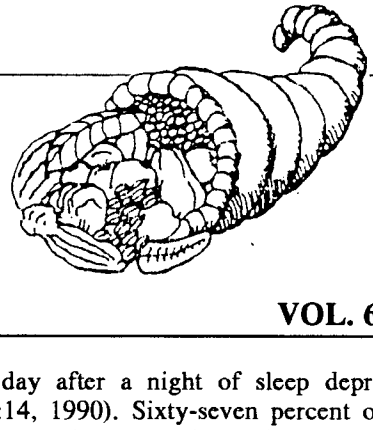
THE MCDOUGALL NEWSLETTER



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INFORMATION

SLEEP FOR MOOD CONTROL

HOW MUCH SLEEP IS ENOUGH?

From childhood we are taught that sleep is good for us--the more the better--a minimum of 8 hours a night, even for healthy adults. These assertions are reinforced by relief from pain and worry, and refreshment derived from a good night's sleep.

Young people need more sleep than adults. A newborn baby may spend half to three-fourths of its day asleep. Children may need 8 to 10 hours to replenish themselves. Pregnancy temporarily increases the need for rest; and during times of illness sleep and rest may be helpful, if not required, for recovery.

However, in adulthood, 8 hours a night is usually too much sleep for most people. Many of us actually feel and function best on 5, 6, or 7 hours a night. Some people do well on less than 5 hours a night. As we age, sleep requirements become less; some seniors may rest comfortably for only three or four hours a night. Trying to get more sleep than you need commonly results in insonmia as the body tries to adjust to your efforts to over rest it.

People who change to a high carbohydrate diet also report less time spent sleeping, more restful sleep, and an increase in dream activity. An increase in rapid eye movement (REM) sleep has been observed by electroencephalogram (EEG) when subjects are switched to a high-carbohydrate, low-fat diet (Lancet 2:723, 1975). REM activity is associated with increased body activity and dreaming.

SLEEP CAUSES DEPRESSION

Major depression, requiring medical attention, is present in up to 6% of the population with many more people suffering from lesser degrees of depression that still interfere with their life.

Too much sleep is the cause of serious psychologically harm, especially depression, for a large number of people (JAMA 267:548, 1992). Because sleep causes depression it is referred to as "depressogenic" in the psychology literature. Wakefulness is antidepressogenic. Depressed patients, who are likely to respond to sleep deprivation, characteristically feel worse in the morning and gradually become freer of their symptoms when the evening approaches, as the depressant effects of the previous night's sleep wears off through the wakeful hours of the day.

SLEEP DEPRIVATION THERAPY

A review of 61 papers published between 1969 and 1990 in 13 countries involving over 1700 patients found that an average of 59% of patients show a marked decrease in depressive symptoms the day after a night of sleep deprivation (Am J Psychiatry 147:14, 1990). Sixty-seven percent of people diagnosed as having endogenous depression responded to sleep deprivation. (Endogenous depression seems to come from within and has no obvious outward cause such as a death in the family.) Sleep deprivation therapy has also been helpful with patients suffering from depression related to other common situations, such as premenstrual syndrome (Am J Psychiatry 144:808, 1987).

Staying awake all night permits the washout of the depressant effect of the previous night's sleep to continue uninterrupted until the improvement is complete. Usually complete relief of depression is attained after a single sleepless night.

The combination of antidepressant medications, such as lithium with sleep deprivation has been helpful for many severely depressed people. Approximately 1/3 of patients resistant to medication alone are helped with the addition of sleep deprivation to their therapy. This method will also speed up the onset of relief from depression when taking medication. Thus the risk of suicide is decreased almost immediately and hospital stays can be shortened. Sleep deprivation as a sole therapy may be especially helpful for patients who cannot tolerate the side effects of medication.

Sleep deprivation can be used as a diagnostic tool. Sometimes depression and dementia are confused in elderly people. These older people appear to be losing their intellect when actually their dulled response is a result of depression. Sleep deprivation can be used to distinguish these very different conditions. In 1986, four elderly confused patients responded to a night of total sleep deprivation with a return of their mental function (Can J Psychiatry 31:731, 1986). Older people tend to sleep more because of lack of outside interests; therefore, they are likely candidates for sleep-induced depression.

For some people improvement after sleep deprivation can last for several weeks. With relapse the treatment is simply repeated. With other people one full night's sleep may result in a relapse of symptoms (Am J Psychiatry 147:14, 1990). Some patients are so sensitive to the depressing effects of sleep that they relapse even after a short, 2 to 15 minute, nap. After a period of treatment with a carefully scheduled program these fragile people can be controlled.

The most serious side effect of sleep deprivation is that the mood swing can become too much, causing mania (elation hyperirritability). This highly elevated state can be reinforcing by causing more insomnia, fueling the mania. Many common emotional reactions to life's events, like joy, sorrow, anger, and fear; and other circumstances, such as surgery, childbirth bereavement, drugs and drug withdrawal can disturb sleep and have been reported to trigger mania. Avoidance of sleep disturbances many be helpful for people who suffer from mania.

PRACTICAL SLEEP MANAGEMENT

Elevation in mood by controlling sleep is not limited to people who are severely depressed--two studies have reported elevation of mood in "normal" subjects deprived of sleep (Am J Psychiatry 147:14, 1990). With this in mind, manipulation of your sleeping behavior has the potential of controlling your moods to your benefit.

Partial deprivation is as effective as total sleep deprivation for relieving depression for many people (Am J Psychiatry 149:161, 1992). Late sleep deprivation, where the patient is awakened at 2:00 AM and kept awake until 10:00 PM is more effective than depriving the person of sleep by delaying bedtime. This pattern still allows for 4 hours of sleep per night which is enough to relieve fatigue that is expected from total sleep deprivation. For many people relief of depression on a long term basis is accomplished with the use of partial sleep deprivation once every 2 to 5 days. This technique is simply used "as needed" to elevate the mood, and relieve depression.

Sleep management can be self-tailored to meet the needs of the individual and utilized on an "as needed" basis. The "right amount" of sleep for you will be determined by trial and error---closely observing your own response to sleep. Find the right balance between fatigue which needs to be relieved by adequate rest and your mood which can be depressed by too much sleep. If you are depressed now, then your first step is to cut 1 to 2 hours off your allotted time to sleep. You will need to allow time for your body to adjust. Expect to feel fatigued for a day or two, but also expect elevation of your mood to start after a day or two also. Add or subtract half hour intervals of sleep based on your mood and your fatigue level.

THE TRIPLE WHAMMY

Sleep manipulation, diet, and exercise all effect your mood and they all effect each other. Both diet and exercise enhance the effectiveness of sleep; and the correct amount of sleep will help you control your mood so you will be more likely to take good care of yourself with a healthy diet and daily exercise. All three share the benefits of being highly effective, of rapid-onset, under self-control, cost-free, well-tolerated, and non-toxic. Unfortunately, because these tools are also non-profit, they are likely to achieve popularity in only a small select segment of the population--those of us interested enough in a good life to put in the effort to finding correct information and taking care of ourselves.

INFOMMERCIAL IS RELEASED

A half hour television commercial introducing people to the McDougall Program was released in a national television test market on November 14th. The segment takes a very strong stand against modern medicine and a stand for self control of your health through diet and lifestyle. The response has been phenomenal, with larger than hoped for orders for the product. The infommercial sells a home version of the McDougall Program which includes an audio album of 6 cassettes, a video, The McDougall Program--12 days to Dynamic Health, The McDougall--Health-Enhancing Cookbook, and The McDougall Report--Life-Saving Medical Facts Your Doctor Never Told You. Most of this is material from our previous works. Faithful followers of our work will find little original substance. However, the new packaging and cleaned-up presentation is well worth the purchase, especially for people new to the program. The cost is about $150 (3 payments of $49.95). Ordered by calling (800) 453-4949.

EXPANDED RADIO AUDIENCE

Beginning the first of November 1992 Dr. McDougall's call-in radio show expanded. The previous range was limited to the North Bay Area. Now people can receive the show from the south to Monterey Bay (including all of San Francisco, The East Bay, and the South Bay) to Humboldt County north, to the east as far as Reno. The new station, KST 650 AM, originates in Sacramento, California. The show is from 11 AM to noon daily Monday through Friday; and "the best" is replayed 7 PM Saturdays. Tell friends and family to listen.

Where will he turn up next?

PRODIGY BULLETIN BOARD

A McDougall computer support group has sprung up nationwide on Prodigy. Join the fun, make friends and get extra help. Call (800) 776-3552 ext. 551 for a free start-up kit. See Sept/Oct 92 Newsletter for details.

RESEARCH

RESULTS OF A SECOND-OPINION TRIAL AMONG PATIENTS RECOMMENDED FOR CORONARY ANGIOGRAM by Thomas Graboys in the November 1992 Journal of the American Medical Association (268:2537) studied the overuse of angiograms. Angiograms are studies performed by inserting a tube into the arteries, then injecting a "dye" that shows up on x-rays. In this case the heart (coronary) arteries are being studied. One hundred seventy-one patients were evaluated with a second opinion for the need for an angiogram. With the use of established medical criteria 168 (80%) were judged not to require an angiogram; it was recommended in six. In 28 (16%) the recommendation was deferred pending other studies. After a mean follow-up of 46.5 months among the 168 patients there were seven cardiac deaths (annual mortality of 1.1%). Ultimately 19 patients experienced heart attacks, and 27 (15.4%) went on to have bypass surgery.

The authors conclude: "In a large fraction of medically stable patients with coronary artery disease who are urged to undergo coronary angiography, the procedure can safely be deferred...we reasonably conclude that an estimated 50% of coronary angiography currently being undertaken in the United States is unnecessary, or at least could be postponed."

Concerning the surgical treatment of coronary artery disease, they say: "Moreover, there is no control study that addresses the issue as to whether coronary angioplasty improves prognosis. For a large fraction of individuals undergoing coronary artery bypass surgery, there is no evidence that it improves

prognosis over medical management."

COMMENT: In 1990, 380,000 bypass operations were performed compared to 180,000 in 1983. In 1983, 30,000 angioplasty operations were performed, in 1990 the number rose to 285,000. All of these procedures required a preceding angiogram. The authors state. "Once the coronary angiography is undertaken, the course is largely set. The information obtained constitutes the road map for directing either of the two interventions."

PROPER INDICATIONS FOR ANGIOGRAPHY:

1) a substantial drop in blood pressure with chest pain or ECG changes with exercise (on a treadmill). 2) new occurrence of symptoms at rest (like chest pain) or a reduced level of exertion (chest pain brought on earlier by activity) despite effective drug therapy. 3) chest pain with pulmonary edema (lung congestion). 4) intolerance of heart pain relieving medications. 5) Serious heart irregularities (primary ventricular fibrillation). Thus those with, "predictable exertional symptoms, specifically, the absence of rest or nocturnal angina; compensated ventricular function; and an exercise stress test free of exertional hypotension" can defer their angiogram, safely.

Even though the facts of modern medicine's failure are repeatedly presented in the medical literature the business continues to thrive. Nothing is likely to change this financially driven, unethical course. Therefore, you must be a distrusting consumer when dealing in the medical market.

TEN-YEAR FOLLOW-UP OF SURVIVAL AND MYOCARDIAL INFARCTION IN THE RANDOMIZED CORONARY ARTERY SURGERY STUDY by Edwin L. Alderman in the November 1990 issue of Circulation (82:1629), showed no difference in survival and freedom from nonfatal myocardial infarction, whether stratified on presence of heart failure, age, hypertension, or number of vessels diseased. As a whole group there was no significant difference in medical vs. surgical 10-year survival (medical 79% vs. surgical 82%).

Only one small subset of patients showed survival benefits for surgery, those with dysfunction of the left side of their heart (shown by a left ventricle ejection fraction of 35% to 50%). The patients were divided into three groups: Group A) patients with angina (chest pain) and an ejection fraction equal to or greater than 50%; Group B) patients with chest pain and an ejection fraction less than 50% (86% were between 35% and 50%); Group C) asymptomatic patients who had a heart attack within 6 months.

Survival:

Overall: medical 79%; surgery 82%

Group A: medical 86%; surgery 82%
Group B: medical 59%; surgery 80%

No survival benefits were observed in one, two, or three vessel disease for surgery (For a vessel to be considered significantly involved closure would be 70% or greater).
Overall 10-year survival based on number of vessels involved:

One vessel: 83%
Two vessels: 81%
Three vessels: 75%

No survival advantage was seen for people with involvement of the left anterior descending (LAD) artery regardless of whether it was 50% or 70% closed; whether the lesion was proximal or midvessel; or whether present in conjunction with one, two, or three vessel disease. The European study observed a survival benefit for patients with LAD involvement.

The authors conclude: "...a strategy of initial medical therapy does not impose a long-term penalty in terms of survival or nonfatal myocardial infarction. Moreover, surgery, although beneficial in the patient with LV dysfunction, may impose a long-term disadvantage on patients with preserved LV function and controllable symptoms, particularly with regard to nonfatal infarction."

COMMENT: There have been three major studies that have compared the benefits of coronary artery bypass surgery with medical treatment designed to relieve chest pain. The studies are the Veterans Administration Cooperative Study Group, the European Coronary Surgery Study, and the Coronary Artery Surgery Study (CASS). In all three studies early benefits on survival diminished or disappeared as time passed; usually by the fifth year of follow-up. Long-term survival, especially survival free of events, such as heart attacks, was best for people treated with a medical approach initially. Early bypass surgery was consistently associated with a greater frequency of events beyond 4 to 5 years. They attributed this long-term deterioration to progressive occlusion of the grafts from atherosclerosis. By 10 years only 60% to 65% of the grafts are still open, and approximately half of these grafts are significantly narrowed. Also progression of the disease occurs in half the native arteries in 10 years.

The greatest question on a patient's mind when he or she faces heart surgery is "How much longer will I live if I have the surgery?" Most people assume the doctor wouldn't even suggest the operation if that question wasn't already incontrovertibly answered in favor of having the surgery. If patients threatened with bypass surgery only knew the facts, I believe very few would submit to their doctor's prescription. In most cases bypass surgery offers no survival advantages, but provides real opportunities for serious complications, brain damage, pain, suffering, worry, false reassurance, and expense.

RECIPES

PINTO BEAN LOAF

SERVINGS: 1 LOAF
PREPARATION TIME: 15 MINUTES
(NEED COOKED BEANS)
COOKING TIME: 45 MINUTES

3 cups cooked pinto beans, mashed
1 cup tomato sauce
1 cup bread crumbs, finely ground
1/4 cup minced onion
1/4 cup quick oatmeal
3 teaspoons Egg Replacer mixed with 4 tablespoons water, beat until frothy

fresh ground pepper to taste
1/4 cup catsup or barbeque sauce

Preheat oven to 350 degrees.

Combine all ingredients, except catsup, in a large bowl. Mix well. Turn into a non-stick loaf pan, 9 1/4 x 5 1/4 x 3, and flatten. Spread catsup or barbeque sauce over the top. Bake at 350 degrees for 45 minutes.
NOTE: Makes a good sandwich spread when cold.

CARROT CAKE
Contributed by Julie Seward

SERVINGS: MAKES 1 LAYER CAKE
OR 1 9 X 12 SHEET CAKE
PREPARATION TIME: 20 MINUTES
REST TIME: 12 HOURS
COOKING TIME: 1 HOUR

1 1/3 cups water
1 1/4 cups chopped dates
2 cups finely grated carrots (6 medium - large)
1 teaspoon ground cloves
1 teaspoon cinnamon
1/2 teaspoon nutmeg
1 cup chopped toasted pecans
1 3/8 cups oat flour (ground old-fashioned oats)
1 cup whole wheat pastry flour
2 teaspoons low-sodium baking powder
1 teaspoon baking soda

In a medium saucepan, combine the water, dates, carrots, cloves, cinnamon, and nutmeg. Bring the mixture to a boil over moderately high heat, reduce the heat, and simmer the mixture for 5 minutes. Cover the pan, and let the mixture rest for 12 hours (refrigeration is not necessary).

Preheat oven to 275 degrees.

In a medium bowl, combine the nuts, flours, baking powder, and baking soda. Add the carrot mixture, stirring to combine the ingredients. Divide batter between two non-stick round cake pans, or use 1 9 x 12 oblong baking pan. I line mine with waxed paper or parchment paper.

Bake for 1 hour at 275 degrees.

FAVORITE OATMEAL COOKIES
Contributed by Julie Seward

SERVINGS: MAKES 60-90 COOKIES
(DEPENDING ON SIZE)
PREPARATION TIME: 1 HOUR
COOKING TIME: 15 MINUTES

1 pound pitted dates
2 cups water
1/3 cup tahini (sesame seed paste - available at health food stores.) (All natural old-fashioned peanut butter may be substituted.)

1 cup wheat germ
9 cups old-fashioned rolled oats
2 teaspoons baking powder
2 teaspoons baking soda
1/2 teaspoon salt
2 1/2 teaspoons vanilla
2 cups chopped toasted pecans
2 1/2 cups raisins

Chop dates in food processor. Add part or all of the water and blend until dates are pureed. Pour puree and any remaining water into a very large mixing bowl. Add tahini and blend well. Add wheat germ, oats, baking powder, baking soda, and salt and blend well. Add vanilla while beaters are mixing the dough. Slowly blend in nuts and raisins. Batter will be very stiff. Blend until all ingredients are evenly distributed.

Preheat oven to 350 degrees.

Drop onto non-stick cookie sheet and flatten with a spoon. Or shape by hand into desired shapes. These cookies will not flatten or spread. They may be baked close together. Bake 12 to 15 minutes or more, depending on size, at 350 degrees. Store in refrigerator.

HELP

DONATIONS

TO THE MCDOUGALL PROGRAM

The McDougall Lifestyle Change Research Fund--2574.1040 will be money I personally manage for research and education. The McDougall Program Fund--2574.1039 will be money managed by The McDougall Program administrative staff, and used for research and education. Send to The McDougall Program, c/o St. Helena Hospital, Deer Park, CA 94576. ALL TAX DEDUCTIBLE.

MORE HELP

Books and Audio Cassettes: The McDougall Program--$10.95; The McDougall Plan--$10.95; McDougall's Medicine--A Challenging Second Opinion--$10 (Hardcover); Volume I & II of the Cookbooks--$9.95 each. The McDougall Video--$25. McDougall Program Audio Cassette Album (8 tapes)--$59.95. Add postage ($4 first book, audio album, or video and $2 each additional item)

The McDougall Program at St. Helena Hospital, Deer Park, CA. Two weeks of physician supervised live-in care designed to get people off medication, out of surgery and living again--call 1-800-358-9195 (outside California) or 1-800-862-7575 (California).

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IS IT TIME TO RENEW?

Look at your envelope for a renewal notice. If your envelope has a stamped message on it that says, "**time to renew,**" then don't hesitate. This is the only notice you will receive. Right now make out a check for $12.00 for another year of the McDougall Newsletter. Send your check with your name and address, or even easier, enclose your mailing address from this envelope. Mail to The McDougall Newsletter, P.O. Box 14039, Santa Rosa, CA 95402.

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