Parasomnias and the Law: “But Officer, I was asleep!”
By Todd J. Swick, MD

It has been estimated that 20 percent of children and 4 percent of adults experience disorders of partial arousal on more than an occasional basis. These parasomnias include sleepwalking, sleep terrors and confusional arousals. Some people with parasomnias experience abnormal and even violent behaviors that can arise from the sleep period.

Parasomnias are undesirable behavioral or experiential phenomena arising from sleep. These can occur out of both stage N sleep (non-rapid eye movement sleep) and stage R sleep (rapid eye movement sleep). The behaviors can be simple or complex. They can be stereotyped or random and can involve violent and/or illegal behavior.

The most common causes of abnormal sleep-related behavior can be classified in several categories. The first is disorders of arousal from stage N sleep. This includes sleepwalking, sleep terrors and confusional arousals, which encompasses both severe morning sleep inertia (i.e., “sleep drunkenness”) and sleep-related abnormal sexual behaviors (i.e., “sleepsex”). The second is REM sleep behavior disorder (RBD), which is one of the parasomnias usually associated with stage R sleep. The third category is nocturnal seizures, which includes post-ictal fugue states. The fourth category is psychogenic nocturnal dissociative disorders (i.e., events occurring with abrupt transition to wakefulness). This includes psychogenic amnesia, fugues and multiple personality disorder. Munchausen syndrome (i.e., a mental illness involving intentional deception) is the fifth category, and the final category is malingering (i.e., pretending to have an illness). In a recent review article in Sleep Medicine Reviews, Mark Pressman, PhD, discusses the subject of parasomnias and their legal implications from many vantage points. The theme of the article is that people in whom parasomnias occur typically have predisposing factors that are primed and are brought out by precipitating factors. Pressman contends that in the absence of these factors it is unlikely that an episode of a parasomnia occurred.

Predisposition is based on genetic susceptibility (i.e., a strong family history). Priming factors include situations and substances that increase slow wave sleep or make arousal from sleep more difficult. These include sleep deprivation, alcohol, medications, situational stress and intercurrent illness (in particular illnesses related to a fever). Precipitating factors include sleep disordered breathing, periodic limb movements of sleep, noises, and touch.

The Sleep Defense
Legal cases involving parasomnias date back more than 100 years to when Maria Bickford was murdered by a lovesick admirer in Boston in 1846. The murderer had a “long history” of sleepwalking and had no recollection of the event. The defense successfully argued that a person, to be found guilty of murder, needs to have conscious volition; if you are asleep then by definition you are not conscious and cannot be held criminally liable. Over the years there have been many more cases in which defendants have argued that the illegal act in question occurred while sleeping. This argument has been applied to several different criminal activities including sexual assault, physical assault and murder. The outcomes of these cases have been variable with some acquittals and many convictions. Defense strategies tend to focus on language in penal codes dealing with a defendant’s intent, objective and awareness, arguing that a person who is sleeping does not meet the criteria for culpability. For example the Texas penal code states, “A person acts intentionally, or with intent, with respect to the nature of his conduct or to a result of his conduct when it is his conscious objective or desire to engage in the conduct or cause the result” and “A person acts knowingly, or with knowledge, with respect to the nature of his conduct or to circumstances surrounding his conduct when he is aware of the nature of his conduct or that the circumstances exist.”

In 2007 Mark Mahowald, MD, and Carlos Schenck, MD, of the Minnesota Regional Sleep Disorders Center at Hennepin County Medical Center in Minneapolis, Minn., published guidelines for considering the validity of a “sleep defense.” An essential element of a sleep defense is an “independently verified history and/or sleep laboratory findings to suspect a bona fide sleep disorder,” ideally with previous documentation of similar episodes. The behavior tends to be “abrupt, impulsive, senseless and blatant.” Afterward, the defendant should be perplexed and may display amnesia, making no effort to cover up what happened.

A Sleepwalking Case
In recent times there have been several notable cases in which the defense contended that the illegal act arose out of sleep, making it a “sane automatism” for which the defendant should not be criminally liable. In other words, acts committed while sleepwalking should be regarded legally as a “non-insane automatism.” From Canada came the case of Kenneth Parks. He was acquitted of the murder of his mother-in-law and the attempted murder of his father-in-law after it was

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established that Mr. Parks had a history of sleepwalking and sleep talking and on the night in question was severely sleep deprived. There was also a strong family history of abnormal sleep behavior involving multiple family members on both his mother’s and father’s side.

Mr. Parks fell asleep on the couch in his home and then got up, drove several miles to his in-laws and then went into their home; he stabbed his mother-in-law multiple times and struck her with a tire iron causing blunt force injuries to her face and head. He strangled his father-in-law to unconsciousness. Afterward, he turned himself in to the police with blood on his hands (after cutting himself with the same knife he used to stab his mother-in-law), stating that he had a dream that he “killed someone with my bare hands” but had no memory of the event. He also was unaware that he had a serious injury of his own, having severed the flexor tendons in both hands. This was significant for the presence of “dissociative analgesia,” the absence of awareness of pain and/or injury that can be a feature of the sleepwalking state.

The defendant was evaluated at great length by sleep experts. The decision of the jury, which was upheld by the Canadian Supreme Court, was that the murders occurred when Mr. Parks was incapable of knowing the consequences of his actions; therefore he could not be held criminally liable.

**Sleep & Sexual Behavior**

Behaviors other than murder have been attributed to parasomnias in criminal cases. Sexual assault cases have been brought against defendants who have contended that they were asleep during the action and have pointed to prior history of such acts with either consenting partners or bedmates. All have the common situation in which the individual had no recollection of the alleged act and had a history of complex and/or prolonged parasomnias, usually sleepwalking.

In 2002, Christian Guilleminault, MD, and colleagues reported on 11 cases of atypical sexual behavior during sleep that involved harm to the patients or bedpartners. The ages ranged from 16 to 43, and nine out of the 11 patients were men. Five engaged in sexual assault, two engaged in masturbation and four engaged in sleepsex with their bed partner.

The 2005 International Classification of Sleep Disorders, 2nd Edition, indicates that confusional arousals “may involve aggressive or violent behavior or inappropriate sexual activity with oneself or the bed partner.”

In June 2007 Carlos Schenk, MD, and colleagues published a literature review and the first classification of sleep related disorders associated with abnormal sexual behaviors and experiences. They grouped these disorders into four main categories: parasomnias with abnormal sleep-related sexual behaviors (i.e., confusional arousals, sleepwalking, RBD); sleep-related sexual seizures; sleep disorders with abnormal sexual behaviors during wakefulness and wake-sleep transitions (i.e., a form of recurrent hypersonmia called Kleine-Levin syndrome, severe chronic insomnia, restless legs syndrome); and special clinical considerations (e.g., narcolepsy, sleep-related dissociative disorders, nocturnal psychotic disorders).

The review identified 116 cases of Kleine-Levin syndrome, parasomnias, and sleep-related seizures related to “sleep and sex.” All parasomnias cases reported amnesia for the sleepsex, whereas only 29 percent of the sleep-related-seizure patients were amnesic. Clonazepam therapy at bedtime was effective in 90 percent (i.e., 9 of 10) of treated parasomnia cases. All five treated patients with sleep-related seizures responded to anticonvulsants. The hypersexuality in Kleine-Levin syndrome did not respond to any treatment.

Clearly, the recognition of sexual activity during sleep and it’s emotional, psychological and legal impact makes it critical for the sleep specialist to ask about and investigate the issues surrounding this behavior. The reports point out that treatment of co-existing sleep disorders or treatment of the primary parasomnia can stop the sleepsex and avoid further emotional, physical or legal problems.

**References**


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