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The Night-mare on the Analyst's Couch

> "For the true significance of the Nightmare to be properly appreciated, first by the learned professions and then by the general public, would . . . entail consequences, both scientific and social, to which the term momentous might well be applied."
>
> –Ernest Jones (1931, 8)

In 1887, Guy de Maupassant published "Le Horla," a tale of horror that reveals its protagonist's increasingly anguished thoughts about a nocturnal visitor through a series of diary entries:

> May 25. As the evening comes on, an incomprehensible feeling of disquietude seizes me, just as if night concealed some terrible menace toward me. I dine quickly, and then try to read, but I do not understand the words, and can scarcely distinguish the letters. Then I walk up and down my drawing-room, oppressed by a feeling of confused and irresistible fear, a fear of sleep. . . . Then, I go to bed, and I wait for sleep as a man might wait for the executioner. . . . I sleep—a long time—two or three hours perhaps—then a dream—no—a nightmare lays hold of me. I feel that I am in bed and asleep—I feel it and I know it—and I feel also that somebody is coming close to me, is looking at me, touching me, is getting on to my bed, is kneeling on my chest, is taking my neck between his hands and squeezing it—squeezing it with all his might in order to strangle me. I struggle, bound by that terrible powerlessness which paralyzes us in our dreams; I try to cry out—but I cannot; I want to move—I cannot; I try, with the most violent efforts and out of breath, to turn over and throw off this being which is crushing and suffocating me—I cannot! And then suddenly I wake up, shaken and bathed in perspiration; I light a candle and find that I am alone. (Maupassant, 4–5)

The narrator thus senses the unearthly presence of the Horla (from the French *hors,* meaning "outside" and *de la,* meaning "there"), a being whom he

comes to believe is at the vanguard of a group of extraterrestrials determined to subjugate humanity. The protagonist's journal entries reveal progressively more disturbing sensory experiences, while—to the reader—his sanity becomes increasingly suspect. Because of Maupassant's skill as a writer, it is not possible to know whether the encounter is merely a symptom of the protagonist's troubled mind or, conversely, whether his escalating anxiety is a natural consequence of the actual presence of the evil Horla (Lovecraft 1927).

This short story was published after some of the earliest reports of sleep paralysis appeared in the medical literature (e.g., Binns 1842; Mitchell 1876). The details of the encounter with the Horla are clearly consistent with descriptions of the traditional night-mare attack, but Maupassant's linking of sleep paralysis to psychological phenomena, such as anxiety and panic attacks, represents a shift away from earlier cultural understandings of the phenomenon.[1] "Le Horla" is an example of the way in which the increasing accessibility and popularization of scientific psychology in the nineteenth century provided new examples of and explanations for bizarre and uncanny experiences, including the night-mare (Cheyne n.d.).[2] In order to appreciate the pathopsychological trajectory of the night-mare over the past century, however, we must begin with the earliest psychoanalytic interpretations of the experience.

Pathologizing the Night-mare

When American writer Max Eastman visited Sigmund Freud's Vienna apartment in 1926, he noticed a print of John Henry Fuseli's *The Nightmare* hanging on the wall next to Rembrandt's *The Anatomy Lesson of Dr. Nicolaes Tulp* (Powell 1973)—"to express pictorially, perhaps, Freud's intention to render in medical terms what had always been seen as supernatural" (Thomas 1992, 70). Although Freud was surely aware of the night-mare, he does not directly address the phenomenon in his writings, focusing instead on dreams. In *The Interpretation of Dreams,* however, he does describe situations in which the sleeper feels that the ability to move is impaired:

> What is signified by the sensation of impeded movement, which so often occurs in the dream, and which is so closely allied to anxiety? One wants to move, and is unable to stir from the spot; or one wants to accomplish something, and meets one obstacle after another. . . . It is convenient, but inadequate, to answer that there is motor paralysis in sleep, which manifests itself by means of the sensation alluded to. . . . We are justified in supposing that this sensation, constantly appearing in sleep, serves some purpose or other in representation, and is brought about by a need occurring in the dream material for this sort of representation. . . . The sensation of impeded motion represents a *conflict of will.* (Freud 1903, 311–312)

Freud contends that, during such a dream, the sensation of inhibited motor movement represents the conflict between a desire for an action and the restraint of that action. After analyzing thousands of dreams, he became convinced that, without exception, "every dream represents the fulfillment in the imagination of some desire on the part of the patient, a desire that has either been 'repressed' in the waking state or else could not for some reason or other come to expression" (Jones 1931, 42). If the psychological conflict is so great that no compromise between the wish and its fulfillment can be reached, he reasons, then the sleeper awakens. Variations of this idea—the consequence of the sleeper's consciousness recognizing the nature of the repressed desire—would influence night-mare interpretation for decades.

In 1931, Ernest Jones, a member of Freud's inner circle and his official biographer, published his seminal work, *On the Nightmare.* Jones used psychoanalysis in an effort to bring new understanding to the phenomenon, which he believed to be central to human experience.[3] He was not satisfied with previous religious or physiological formulations of the disorder: "When clerical belief ascribed nightmares to evil spirits and medical to bodily disturbances they both absolved the subject's personality from any share in bringing them about" (1931, 7). Jones was particularly displeased with what he perceived to be inattention to the problem on the part of his medical colleagues:[4] "No malady that causes mortal distress to the sufferer, not even seasickness, is viewed by medical science with such complacent indifference as is the [night-mare]" (1931, 13).

Jones used the word *nightmare* in what he (correctly) considered to be its traditional sense: a phenomenon characterized by "(1) agonizing dread; (2) sense of oppression or weight at the chest . . . ; [and] (3) conviction of helpless paralysis" (Jones 1931, 52). Significantly, though, he did not include the impression of wakefulness as one of the defining characteristics of the night-mare. Because he did not recognize that the sensations occur in a semi-waking state, Jones characterized the context in which these symptoms are experienced as a type of disturbing dream. To be fair, Jones was writing before laboratory sleep research had revealed the stages of sleep, but the sharp distinctions between sleep paralysis and dreams could have been easily articulated by anyone who had experienced both. By not acknowledging the unique state of waking consciousness in which the night-mare occurs, Jones not only contributed to the long-standing scientific confusion over the significant differences between night-mares and "bad dreams" but also lost the opportunity to benefit from the firsthand knowledge of night-mare sufferers (Hufford 1982).

Jones began with the premise that night-mares are dreams; therefore, when his ideas were challenged by the traditional, historical descriptions of night-mare sufferers, he condescendingly concluded that "difficulty in distinguishing dreams from the experiences of waking life is naturally greater in less tutored

minds, such as those of children and savages" (Jones 1931, 60).[5] Perhaps most importantly, however, by linking the concepts of night-mares and dreams, Jones's interpretations of the two became fused—bound together by Freud's theory of dreams and their meaning. To Jones, night-mare encounters were not simply rooted in the misunderstandings of the ignorant; they were signs of psychopathology.

Like Freud, Jones saw all dreams (including, erroneously, night-mares) as expressions of unconscious content, and he considered all fear represented in dreams to relate specifically to unconscious sexual conflicts.[6] Jones viewed the night-mare as a form of "*Angst* attack," due to an intense mental conflict regarding "a repressed component of the psycho-sexual instinct" (1931, 54).[7] As he wrote:

> Conflict of this fierce intensity never arises except over matters of sexuality, for on the one hand the sexual instinct is the source for most resistless desires and impulses, and on the other no feelings are repressed with such iron rigor as are certain of those that take their origin in this instinct. . . . The malady known as Nightmare is always an expression of intense mental conflict centering about some form of "repressed" sexual desire. . . . An attack of the Nightmare is an expression of the mental conflict over incestuous desire. (1931, 43–44)

To delineate the steps which comprise what appears to be a leap of logic: It was Jones's contention that, in the night-mare, dread reaches its maximum intensity. He believed that the source of the anxiety was located in the area of maximum repression or conflict. Jones insisted, moreover, that, in every case in which the night-mare had been psychoanalyzed, the difficulty could be traced to repressed incestuous desires, and that the introduction of this desire into consciousness was followed by the permanent cessation of the disorder.

Jones's approach represented a change from external spiritual and "physical explanations" for the night-mare to an emphasis on internal, psychological impairment: "In subjects who pass as being mentally normal, Nightmares never occur as isolated to morbid phenomena; on investigation it will always be found that other manifestations of *Angst* neurosis are present, with or without evidences of hysteria. In short, Nightmare may in such a subject be regarded as a symptom of this affection, and should be treated accordingly" (1931, 53). Following Jones, many investigators were interested in the influence that unconscious mental activity has on the subjective experience of night-mare symptoms. Subsequent researchers who studied the psychological significance of the night-mare conceptualized the phenomenon as an expression of mental conflict concerning areas as diverse as incestuous wishes, aggression, death, and sexual identity (Liddon 1970, 1030).[8]

Linking the Night-mare and Sleep Paralysis

The changing interpretations and understandings of the night-mare's features can be traced across different eras and in different cultural contexts. As we have seen, the night-mare has been ascribed to causes as diverse as demons and dyspepsia—and the attribution often reveals more about the sociopolitical environment than the actual phenomenon. The investigator's own understanding of the night-mare event not infrequently seems to function as a Rorschach inkblot test. Psychiatrist Jerome M. Schneck, in a 1948 article about the psychodynamics of sleep paralysis, discusses the case of a married, twenty-three-year-old man, who, notably, had no history of narcolepsy and presented with anxiety and a history of sleep paralysis. The patient, who had served overseas and been in combat for four months with an anti-aircraft unit, was a prisoner at a United States Disciplinary Barracks (for committing a robbery). Schneck describes the features of his case:

> The patient would doze, then find that he was unable to move; but he would groan and be awakened by others. The episodes probably lasted for a minute and a half to two minutes but to him the time seemed 15 minutes to an hour. On several occasions he had gone to sleep, keeping one foot near the edge of the bed, because, when the sleep paralysis set in, he might be able with great effort to force the foot off the bed, thus terminating the episode. When paralyzed, he would be aware that he was awake although unable to move, and he would be unable to open his eyelids. Bunk-mates at previous installations had been instructed by him simply to touch him when they heard him groan—in order to dispel the paralysis. (1948, 465)

The patient felt that he was awake, and knew where he was, but would experience auditory and visual hallucinations. On one occasion he heard

> someone come in through the barracks' door and walk the length of the floor toward his bed. He felt the bedcover being drawn from him and experienced the pressure of a knife against his chest. He could not identify the assailant, and his paralysis was complete. His groaning attracted attention, and he was assisted to awaken. At times the patient had had the hallucination that trucks were coming at him and that he was unable on his part to escape from their path. At other times, small airplanes dove directly at him. Once he felt he was walking along a trail. Japanese shot at him, hit him, and he could see the bullet holes. He attacked a Japanese and cut him. Other Japanese then attacked him with guns and bayonets. (Schneck 1948, 464–465)

Schneck explains that "consideration of the psychodynamics was stimulated by several facts pointing to the possible implication of latent homosexuality in symptom formation" (1948, 462–463).

> The hallucinatory episodes involving the trucks and airplanes, in themselves meaningless, may be allied to basic ambivalence toward homosexuality, with the panic that it instills, and the fear of assault. The episode of the Japanese attack, which may be connected with the war situation insofar as manifest elements are concerned, may nevertheless be associated likewise with mixed attitudes toward strong latent homosexual tendencies. The existence of associated anxiety could be substantiated by an interpretation of the symbolic significance of the assault by the person with a knife. The history of drinking in male company contributes affirmatively to the conjecture regarding the homosexual component. (Schneck 1948, 466)

This analysis is clearly (and quite ridiculously) tailored to a preconceived conclusion. It is much more likely that Schneck's examination simply exemplifies the misunderstandings that ensue when investigators unfamiliar with the night-mare's history, symptomatology, and epidemiology nevertheless attempt to interpret it.

Twentieth-century psychologists and psychiatrists have associated the night-mare with a variety of mental health and neurological concerns: neuroses, including personality conflicts characterized by indecision (Van Der Heide and Weinberg 1945), conflict between passivity and aggressivity (Payn 1965), and guilt about aggressivity (Levin 1961); psychoses (Liddon 1970); and even epilepsy (e.g., Ethelberg 1956; Rushton 1944). The majority of the anecdotal sleep paralysis cases reported in the medical literature from the 1940s to the 1960s, however, were interpreted as manifestations of a passive-aggressive conflict present in the patient's personality. In other words, during a sleep paralysis episode, the patient wants to move (be aggressive) but is unable to (remains passive) (e.g., Payn 1965; Schneck 1948; Van Der Heide and Weinberg 1945). Indeed, more than two decades after Schneck's first report on sleep paralysis, he himself noted that, although the initial data suggested the apparent importance of conflict over latent homosexuality, "subsequent studies strongly suggested the role of a broader issue involving conflict over opposing personality trends. Strivings toward active, aggressive functioning seemed to clash with leanings toward inactivity and passivity. The aggressivity-passivity problem is evidently expressed at certain times in the sleep paralysis attacks" (1957, 146).

Reports by other investigators soon confirmed that the occurrence of sleep paralysis (isolated from narcolepsy) was far more frequent than Schneck and other psychiatrists had realized. G. Browne Goode, for example, evaluated medical students, student nurses, and hospital in-patients and reported an incidence of

6.1 percent (1962). Henry C. Everett discovered that 15.4 percent of freshman medical students had had attacks of sleep paralysis (1963). This growing awareness that the frequency of the occurrence of sleep paralysis may have been underestimated provided a significant challenge to the exclusively psychopathological view of the night-mare.

A pivotal development in the understanding of the historical and cultural context of sleep paralysis came with the publication of Sim Liddon's "Sleep Paralysis and Hypnagogic Hallucinations: Their Relationship to the Nightmare" (1967). Liddon, an American psychiatrist, was one of the first to articulate the connection between the night-mare and sleep paralysis: "A full comparison of the present day reports . . . with the older descriptions of the nightmare, leaves little room to doubt that sleep paralysis and hypnagogic hallucinations were important features of the nightmare" (1967, 88). He notes that the night-mare and sleep paralysis "have other points of similarity besides the motor paralysis: severe anxiety is usually present in both conditions; . . . also, the feeling of suffocation so characteristic of the nightmare is at times described as accompanying sleep paralysis. But the most striking similarity is the fact that they both may be accompanied by a rather frightening hallucinatory experience" (1967, 89). Earlier researchers had conjectured that sleep paralysis may have "an organic substrate, which is used to express and solve emotional conflicts" (Payn 1965, 432), but Liddon goes a step further by suggesting that "the experience of sleep paralysis has no specific psychological meaning in itself and that it might be interpreted by different patients in different ways. . . . Such an idea would help explain the many different formulations about the psychological significance of sleep paralysis" (1970, 1031).

Liddon (like Jones before him) believed that sleep paralysis was associated historically with folk traditions, but it was not until the 1970s that researchers linked a culture-specific supernatural belief to sleep paralysis. It was David Hufford who published the first academic account of the congruence between the traditional pressing spirit of Newfoundland and sleep paralysis (1976); this was followed, two years later, by a corroborating article by sociologist Robert C. Ness (1978).[9] The work of these researchers in connecting traditional night-mares, as they were experienced by healthy people in the community, with episodes of sleep paralysis produced the data necessary to challenge earlier psychopathological assumptions.

As scientists became more aware of the night-mare's consistency across experiences (among different people) and how commonly it occurred in healthy individuals, the interpretation of night-mare attacks as signs of neurosis became more difficult to defend. First of all, it did not make sense that the consistent features of the night-mare experience among varied individuals were accounted for by a host of psychodynamic causes. Secondly, the night-mare experience simply seemed too prevalent to be characteristic of a disease

process: "Any condition afflicting 15 percent or more of the general population, but remaining largely undiagnosed, must hopefully not be too serious" (Hufford 1982, 162). It began to appear more likely that researchers' lack of familiarity with the phenomenon's stability and frequency contributed to, if not created, the impression that the night-mare indicated the existence of pathology.[10]

The Night-mare and Current Issues in Mental Health

Even after researchers recognized the apparent universality of sleep paralysis, many psychologists and psychiatrists continued to emphasize that the obligatory neurophysiological features of sleep paralysis are used by individuals to express and solve mental conflicts (e.g., Payn 1965). We have seen that sleep paralysis can include auditory hallucinations (such as footsteps or verbal threats); visual hallucinations (an imposing, threatening figure); and sensations of pain, strangulation, extreme fear, and even impending death. The nature of these features has led some researchers to believe that the night-mare is implicated in contemporary psychological concerns. Two of these issues—memories of childhood sexual abuse and the experience of post-traumatic stress disorder—exemplify current psychological engagement with the night-mare.[11]

Memories of Childhood Sexual Abuse

Repressed memory is a theoretical concept that describes a significant memory—usually traumatic—that has become unavailable for recall. According to proponents of the theory, repressed memories may sometimes be recovered long after the event. The majority of these memories are spontaneously recovered in response to a variety of triggers, but they can apparently also be prompted through the use of memory recovering techniques, such as hypnosis and guided visualization. Critics of these methods, including mainstream psychologists and psychiatrists, are concerned that their use may result in patients "recalling" events that never occurred.

In *Victims of Memory: Sex Abuse Allegations and Shattered Lives,* investigative journalist Mark Pendergrast makes the highly controversial argument that some individuals who report recovered memories of childhood sexual abuse may have misinterpreted episodes of sleep paralysis as reemerging fragments of repressed memories (1996). In other words, some individuals may mistake sleep paralysis episodes for the nighttime resurfacing of dissociated fragments of buried memories of childhood sexual abuse. Pendergrast suggests that a person who experiences sleep paralysis that is accompanied by visions of a bedroom intruder and hallucinated bodily sensations might assume that he or she had been sexually victimized as a child, particularly in the absence of an alternative frame of reference. As one woman explained to him: "My eyes would just be open, and I would be frozen in terror in my bed, stiff. I couldn't even breathe. . . .

Well, I had never understood this, but now I connected it with the possibility of sexual abuse" (Pendergrast 1996, 259). In his book, Pendergrast reveals that he lost contact with his two adult daughters, apparently in connection with psychotherapy they received that involved repressed memories of childhood sexual abuse. Attempting to understand his own family's situation, Pendergrast noted a pattern of accusation and self-estrangement that follows unearthed "repressed memories of sexual abuse" in the United States and Canada. He argues that, in the late 1980s, people were encouraged by self-help books such as *The Courage to Heal* (Bass and Davis 1988), television talk shows, and therapists to believe that their problems as adults might stem from experiences of childhood sexual abuse.

Psychologist Ronald C. Johnson makes related claims in his examination of the psychological processes by which memories of satanic childhood sexual abuse were re-created in settings with counselors and ministers in the 1980s. Johnson asserts that satanic abuse allegations parallel alien abduction and historical witchcraft accusations in that the experiences are constructed into altered accounts by examiners' leading queries:

> The way repressed memories of childhood sexual abuse, including ritual satanic abuse, are restored and treated closely resembles the way memories are restored and treated in persons claiming to have been kidnapped by space aliens. The witchcraft trials in Salem have similarities to both of these. Persons claiming victimization learn of a possible cause for their distress and find specific persons to blame. They learn their symptoms from books, authority figures, or other "victims." Their beliefs are reinforced and validated by therapists, support groups, and, to varying degrees, the general community. (Johnson 1994, 41)

Johnson bases much of his analysis on Lawrence Wright's report, "Remembering Satan," in *The New Yorker* (Wright 1993). One of the memories recounted from this case is of a boy (Chad) who, as Johnson says, "eventually recalled being plagued by a witch, being bound and gagged" and sexually abused (Johnson 1994, 43). Chad's actual memory is of a repeated experience, detailed as follows:

> A witch would come in my window. . . . I would wake up, but I couldn't move. It was like the blankets were tucked under and . . . I couldn't move my arms. "You were being restrained?" Peterson [a psychologist] asked. Right, and there was somebody on top of me. . . . Chad then recalled that . . . he would find himself on the floor, and a fat witch with long black hair and a black robe would be sitting on top of him. (Wright 1995, 63)

The binding, gagging, and sexual abuse were inferences that the interrogators drew from what appears to be a recollection of a series of night-mare encounters.

Wright, interestingly, does not use the term *sleep paralysis* in his article; his only reference to the disorder is a brief mention of the Old Hag in a footnote (198).

It is concerning that when sexual abuse memories are recovered by therapists who are unfamiliar with the night-mare, a recollection of a sleep paralysis event can be interpreted as a "screen" that hides the real memory.

> These accounts share some striking consistencies because they are shaped by the sleep paralysis pattern that served as their starting point. I hasten to add that this observation does not in itself challenge the reality of either sexual abuse or even alien abduction. I have no doubt that the former occurs and no basis for a strong opinion about the latter. But it *does* challenge the use of clearly recognizable memories of sleep paralysis as in themselves either suggestive of abuse or abduction, or as a useful starting point for memory recovery. (Hufford 2005, 37)

Given the potential clinical, legal, and (above all) moral implications of associating sexual abuse with sleep paralysis, it is unfortunate that there is inadequate research on this subject. Psychologists Richard J. McNally and Susan A. Clancy conducted one of the few studies to examine the topic. A premise of their investigation was that an extremely distressing episode of sleep paralysis may be of sufficient intensity to elicit symptoms that could be mistaken as an emergent memory of an actual event. "Theoretically . . . sleep paralysis with its possible sexual connotations could result in false accusations of sexual abuse" (de Jong 2005, 90). McNally and Clancy's study was designed to explore Pendergrast's assertion; they asked four groups of adults who had previously participated in trauma and memory research to complete a questionnaire on sleep paralysis experiences. The participants included people who reported repressed, recovered, or continuous memories of childhood sexual abuse, in addition to a control group of individuals who had no reported history of childhood sexual abuse. "For those reporting childhood sexual abuse, episodes of sleep paralysis are generally negative experiences, in which people are left in a state of anger, sadness, and fear." Episodes of sleep paralysis are implicated by participants "as lingering after-effects of childhood sexual abuse, possibly as another form of reexperiencing. Whether episodes of sleep paralysis might be indicators of repressed childhood sexual abuse memories remains largely unexplored; however, negative sleep paralysis episodes do seem to be more prevalent among those who report childhood sexual abuse" (McNally and Clancy 2005, 600–601).[12] Clearly, as long as the night-mare remains largely unrecognized in a given cultural setting—either by the general public or by researchers—the controversy will continue.

Experiences of Post-traumatic Stress Disorder

Another psychological issue associated with the experience of sleep paralysis is post-traumatic stress disorder, a severe and ongoing emotional reaction to

extreme trauma, such as being threatened with or experiencing great physical or psychological harm. Cambodian (Khmer) refugees have a high rate of post-traumatic stress disorder, as well as high rates of sleep paralysis. Devon Hinton, a psychiatrist and medical anthropologist at Harvard University, has conducted extensive research on sleep paralysis as a key dimension of the response to distress and trauma among Khmer refugee patients at a psychiatric clinic. The Cambodian term for sleep paralysis is *khmaoch sângkât,* "the ghost pushes you down": a dead person or supernatural being approaches the supine person and then puts a hand on the chest or neck, pushing down, causing chest tightness and making breathing difficult. Hinton presents several examples of *khmaoch sângkât,* including the case of Krauch, a forty-eight-year-old Khmer man who also experiences post-traumatic stress disorder:

> Krauch usually saw a black shape moving towards his body and, once it reached him, it seemed to wrap around him, severely impeding breathing. Krauch believed that the shape was either a demon or a ghost. In the week prior to his most recent clinic visit, Krauch had a new sleep paralysis visitor: a demon with fangs who held a nail-studded club. While Krauch was attempting to fall asleep, this new demon walked up to his side; he tried to move but couldn't. The demon pushed down on Krauch's chest with one hand, making him feel extremely short of breath. The demon then raised the club with the other hand, as if about to swing it down on Krauch's head; with its fangs protruding ominously close, the demon stood like this—one hand pushing down on Krauch's chest, the other holding the club above his head—for about two minutes. Then, just as the creature started to swing the club, Krauch was able to move. He sat up, seized by terror. For five minutes he felt his heart beat frantically, his ears rang, and his vision was blurry. . . . Krauch thought the being wanted to steal his soul by killing him directly or by scaring his soul out of his body. (Hinton et al. 2005, 54–55)

Hinton's research documents the highest rates of sleep paralysis reported in the literature: 60 percent of his Khmer patients with post-traumatic stress disorder experienced sleep paralysis (Hinton et al. 2009).[13] Hinton (as well as Bell, Dixie-Bell, and Thompson 1986; Ohayon et al. 1999; Paradis, Friedman, and Hatch 1997) suggests that panic disorder, post-traumatic stress disorder, and general stress greatly increase the rate of sleep paralysis. The very high prevalence of this parasomnia in the refugee Khmer population appears to be generated by cultural meanings and trauma resonances. Khmer believe that *khmaoch sângkât* is caused by various types of bodily dysfunction: "a dangerous weakness of the body; a 'weak heart' that may suddenly stop functioning properly, bringing about bodily 'freezing' (*keang*); an acute disturbance of the bodily flow of blood and a wind-like substance, or *khyâl—khyâl* runs alongside blood in vascular

conduits—may cause a temporary (and quite possibly permanent) loss of limb function, as well as a dangerous surge of blood and *khyâl* upward in the body" (Hinton et al. 2005, 48).

During sleep paralysis, Khmer frequently see supernatural beings, such as a ghost sent by a sorcerer to kill the victim by putting objects into the body, a demon that wants to scare the soul from the body and cause death, or the ghost of someone killed during the Pol Pot regime. Hinton suggests that the figure seen in sleep paralysis may evoke trauma memories and survival guilt. The sensations experienced, particularly chest tightness and shortness of breath, may also recall "trauma memories encoded by the same sensations: near-drowning experiences; having a plastic bag placed over the head; being forced to carry heavy loads on the head or shoulders during the Pol Pot regime" (Hinton et al. 2005, 48).

Hinton's approach is instructive because, unlike earlier researchers of the psychopathology of the night-mare, he employs a method that respectfully engages the context of the patient's own understanding of the event. I have found that a willingness to use cross-cultural exploration (even in situations where the two "cultures" represented are simply those of health care professionals and patients) leads to awareness of the frequency of sleep paralysis, greater understanding of the distress sleep paralysis can cause, and the development of tailored interventions to ameliorate negative effects of sleep paralysis.

The Stigmatized Night-mare and Suppressed Reporting

The views that Ernest Jones expresses in *On the Nightmare* are typical of scholarly explanations that rely on the idea that people who experience night-mares are victims of both naïve thinking and psychopathology. Despite recent innovative research, these views remain common in some settings. It is a testament to the strength of cultural norms and expectations that such a widespread experience can remain hidden and misunderstood. When the night-mare is stigmatized, the reporting of encounters and sharing of experiences are suppressed. It seems likely that the majority of people in the United States who have had terrifying sleep paralysis experiences never told anyone about them—unless the individuals are part of a community that recognizes and can contextualize the attacks (such as groups with a strongly spiritual worldview).

When psychological aspects of the night-mare experience are investigated exclusively in people with mental health issues, researchers can draw the erroneous conclusion that the condition itself is a sign of psychopathology. Clearly, sleep paralysis may coexist with serious emotional disorders, but the tendency to look for study subjects among those previously diagnosed with psychopathology can reinforce a presumed connection. The mere co-occurrence of sleep paralysis and psychological problems does not prove causality. The psychoanalytic

approach that considered sleep paralysis to be a sign of psychopathology (Payn 1965) has largely been abandoned (Kryger, Roth, and Dement 2000), but patients who do summon the courage to report a night-mare experience in a health-care setting still run the risk of having their accounts misinterpreted. These misunderstandings are not limited to American biomedical settings. Jude Uzoma Ohaeri, a psychiatrist at University College Hospital in Nigeria, describes the following case:

> This 37-year-old man is a top management executive of one of the multinational companies and hails from a Muslim polygamous home of middle class status. He was referred by a neurologist. Since adolescence, he had been experiencing at least weekly attacks of isolated sleep paralysis. He had not worried about this because his father had similar problems, and in his father's case, the frequency of attacks reduced considerably with advancing years. But this man's own attacks were increasing in frequency with years. In his early undergraduate years in one of the local universities, he had been so worried by this problem that he had gone to sleep on the premises of one of the Pentecostal churches who had promised him "deliverance" from the spirits causing the isolated sleep paralysis. He stopped attending Christian faith healers because he had attacks of isolated sleep paralysis in all the nights he spent at the church. For many years thereafter, he continued to see only native doctors because the family opinion (which he agreed to) was that the problem was partly "spiritual," and they thought it would follow the same course as the father's. Eventually, the man had to see a doctor because he thought it was affecting his social functioning and a friend had suggested it might be "epilepsy." The isolated sleep paralysis experience alarmed him because in the midst of the paralysis, when he felt his life was most threatened, he could not even move his body to touch his wife sleeping beside him for help. This problem had so affected his life functioning that he was afraid of sleeping outside his home. On one occasion when he went to a conference at the new Federal capital of the north, he had to invite his driver to sleep with him in his five star hotel room. . . . Before being referred to the psychiatrist he had had a skull radiograph, two electroencephalograms, and biochemical investigations, all of which revealed no abnormality. (Ohaeri 1992, 522–523)

Ohaeri emphasizes that physicians "practicing in developing countries should take into consideration that fears of supernatural causation contribute to certain experiences in the clinical presentation of their patients" (522–523). Because these patients rarely spontaneously volunteer these fears, clinicians must develop the skill to elicit the information.

Night-mare sufferers who share their experiences anonymously as part of online sleep paralysis "communities" often describe situations in which they

feel that physicians misattribute their night-mare symptoms. Concerns about these errors have been increasingly reported in the medical literature of the past decade. If the nature of sleep paralysis is not more widely understood, it seems likely that these diagnostic and treatment errors will continue to be made. Psychiatrists Sricharan Moturi and Anna Ivanenko note that "descriptions of hypnic hallucinations and sleep paralysis symptoms may lead to diagnostic misinterpretations of patients as psychotic, anxious, and/or depressed" (2009, 41), and they urge clinicians to "be aware that perceptual disturbances like hypnic hallucinations restricted to awakening and falling asleep are not sufficient to diagnose the patient with a psychotic disorder" (2009, 38). Researchers at the Medical University of South Carolina report findings from a case-control survey that indicate approximately 50 percent of psychiatrists (excluding those trained in sleep medicine) misdiagnosed sleep paralysis-related visual hallucinations as a "psychotic" disorder (Uhde, Merritt-Davis, and Yaroslavsky 2006). Night-mare sufferers' concerns appear to be well justified.

Internists, psychiatrists, and therapists approach their patients with a defined set of diagnostic categories—and night-mare or sleep paralysis are not typically among them. The problem of trying to fit diverse cultural experiences and interpretations into one nosological system is noted in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders:*

> A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture. For example, certain religious practices or beliefs (e.g., hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestations of a Psychotic Disorder. (American Psychiatric Association 2000, xxxiv)

Significantly, sleep paralysis is no longer treated as a pathological condition, but as a parasomnia:

> Sleep paralysis: an inability to perform voluntary movement during the transition between wakefulness and sleep. The episodes may occur at sleep onset (hypnagogic) or with awakening (hypnopompic). The episodes are usually associated with extreme anxiety and, in some cases, fear of impending death. Sleep paralysis occurs commonly as an ancillary symptom of narcolepsy and, in such cases, should not be coded separately. . . . Most sleep-related hallucinations are visual and incorporate elements of the actual environment. For instance, individuals may describe objects appearing through cracks in the wall or describe objects moving in a picture on the wall. The hallucinations may also be auditory (e.g., hearing intruders in the home) or kinetic (e.g., sensation of flying) . . . Hypnagogic

> and hypnopompic hallucinations are present in approximately 10–15 percent of the general population. . . . 40–50 percent of normal sleepers report having had isolated episodes of sleep paralysis at least once during their lifetime. Sleep-related hallucinations and sleep paralysis may occur simultaneously, resulting in an often terrifying experience of seeing or hearing unusual things and being unable to move. (American Psychiatric Association 2000, 610)

This clear articulation of the non-psychopathological nature of sleep paralysis, together with the provision of a cross-cultural approach to psychiatric care, will hopefully increase sensitivity to the ways in which the night-mare may manifest in different cultural settings, as well as "reduce the possible effect of unintended bias stemming from the clinician's own cultural background" (American Psychiatric Association 2000, xxxiv).

In settings where there is no local tradition to legitimate sleep paralysis, the event may be interpreted by the experiencers themselves as evidence that they are—or are at risk of—becoming insane. When informed health-care providers use this opportunity to explain and provide a name for the sleep phenomenon, they find that their patients are (understandably) greatly relieved (Paradis, Friedman, and Hatch 1997). In the absence of a cultural framework, information alone may prove beneficial by helping individuals realize that sleep paralysis is experienced by a large percentage of the population (Wing, Lee, and Chen 1994).