

## *Sexsomnia: Overcoming the Sleep Disorder Defense*

BY RAMI S. BADAWY, J.D.

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CAN A SLEEPING DEFENDANT involuntarily sexually assault a child? Many defendants are now claiming involuntary sexual assaults on children and adults, alike. In Canada, a 33-year-old man was acquitted of sexually assaulting a woman he had met earlier in the evening, despite a full confession to law enforcement.<sup>1</sup> In New Jersey, a 41-year-old man was acquitted of attempted aggravated sexual assault and sexual assault despite testimony from the seven-year-old victim that she awoke to the defendant on top of her with his penis pressed against her vagina and the defendant's admission that he woke up naked next to the victim. The girl's mother, the defendant's girlfriend, also testified that shortly after the incident she witnessed the defendant naked and covered in baby oil.<sup>2</sup> Finally, in a trial convened at Randolph Air Force Base in Texas, the defendant admitted to rubbing his fingers on his 12-year-old daughter's vagina but claimed the act was involuntary.<sup>3</sup>

In all three cases, the defendants sought to avoid criminal responsibility for their conduct even though overwhelming evidence existed that each committed the crimes charged against them. All defendants argued that they were not criminally liable for their actions because they were unconscious during the incidents; thus, they did not possess the culpable mental state required to convict. In short, the defendants claimed that they were not guilty because they suffered from a sleep disorder: sex-

somnia.

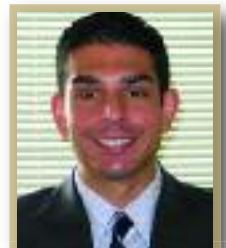
In child abuse cases involving sexual assault, prosecutors and investigators increasingly face this relatively new defense. Judges are allowing defense medical experts to testify that defendants were asleep at the time they sexually assaulted or attempted to sexually assault children. Sexsomnia is typically offered in child sexual abuse cases involving:

(1) prompt disclosure by the victim of the abuse or attempted abuse; (2) little question as to the identity of the perpetrator and/or that the act occurred; and (3) a claim by the defendant that he or she has little or no memory of the incident.

Prosecutors and investigators must understand and distinguish legitimate sleep disorders from intentional sexual abuse. This article will provide a brief and general overview of what is currently known and accepted about sleep disorders and then examine more controversial claims of sleep violence. Finally, this article will discuss strategies for dealing with the sexsomnia defense.

### **WHAT IS PARASOMNIA?**

There are four stages of sleep, collectively known as slow-



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wave sleep (“SWS”).<sup>4</sup> From stage one to stage four, the brain’s electrical activity slows along with the body’s breathing and heart rate.<sup>5</sup> Muscle tone also decreases.<sup>6</sup> Rapid eye movement (“REM”) or dreaming sleep occurs after two hours of slow-wave sleep.<sup>7</sup> While brain activity and heart and breathing rates increase during REM sleep, muscle tone remains absent.<sup>8</sup> The presence of muscle tone in slow-wave sleep allows the sleeper to move while REM sleep is marked by no muscle tone making anything but small movements, impossible.<sup>9</sup>

Throughout the duration of sleep, the body alternates between slow-wave and REM sleep. Following the initial REM period, which only lasts approximately 15 minutes, the sleeper returns to slow-wave sleep for as long as four hours.<sup>10</sup> The sleeper then rotates between REM and SWS every hour and a half for the remainder of the night until the sleeper eventually awakens from REM sleep.<sup>11</sup>

Many people have trouble sleeping and may suffer from a parasomnia. Parasomnias are disorders involving abnormal behavioral and physiological events occurring in association with sleep, specific sleep stages, or sleep-wake transitions.<sup>12</sup> These disorders are classified as either arousal disorders, sleep wake transitions disorders, or parasomnias associated with REM sleep.<sup>13</sup> Parasomnias include nightmare disorder, sleep terror disorder, and sleepwalking disorder.<sup>14</sup> Parasomnias in adults are commonly triggered by stress, sleep deprivation, and consumption of alcohol and/or drugs.<sup>15</sup>

Nightmare disorder is the repeated occurrence of frightening dreams that cause an individual to awaken from sleep.<sup>16</sup> Nightmares occur during REM sleep and are more likely to occur during the second half of the night when REM sleep becomes longer.<sup>17</sup> Although the actual prevalence of nightmare disorder is unknown, as many as 50 percent of children ages three to five years suffer from sleep disrupting nightmares.<sup>18</sup>

Sleep terror disorder involves repeated incidents of sudden awakening from sleep with a scream or other vocal indicator of distress.<sup>19</sup> Typically, individuals experiencing a sleep terror will sit up in bed with a frightened expression on their faces. They will usually exhibit symptoms of anxiety including increased heart rate, heavy breathing, sweating, and increased muscle tone.<sup>20</sup> A sleep terror episode can last as long as 10 minutes.<sup>21</sup> Sleep ter-

rors occur during stage four of short-wave sleep, within two hours of going to bed.<sup>22</sup> Sleep terror disorder begins in childhood and resolves as children reach adulthood.<sup>23</sup> Sleep terror disorder occurs in one to six percent of children and in less than one percent of adults.<sup>24</sup>

Sleepwalking disorder is characterized by episodes of motor behavior initiated during sleep which includes an individual rising and walking about.<sup>25</sup> Individuals experiencing an incident of sleepwalking exhibit a lack of alertness and are unresponsive to outside communication.<sup>26</sup> Following an episode of sleepwalking, individuals will have little or no memory of the event. After being awoken, the individuals may be confused or disoriented before becoming fully aware of their surroundings and exhibiting appropriate behavior.<sup>27</sup>

Sleepwalking is also known as sleep transition disorder because it occurs when the brain is shifting from slow-wave sleep to REM sleep.<sup>28</sup> Accordingly, most incidents occur one to two hours after the onset of sleep.<sup>29</sup> Sleepwalking begins during childhood, between ages four and eight with episodes peaking at age 12.<sup>30</sup> Sleepwalking rarely manifests for the first time during adulthood.<sup>31</sup> Approximately 2.5 percent of the general population suffers from sleepwalking disorder.<sup>32</sup> More specifically, only 0.5-0.7 percent of adults experience weekly to monthly episodes of sleepwalking.<sup>33</sup> Therefore, in diagnosing a sleep disorder, it is important to consider the individual’s prior history, or lack thereof, of aberrant behavior during sleep, which likely began during youth.

## **WHAT DOES MEDICAL LITERATURE SAY ABOUT VIOLENT AND SEXUAL BEHAVIOR DURING SLEEP?**

Some researchers have argued that there is a long history of violent behavior occurring during sleep. In one

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article, Dr. Peter Fenwick of the Institute of Psychiatry in London, indicated that there were reports of, “a total of about 20 cases of murder during sleepwalking between 1791 and 1974...”<sup>34</sup> One of those assaults cited occurred in 1600, when a knight stabbed his friend to death after he was awakened from sleep.<sup>35</sup> Another incident occurred in 1858, and reportedly involved a mother who awoke from a dream that her house was on fire and threw her infant son out of a window to his death.<sup>36</sup> More recently, in 1961, an American pilot allegedly strangled his wife in his sleep.<sup>37</sup>

Fenwick argued that these cases were examples of automatic behavior. The legal definition of automatism comes from an English case, *Bratty v. Attorney General for Northern Ireland*: “The state of a person who, though capable of action, is not conscious of what he is doing...it means unconscious involuntary action and it is a defence because the mind does not go with what is being done.”<sup>38</sup>

In 1989, the *Journal of Forensic Sciences* published an article discussing the possibility of dangerous automatic behavior occurring during sleep.<sup>39</sup> In that article, the cases of four men with histories of injurious behaviors during sleep were referred to the Minnesota Regional Sleep Disorders Center for Evaluation.<sup>40</sup> Each of the subjects underwent a formal psychiatric examination, polysomnographic study, and an electroencephalogram.<sup>41</sup> The results of the study indicated that various types of parasomnias including night terrors or sleepwalking could result in serious injury or death to the individual suffering from the disorder.<sup>42</sup>

Despite reports of sleep related violence, there have been few descriptions of sexual activity or sexual violence during sleep. In 1986, a researcher published the case of a 34-year-old man who engaged in masturbation two to three times per week while sleeping.<sup>43</sup> The subject’s wife stated that the subject could not be awoken during those episodes.<sup>44</sup> The subject also indicated that he had no memory of masturbating the next morning. He also described a history of talking in his sleep and suffering night terrors.<sup>45</sup> The subject declined an EEG study in an attempt determine if the incident was a somnambulistic variant, an unconscious incident of automatic behavior.<sup>46</sup>

In 1989, Thomas Hurwitz and his colleagues at the University of Minnesota Medical School published a case study of three men who, while apparently sleeping, engaged in hand to vagina contact with pre-adolescent children in their care.<sup>47</sup> Two of the men committed two separate acts of sexual abuse and one provided a history of alcoholism and admitted to consuming alcohol and “speed” prior to assaulting his 10-year-old daughter.<sup>48</sup> Hurwitz, *et al.*, concluded that while sleep laboratory evaluation is required in cases seeking forensic testimony, “[r]arely, sleep disorders such as obstructive sleep apnea with associated sleep drunkenness and sleepwalking could eventuate in aberrant sexual behaviors not representative of criminally purposeful offenses.”<sup>49</sup>

Another published study described the cases of two men suffering from sleep disorders who reportedly engaged in sexual conduct while sleeping.<sup>50</sup> The first case involved a 43-year-old man who had a history of sleep eating and sleep walking.<sup>51</sup> According to his partner, the two would have intercourse while the subject was snoring and the subject would have no memory of the event the following day.<sup>52</sup> The second case involved a 45-year-old male with a history of sleep walking. He was arrested and charged with sexual assault for “fondling” the friend of his 14-year-old daughter who was sleeping next to his daughter in the defendant’s residence.<sup>53</sup> The subject claimed to have no memory of the incident that reportedly lasted for “seconds.”<sup>54</sup>

In the discussions section of the article, the authors debate the medical and legal implications of sleepsex asking whether sleepwalkers are awake and conscious.<sup>55</sup> “It is a difficult task to decide whether unusual behavior in the sleep setting represents frank sleepwalking occurring during true sleep, or whether the behavior represents such varied phenomenon as a confusional arousal, noc-

turnal delirium, sleep drunkenness with automatic behavior... malingering, or other volitional, willed behavior.”<sup>56</sup> The authors add that of the few cases reported that involve sleep and crime, the majority do not involve sex.<sup>57</sup>

## **DOES SEXSOMNIA REALLY EXIST?**

In 2003, Canadian psychiatrist Colin Shapiro first used the term “sexsomnia” to describe a new and “distinct variant of an existing type of parasomnia; that is sleepwalking.”<sup>58</sup> Shapiro and his colleagues defined sexsomnia as a sleep disorder that involved both complex motor and autonomic activity with sexual arousal, which distinguished it from sleep walking.<sup>59</sup> In support of his theory, Shapiro described the cases of 11 individuals, men and women, with a prior history of sleep disorders, who each engaged in some type of sexual behavior while sleeping. In one case, a 16-year-old male who allegedly had hand to penis contact with his uncle while sleeping, also reportedly downloaded male pornography from the Internet while apparently sleepwalking.<sup>60</sup> Shapiro concluded that episodes of sexsomnia involve an “impairment of consciousness and awareness and, consequently, a relative lack of (legal) responsibility for the resulting behavior.”<sup>61</sup>

In their paper, Shapiro, *et al.*, disclosed several weaknesses underlying their theory. The authors admitted that sexual behavior in sleep is not yet recognized by physicians.<sup>62</sup> The authors also conceded that the etiology or cause of sexsomnia was unknown and that a male sex bias existed in the 11 subjects that were studied.<sup>63</sup> Finally, the authors were unable to provide any statistics concerning the prevalence of sexsomnia in the general population citing the need for a “formal study.”<sup>64</sup>

In 2007, Shapiro and his colleagues attempted to bolster their theory of sexsomnia by publishing the results of a 28-question Internet survey concerning sexual behavior in sleep.<sup>65</sup> Analyzing the responses of 219 individuals, the authors concluded that sexual behavior in sleep was “more common than thought, involving a relatively proportionate number of females and males across different age groups.”<sup>66</sup>

The authors again, however, pointed out the weak-

nesses in their research conceding that there was limited control over “bogus and duplicate answers” and that the responding population did not have a “clinically established diagnosis” of sexual behavior in sleep.<sup>67</sup> Further highlighting the limited use of their research, the authors stated that, “the results of surveys such as this one are not as statistically reliable when compared to controlled studies and should serve mostly as an orientation rather than as a conclusive scientific tool.”<sup>68</sup>

Additional research raises further questions about the legitimacy of sexsomnia. Although it is scientifically accepted that male erections generally occur in REM sleep, sleepwalking occurs during stages three and four of SWS.<sup>69</sup> “Most parasomnic behavior, with or without sexual content, does not occur in slow wave sleep (SWS) but arises out of SWS, suggesting that the presence of erections implies sexual intent.”<sup>70</sup> To explain sexual arousal during SWS, researchers argue for the creation of a new classification of parasomnia, sexsomnia. Those same researchers, however, contradict themselves by citing episodes of sexsomnia without sexual arousal, making a diagnosis of this condition difficult, to say the least.<sup>71</sup>

The presence of amnesia following sleep related sexual behavior, a supposed characteristic of sexsomnia, also remains an open question. A study published in 2007 cited complete amnesia for sleepsex in all 31 parasomnia cases that were reviewed.<sup>72</sup> Less than half of the individuals suffering from sleep epilepsy, however, reported having amnesia for their sleep related sexual behavior.<sup>73</sup> Those authors suggested, “embarrassment in recalling sleepsex would lead to no reported recall; and in medicolegal cases, claiming amnesia for sleepsex would carry secondary gain.”<sup>74</sup> The authors concluded that more data was needed to determine the presence of amnesia of sleepsex related to parasomnias.<sup>75</sup>

It is impossible to definitively diagnose sexsomnia. Some researchers have suggested the presence of certain factors for diagnosing sexsomnia: (1) a family history of sleepwalking; (2) prior incidents of sleepwalking; (3) disorientation upon awakening; (4) observation of confusional/automatic behavior during the event; (5) amnesia for

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the event; (6) trigger factors such as the use of drugs or alcohol, sleep deprivation, or stress; (7) no attempt to conceal the incident; and (8) the behavior is out of character for the individual.<sup>76</sup> It is also suggested that nocturnal polysomnography (“PSG”) should be used to study the overnight sleep patterns of an individual to diagnose sexsomnia.<sup>77</sup> With the exception of the PSG, all of these criteria are clinical and are made on the basis of history from the subject or someone who has knowledge of or has witnessed the subject. There is no medical test or definitive marker for the diagnosis of sleepwalking or sexsomnia.

It should be noted that the current edition of the *International Classification of Sleep Disorders* does not recognize sexsomnia.<sup>78</sup>

### **RESPONDING TO SEXSOMNIA: THE ROLE OF THE INVESTIGATOR**

Law enforcement officials investigating incidents of child sexual abuse in which the suspect may assert a sexsomnia defense should gather evidence to overcome that defense. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (“DSM-IV”) the diagnostic criteria for sleepwalking disorder includes “repeated incidents of complex motor behavior initiated during sleep...”<sup>79</sup> Accordingly, investigators should explore whether the suspect has a prior history of sleepwalking or if the first time happened to involve the sexual abuse of a child. The DSM-IV also indicates that 80 percent of individuals who sleepwalk have a family history of sleepwalking and sleep terrors.<sup>80</sup> Thus, investigators should interview the suspect’s parents and/or siblings about a family history of parasomnias. Finally, the DSM-IV’s diagnostic criteria for sleepwalking states that “sleepwalking must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.”<sup>81</sup> As such, investigators should examine whether or not the suspect attempted to avoid situations that would reveal his behavior to others: examples include sleeping alone or spending the night at

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friends or relatives residences. Of note, the DSM-IV states that although episodes of unlocking doors and operating machinery have been reported, most behaviors during sleepwalking are routine and of low complexity.<sup>82</sup> Similarly, it would be rare for a sleepwalker to engage in the complex action of sexually abusing a child, especially if the attack involved removing the child’s clothing and penetrating him the child.

Investigators should also closely examine the actions of the suspect both during and after the attack. Investigators should carefully review the victim’s description of the assault to determine if it is consistent with the actions of someone who is asleep, engaging in automatic behavior or is there an indication of consciousness. Did the suspect pull the child’s pants down? Did the suspect say anything to the child during the assault? Did the suspect pull the child’s pants up after the assault? Did the suspect apologize to the child, which would indicate consciousness of guilt? Did the suspect tell the child not to tell or engage in other conduct in an attempt to conceal his actions?

Investigators should also talk to the non-offending parent about the suspect’s actions after the attack. Did the suspect disclose the incident to the other parent immediately after the incident or did the suspect wait? If the suspect “accidentally” sexually abused the child, did he or she seek immediate treatment or counseling for the child as one would expect? Did the suspect make any attempts to seek counseling or take any measures to ensure that he or she would never “accidentally” sexually abuse children during sleep again? Failure to take these actions indicates the suspect engaged in intentional sexual abuse.

In *U.S. v. Harvey*, the court rejected the sexsomnia defense based upon the evidence gathered by investigators.<sup>83</sup> In *Harvey*, the appellate court, affirming the defen-

dant's conviction for engaging in hand to vagina contact with his 12-year-old daughter, found that the defendant's actions were "wholly inconsistent with acts by a person who claims that his actions were a sleep disorder-induced unconscious act."<sup>84</sup> The court noted that the evidence revealed the defendant pulled his daughter's pajamas and panties down and then pulled them back up when she woke up. The defendant also apologized to his daughter for his conduct later that day, stating, "I'm sorry for what I did," and "it'll never happen again."<sup>85</sup> Additionally, the defendant did not disclose the conduct to his wife until he was confronted by her, weeks after the incident occurred.

### **CHALLENGING TESTIMONY ON SEXSOMNIA UNDER FRYE OR DAUBERT**

Testimony about unproven conditions like sexsomnia can be challenged on its validity and lack of acceptance in the general medical community under *Frye*<sup>86</sup> or *Daubert*.<sup>87</sup> Prosecutors should remind judges of their roles as gatekeepers when presented with novel and unreliable scientific evidence and the requirement "to preclude the use of testimony based on obscure scientific theories that have the potential to mislead lay jurors awed by an aura of mystic infallibility surrounding scientific techniques, experts and the fancy devices employed."<sup>88</sup> As the Connecticut Supreme Court held in *Connecticut v. Griffin*, to be considered reliable, scientific theories require more than discussion in professional journals and at seminars, it must be "generally accepted as scientifically valid."<sup>89</sup> This tactic should be used to inform and persuade the judge to require the defense to put the diagnosis of sexsomnia in context. This requires the prosecutor to understand sexsomnia, sleep, and recognized sleep disorders. Prosecutors can use this information to educate the court about the differences between recognized sleep disorders and sexsomnia, as sexsomnia lacks diagnostic criteria and support in the medical community.

### **CROSS EXAMINATION OF THE DEFENDANT AND/OR DEFENSE EXPERT**

In the event that the court admits testimony about sexsomnia over the prosecution's objection, prosecutors must be prepared to vigorously cross-examine the defense expert. First, prosecutors should not only seek disclosure of the expert's opinion, but the basis of that

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opinion including any articles that the expert may have relied upon. That information should form the basis of an effective cross-examination. Additionally, the defense expert should be asked to describe in detail the conduct and the implausibility that the defendant sleepwalker would engage in this particular activity and would not wake up. The prosecutor should walk the defense expert through the defendant's actions, using the following questions:

- The defendant walked out of his bedroom?
- The defendant walked down the hall?
- There are numerous rooms in the house?
- The defendant could have walked into the bathroom? The kitchen? The living room? The basement?
- The room the defendant walked into, however, was his daughter's bedroom?
- There are many things that he could have done while sleepwalking?
- He could have made breakfast?
- He could have turned on the TV?
- He could have started the car? Mowed the lawn?
- Instead, the defendant had sex with his daughter?
- The defendant did not wake up when he pulled his pants down? He did not wake up when pulled his daughter's pants down? He didn't wake up when he penetrated her vagina with his penis?
- He did not wake up when she screamed?

A similar cross-examination could be used on the defendant if he testifies.

When presented with a sexsomnia defense, prosecutors and investigators should consider the surrounding circumstances, analyze the defendant's past history, evaluate the medical evidence, and consider the criteria used by those advocating for the recognition of sexsomnia as

a new sleep disorder. Prosecutors must aggressively work to prevent judges and jurors from considering unfounded scientific testimony in child sexual abuse cases and then vigorously cross-examine defendants and their experts to expose the sexsomnia defense as invalid.

## ENDNOTES

- 1 Melissa Juergensen, *Groups Vow to Fight 'Sexsomnia' Ruling*, Ottawa Sun, December 8, 2005, at 12.
- 2 *State v. Overton*, 815 A.2d 517 (N.J. Super. Ct. App. Div. 2003).
- 3 *U.S. v. Harvey*, 66 M.J. 585 (A.F. Ct. Crim. App. 2008).
- 4 Peter Fenwick, *Automatism, Medicine, and the Law*, 17 *Psychological Medicine* 1, 13 (1990).
- 5 *Id.*
- 6 *Id.*
- 7 *Id.*
- 8 *Id.*
- 9 *Id.*
- 10 *Id.*
- 11 *Id.*
- 12 Diagnostic and Statistical Manual of Mental Disorders Text Revision (American Psychiatric Ass'n ed., 4th ed. 2000) at 630.
- 13 Monica L. Andersen, Dalva Poyares, Rosana S.C. Alves, Robert Skomro, Sergio Tufik, *Sexsomnia: Abnormal sexual behavior during sleep*, 56 *Brain Research Review* 271, 272 (2007) citing International Classification of Sleep Disorders, Diagnostic and Coding Manual (American Academy of Sleep Medicine ed., 2nd ed. 2005) at 208.
- 14 *Id.* at 631.
- 15 Colin M. Shapiro, Nikola N. Trajanovic, J. Paul Fedoroff, *Sexsomnia—A New Parasomnia*, 48:5 *Canadian J. Psychiatry* 311, (June 2003).
- 16 *Id.*
- 17 *Id.*
- 18 *Id.* at 632.
- 19 *Id.* at 634.
- 20 *Id.* at 635.
- 21 *Id.* at 634.
- 22 Fenwick at 14-15.
- 23 *Id.* at 15.
- 24 Diagnostic and Statistical Manual of Mental Disorders, §307.46 at 636.
- 25 *Id.* at 639.
- 26 *Id.*
- 27 *Id.*
- 28 Irshaad Osman Ebrahim, *Somnambulistic Sexual Behavior (Sexsomnia)*, 13:4 *J. Clinical Forensic Medicine*, 219-224 (May 2006).
- 29 *Id.*
- 30 Diagnostic and statistical Manual of Mental Disorders, §307.46 at 641.
- 31 *Id.*
- 32 Fenwick, at 14.
- 33 Diagnostic and Statistical Manual of Mental Disorders, §307.46 at 641.
- 34 Fenwick at 15.
- 35 *Id.*
- 36 *Id.*
- 37 *Id.*
- 38 Bratty, 46 Cr. App. R. 1 (1963).
- 39 Mark W. Mahowald, Scott R. Bundlie, Thomas D. Hurwitz, Carlos Schenk, *Sleep Violence-Forensic Science Implications: Polygraphic and Video Documentation*, *J. Forensic Sciences* 413-432 (March 1990).
- 40 *Id.* at 414.

- 41 *Id.*
- 42 *Id.*
- 43 K. E. Wong, *Masturbation During Sleep—A Somnambulistic Variant*, 27:6 *Singapore Medical J.* 542, 543 (December 1986).
- 44 *Id.*
- 45 *Id.*
- 46 *Id.*
- 47 Thomas D. Hurwitz, Mark W. Mahowald, Janet L. Schluter, *Sleep Related Sexual Abuse of Children*, 18 *Sleep Research* 246 (1989).
- 48 *Id.*
- 49 *Id.*
- 50 David Saul Rosenfeld, Antoine Jean Elhajjar, *Sleepsex: A Variant of Sleepwalking*, 27:3 *Archives of Sexual Behavior* 269 (1998).
- 51 *Id.* at 270.
- 52 *Id.*
- 53 *Id.* at 272.
- 54 *Id.*
- 55 *Id.* at 274.
- 56 *Id.*
- 57 *Id.*
- 58 Colin M. Shapiro, Nikola N. Trajanovic, J. Paul Fedoroff, *Sexsomnia—A New Parasomnia*, 48:5 *Canadian J. Psychiatry* 311, 312 (June 2003).
- 59 *Id.* at 314
- 60 *Id.*
- 61 *Id.*

(Continued on page 30)

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62 Id. at 312.  
 63 Id. at 312, 316.  
 64 Id. at 316.  
 65 Nikola N. Trajanovic, Michael Mangan, Colin M. Shapiro, *Sexual Behavior in Sleep An internet Survey*, 42 *Social Psychiatry and Psychiatric Epidemiology* 1024-1031 (2007).  
 66 Id. at 1029.  
 67 Id.  
 68 Id.  
 69 Andersen at 276.  
 70 Id.  
 71 Id. at 277.  
 72 Carlos H. Schenck, Isabelle Arnuff, Mark W. Mahowald, *Sleep and Sex: What Can Go Wrong? A Review of the Literature on Sleep Related Disorders and Abnormal Sexual Behaviors and Experiences*, 30:6 *Sleep* 683, 698 (2007).  
 73 Id.  
 74 Id.  
 75 Id.

76 Ebrahim at (online 8).  
 77 Id. at (online 9).  
 78 International Classification of Sleep Disorders, Diagnostic and Coding Manual, 2nd ed.  
 79 Diagnostic and Statistical Manual of Mental Disorders Text Revision (American Psychiatric Ass'n. ed., 4th ed. 2000) at p. 639.  
 80 Id. at 642.  
 81 Id. at 639.  
 82 Id. at 639.  
 83 *Harvey*, 66 M.J. at 586-87.  
 84 Id., at 587.  
 85 Id.  
 86 *Frye v. United States*, 54 App. D.C. 46, 293 F. 1013 (1923).  
 87 *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993).  
 88 *Connecticut v. Griffin*, 869 A.2d 640, 649 (Conn. 2005).  
 89 *Griffin*, 869 A.2d at 651.

## Message from the President

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ing. There are many areas in which NDAA and NAPC can work together and accomplish much more than if we were working separately, and our relationship can and should get even stronger in the years to come.

In addition to NAPC, we have made concentrated efforts to work with many groups on areas of mutual interest. For example, we are working closely with the American Academy of Forensic Scientists (AAFS), the Consortium of Forensic Scientists Organization (CFSO), and many other groups and governmental agencies regarding the NAS report. We are similarly working more closely with the International Association of Chiefs of Police (IACP), the FOP, and other law enforcement groups on various topics of mutual interest. In mid-April for the first time, NDAA and the ABA Criminal Justice Section held their spring meetings together in Charleston, SC, and actually had some joint committee meetings. The ABA Criminal Justice Section is made up of judges, prosecutors, defense attorneys and academicians. While there were some topics on which we understandably disagreed, there were also many on which there was substantial agreement. The important thing is that for the first time in a long time, perhaps for the first time ever in some instances, NDAA is reaching out to, connecting with, and having meaningful input with other groups on areas of mutual importance. This is what we should be doing, as the “voice of Americas prosecu-

tors,” and we are doing it better than ever before.

I am also happy to announce that for the first time in a long time, our Web site has undergone and is still undergoing substantial renovation. If you have not been to the Web site in a while, I encourage you to sign on. You won't believe the new look. It now reflects the professionalism that is NDAA. I want to publicly thank those staff members in Alexandria who have worked tirelessly on this effort.

All of this progress would not have been possible without the dedication of all our faithful employees in Alexandria and Columbia, who are simply the best. Further, Scott Burns is doing an outstanding job as executive director and provides great leadership to this organization. Morale among the staff has never been higher, and people from DOJ, Congress and many other groups regularly mention what an outstanding job he is doing and how it is clear that NDAA is back.

More importantly, however, all of this progress would not have been possible without the hard work and dedication of the more than 7,000 of you who make up NDAA. All of you have full time jobs, families, and many other important things to do in your respective jurisdictions. Yet you take the time whenever asked, and often even when not asked, to support NDAA in ways far too numerous to mention. Just as the communities you serve are lucky to have you, NDAA is lucky to have you as a member. You make a difference every day in our fight to do justice and it is an honor to serve as your president. It is because of you that the future of NDAA is so bright.