

Sexsomnia—A New Parasomnia?

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Objective: To describe a distinct parasomnia involving sexual behaviour, which we have named sexsomnia.

Method: We have used a case series as a basis for the description of sexsomnia.

Results: Eleven patients with distinct behaviours of the sexual nature during sleep are described. The features in common with other nonrapid eye movement arousal parasomnias, such as sleepwalking are documented. Some patients had simply been referred to a tertiary sleep clinic for investigation of unrelated sleep problems. A small number had been involved in medicolegal issues. Sexsomnia has some distinct features that separate it from sleepwalking. The automatic arousal is more prominent, motor activities are relatively restricted and specific, and some form of dream mentation is often present.

Conclusions: A significant number of patients with this unusual parasomnic behaviour were identified only after specific questions were asked, suggesting that the behaviour is more common than previously thought.

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Clinical Implications

- Psychiatrists should remember to ask about parasomnia in general; it is more frequent than previously thought and may result in an inappropriate or unwanted behaviour.
- Psychiatrists should ask specifically about sexual behaviour during sleep.
- Cases of alleged sexual molestation may in fact have a parasomnia as a basis.

Limitations

- This is a clinical case report series and as such does not evaluate the incidence of this phenomenon.
- Case reports are based on the patients presenting and therefore may overemphasize the medicolegal dimension.
- The parasomnias in general are not completely understood in terms of their neurophysiology.

Key Words: *sleep, parasomnia, sexsomnia, sleep sex, forensic medicine, medicolegal*

Parasomnias are well-described, common nocturnal phenomena. By definition, parasomnias are “events that occur intermittently or episodically during the night” (1,2). They may occur in any phase of sleep. Most parasomnias are characterized by partial arousals before, during, or after the event. There are several classifications of the major parasomnias—a widely used description of the types of parasomnias is provided in DSM-IV (3) and the International Classification of Sleep Disorders (4). New additions are expected to enter the

International Classification, for example, the newly described disorder of sleep eating (5) and overlap parasomnias (6).

While parasomnias are considered normal in children, where the prevalence is relatively high (> 15%), in adults they may be indicative of a psychopathology, and the prevalence is relatively low (> 6%) (7). The most common precipitants of parasomnic behaviour in adults are stress, sleep deprivation, and alcohol or drug consumption. It is common for family members to have similar parasomnias.

In a previous forensic study of men who commit sexual assaults, we noted that 2% of sexual assault cases tried before the court involved sleeping victims (8). A higher percentage (10%) of outpatients assessed in a forensic psychiatry clinic involved a sleeping victim. In that study, 4 primary reasons were identified. They were 1) the fulfillment of sadistic or paraphilic fantasies, 2) an attempt to bypass rejection or observation by the sleeping victim, 3) sexual opportunism, and 4) sexual behaviour occurring while the attacker him- or herself was sleeping. With regard to the latter reason, we presented a detailed report of 2 men who had sex while they were sleeping (including a polysomnographic [PSG] recording of one of the men) (9). At that time we speculated that sexual behaviour while sleeping must be rare.

The purpose of the present paper is to describe a series of 11 cases of people initiating sexual behaviours while asleep, raising the possibility that the syndrome is more frequent than initially suspected. We believe that sexual behaviour in sleep constitutes a new clinical entity (sexsomnia) or should at least be viewed as a distinct variant of an existing type of parasomnia; that is, sleepwalking. The clinical spectrum of nocturnal behaviour exhibited by the patients who were referred to a tertiary sleep clinic was indeed sufficiently different to distinguish the sexsomnia as a completely separate category of parasomnias. Several of these patients were referred to the sleep clinic for some other reason (that is, unrelated to their sexual behaviour in sleep) or because of a forensic matter, and only subsequently did the issue of sexual behaviour during sleep emerge. This emphasizes the old adage that asking a right question is essential in medicine (see below). For many patients, embarrassment or a sense of guilt delayed or prevented medical presentation. We anticipate that the number of potential cases is large, but sexual behaviour in sleep is not yet recognized by physicians as a behaviour of note or a problem and, hence, is not considered in history taking or meriting referral for clinical evaluation.

The etiology of this parasomnia is unknown. The uniqueness of the condition is the involvement of a partner (occasionally a willing partner) and that the behaviour consists of complex autonomic, motor, and behavioural elements.

Brief Case Reports

Eleven case histories of patients are presented in this report.

JK, a 27-year-old married nightclub bouncer, was referred to the third author by his wife's psychiatrist. She had complained that her husband frequently sexually assaulted her while she was sleeping. Criminal charges had been laid, and she was considering leaving the marriage. Mr K had admitted engaging in attempted cunnilingus and sexual intercourse with his sleeping wife. He claimed he was aware of these activities only because his wife told him. Apparently, he had no recollection of the events. He admitted to past voyeuristic activities and sexual arousal from having sex with his wife when she was "tied up." In addition, they had engaged in mutually consenting "swinging." He had a history of multiple-substance abuse, which was in remission at the time of the assessment. His sleep history was significant for snoring and a personal (as well as family) history of sleepwalking. His wife also

described instances in which he screamed and talked in his sleep. He had daytime sleepiness which he self-treated by consuming up to 30 cups of coffee a day and by taking "power naps."

Results of an overnight sleep study showed evidence of several abrupt and spontaneous arousals from slow-wave sleep (SWS) associated with increased heart rate and compatible with a diagnosis of parasomnia. In addition, a high Respiratory Disturbance Index and decreased oxygen saturation were noted, diagnostic of sleep apnea. Mr K and his wife consented to undergo a second sleep study in their home in which a sleep EEG recording of Mr K was made while they were videotaped. The PSG record again revealed PSG features consistent with parasomnia and sleep apnea. However, no sexual activity was observed on the video recording or reported by the couple on this occasion.

Following treatment with continuous positive airway pressure (CPAP), Mr K's sexual activities with his wife while they were sleeping stopped completely. Two months after beginning CPAP (in which time there were no nocturnal sexual assaults), Mr K discontinued CPAP because of "discomfort." Nocturnal sexual assaults resumed within 2 weeks and ceased again when CPAP was reinstated.

CJ is a 39-year-old married man with 5 children who was legally charged with sexually touching his 13-year-old daughter while she was sleeping. The event was alleged to have occurred 4 years earlier (when his daughter was 9 years old). On the evening in question, his daughter had a nightmare, went to her parents' bedroom while they were asleep, and got into bed between them. Mr J's daughter said that he sexually touched her during the night. According to his daughter, both she and her father were awake at the time. Mr J insisted that, if he had touched her, he must have been sleeping. He explained that both he and his wife would often initiate sexual contact while the other partner was sleeping. Generally, the couple's sexual relationship was good, and no other sign of unusual sexual interest was reported. Mr J and his lawyer wondered if he had mistakenly touched his daughter. There is no history of Mr J having walked in sleep; however, his wife stated that there probably were times that he had spoken in his sleep ("mumbling"). Mr J reported being under stress and having sleep deprivation at the time of the alleged assault.

The PSG assessment showed intrusions of alpha EEG activity into SWS and SWS arousals. On this basis, a clinical assessment of parasomnic behaviour was made, although video recording did not reveal any features suggestive of parasomnia. The evidence was accepted in court, and Mr J was acquitted.

AF is a 32-year-old single unemployed mechanic. He was referred to the sleep clinic by his barrister after having been accused of sexually assaulting a young girl. Mr F had suffered a traumatic personal loss. (His father died a violent death, and Mr F had to identify his father's crushed body.) This led to a change in behaviour, including the initiation of excessive use of alcohol. On the night in question he visited his friend's home after drinking heavily. He also used marijuana. He then

had taken a nap, sharing the bed with 2 children, and was subsequently awakened by a friend who said that one of the children, a 10-year-old girl, claimed that he had inserted a finger into her vagina. Mr F could not recall the event, saying he had been asleep at the time. His sleep history was significant for sleep talking and, on one occasion, sleepwalking. There was also a family history of parasomnia.

A sleep study was carried out, which supported the notion that Mr F has a parasomnia. Again, video recording did not show any unusual behaviour. Mr F was acquitted on the charge of sexual assault.

LD is a 35-year-old married man referred by his psychiatrist for assessment of his parasomnia. He was accused of sexually assaulting a 12-year-old girl and sentenced to 3 years probation with no jail time. He initially admitted to the offence, but by the time he saw his psychiatrist, he denied it. From his medical history, we learned that his mother abused alcohol while pregnant, resulting in Mr D suffering from fetal alcohol syndrome. He is mentally retarded with a history of alcoholism and multiple-substance abuse. He has also previously been diagnosed as having schizophrenia and has been treated with neuroleptics in the past. His sleep history was notable for sleep talking and sleepwalking. He also claims he has dreams of having sexual intercourse with young girls and apparently enacts these by having intercourse with his wife, who is convinced that he is asleep while engaging in sex. He has no knowledge of his sexual performance and is only aware of this behaviour from his wife's reports.

Two consecutive sleep studies were carried out at the sleep clinic, with Mr and Mrs D sleeping together. PSG recordings of Mr D only were made. These revealed features typical for nonrapid eye movement (NREM) parasomnia. On this occasion, however, the video surveillance showed Mrs D initiating sexual foreplay, which led to intercourse, performed by Mr D while he was "drifting" between stage 1 and wakefulness. The patient was not aware of this in the morning.

DW is a 43-year-old divorced police officer. He has an extensive sleep history of parasomnias. A few years previously, he had stood trial for impaired driving and driving under the influence of alcohol. His defence was that of parasomnia, based upon a previous history of sleepwalking and sleep talking, which had intensified in the 2 years prior to his offence. Many features surrounding the case supported the parasomnia (sleepwalking) claim. He was acquitted, and this aspect of his case was described by McCall-Smith and Shapiro (7). Subsequently (and totally independent of any forensic issue), it was discovered that Mr W had another manifestation of his parasomnia, namely sexsomnia. This emerged at a "routine" follow-up at which the first author had commented to Mr W that his "sleep-driving" was being rivalled as the most unusual

of parasomnias. A description of sexsomnia was given, and Mr W responded by saying "Oh, but I do that." The disingenuous response by the interviewer "but you never told me" was followed by Mr W saying "but you never asked." Mr W's 2 current girlfriends independently confirmed that he frequently engages in sexual behaviour while asleep. One describes him as a "different person" during these activities—apparently, he is a more amorous and gentle lover and more oriented toward satisfying his partner when he is asleep.

JD, a 27-year-old single factory worker, was self-referred to his family physician because of a problem of "having sex with my girlfriend while I am asleep." There were no criminal charges. He felt this activity occurred more often after consuming alcohol. He underwent an overnight sleep study that revealed a redistribution of SWS across the night, instead of its usual occurrence primarily during the first one-third of the sleep period. He had frequent spontaneous arousals during the SWS. Within 2 weeks of initiating treatment with clonazepam 0.5 mg daily, the behaviour decreased but did not completely eliminate the nocturnal sex incidents. This remission continued after the clonazepam was discontinued. Follow-up of this remission was at 6 months.

AK is a 38-year old female reporter who asked for professional help after her husband, to whom she was married for 2 months, had awoken repeatedly at night only to find his wife apparently masturbating in her sleep. When he awakened her, she was always unaware of her behaviour and very embarrassed. They both claim to have a good sexual relationship, both before and since their recent marriage, which is the second for both. Ms K initially described no previous history of sleepwalking or sleep talking, but there were indications that she sometimes wakes in a confused state. Subsequently, she remembered that, before her first appointment, she had once awakened to discover she had urinated in a cupboard. In addition, stress at her work and a death in her family were reported. (Her mother died after a prolonged illness.) A PSG study revealed arousals during SWS.

JK is a 40-year-old female clinical scientist who described repeated masturbation during her sleep that led to some estrangement between her and her husband. She described a family history of parasomnia (but no personal history). She did not have a polysomnogram.

TC is a 28-year-old married man referred by another sleep clinic with a putative diagnosis of narcolepsy and failure to respond to stimulants. (The symptoms reported were severe sleepiness and hypnagogic hallucinations.) Seen with his wife, he described excessive daytime sleepiness dating back to his last years at high school. His sleepiness was dramatic and has led to significant accidents at work and in the home (involving their young children). There were no forensic

issues. Mr C had a developmental delay. Interestingly, the patient also reported some of the features of Kleine–Levin syndrome, including dramatically fluctuating appetite and libido and a history of heat stress requiring hospital admission. He had a clear history of night terrors and sleepwalking. His wife described several occasions of sexual initiation while he was asleep leading to full intercourse prior to his awakening. She also described his total disregard for her menstrual status when initiating sexomnia (very unlike during waking intercourse), and she stated that occasionally in this situation, she would have to shake him to wake him and say “Hey, I’ve got a pad on.” His sleep assessment shows a Periodic Leg Movement Index of 12 per hour and extreme sleepiness on the Multiple Sleep Latency Test (mean sleep latency of 1.9 minutes), even though he was on methylphenidate at the time.

KB, a 37-year-old married police officer, presented at Sleep Rounds in a teaching hospital with severe parasomnia, especially sleepwalking with driving in sleep, particularly when under stress and amplified by alcohol consumption. He had features of upper airways resistance syndrome and apparent response of his parasomnia to clonazepam. At these rounds, he and his wife were asked for the first time about initiation of sexual behaviour in sleep during the group interview, to which both responded in the affirmative.

A subsequent telephone interview amplified that Mr B would initiate sexual behaviour in his sleep approximately once monthly. His wife describes him as more aggressive and more amorous at these times than when he is awake. He indulges in behaviours while asleep that he does not undertake when awake. She says that, in some of these episodes “there is no stopping him”; however, on one occasion when he grabbed her around the neck, she slapped him hard, and he immediately awoke and stopped the behaviour. The sleep study showed typical features of NREM parasomnia.

WW is a 16-year-old male who slept over at his uncle and aunt’s home. The uncle awoke to discover his nephew fondling his (the uncle’s) testicles. His wife (initially asleep) awoke, and the nephew was escorted back to bed. At the time of being referred to a psychiatrist, Mr W was aware that he had been sleepwalking but was surprised and distraught to discover the details of his behaviour when hearing his mother’s description to the psychiatrist at an initial consultation. There was also an account by the mother of finding her son on one previous occasion—apparently unaware of his surroundings—downloading male pornography from the Internet. The mother had been baffled (although aware of her son’s sleepwalking behaviour) and had chosen to ignore the incident after guiding her son to bed.

In addition to these consecutive cases, a further 9 cases have been seen with no illustrative features to report. One of these cases (which came to court in Edmonton) resolved after the initiation of CPAP. Table 1 summarizes the initial 11 cases.

Discussion

There has been a steady progress in identifying the complexity of nocturnal behaviour from a time when somnambulism (sleepwalking) was the only parasomnia known to medicine.

Sexual content as part of purportedly parasomnic behaviour has been described in the medical literature (9,10), from early 19th century descriptions of indecent exposure during sleep (11), which with the benefit of hindsight were almost certainly fugue states, to the recent identification of high-risk parasomnic behaviour (12). The authors have already described an initial series of patients who suffer from a unique type of parasomnia and have presented their work (9) at the American Sleep Disorders Association conference in 1996.

In assessing parasomnic behaviour in general and identifying a new disorder in particular, it is necessary to address several important questions regarding complex behaviour in sleep. First, one must consider whether it is possible to perform complex acts while asleep. To answer this, we should view the brain as a network of different groups of neurons, which may be variably active. Many subcortical and cortical neurons are indeed inactive during sleep. However, the reticular formation and hippocampal structures, for example, will react even during sleep to any external stimuli, initiating movement to preserve the integrity of the body. On the other hand, cortical structures are normally very active during REM sleep as part of the dream mentation. Also, a good measure of primary and secondary (higher-order) functioning is preserved during sleep, which may give an impression that, during a parasomnic episode, something exists that could be viewed as purposeful act. However, a person experiencing a parasomnic event does not have a fully “awakened” brain—some of the cortical structures, such as those responsible for memorizing and learning or those that help us to distinguish events from objective reality and intrinsic experiences, remain inactive, making some of the higher-order functions, including the consciousness, impaired. As an example, a person with parasomnia can walk (13), operate a motor vehicle (14), eat (5), perform a sexual act (9), or even kill (15) without the ability to, if we simplify, (fully) control his action. This implies that wakefulness and sleep may occur in a fragmented way and may be concurrent. The result is parasomnic behaviour with either complex motor or, as in sexomnia, motor and autonomic activity (Table 2). At the same time, there is an impairment of consciousness and awareness and, consequently, a relative lack of (legal) responsibility for the resulting behaviour.

It is possible that complex (sexual) behaviour in sleep is multifaceted in its etiology. From the neurophysiological perspective, one must consider the possibility of a neurological substrate, such as seizure disorder, brain insult or lesion, toxic reaction (the role of alcohol or psychotropic drug use was evident in several cases we describe), or neurodegenerative disease, as well as genetic inheritance and past physical and sexual abuse. Recent studies (16–18) prove that some of the complex motor behaviours, namely, episodic nocturnal wanderings, paroxysmal dystonia, and paroxysmal arousals, represent a form of nocturnal seizures with minimal EEG correlates. It is also necessary to stress the relation of sleep apnea, sleep fragmentation, and sleep deprivation to parasomnias. The role of sleep apnea in the case of Mr K is persuasive. Both the resulting hypoxia, but especially the sleep fragmentation leading to partial arousals, may have been

Table 1 Case summaries for 11 patients with episodes of sexsomnia

	JK	CJ	AF	LD	DW	JD	AK	JK	TC	KB	WW
Family history of parasomnia	Yes	na	Yes	na	Yes	na	Yes	Yes	Yes	Yes	na
Personal history of parasomnia	Yes	Yes	Yes	Yes	Yes	na	Yes	No	Yes	Yes	Yes
Alcohol and substance abuse	Both	No	Both	Both	Alcohol	No	No	No	No	No	No
Polysomnographic features of parasomnia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	na
Other related diagnosis	Sleep apnea, paraphilia	—	PTSD ^a and major depression	Schizophrenia	—	—	—	—	Developmental delay	No	No
Medicolegal issues	No	Yes	Yes	Yes	NRS ^b	No	No	No	No	NRS ^b	No
Sex	Man	Man	Man	Man	Man	Man	Woman	Woman	Man	Man	Man

^aPTSD = posttraumatic stress disorder; ^bNRS = not regarding sexsomnia (other medicolegal issues had occurred).

Table 2 A clinical classification of the major parasomnias

Simple motor	Sleep starts (hypnic jerks)
	Isolated sleep paralysis
Simple behavioural	Confusional awakening (sleep drunkenness)
	Sleepwalking (somnambulism)
	Sleep terrors (pavor nocturnus, incubus attacks)
Complex behavioural (suggested)	Sexsomnia (sexual behaviour in sleep)
	Sleep eating
Psychosensory	Terrifying dreams (rapid eye movement (REM) nightmares)
	REM-sleep behaviour disorder
Autonomic	Painful erections
	Bedwetting (enuresis nocturna)
This classification of parasomnias is based on that described by Broughton and Shapiro (1).	

factors in triggering the sexsomnia in this case. We also observed features of parasomnia related to SWS and partial arousals in other cases of sexsomnia and made a tentative conclusion that this parasomnia is most likely related to SWS, in degree similar to sleepwalking (with greater margin of confidence, we see it as NREM parasomnia). This would place sexsomnia in the same group with other NREM parasomnias such as sleepwalking, sleep terrors, and confusional arousals, all of which have partial arousal as a main feature, resulting in an intermixed sleep-wake state and complex behaviour. From this vantage point, one will appreciate the fact that sexsomnia (with other parasomnias) lies between certain types of sleep-specific seizure disorders on one side of the continuum and dissociative psychiatric disorders on the other.

The observation that the sexual behaviour in sleep may arise from either a dreamlike experience (or NREM dreaming) or, perhaps, dreaming with sexual content (a feature of rapid eye movement [REM] sleep) is noteworthy. This is not something that would bring the sexsomnia closer to REM parasomnias, since the recall of dreamlike experience has been associated with other types of NREM parasomnias, such as sleep terrors and sleep talking. There is evidence that the organization and affect associated with the sexual behaviour during sleep (for example, the cases of DW and KB) is different in sleep, or these behaviours could be a replication of patterns seen during wakefulness (for example, LD).

We consider sexsomnia to be a distinct entity in the family of parasomnias. The unique combination of activated systems in sleep, namely, specific motor and autonomic activation, supports this view. It may be difficult to distinguish between typical sleepwalking and sexsomnia. We propose several guidelines that will assist in this process (Table 3). The main features of sexsomnia, as opposed to sleepwalking, include frequently present sexual arousal with autonomic activation (for example, erection, vaginal lubrication, ejaculation, sweating, cardiorespiratory response). Sexsomnia without sexual arousal is also reported (for example, in the case of AF), and this may hinder correct diagnosis. The rule of thumb should be to study the behavioural patterns. If there is predominant behaviour oriented to the genital areas, there is greater likelihood for sexsomnia, as opposed to parasomnic activity that is only sporadically and incidentally oriented to genital areas. For example, we excluded from this series a patient who was touching his genital area while urinating as part of the more complex range of his sleepwalking behaviour. This example would not be equal to touching the genital area in a person in whom this is the primary pattern of behaviour and who frequently engages in masturbation in sleep.

When assessing the possibility of the sexsomnia in any particular case, it is important not to summarily exclude this condition on a basis of existing sexual arousal. The argument that,

Table 3 Common and distinguishing features of sleepwalking and sexsomnia

Sleepwalking	Sexsomnia
Usually originating from slow wave sleep	Originating in most cases from nonrapid eye movement sleep
Usually occurs in the first one-third of the night	Occurs any time during sleep
Autonomic activation largely limited to cardiorespiratory functions	Widespread autonomic activation
Sexual arousal not present	Sexual arousal frequently present
Duration less than 30 minutes	Duration possibly exceeding 30 minutes
Occasional violence, injury, and self-injury	Exceptional violence or injurious behaviour
Walking out of bed	Exceptionally walking out of bed
Predominantly in children	Predominantly in adults

in males, nocturnal erections normally do not occur in SWS sleep—thus making it impossible to have a genuine parasomnia, and concurrent erection (sexual arousal)—does not take into account the fact that most parasomnic behaviour, with or without sexual content, does not occur in SWS but rather arises out of SWS. Further, it is suggested that the presence of erections implies sexual intent. We were indeed able to establish underlying conscious or subconscious sexual intent in several of our patients with sexsomnia. Sexual intent (particularly subconscious) derived from the sexual drive is deeply rooted in the human psyche. This potent force in human behaviour can be recognized in various human activities, and for this reason, we believe that we cannot exclude the possibility of genuine parasomnia that features such underlying intent. When judging the possibility of complex sexual behaviour occurring in sleep or out of sleep, one should be cognizant of a range of normal sleep-related phenomena that may or may not have sexual context but do not constitute parasomnic behaviour or abnormality in medical terms. These include nocturnal erections, vaginal lubrication, nocturnal emissions, dream orgasms (“wet dreams”), and morning erections (REM sleep related in a postawakening state).

The assessment of patients with sexsomnia should, when possible, include a full EEG as part of the PSG recording with the bed-partner present. Considering the frequency of occurrence, the behaviour may not be “caught” in the clinical setting, especially when the number of nights available for PSG recording is limited. The incidence of parasomnic events is generally lower in the clinical setting (19). This is true for all types of adult parasomnias, and from that point, the sexual behaviour in sleep is not an exception.

In this series of patients with sexsomnia, there is a high incidence of paraphilic behavioural patterns. We do not know whether this is a consistent trait of these patients or merely an opportunistic sleep-related behaviour. We believe that nonparaphilic sexsomnia is less likely to be seen in a clinical setting. Such nocturnal incidents may be considered as odd

but still within present social norms, particularly if the partner is a willing participant.

From the legal perspective “a sleep walker’s ability to control voluntarily even complex behaviour is severely limited or not available,” and it is considered as a cause of “non-insane automatism” (R v Parks) (20). However, the ruling that sleepwalking may, under certain circumstances, constitute a “disease of mind” is also known (R v Burges) (21). The issue of legal responsibility may arise if patients refuse treatment and repeatedly expose themselves to parasomnia-inducing factors and situations, resulting in sexsomnia. All our patients who were legally implicated were subsequently exculpated on a basis of a sane automatism. In these forensic cases, there was evidence of parasomnia in their respective sleep studies and personal history of sleepwalking or sleep talking; further, in absence of any detectable mental illness, neuropsychiatric deficit, or brain disorder, their cases were successful in a court of law. We are not aware of any recidivism, and it appears that these patients do not present a “continuing danger” to society. Finally, when assessing a sexsomnia case, one should always be aware of possible malingering, the incidence of which may be higher than in other parasomnias.

We cannot give any figures regarding the prevalence of sexsomnia—this will require a formal study. The sex bias in this sample of sexsomnia patients is male, with a smaller but clinically significant percentage of female patients.

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Résumé : Sexsomnia—une nouvelle parasomnie?

Objectif : Décrire une parasomnie distincte incluant un comportement sexuel, que nous avons nommée sexsomnia.

Méthode : Nous avons utilisé une série de cas à la base de la description de la sexsomnia.

Résultats : Onze patients ayant différents comportements de nature sexuelle durant le sommeil sont décrits. Les caractéristiques communes à d'autres parasomnies d'éveil du sommeil non paradoxal, comme le somnambulisme, sont documentées. Certains patients avaient simplement été adressés à une clinique du sommeil tertiaire pour examiner des problèmes de sommeil non reliés. Un petit nombre d'entre eux étaient impliqués dans des questions médico-légales. La sexsomnia a certains traits distincts qui la séparent du somnambulisme. L'éveil automatique est plus prééminent, les activités motrices sont relativement restreintes et spécifiques, et une certaine forme de conscience onirique est souvent présente.

Conclusions : Un nombre significatif de patients ayant ce comportement parasomniaque inhabituel a été trouvé seulement après que des questions spécifiques ont été posées, ce qui indique que le comportement est plus fréquent qu'on ne l'avait d'abord cru.