

SEXSOMNIA: THE DIFFICULTIES OF DIAGNOSIS

The rare condition of 'sexsomnia' (or 'sexomnia') is a form 'arousal' disorder. The most commonly known example of an arousal disorder is sleepwalking. In cases of sexsomnia, the subject commits a sexual act whilst asleep and so it occurs when the subject is wholly unaware of their actions. The condition of sexsomnia has been reported in medical journals for some 15 years but was only officially recognised as a sleep disorder in the International Classification of Sleep Disorders, in 2005. Consequently, few legal cases have taken place where it has been offered as a defence to a criminal charge. Some which have arisen are dealt with in Quinton Newcomb's section of this article, focussing primarily on the question of whether sexsomnia is *sane*, or *insane*, automatism. This part of the article considers the general features of the condition and how it can be diagnosed.

Subjects of sexsomnia generally have little or no memory of the acts committed upon waking, or they wake up during the act in bewilderment. Reactions of victims range from enjoying the experience (most commonly within the context of an established relationship, in which instance the events are rarely reported), to victims who feel disgusted, angry or confused. Reasons for not reporting the condition may include shame, embarrassment or fear. Consequently it is thought that sexsomnia may be a more common condition than it appears from the reported cases and is not as rare as the literature would suggest.

The 7 Triggering Factors:

The triggering factors which *may* cause sexsomnia, are:

- A history of sleep disorders, such as sleep walking;
- A family history of arousal disorders;
- Too much alcohol;
- Too little sleep;
- Too much stress;
- The presence of a bed partner;
- The existence of a sleep apnoea, such as very heavy snoring (as distinct from normal snoring, which is not a sleep apnoea).

A sexsomnia subject will usually have a *personal* history of a form of arousal disorder, because it usually inherited, but it does not follow that an absence of such a history precludes a diagnosis of the condition.

It is important therefore to consider the existence of a *family* history of arousal disorders, but again, the absence of such does not preclude a diagnosis of sexsomnia.

Sexsomnia has been noted to appear in adult life, and is usually, but not exclusively, found to be in existence in males aged in their 20's to 30's. It also affects some females but this is much more unusual.

The condition usually comprises the simultaneous convergence of various triggering factors, such as excessive alcohol consumption, a build-up of a lack of sleep and a prolonged period of stress, together with the presence of a bed partner with whom the subject might not be used to sharing a bed. It is also recognised that any single one of the triggering factors may be sufficient for the condition to appear.

In relation to the question of alcohol there is a divergence of opinion on its effect as a triggering factor, with some arguing that it only arises in cases of acute alcohol consumption. In some subjects it has been found to have no effect at all.

Sexsomnia subjects will usually commit sexual acts on a person close to them, e.g. on a bed partner in the same bed. The subject characteristically does not leave the bed.

Clinical cases of the condition have included same-sex sexsomnia (rarer than sexsomnia between different sexes). Reported conduct has consisted of sexual acts across the entire spectrum, ranging from sexual intercourse, masturbation, oral sex and fondling to merely talking sexually.

Very often the triggering factors of sexsomnia are self-reported, save for sleep apnoea and a history of arousal disorders which may be seen in medical records, both of which can be independently verified.

Understanding the sleep cycle:

It is necessary to briefly consider the sleep cycle to understand the stage in sleep at which the condition is most likely to arise.

It is well known that there are two main states of sleep, non rapid eye movement (NREM) and rapid eye movement (REM) sleep. During a normal night's sleep, there are approximately five sleep cycles of around 90 minutes each, comprised of NREM sleep followed by REM sleep in each cycle. There is approximately 75% NREM sleep and 25% REM sleep during each night. The deepest stages of NREM sleep (stages 3 and 4) occur in earlier sleep cycles but within each cycle they are preceded by the lighter stages (stages 1

and 2), from which the subject is much more easily aroused. Sexsomnia, like other NREM sleep arousal disorders, usually occurs during the first or second sleep cycles.

The consumption of alcohol has long been recognised as affecting the quality of sleep: its presence may affect the sleep pattern for sexsomnia and contribute to determining when the lighter stages of sleep occur.

The Difficulties of Diagnosis:

At present there are no medical sleep tests to identify sexsomnia as a matter of certainty. Physiological sleep recordings, in between episodes, are generally considered to be an unreliable means of diagnosing arousal disorders. There are however tests, which may establish the existence of other sleep disorders, such as sleep apnoea, which could trigger an arousal disorder such as sexsomnia.

The diagnosis of sexsomnia is therefore a difficult matter. The clinical features to be considered when considering a potential case of sexsomnia are:

- A convincing personal history of an arousal disorder, usually starting in childhood;
- Often a family history of sleep disorders;
- No premeditation or motive: or acting out of character;
- The action is usually brief and occurring usually at least one hour after going to sleep, or on being aroused from sleep for whatever reason (e.g. sleeping in a strange environment or alcohol consumption);
- The Victim merely happened to be present and may have been the stimulus for the arousal;
- Remorse, perplexity or horror on regaining consciousness with no attempt to conceal the act;
- Evidence of lack of awareness during the act with complete or partial amnesia for the event;
- The episodes are provoked by sleep deprivation, stress, alcohol or medication.

It may be a difficult task for a jury to determine whether a Defendant was genuinely asleep or was merely purporting to be asleep and pretending to be unaware of their actions. No expert witness can provide a final answer upon the crucial question of whether the Defendant was *actually* asleep. Only the parties were who were present before, during and/or after the allegedly sexsomnia event can shed light on that vital question. If the Defendant was not asleep, then sexsomnia does not arise at all. If the Defendant was

genuinely asleep at the time of the commission of the sexual acts, then *sexsomnia* amounts to a *complete* defence to any sexual charge.

Unfortunately, current information about *sexsomnia* is still very restricted due to the limited research which has been conducted into it, most notably in Canada. Consequently, there are few clinicians with experience of diagnosing and or dealing with cases of alleged *sexsomnia*. From our experience we would be happy to assist Solicitors to find appropriate medical assistance in any given case.

Georgina Gibbs

Chambers of Michael Hubbard Q.C. and Karim Khail Q.C.

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