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Sleep paralysis in adults reporting repressed, recovered, or continuous memories of childhood sexual abuse

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Abstract

Sleep paralysis typically occurs as individuals awaken from rapid eye movement sleep before motor paralysis wanes. Many episodes are accompanied by tactile and visual hallucinations, often of threatening intruders in the bedroom. Pendergrast [Victims of Memory: Incest Accusations and Shattered Lives, HarperCollins, London, 1996] proposed that individuals who report repressed or recovered memories of childhood sexual abuse (CSA) may misinterpret episodes of sleep paralysis as reemerging fragments of dissociated (“repressed”) memories of CSA. To investigate this issue, we administered a sleep paralysis questionnaire to people reporting either repressed ($n = 18$), recovered ($n = 14$), or continuous ($n = 36$) memories of CSA, or to a control group reporting no history of CSA ($n = 16$). The prevalence of sleep paralysis was: repressed memory group (44%), recovered memory group (43%), continuous memory group (47%), and control group (13%). Among the six individuals in the recovered memory group who had experienced sleep paralysis, one interpreted it as related to sexual abuse (i.e., a rate of 17%). All other participants who had reported sleep paralysis embraced other interpretations (e.g., saw a ghost). Dissociation and depressive symptoms were more common among those who had experienced sleep paralysis than among those who denied having experienced it.

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Most dreaming occurs during rapid eye movement (REM) sleep (Hobson, 1995, pp. 44–45)—a stage when sleepers are unable to move. Paralysis during REM sleep is a good thing; otherwise, sleepers would likely act out their dreams, possibly hurting themselves.

However, as a person emerges from REM sleep, the forebrain neuronal systems enabling perception sometimes activate before the spinal motor mechanisms reestablish muscle tone, thereby producing an episode of sleep paralysis (Hobson, 1995, pp. 175–176). During sleep paralysis, the person is awake, aware of his or her surroundings, and aware of an inability to move. Sometimes the perceptual activity of dreaming intrudes into awareness, producing hypnopompic (“upon awakening”) hallucinations—dreaming with one’s eyes open, so to speak. Typical hallucinations include sensing or seeing an intruder in the bedroom, hearing footsteps or strange sounds, or feeling tingling sensations in one’s body. Moments later, perceptual and motor functioning realign, the hallucinations vanish, and the awakening person can move once again. About 95% of people experience terror during episodes accompanied by hallucinations (Cheyne, Newby-Clark, & Rueffer, 1999).

Rarely more pathological than the hiccups, sleep paralysis has been experienced by about 30% of the general population of college students, and about 5% have had an episode accompanied by the full range of hallucinations, including visions of intruders in the bedroom (Cheyne et al., 1999). Unfamiliar with the phenomenon, many people hit upon diverse explanations ranging from incubi and ghosts (Hufford, 1982) to encounters with space aliens (Clancy, McNally, Schacter, Lenzenweger, & Pitman, 2002; McNally et al., 2004b).

People who believe they harbor repressed (or dissociated) memories of childhood sexual abuse (CSA) base their conclusions on diverse presumed “indicators” such as nightmares, symptoms of depression, and so forth (McNally, Clancy, Schacter, & Pitman, 2000). Accordingly, Pendergrast (1996, pp. 118–120) has suggested that some individuals may misinterpret sleep paralysis episodes as signifying the nighttime resurfacing of dissociated fragments of buried memories of CSA. Someone who experiences sleep paralysis, accompanied by hallucinated bodily sensations and visions of a bedroom intruder, might assume that he or she had been sexually victimized as a child.

To explore Pendergrast’s idea, we asked four groups of adults who had participated in our trauma and memory research to complete a questionnaire tapping sleep paralysis experiences. The repressed memory group included persons who believe they were sexually molested as children, but who have no autobiographical memories of such violation. They inferred their history of abuse from diverse “indicators” (e.g., weight gain, sexual dysfunction, depressed mood). The recovered memory group included persons who reported remembering at least one episode of CSA after many years of not having thought about it. The continuous memory group reported never having forgotten their CSA. The control group denied a history of CSA.

We tested for differences among the groups in reported prevalence of sleep paralysis, and examined the explanations endorsed by the participants. Given that

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