Introduction

On a winter morning in early January 1981, Xiong Tou Xiong, a twenty-nine-year-old man, was found dead in the bed of his Portland, Oregon home. He had not been ill; his death was sudden and unexpected. Two days later, Yong Leng Thao, a forty-seven-year-old man, died on the way to a Portland hospital after his wife found him lying in his bed, unresponsive (Davidson 1981). He had been up late watching television with an uncle and had gone to bed after midnight, briefly waking his wife. Both were soon asleep. "Then came his labored breathing, so loud that it awakened her. She shook him. . . . [In the] next moments of horror, she realized that she could do nothing more" (Curry 1981, B16).

Both of the men who died were Laotian Hmong refugees who had recently immigrated to the United States. Their deaths were brought to the attention of Larry Lewman, the medical examiner of Multnomah County. In reviewing recent reports, Lewman soon found two additional cases of sudden, unexpected death. Searching for further clues, he telephoned the coroner's office in St. Paul, Minnesota, a city in which, like Portland, many Southeast Asian refugees had settled. As forensic scientist Michael McGee recalls, he was told: "We have a large Southeast Asian population here, and we can't figure out what's happening. We have no idea why these people are dying. Would there be any chance you guys are experiencing the same thing?" (Meier 2004).

In fact, death records in St. Paul showed that four Laotian Hmong refugees had died suddenly in their sleep. A mysterious pattern was beginning to emerge: all of the victims had died unexpectedly; all were men between the ages of twenty-five and fifty; all were apparently healthy; and all had died while they were asleep. Also, in all cases for which autopsies had been conducted,[1] findings were negative.

Sudden deaths among the Hmong continued throughout the mid-1980s, but no medical cause could be found. In 1986, when I first learned of the

unexplained nocturnal deaths, I was a graduate student in Los Angeles, studying traditional belief narratives. What little I had heard about the syndrome—that seemingly healthy people died in the night, on their backs, with looks of terror on their faces—was strangely evocative of the traditional nocturnal pressing spirit attacks I had been researching. I knew that these nocturnal visitations (termed "sleep paralysis" in the scientific literature) were characterized as terrifying, *but ultimately harmless* experiences. Still, as I continued to research the nocturnal spirit attacks in different sociocultural contexts, I became intrigued by the possibility of a relationship between the traditional nocturnal experiences and the Hmong immigrants' sudden deaths.

I began to study the pattern of the unexplained fatalities and learned that the first reported case of what would later become known as Sudden Unexpected Nocturnal Death Syndrome (SUNDS) had actually occurred in 1977, with the death of Ly Doua in Orange County, California (Maxwell 1981a, 1981b). The incidence of the deaths peaked in 1981 and 1982, and it was this preponderance of cases that resulted in the recognition of a pattern that might not otherwise have been noticed until much later. The median age at death for victims of the syndrome was thirty-three, and the median length of time that they had been living in the United States before death was seventeen months.

What was most striking for me, as a student of traditional narrative, however, was the fact that the symptoms of SUNDS-related events reported by epidemiologists mirrored the characteristics of the nocturnal pressing spirit attack as it has been known in folk tradition across cultures and throughout history: the victim's impression of wakefulness, inability to move or speak, realistic perception of the immediate environment, intense fear and anxiety, lying in a supine position, feeling pressure on the chest, difficulty breathing, and awareness of a "presence" that is often seen or heard. The *night-mare,* as I have chosen to call this encounter (for lack of a contemporary, widely recognized term), is distinct from all other sleep phenomena, including generic "bad dreams" and night terrors. The prevalence of the night-mare is remarkably high, with 25–30 percent of healthy people around the world experiencing at least one episode. In the United States, though, the night-mare leads a paradoxical existence: the experience is simultaneously very common and little known.

Across cultures and throughout history, encounters with nocturnal pressing spirits have many similarities. Although these commonalities seem to point to a shared biological framework, individual experiences can also contain distinctive details that prompt local, cultural interpretations. The night-mare experience, therefore, presents a unique opportunity to study the reciprocal influence of culture and biology by providing a lens through which to view the interconnectedness of mind and body (Hinton, Hufford, and Kirmayer 2005); the night-mare illustrates the dynamics and consequences of the interaction between cultural beliefs and human physiology.

Before venturing further, it is worth noting the lexical challenge at the heart of this inquiry into such a common, yet unfamiliar, experience. Contemporary English terminology is inadequate in its ability to reference "an encounter with a nocturnal pressing spirit"—there is literally no word to describe the experience. One solution to this dearth of vocabulary would be to adopt the name of a culture-specific spirit to represent the experience globally; for example, by using Newfoundland's *Old Hag* to refer to all nocturnal pressing spirit encounters. This strategy, though, conflates local representations with broader understandings. On the other hand, selecting a term such as *sleep paralysis* might seem to imply that I am privileging the scientific explanation as the "true" account of the event. In the end, after choosing from a number of poor candidates, I am left with the (perhaps inelegant but) historically potent *night-mare* to denote the experience.

I use the term *night-mare*—with a hyphen—in its original sense of a nocturnal visit of an evil being that threatens to press the very life out of its terrified victim. The *Oxford English Dictionary* (1989) defines this creature as "a spirit or monster supposed to beset people . . . by night, settling upon them when they are asleep and producing a feeling of suffocation by its weight." In the field of sleep research, this experience is termed "sleep paralysis": an individual, in the process of falling asleep or awakening, finds himself or herself completely awake, but unable to move or speak. The person often feels an oppressive weight on the chest or body and a sense of suffocation. Frequently, he or she sees a shadowy or indistinct shape approaching and becomes increasingly terrified. The episode may last from seconds to minutes, until the "sleeper" is suddenly released and able to move once more. Sleep researchers understand these sensations to be a disturbance of the normal regulation of sleep, in which the muscular paralysis characteristic of REM sleep—and designed to keep us from acting out our dreams—occurs during a state of waking awareness (Hinton, Hufford, and Kirmayer 2005).

Further complicating the issue of nomenclature are two sleep occurrences that are seemingly related to, but actually quite distinct from, the night-mare. One of these nocturnal events is commonly referred to as a "nightmare" (without the hyphen) and indicates a frightening dream. Although, as we shall see, the etymology of the word *nightmare* is closely connected to sleep paralysis; in contemporary use, the term refers broadly to any disturbing dream. In a typical bad dream, the sleeper awakens in the middle of a sleep cycle and experiences a strong, unpleasant emotional response, as well as vivid (if often short-term) recall of the features of the dream. This standard anxiety dream, although it can be extremely distressing, is unrelated to the night-mare encounter in both its symptoms and the specific stage of sleep in which it appears (Hufford 1976, 1982; Liddon 1967).

The other sleep event that is often mistakenly merged with the night-mare—because of our inadequate terminology—is the "night terror," or *pavor nocturnus.* During a night terror, the sleeper seems to awaken in fear and agitation,

screaming and thrashing about, but then falls back asleep and remembers little or nothing of the incident in the morning (Kryger, Roth, and Dement 2000).[2] Both generic bad dreams and night terrors have been confused with sleep paralysis in medical and early sleep literature—but, significantly, never by those who have experienced a night-mare attack.

In relying on a mere hyphen to distinguish such an impactful experience (night-mare versus bad dream), I am reminded of a passage from anthropologists Nancy Scheper-Hughes and Margaret Lock's seminal work, "The Mindful Body: A Prolegomenon to Future Medical Anthropological Research," in which they explain the difficulty of describing a phenomenon that is not accompanied by accurate terminology:

> As both medical anthropologists and clinicians struggle to view humans and the experience of illness and suffering from an integrated perspective, they often find themselves trapped by the Cartesian legacy. We lack a precise vocabulary with which to deal with mind-body-society interactions and so are left suspended in hyphens, testifying to the disconnect of our thoughts. We are forced to resort to such fragmented concepts as the bio-social, the psycho-somatic, the somato-social as altogether feeble ways of expressing the myriad ways in which the mind speaks through the body, and the ways in which society is inscribed on the expectant canvas of human flesh. (1987, 10)

The challenge Scheper-Hughes and Lock describe not only resonates with my own struggle to locate a "precise vocabulary," but also points to the fractured concept of mind-body that complicates any discussion of the night-mare. One of the assumptions that has been paradigmatic to biomedicine and that shapes so much of scientific thought more broadly is the much-noted Cartesian dualism that separates the body from the mind and the real (visible, measurable, evidence based) from the unreal (supernatural, religious, unprovable). This dichotomy, however, is a culturally and historically specific construction that is not universally shared. In order to begin to understand the night-mare phenomenon as it has been and is currently experienced by so many people worldwide, we must start by suspending "our usual belief and cultural commitment to the mind/body, seen/unseen, natural/supernatural, magical/rational, rational/irrational, and real/unreal oppositions and assumptions" (Scheper-Hughes and Lock 1987, 6). It is neither necessary nor advisable (nor indeed possible) to dispense with these notions permanently, but it is essential to adopt a wider lens in order to view the complexity of this phenomenon more completely. The medical folklorist David J. Hufford justifies the need for this inclusive, holistic approach:

> Analyses that "fully explain" local traditions by either psychosocial etiology or as "cultural frosting on a biological cake," do implicitly contradict local beliefs, showing them to be fundamentally incorrect accounts of

> reality. This interpretation may sometimes be the most plausible one, but exclusionist approaches make such reductive conclusions the starting points rather than hypotheses to be empirically tested. (1988, 510)

Beginning with the assumption that human beings are simultaneously biological and cultural, my challenge is to present a balanced approach—one that avoids initially privileging either biology (bodily states or processes) or traditional belief (mind or mental processes). Anthropologist Daniel Moerman provides a useful framework for this strategy with his notion of the *meaning response*, "the psychological and physiological effects of meaning in the treatment of illness" (2002, 14). When the meaning effects comprise positive outcomes, they include what is often referred to as the "placebo effect"; when the outcomes are negative, they include what has been termed the "nocebo effect."

Placebo comes from the Latin word meaning "I shall please." The Catholic Vespers of the Office of the Dead began with the word *placebo* (*Placebo Dominum in regione vivorum*), and, in the thirteenth century, the term was adopted as the name of that service. Because some people attended the funeral service and sang the Placebo (that is, simulated mourning) hoping to be rewarded by the relatives of the deceased, the word came to mean "a sycophant." It is in this sense that Chaucer, writing in the fourteenth century, observed: "Flatterers are the Devil's chaplain, always singing *Placebo*" (c. 1390).[3] At the end of the eighteenth century, the word began to be applied to sham medical substances (simulated treatments) that physicians knowingly doled out to "please" patients (even though the treatments occasionally had positive effects). In the early nineteenth century, a medical dictionary defined *placebo* as "an epithet given to any medicine adapted more to please than benefit the patient" (Hooper 1811, 942). Over the next 150 years, *placebo* transformed in meaning from an inert substance given deliberately to please a patient into a treatment believed efficacious by a physician and later determined to be inert (Harrington 2008). Today, placebos are increasingly studied as keys to the mysteries of the beneficial (and often unplanned and unanticipated) effects that occur in the process of treating disease. As a simple example, an often-cited instance of the positive effects of the meaning response is found in the study of a suburban Pennsylvania hospital that showed that surgical patients who stayed in a hospital room with a window view of a natural setting recovered more quickly than a matched sample of patients who had a view of a brick wall (Ulrich 1984).

In contrast to the positive effect of the meaning response, the *nocebo* (from the Latin for "I shall harm") phenomenon consists of a negative outcome. An example of "placebo's evil twin" is found in the results of a large study conducted by sociologist David P. Phillips and colleagues that examined the cause of death of adult Chinese Americans and randomly selected matched European American controls. The researchers found that "Chinese Americans, but not whites, die significantly earlier" than expected "if they have a combination of disease and

birth year which Chinese astrology and medicine considers ill-fated" (Phillips, Ruth, and Wagner 1993, 1142). For example, among Chinese Americans who died of illnesses related to lung diseases (such as bronchitis, emphysema, and asthma), those who were born in "*metal* years"—lungs are the organ of metal (Beinfield and Korngold 1991)—had an average age at death that was five years younger than among those born in other years who also died from these lung diseases. No such differences were evident in a large series of white European Americans who died of similar causes in the same period. Furthermore, the intensity of the effect was shown to be correlated with "the strength of commitment to traditional Chinese culture." According to Moerman, it is clear from this case that the significant difference in longevity "among Chinese Americans (up to 6 or 7% of length of life) is not due to having Chinese genes, but to having Chinese ideas, to knowing the world in Chinese ways" (2002, 78). The beliefs people hold and the ways in which men and women understand the world and their place in it can have profound consequences for their health.

Many people find it enormously difficult to accept the possibility of any sociocultural or psychological influence on illnesses that appear to be obviously biological or physiological. I have taught medical students and residents at an academic medical center for many years, and I can attest to the fact that it is still the case that much standard health professional training teaches that diseases are either wholly organic or wholly psychological—and that it is crucial to distinguish sharply between the two. As anthropologist Robert Hahn notes, "the fact is that phenomena that essentially come down to what people believe are conceptually difficult in our medical system" (as well as, I would add, in the medical social sciences). "Health is thought to be a biological phenomenon. More psychosomatic elements are hard to deal with" (Reid 2002, HE-01).

We know that understandings of the specific "facts" of health and illness differ dramatically in medical cultures around the world. How the proper sick role is understood, appropriate relationships between patient and healer defined, or causes of disease explained, varies widely. Even with the universalist biomedical system, illness (and also health) has distinct meanings in different places. In these diverse contexts, in which

> meaning shapes so much of life, it is not surprising that meaning also influences the effectiveness of medical treatment. There is more to biology than biology. This isn't always the case (leaping from a sixteenth-story window ledge will not be much affected by desire, will, or culture). But far more often than we realize, what appears to be an "obvious" biological matter is richly freighted with meaning, history, tradition, or the like; or requires consciousness to do its thing. Indeed, it is probably wise to assume this is the case until it's proven otherwise. (Moerman 2002, 702)

The night-mare, poised as it is between the supernatural and natural worlds, and between the meaningful and the biological, is perfectly positioned to teach us about the seamless connection between our minds and our bodies.

I have conducted field and archival research on the experience and interpretation of the night-mare assault over the past twenty years. In the course of this work, I have studied cultural, historical, and scientific explanations of the night-mare; analyzed hundreds of interviews I conducted with night-mare sufferers, sleep researchers, physicians, historians, museum curators, and others; and examined thousands of postings on Internet listservs, Web logs, and video-sharing Web sites by people who have experienced sleep paralysis. This book traces the trajectory of my own inquiry into the night-mare, from the experience's remarkable cross-cultural consistency and historical continuity; to perspectives on the phenomenon from psychology, biomedicine, and sleep research; to an in-depth look at the Hmong night-mare; and ends with an illustration of the nocebo-linked interplay between meaning (mind) and biology (body).