meeting of the British Medical Association, "Insanity Following the Use of Anesthetics," that highlighted the subject, warning that postoperative delirium was not monocausative; prior dispositions of alcoholism and weak mindedness were contributive.

DaCosta (1910) correctly pinpointed the effects of anesthetics and blood changes in influencing postoperative insanity: "Febrile delirium may perhaps in some cases be due to elevation of the temperature and in others to disturbances of

cerebral circulation, but in the great majority of cases it is due to poison circulating in the blood" (p. 580). His ideas were also linked to the then established gender typing in gynecology. For example, "hysterical delirium is seldom seen except in young women and it is most common at menstrual period" (p. 584). He asserted that "of 1,000 laparotomy cases four will probably go insane" (p. 577). His article interestingly ends with the following: "The writer of this paper does not feel that he has shed light upon the obscurities of the subject. That remains for wiser ones and those of more experience to do" (p. 584).

Muncie (1934) perceptively showed that much prior discussion of the syndrome had been locked into early 20th-century psychiatric thought, relying on degeneracy theory (e.g., especially promulgated by Mayerson, 1925) and arguing that "as things stood, therefore, the patients became psychotic through infection, drugs, cachexia or other agent. The operation, per se, would not be blamed . . . the blame fell on his construction" (p. 682).¹ The first psychoanalyst to be involved in the examination of ICS was Deutsch (1942). With no systematic statistics, she prefaces her article with the following: "The percentage of analytic patients who have had operations before they come to analysis is extraordinarily high" (p. 105). She refers to the postoperative condition as flight neurosis and traumatic neurosis, covering "sleeplessness, anxiety dreams, nightmares, attacks of anxiety with cardiac and respiratory distress, with vasomotor and secretory distress"² (p. 105). For men, she argues that they have a postoperative fear of castration; for women, the operation is equated with delivery and the anxieties of childbirth. Deutsch's patients showered her with postoperative dreams of death, angels, and their own funerals.

There are no reliable norms for the incidence of ICS. Since the mid-1970s, it is believed to have fallen because of less time taken for complicated operations, especially open-heart surgery. More awareness of the syndrome has encouraged some units to prepare patients cognitively for the ICU. American ICUs were the first to deploy psychiatrists as part of the clinical team. Most studies of the syndrome are clinically isolated studies of practitioners' own units, some have researched the syndrome from medical records only, many studies have made no prior assessment of patients' mental well-being, few rely on extensive longitudinal sampling, and few involve patients of ethnic minorities. Danilowicz and Gabriel (1980) argue that non-English people have high rates of ICS; studies also differ on the range of behavior to be included under ICS.

In the 1960s, it was reported that between 40% and 57% of ICU patients experienced ICS (Wilson, 1987). Kornfeld (1969) found similar figures from reviewing his medical records, but he revised the figure to 70% after interviewing the patients. Hale's (1977) data from his ICU show that 7% of the population required psychiatric consultation during the 6 months following discharge. The syndrome seems to appear between the third and seventh day in the ICU for those who are conscious. Tess (1991) concludes that "confused patients are 2-5 times more likely to die than nonconfused patients" (p. 395) and more likely to be permanently impaired cognitively and needing admission to psychiatric hospitals. To indicate the seriousness of the iatrogenic ICS, Tess recorded a 36% mortality of those with a preoperative psychiatric diagnosis. This could be related to organic brain disorder reflecting cardiovascular deterioration. Furthermore, 54% of patients with preoperative psychiatric conditions progressed to postoperative delirium, which mainly consisted of hallucinations, commencing with visual then auditory symptoms, thus fulfilling Savage's (1887) warning about the syndrome's complexity.

Some people are more prone to ICS than others. The elderly, those over 65 years of age, are one example. They may be developing dementia before admission and are more likely to have hearing and visual defects. The cholinergic effects of drugs are known to cause confusion in the elderly. The elderly also have a significant reduction in cerebral blood flow (Stanley, 1991). Those under 14 years of age seem to be able to avoid the syndrome, but the reason for this is not clear. It is possible that the ICU staff give children more personal contact. It is also possible that, with adults, the staff is more task orientated and likely to minimize contact with dying adults as a personal coping strategy.

The organic effects of the operation and ICU treatment have been frequently cited. The pump oxygenator disturbs the serum-protein balance; levels of serotonin and catecholamine also rise during bypass surgery and have been blamed for patient confusion. The greater the time spent under surgery, the greater the chance of being afflicted with the ICS. Multiple-valve surgery is more conducive than single. Those with multiple arterial pressure below 50 mmHg are more inclined toward ICS. In addition, patients with O-type blood have lower rates (Tucker, 1993).

The ICU culture has been highlighted especially for its generated stress to patients and the nursing staff, the latter also administers to the needs of relatives who camp around the unit. Kleck (1984) referred to the ICU "as a totally foreign environment" (p. 22). He calculates that ICS affects 10% to 20% of open-heart surgery patients. Hay and Oken (1972) and others have invoked military images of the ICU, with the foe being death:

A stranger entering ICU is at once bombarded with a massive array of sensory stimuli. The great impact comes from the intricate machinery, with the flashing lights, buzzing and beeping monitors, gurgling suction pumps and whooshing respirators. Simultaneously one sees many people rushing around busily performing life-saving tasks. The atmosphere is not unlike that of the tension charged strategic war bunker. Desperately ill are hooked up to that machinery and, in addition to mechanical stimuli, one can discern moaning, crying, screaming and the last gasps of life, signs of blood, vomiting and excrete, exposed genitalia, mutilated wasting bodies and unconscious and helpless people. (p. 112)

There is more patient privacy today. Dyer (1995) argues that ICUs have features in common with torture. Patients are secured in isolation; lack visual stimulation (often looking at a blank ceiling); are time disorientated; are sensory overloaded with meaningless noise, both mechanical and human; are often in pain and thirsty; and are moved into uncomfortable body positions over which the patient has no control.³ Puntillo (1988) emphasizes that critically ill patients are especially vulnerable to pain and have the greatest difficulty in communicating it to the staff. Robillard (1994) has commented that the "treatment in ICUs probably evoke more anxiety than any other field of hospital care" (pp. 383-393).

Specifically, the lack of sleep is a key feature of ICS (Helton, Gordon, & Nunery, 1980). In my experience, patients can have only 1 to 4 hours of sleep in the first 24 hours in the ICU, with the result being an absence of rapid eye movement (REM) sleep with dreaming. Sixty to 90 minutes is one cycle of sleep. Experiments with normal individuals involving sleep deprivation indicate that major psychiatric symptoms appear on about the fourth day or earlier. Disturbing noise comes from

staff conversation. Rosini, Howell, and Trodes (1974) suggest that staff noise is a product of staff tensions.

U.S. standards recommend that ICUs' noise levels should not exceed 45 dB during the day, 40 dB during the evening, and 25 dB at night so that diurnal rhythms for ICUs may be created (Safar, 1984). Bentley, Murphy, and Dudley (1987) recorded the noise levels in Saint Mary's ICU in London and found it to be the highest of any ward in the hospital. During the day, the noise level was on a par with heavy street traffic, over 70 dB. Wilson (1972) demonstrated that patients without windows for viewing were twice as likely to experience organic delirium in the ICU. In addition, without a complete explanation, he showed that patients with abnormal hemoglobin or blood urea nitrogen levels were three times more likely to have delirium. Helton et al. (1980), among others, have produced disorientation scales to measure the degree of ICS. He noticed that patients without windows for viewing were more prone to ICS.

ICU culture is important in other ways. U.S. units have the lowest mortality, providing that (a) standard protocols are adhered to and doctors do not do their own thing by constructing unique treatments for each patient; (b) the medical unit director has overall authority for administration, especially admissions and discharge; (c) the nurses have high educational qualification; and (d) nurses and doctors have collegueship relationships—noticeable in my unit, with all on first-name terms (Thibault, 1984).

ICUs have developed their own rituals; former patients return to have their photographs taken for ward displays, which is intended to reinforce the faith of current patients' own relatives. I refused.

Nonecological factors are involved in ICS. Its presence in 54% of early cardiac transplants was due to infection (Hudack, Galon, & Benz, 1990). The drug regime is indicted. Narcotic analgesics, anticonvulsants, and propranolol can produce psychiatric symptoms. Disturbances of blood gases causing hypoxia and electrolyte fluctuations can create psychotic symptoms. Kleck (1984) pointed out that "the most common cause of delirium is withdrawal from drugs for severely agitated delirium" (p. 23). Benzodiazepine is often prescribed for patients' panic states. Its withdrawal often leads to depression. After I came out of my coma, I was prescribed antidepressants without my knowledge.

SOCIAL CONTEXT OF DREAMS

Before implicating dreams in health issues, it is necessary to locate dreaming within sociological contexts in general. Dream investigations have meager references within sociological or anthropological enterprises, despite their cultural universality. Edgar (1995) is a notable exception, although his main drive is instrumental, using dreams as tools for the caring professions (primarily in social work), team building, counseling, and group work. Dream workshops for self-development, self-disclosure, problem solving, and public reshaping of private experiences of metaphoric and symbolic hue have a fragmented lineage. Ullman and Zimmerman's (1979) dream workshops have several developmental benchmarks: Lay participants are not required to have psychoanalytical understanding. They, unlike classical Freudianism (1900), do not regale dreams as "the royal road to knowledge

of the unconscious activities of the mind" (p. 608) involving retrospective (often childhood) interpretations of an individual's biological instincts, both sexual and aggressive, and fermented experiences involving the interplay of intrapsychic conflicts between id, ego, and superego. For Freud, the dream, also an expression of wish fulfillment, was described much like a mushroom spouting from its mycelium, each dream possessing a navel reaching into an unknown tangle of dream thoughts to be unraveled only with much toil and acumen from the analyst.

Ferguson (1996) cogently explains why dreams never fell within the sociological orbit. Modernism, a midwife of sociology, was inimical to the assumed vaporous properties of the dream:

For modernity, established on the basis of a number of decisive oppositions, apparently champions the cause of the objective, rational and real against the subjective, irrational and illusory: and nothing seems more evident than to characterize dreams as subjective, irrational and illusory. (p. 2)

The dream has also been associated with the paraphernalia of ancient veneration (e.g., biblical prophecy) and superstition from which modernism claims to have liberated us. The dream, with its private meanings and assumed lack of external verification could not, for example, provide material for the Durkheimian requisite of social fact.

Anthropology's 19th-century evolutionary frame similarly disbarred the relevance of dreams. Primitives at a lower stage of civilization, according to Tylor (1870), erroneously argued that they could not distinguish imagination (dreams) from reality: Their existence was but one long dream. Being at a prescientific stage, primitives also had a prelogical mentality (Levy-Bruhl, 1923). Freud (1913) also pathologized tribal society's thought processes. His essay, "Omnipotence of Thought," asserts that those who believed witchcraft could be precipitated from dream malevolence were either neurotics or frozen in infantilism. Ironically, Freud's investigations of the ancient world, more specifically, Aristotle's dream analysis, had more to offer to his own theories of dream interpretation than did contemporary knowledge.

The demise of the culture-personality school of American anthropology offered another blow to dream research; dreams had been used as a means of exploring identity creation and interpersonal dynamics. Tuzin (1975) was one of the few anthropologists to carry the mantle of that school, linking dreams in his example of ghosts and the fear of the dead to funeral crises. He also chided predecessors like Lincoln (1935) for the artificial distinction between the individual (unsought) dream and the culture pattern dream. The latter was the province of the anthropologist, whereas the former was to be handed over to the Freudians. Tuzin's tribe buried their close dead under the household hearth; the rites were completed only when their soul or spirit had departed peacefully. Dream interpretation linked the passing status of the deceased's soul with the conduct and expectations of living relatives. Tuzin dismissed as irrelevant the views of psychoanalysts such as Ernest Jones (Freud's heir apparent), whose formulated position was that ghost dreams were the product of early repressed incestuous conflicts with parents. Psychological anthropologists like Herr (1981) have followed Tuzin's path in examining how the "world view of Fijians (on Fulaga) both shape and reflect experience, particularly the effective dream experience" (p. 332). Women's erotic experiences in

nightmares were interpreted as an outlet for their everyday suppressed status, which was ridden with guilt and shame. Young girls must sleep in prescribed body-controlled ways to avoid the above dreams, and they must display controlled body demeanor while walking through the village. The shared effective experience that dreams and nightmare constitute for these rural Fijians composes an essential cultural element (Herr, 1981, p. 350).

The rise of the study of myths actually marginalized the dream, per se. Burridge's (1960) term, *myth dream*, subsumed the consequence of dreaming. Although myth and dream are adjacent, permeable entities that may entail narrative modes of communication, there are essential differences. Kracke (1987) aptly distinguishes myth and dream:

Dreams are personal, highly fluid private experiences of a predominantly sensory nature. Myths are public, fixed linguistic forms, a kind of literature. Dreams are paradoxical—a form of thinking while asleep, in which the vividness of their sensory imagery, more closely resemble waking perceptions than the faint sensory experience accompanying day time thought. (p. 34)

However, the examination of myths had the intention of focusing on the manifest content of dreams (Eggan, 1952; Kuper, 1979). Freud (1900) always maintained that the manifest contents of dreams were a facade no matter how logically constructed they were. Spanjaard (1969), however, gave examples of how Freud violated his own dream edifice by smuggling manifest assumptions into his interpretations despite warning his disciples to the contrary. Spanjaard argues the case that “the role of the dreams in the manifest dream is particularly important as a guide for the construction of one's interpretation, namely in relation to the current conflict” (p. 233). Anthropological interpretations of the manifest content did leave the dream open to the rigid application of the mechanics of rule-governed transformations as applied to myths by Levi-Strauss (1977). As Kuper (1979) puts it (in handling Devereux's [1969] collection of dreams), “My concern is with the internal dialectic of the dream, its development from an initial to a final solution. I treat the dream as a form of argument, conducted by the rules not of logic but of mythologic” (p. 647). Crude use of the manifest content also lead sterilely to dream counting of content, a practice that Seligman (1923) could claim to have originated with his request to colonial administrators and missionaries to send him type dreams. His purpose was to show that the same manifest content had the same latent meanings (the latter was equated with mind unconsciousness) across cultures. His initial manifest request included type dreams of flying, fire, and cooked meat. In the 1940s, area files of dream content were constructed in American universities and used by those attempting universal definitions of this or that.⁴

The anthropological interest in altered states of consciousness, inspired by the rise of drug cultures in the West in the 1960s, covered a rag bag of items such as spirit possessions, visions, trances, drug-induced hallucinations, mysticism (primary of Eastern religions), and so-called culture-bound psychiatric conditions of hysteria. This examination found studies of dreams struggling for intellectual independence from the collective category of pathological disturbance. Bourguignon (1972) attempted to order the above by locating dreams along a continuum, with dreams shading into hypnagogic imagery, daydreams, hallucinations, and then trances.

DREAMWORK AND HEALTH

After this circuitous dream trip, I come to the nub: nightmares experienced as part of the ICS. One advantage of being a patient is that you can talk to (interview) fellow patients without going through ethical committees. We shared the same experience of initial dream horror. So burdensome were these events that patients (like me) wrote them down as an attempt to neutralize them. For some, they had the status of *memento mori*; I have excluded from this article the discussion of experiences of near death. Some, like me, visited the ICU to collect clues from the staff and surroundings about their dream experiences. I follow Hartman (1984) in considering nightmares as "waking up from sleep terrified (without external cause). They are often alien to us yet obviously ours, too, as though we have given birth to a monster" (p. 10). My nightmares began during my coma in the ICU, then they continued when I was transferred to a high-dependency ward. I was so terrified that I attempted to forestall them by not sleeping at night.

Hartman (1984) has taxonomized nightmares under a host of headings such as deep-sleep nightmare, hypnagogic nightmare, incubus attack, and so on. I cannot fully locate mine. Interestingly, those 3 million Americans who claim an alien encounter explain it by the modern equivalent of an incubus attack, that is, having a frightening creature sit on them. Nightmares are extremely rare, with most adults experiencing one or two per year and the number decreasing with age if they are healthy (Hartman, 1984). According to Hartman, a typical nightmare occurs in the latter part of sleep; sleep laboratory research has pinpointed it to the deep-sleep period. On awakening from this long frightening dream, the subject can offer a vivid recall of it. In contrast, night terrors occur early in sleep, with subjects often awakening with body jerks and having a hazy memory of the dream content.

Nightmares have long been associated with some health conditions, even before epileptics' nocturnal seizures and the initiation of severe bouts of depression, psychosis, and schizophrenia (psychotics often have difficulties in distinguishing a nightmare from frightening daytime awakened happenings). In addition, nightmares often accompany the sudden withdrawal of antidepressant medication. It is common for schizophrenic patients to conceal the presence of nightmares, not wishing their condition to appear more severe than it really is. Sacks (1974) reports nightmares occurring in patients with postencephalitic Parkinsonism. Freud (1900) wrote little on nightmares except that it was a wish for punishment. Dream diagnosis of illness, although common among the ancient Greeks, has recently been revived. Psychotherapist Ian Murray (1997) recently made an appeal in *The Times* for readers to send him their examples of this type of dream.

Searching to make sense of my nightmares, I considered them as ethnographic pieces. After my hospital discharge, I discovered that Foster (1973) had written on the ethnography of dreams. His Mexican research was focused more on the attitudes and values that his respondents displayed to dreams as part of their cultural meta-imageries. Dreams are social processes in which the dreamer is wedged, sometimes as powerful initiators of events and other times as recipients of events. Dreams give their owner the capacity to be present in limitless guises, both in status and in age. Old shambolic men can reappear as young, active, and handsome, replaying past roles. The dreamer also has a sensate presence as an observer or narrator who is above the happenings. I am aware of the philosophical combative

disputes about the reality of dreams that are skated over in this article. For example, see Ayer's (1960) rebuttal of Malcolm's assertion that "our dreams are not delusive experiences, because they are not experiences at all" (p. 517). Descartes (see Cottingham, 1986) and Russell (1927) both conclude that "waking experiences are not intrinsically distinguishable from the delusive experiences that make up our dreams."⁵ Malcolm (1956) adopted the Wittgensteinian position that the proof of an inner process (dreaming) must be validated by an outward criteria; that is, external accessible proof is needed to show that dream events did occur.

It is impossible to summate my initial nightmares without resorting to the use of metaphors and what Wittgenstein would recognize as technical language, which must be brought home to everyday reasoning. My nightmares were foremost animistic; any phenomena could unpredictably take on a life-form that was not necessarily human. It was like existing in a gigantic kaleidoscope that was constantly shaken. Colors were heightened. Impending danger was constant. I was in continuous motion, flying through the sky, above the sea, and over ragged, barren mountains. Space and time seemed eternal. There were no everyday temporal-spatial markers to hinge my existence. I had no notion of body and self, yet, I felt my invisible body being shredded. Perilous bridges had to be traversed. A huge tree linked sky and earth. I was accompanied by beasts that I did not recognize but with whom I could converse.

I discovered that other ICU patients experienced the same nightmares. One woman involved in a road accident believed that a Moroccan doctor dressed in a long cape was bent on killing her. She also experienced being dragged uncontrollably through the water. Another told of his flights over the North Pole. Another was imprisoned in a monster fairground, permanently attached to a roller coaster. To all of them, their experiences seemed endless and vividly real.

Drawing on my anthropological training, I made sense of the nightmares by noting how they matched accounts of shamanistic flights of ecstasy. Shamanism has been regarded as an early form of religion. It also has components in other religions. Cross-cultural psychiatry has given Shamanism prominence as a healing technique. Drawing on Eliade (1988), I will try and make the case for my having shamanistic dreams. First, a crude sketch of shamanism will be provided.

The shaman (healer) is initiated often because of recovery from a serious illness or because of having dreams recognized by others as having shamanistic flight characteristics. Shamanism is an externalizing health belief model in which the cause and cure for illness or misfortune originates outside the body, often within the social or moral order, which must be repaired before a cure is possible. Illness results from the loss (or stealing) of the soul. The shaman's capacity to leave his or her body and undertake mystical journeys through mountain and sea—he or she can be guided by the spirits of other shamans—enables him or her to recover and return lost souls. He or she can also accompany the soul of the dead to a peaceful resting abode. Perilous bridges "as narrow as a hair" (Eliade, 1988, p. 203) have to be crossed. There are many variants. Japanese shamans are usually blind women; blindness offers the special advantage of hidden sight. Linking sky and earth is the world tree or cosmic tree, the central axis of the world. The shell of shamans' drums are made from this tree. Trees in general have a special significance in shamanistic rites. There is no cosmic tree in Japanese shamanism, but there is a wondrous mountain (Blacker, 1992). On shamanistic flights, obstacles (*pudak*) have to be overcome, and protective gods of the underworld have to be placated. Not only is the health of

the individual restored with his or her returned soul but the shaman is also maintaining balance and harmony in the grand spheres that compose the world. Humphrey (1995) explains that, to the shaman, powers of the land are often anthropomorphized to produce fertility and health. Shamanistic performances of legitimization derive from the harnessing of nature's energy and from former souls of the deceased. However, nature's energy is independent of the latter, which is often reproduced to form harmony or mystical idealization (Humphrey, 1995, p.141). Shamanistic journeys are ritualized, a spatial liminality; it is "travelling that is not travelling" (p. 144).

Shamanism has been investigated by Western (cosmopolitan) medicine. Peters and Price-Williams (1980) have compared shamans' altered status of consciousness across 47 cultures and claim that trauma and spirit possession for magical flights are not dissociative states that imply amnesia. On the contrary, "There is much data available on shamans with stable and strong personalities who manifest no evidence of distorted episodes or deviance" (Peters & Price-Williams, 1980, p. 407). The belief that my nightmares were flights of ecstasy is not fanciful. My endless search was for my soul or self. The ICU had transformed me into a medical product, an appendage of machines. I had no autonomous self. When I was initially passed to the high-dependency ward, I had little control over physical movement, thought, and communication. Cohen (1988), a Dutch psychoanalyst who survived a dehumanizing concentration camp, explains that he survived only by having his soul being elsewhere. I now know what he means.

I had other waves of dreams, but I do not know if they can be classed as part of the ICS. After the flights of ecstasy, there was a sequence of dreams in which I met the dead. I was with my deceased parents, as I knew them in my youth. The ancestral encounters were happy experiences, and like Odysseus in Hades, I was pleased to meet them, gossip with them, and gain reassurance from them. Their refusal to let me stay with them was very saddening. The next dream wave concerned the cosmic tree in a shapeless, shamanist landscape. It instructed me authoritatively to kill my parents with an axe. My parents were now transmogrified into two oxen; the fact that they were oxen was not regarded as being unusual while dreaming. As I recalled in the dream, the refusal to slaughter them was based on known memories of their unselfish nurturance and of the kindness that they had shown to me. This dream vista was matched with the known practices of the Nuer (a stateless, cattle-rearing Nilotic people) made famous by Evans-Pritchard's (1956) ethnography. I remembered that when their lineage separation occurred, the ceremony was marked by the slaughter of an ox. The strong feelings produced by the dream of ancestral conjoining was successfully challenged by the message insisting that this relationship now be severed and that I be firmly implanted with the living.

DISCUSSION

Although ICS has a long and sometimes complicated genealogy, nothing is known about it in my intellectual homeland of medical sociology and anthropology. Strauss (1968) was the first sociologist newcomer to the ICU, referring to its practices as frontier nursing. Although I talked endlessly about the syndrome's dream effects on me, neither the medical nor the nursing staff referred to it by name. On

busy ward rounds, dreams of affliction had no place in the order of things. Persistence finally brought a referral to a psychiatrist, whose only concern was whether I was hearing voices.

In one way, this article is a personal indulgence, trying to make sense of my despair and helplessness. I have avoided hooking my data into a postmodernist frame or treating it as an exercise in critical reflexivity. I have also not gone down the road of offering a full-blown illness narrative. However, my voice constantly fractures the academic narrative. It first happened when I was elaborating the ICU clinical context fermenting the ICS after major surgery. Patient alienation or its bourgeois equivalent of stress is indicted for producing psychiatric disorders. Second, the related horror dreams, my only communication while comatose, legitimately permitted me to use my own dream exemplars and interpretations.

The clinical literature offers many dream examples replicating mine. Why dreams have not been an important sociological concern has been explored. Their recent hinging to the technology of the dream laboratory of psychologists and physiologists, which produced neat pictographic data of brain waves and eye movement, has further shifted dreams from sociology's grasp. Sociologists belabored with personal illness and others not so afflicted have not raised any questions about the critical connections between dreaming and sickness.

The manifest dream content was treated as an ethnographic production or cultural slice rather than as something hooked into the Freudian mind labyrinth. Tedlock (1987) goes further by arguing that "the concept of manifest content should be expanded to include more than the dream report. Ideally it should include dream theories or interpretation, ways of sharing, including the relevant discourse frame and the cultural code for dream interpretations" (p. 25).

She offers no guidelines as to what the relevant discourse frame may be; here, obviously, personal ideologies come into being. Some may dispute the use of my shamanistic parallel as sham reflexivity. In sociology in general, proof is often an aesthetic sense that things could have worked out in the manner thus described (Richman, 1983) or at the status described by Weber (see Gerth, 1948) as objective possibility.

Eggan (1952) aptly refers to the manifest content of dreams as "a challenge to social science" (p. 469).⁶ She continues that

in dreams, then, a subject can deal with a situation somewhat in terms of his own interpretation of it—as if he was playing chess with himself. . . . Released image energy (dreams) create a new inner world where the lines between courage and cowardice, love and hate, success and failure, are happily blurred and the dullest individual can be a bold adventurer. (p. 471)

The dream can thus become the playground for the postmodernist. Levi-Strauss (1977) made similar comments about myths: "The mind is left to commune with itself and no longer has to come to terms with objects" (p. 204). The dream nevertheless remains an intelligible form of communication primarily for the individual,⁷ unlike the collectively understood medieval dreams, which were often the inspiration for morality plays. Parman (1991) calls the dream the "ultimate cultural Rorschach" (p. ix): The interpretation depends on using the mind with no holds barred (to paraphrase the physicist Bridgeman referring to how good scientific

research is actually done). Davies (1973), discussing the ontological polarities wrenching sociology, sums up the core epistemological issue of

“How can we know.” With what eyes, thoughts, feelings, acts, assumptions and cognitions is the cultural scientist to approach and engage the human subjects of his enquiry so as to be able in the end, to render as valid and felicitous an account of their being and doing. (p. 333)

The sensateness of dreams presents special difficulties of portrayal and interpretation for sociology.

Nursing is in a strategic position for explaining relationships between a patient's illness progression and dreams. The dream was a valuable artifact in Greek medicine. Patient holism is incomplete without the recognition that some patients, and not just children, have worrying dreams. Patients would need assurance, however, that dream topics are a legitimate aspect of ward communication.

POSTSCRIPT

I expected naively that the writing of this article would in some ways be cathartic, enabling me to draw a line under the most unpleasant and bewildering illness of my life and allowing my normal everyday narrative to flow in the expected fashion. In other words, it would be business as usual. This was not so. I am left impotent, racked with bouts of depression and guilt because of my survival against the odds, and unable to walk without the aid of two sticks. So intense was the ICU staff in monitoring by screen my vital organs that they did not notice that my foot had dropped.

My illness narrative has lessons for health professions. First, there must be an acknowledgment that ICS exists and is a serious condition. To regard it as just another clinical iatrogenesis, a result of the ineptitude of the medical hegemony, detracts from its complexity. To reduce ICS to a product of drug narcosis is equally simplistic, although this is not to deny that pharmacological agents (Easton, 1988) used in critical areas produce disorientation, hallucinations, and paranoia (e.g., from lidocaine, barbiturates, morphine, diazepam, aminocaproic acid, and so forth). However, one specific drug does not produce a distinctive form of nightmares, with its hangover effects, or the script for the dialogue when conversing with the dead in near-death experiences. My medical notes in both the major trust hospital and the later rehabilitation unit never referenced ICS.

Second, after shifting from the ICU to a high-dependency ward, the self initially inhabited two diverse worlds, emerging from the anomie of inner space and time and excitement when it was lodged in a coma to a trivial world of awakening with fixed routines of meals, medications, and a staff who expected you to adopt the prescribed good patient role. Confusions of communication abound. I wanted to tell everyone about my dreams, with worries and strange excitements. A busy, task-orientated ward is no place for this activity. My family was not prepared by the staff for my deluge of weird stories. They were greatly disturbed by my behavior. This phase is also characterized by intense feelings of spirituality, which are normally alien to me. Recently, nursing has recognized this dimension of care. Although this

is Godberg's (1988) concern, her article is primarily one of semantic differentiation, and it concludes by arguing that "nurses are carrying out spiritual care at an unconscious level" (p. 841), which needs to be made more explicit. Settings like ICUs, where spirituality could be best anchored, are not discussed.

Next comes the stage of trying to repair everyday time and reconstruct what had happened clinically. I was initially horrified to learn that my first operation had to be suspended before completion because of the risk. I had the urge to return to the ICU, which became a spiritual *shetl* for me, and trace the voices of the people whose fragmentary conversations that I thought were in my head. One specific voice repeatedly said, "You poor thing, you have been through a lot." This patient discovery stage, on reflection, is dangerous. After realizing how close to death I had actually been, a heavy depression set in. Some U.S. hospitals have a ward team member with psychiatric skills to recognize the aftermath of the ICU experience. This realization stage is also characterized with a deep sense of loss, almost a mourning period for the time spent being out of the everyday world.

The third consideration for health professionals is to recognize systematically that families of ICU patients also suffer. Relatives all recognize that the ICU is a place for harvesting organs from their kin. Twenty-five percent of transplant organs come from the ICU (New, Solomon, Dingwall, & McHalen, 1994). Much nursing research on families in ICU (e.g., Dunkel & Eisendrath, 1983) is concerned with the negative and positive effects of families on ICU staff in generating stress. My family dreaded the time when the topic of organ donation might appear. Brody (1992) perceptively describes how sickness alters the experience of others involved. The suffering of families of the sick, Brody argues, occurs because there is no well-defined, family sick role that they can fill during the crisis time of social disruption (p. 11). My family went through a series of anticipatory bereavements; however, this was not unusual. They were so certain of my death that they boxed all my personal things, especially the academic notes and books that littered the house, and got rid of furniture whose disposal I had resisted. If time is available, nurses could inform families about the lingering guilt of anticipatory bereavement. No UK ICU has mentioned this in its notes for relatives (few have them). Hospital chaplains are more strategically located for this.

There are numerous ways in which the aftermath of ICS has affected my life, not the least of which was academically. I cannot in all honesty give my usual lectures on the evils of modern medical technology because it was the technology that saved me. This footnote, in the mode of postmodernist applied anthropology (Johannsen, 1992), which permits people to represent themselves, because of its egocentrism, may appear critical of the nursing staff. This is not so; I was given much support and kindness.

NOTES

1. Muncie (1934) relates how Kleist (1916) added postoperative psychoses to Bonhoeffer's group of symptomatic psychoses with different subsets, including anxious excitement, stupor, hyperkinetic excitement, and paranoid status.

2. Chew (1986), whose research was done at Addenbrooke's Hospital, lists some patients' dreams concerning body dissociation, with all features colored red. One patient saw "Esther Ranzen advancing on him" (p. 63).

3. Taylor (1971) aptly resorts to a literary source to convey the intensive care unit (ICU). He quoted Swift's *Gulliver's Travels* (1726/1981).

I slept sounder than ever I remember to have done in my life; for when I awakened it was day light. I attempted to rise but I was not able to stir; for as I happened to lie on my back I found my arms and legs were strongly fastened on each side of the ground I likewise felt several slender ligatures across my body, from my arm pits and my thighs I could only look upwards. . . . The light offended my eyes. I heard a confused noise, about me; but in the posture I lay could see nothing. (pp. 55-56)

4. As an example, Griffith, Miyagi, and Akira (1958) constructed a questionnaire to examine the extent to which people in different cultures had the same typical dreams. They conclude that

In most of the 14 dreams (out of 34) which resulted in statistically significant differences between the cultures, the male and female were in agreement, that is, when more American males reported a dream than Japanese males, more American than Japanese females also reported it, and vice versa. (p. 1176)

Hall (1951), another dream counter, collected 10,000 dreams and showed that people dream most often about people of their own age, there were no profound differences between the dreams of the young and the old, 43% of the characters appearing in dreams are strangers, and animals dominate children's dreams.

5. Parman (1991) raises the case of Descartes (1596 to 1650), one of the founders of the scientific method and empirical philosophy, whose three dreams of November 10, 1619 inspired his key work, *Meditations*, which was completed March 1620. Freud attempted to interpret his dreams (one consisted of being in a room full of sparks, another consisted of being given a melon), but he discarded the task.

6. Whether dreams are true or false has always been a matter of historical dispute. Greek mythology is resplendent with examples of dream receivers being deceived. The Greeks had a simple rule of thumb: Dreams passing through a gate of polished horn were true, and those passing through sawn ivory were false. The medical cult of Asclepias (earth spirit) designated medical sites of true dreams where the sick could receive healing dreams (Messer, 1918). In official Islam, truthful dreams no longer exist because the prophet Mohammed was the last recipient of them (hence the bother over Rushdie's *Satanic Verses*). Although Malinowski (1927) argues that Trobrianders paid little attention to dreams, he described a type called official dreams to be used for important decision making. Before setting out on hazardous Kula expeditions, its leaders had to have propitious dreams heralding success.

Confusingly, dreams have fallen prey to romanticized anthropology, with the anthropologist falling in love with his tribe, especially concerning its use of creative dreaming. Dornhoff (1985) has exposed an established, anthropological wisdom that the Senoi (of Malaysia) institutionalized dream sharing, the assumed mainspring of their cooperative culture, resulting in harmony, an absence of mental health problems (disfiguring the West), and fully integrated personalities. One anthropologist, Kilton Stewart (1951) recounts how a Senoi shaman helped him to vanquish his terrifying dreams. The Senoi allegedly fused their dreams with the day order in a manner that gestalt psychologists would applaud. Notions of creative dreaming soon appeared in the West; the Senoi's practice of dream sharing was added to the curriculum of human development at the famous Esalen Institute, the new Shangri-la near Big Sur, California in 1965.

7. Jung's (1963) prospective view of dreams (in contrast to Freud's retrospective stance) had already claimed that dreams contain concealed, personal wisdom essential for self-fulfillment if they are carefully fused with existing life events. In Jung's mysticism, some dream parts were revelatory and have a transcendent function.

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