FALSE BUT SINCERE ACCUSATIONS OF SEXUAL ASSAULT MADE BY NARCOTIC PATIENTS

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Introduction

Many sexual assaults take place in privacy, so accusations are uncorroborated. Sometimes direct evidence of sexual activity is available, but often we rely on the accuser's account. So unless the perpetrator confesses or has previously offended, the testimony of the alleged victim is all there is to go on. If the accuser is honest the attitude displayed will be congruous with that of an innocent and wantonly damaged person: indignation or a similar affect will be apparent, at least until repetition has dulled the style. There would be no ulterior motive. The victim would not go on to embellish the original story, even if tempted to do so by, for example, implications that a modified story would sound more likely. The first complaint may be made days after the offence. The account is often allusive: the victim may mention details such as the molester's after-shave, or rain on the window, so that the account vividly conjures up the scene. These features, together with the victim's luminous sincerity and stainless history, may cause the listener to take the accuser's part in premature closure, and to dismiss denials as inevitable and thus of no weight.

The case histories in this paper demonstrate that accusations may have the above characteristics, but be without any basis in fact. The patients making the accusations were suffering from narcolepsy.

Narcolepsy is a disease which has four main manifestations. Patients are sleepy, and episodically need to nap. They experience loss of muscle tone when emotional, a symptom called cataplexy. On going to sleep or waking they may hear, see, feel or smell things when there is no objective stimulus, and these experiences are called hypnogogic or hypnopompic hallucinations. While half asleep or waking they may, though conscious, be unable to move for a few seconds or a minute, a symptom called sleep paralysis.

Narcolepsy may be diagnosed without any laboratory confirmation, and not all the items in the tetrad need be present for the diagnosis to be made, but the diagnosis may also be supported by laboratory findings. A polysomnographic sleep study, measuring the characteristics of the patient's sleep, may show a short Rapid Eye Movement (REM) latency, that is, REM sleep starts very soon after sleep onset. A multiple sleep latency test (MSLT) may also be used: if the patient is invited to nap on the day following the night study, and is given 5 naps at set intervals, then a short sleep latency (rapidly falling asleep on each occasion), with REM sleep in two or more naps, confirms the diagnosis of narcolepsy. In our laboratory investigations we have found narcolepsy to be diagnosable much more frequently by MSLT than by the previous night's polysomnography, a point which is raised again in the Discussion.

Narcolepsy is associated with the HLA-DR2 marker in almost all cases. Less than 25% of the non-narcoleptic population has this marker. Recently a more precise association has been determined, with HLA-DRw15.PQw6: fewer non-narcoleptics have this marker.

It is now known that some narcoleptic patients have hallucinations which so overshadow their other symptoms that the specialist they are sent to is a psychiatrist instead of a neurologist (1). More than five per cent of the patients designated as schizophrenic are primarily narcoleptic and thus, since narcolepsy takes precedence in this context, are not schizophrenic at all. These patients have so many hallucinations, which they speak of as real (and so display delusions) that it takes care and alertness to diagnose them as narcoleptic.

Narcoleptic's psychotic symptoms, though resistant to conventional antipsychotic remedies, respond promptly to the usual antinarcoleptic remedies.

A research group of which Alan Douglass was the principal investigator, and with which the present author was associated, described the series of patients referred to above, who had psychoses secondary to narcolepsy (1). Subsequently we reviewed all of our other hallucinated patients to see how many had narcolepsy. In the course of these reviews it became clear that narcoleptic patients frequently described sexual assaults. These accusations could be recognised as arising from hallucinatory experiences only after narcolepsy had been diagnosed.

Case reports

Patient No. 1.

A 42-year-old housewife initially complained of anxiety attacks, supervening after waking in a panic, finding she could not move, and anticipating imminent death. Her mother had died shortly before this, and three days before her initial panic attack she had had a hysterectomy. She mentioned that for some months she had been depressed, and has been given tricyclic antidepressants. While depressed, but before receiving any antidepressants, she had started to see "images" e.g. of her dead brother outside the windows on top of a tree; and she sometimes heard people talking in the background when alone. Starting tricyclic antidepressants was associated with lessening of her hallucinations. The inexplicable nature of her symptoms caused me to categorize her as "organic" and proceed to investigations of her physical state. Both I and the neurologist associated with these investigations regarded her depression, though not her other symptoms, as understandable because she had "ample reason" in the circumstances: these circumstances were, according to the patient, that when she was first married her foreign-born father-in-law had continuously molested her sexually in a bizarre manner. Her husband, to whom she had complained, did not attempt to remedy the situation, but simply looked blank. She surmised that he had abstained from confronting his father because they were financially partially dependent upon him, and she had consequently lost so much respect for her husband that the marriage was in jeopardy. As contemporary notes make clear, all her medical attendants acted on the shared assumption that her accusations were true. Indeed, out of curiosity we made some unsystematic

inquiries to find out if the strange sexual behaviour of the father-in-law was culturally acceptable in his country of origin.

Investigations included complete blood count, fasting glucoses, electrolytes, urinalysis, creatinine and urea, liver function tests, EEG, ECG, digital subtraction angiogram of the carotid arterial system (the patient had a strong family history of atherosclerosis), CT scan of the head, ESR, serum B_{12} and folic acid, thyroid function, progesterone and prolactin, all of which were normal. Her DSM-III diagnosis was Schizophrenic Disorder: this amounts only to a statement that an adequate selection of a set of symptoms is present, and is a point of departure rather than a diagnostic destination. She was kept under review in order that any advances in techniques of investigation could be turned to her advantage.

When later questioned specifically, Patient No. 1 said that when tired she would see and hear things; and when starting a nap she would feel something like a worm crawling inside her skin. She drank more than 20 cups of tea a day. She had always napped in the afternoon, and said that without a nap she would not have had the energy to make supper. Once when waking she rolled out of bed and fell to the floor and was unable to move. When she became sad or angry her whole body would go limp and she would hang onto something to avoid collapsing or falling.

Multiple Sleep Latency Test showed a sleep latency of 11.4 minutes, longer than usual for a narcoleptic, but REM in 4/5 naps. The test result was Narcolepsy.

Patient No. 2

This 42-year-old woman had only had one previous psychiatric contact, for rape counselling. She described auditory, visual and tactile hallucinations, astral travel, poisonings, and plots. All were worst at night, and her visual hallucinations occurred only at night. Because of the timing of the symptoms, I had asked her at the outset about sleep paralysis, which she then denied, but I was not acute enough to persist with this line of questioning. The initial diagnosis was "a chronic hallucinatory psychosis of obscure aetiology" and she too was investigated first as an outpatient and then in hospital.

When questioned specifially, Patient No. 2 acknowledged that there were times that she awakened and had been unable to move, but ascribed her disablement to drugs illicitly administered.

This patient described being raped, as follows. She was a single mother, living with her child of 12. A policeman concerned with the welfare of the patient's child (who had committed some minor delinquency) came several times for tea. One day he produced a bottle of the deluxe rye whisky variety wrapped in a velvet bag. Being unused to alcohol, she became nauseated and went to the bathroom to vomit. It was late, and she decided to go to bed. Once she was in bed he came in, took his pants off and raped her: she gave a detailed account of her state of undress, their respective positions, and so on. Following this he misued her, made her take drugs, and left. Subsequently she tried to avoid further contact; when they did meet "he acted as though nothing happe-

ned". The patient saw a psychiatrist for rape counselling. She lost all confidence in the police.

In her chart this episode was included in the history as fact, even after her narcolepsy was diagnosed.

Early in the course of treatment of her narcolepsy, while still insightless, she described another rape, taking place five years after the first. She was a clerk in a large organisation, and her manager gave a party at his house. She had some alcohol, and then went to the bedroom. Her chairman came in and raped her - which she could not prevent because she was for the time being both mute and paralysed. Subsequently, he let some of the other men in who also silently raped her. When she recovered her senses, she found that they had put her clothes back on. She left the party with a female colleague. The next day the men at the office avoided her gaze. She did not dare report her manager in case she lost her valuable job. She permanently lost respect for her supervisors, and was angry at them from that time on. She retired early from her position.

In a subsequent admission history, a note appeared "Rape in the early 80s and other occasions"; that is, her statements were taken at face value by the admitting doctor.

Less likely experiences, such as being stimulated by divine touch to orgasm during working hours, sexual experiences with God or his heavenly manager at night, and having blood taken from her at night by intruders who sometimes raped her, were recorded as delusional: these phenomena were mostly not spontaneously reported by the patient, but were elicited by questions arising from the suspicion that she might have narcolepsy.

MSLT showed a sleep latency of 3.1 minutes, sleep in all 5 naps and REM in two naps, supporting the diagnosis of narcolepsy. The patient had HLA-DR2. She made a good response to amphetamine.

Patient No. 3

This 39-year-old man had been diagnosed as a chronic paranoid schizophrenic, because of his hallucinations, delusions and downhill course. Questioning elicited the tetrad of narcolpesy. He showed sleep-onset REM at nocturnal polysomnography, and at M.S.L.T. a sleep latency of 4.1 minutes, with REM in two naps. The diagnosis of narcolepsy having been confirmed, he was treated with amphetamine and the hallucinations that had plagued him all his adult life at once subsided, with gradual subsequent development of insight.

He said that when he was a young man he had a friend with whom he spent a lot of time, and they would sometimes have a beer or two. He would then become sleepy, and have a nap."My feeling was that I was drugged". After falling asleep he would partially awake, only to find himself elsewhere, for example in a moving vehicle. At these times his friend would fondle him sexually. He could not resist these unwelcome advances because it was as if he was paralysed by drugs. When the patient was fully awake his friend acted perfectly properly. The patient gradually severed the relationship with his friend, who married and left the patient's social circle.

For some time after the patient had put most of his narcoleptic symptoms

into perspective, he continued to regard his sexual molestation as real, and to wonder what drug it could have been, and why it had happened to him. The patient is intelligent and educated and gradually ruefully gained complete insight.

Patient No. 4

The woman of 31 developed a severe hallucinosis, with vivid and horrifying auditory, visual and tactile hallucinations. She became obese, and slept frequently. She made suicide attempts because of the torments, and the command hallucinations. Her life being in danger, she was treated vigorously but no drugs were effective. Electroconvulsive therapy (ECT) temporarily banished the hallucinations (and with them most of the other abnormalities in her mental state) but she received so much ECT that her memory became impaired. She was transferred to me for a second opinion. She had none of the customary antecedents of severe psychoses (such as a family history of similar disorders), so she was admitted for investigations. She turned out to have the narcoleptic tetrad, and sleep laboratory results (MSLT — REM on two naps) confirmed the diagnosis of narcolepsy. Amphetamine banished all hallucinations and she became largely symptom-free and insightful into all aspects of her illness except the sexual attempts and rapes to which she had been subjected during her illness.

She said that she had been sexually assaulted at home, at her original hospital and then at my hospital. The experiences had made her fearful and guarded, and she was unwilling to talk on the topic. With her face twitching and puckering with distaste, she said that after returning home symptom-free, a man had assaulted her in a way she refused to specify in detail. He had come to her door looking for someone who lived in her small town. She did not know the name he cited, and therefore could not guide him. He asked her if he could use her telephone. She at once was not sure whether she believed him and at the same time found his manner pleasant and reassuring. She did not let him in, and watched him walk away towards his car. The patient attended to the needs of her infant daughter, and then to be on the safe side went to the front door to lock it. He was standing outside the door and, apprehending her intention, pushed his way in. She could hear her child playing with her toys in the next room, and recalled the specific squeaks and noises they were producing as the assault commenced. When the assault was over, he left, and she went at once to her child, who was unharmed and had seen and heard nothing.

This episode took place when the patient was tired. Though usually asymptomatic, if she missed or delayed an amphetamine dose she would start to hallucinate. With some modification of her regimen these episodes ceased.

The other patients described in this paper had their experiences of molestation early in their illnesses. Patient No. 4 could not remember her early symptoms in detail, but gave a good account of current phenomena; in this instance she has sexual molestation as a residuum, and it seems real despite her insight into narcoleptic phenomena. As this insight was developing she said wonderingly "I would swear on the Bible that it happens." Subsequently, as her mem-

ory improved, she remembered rapes which antedated diagnosable narcolepsy by several years. Also, over the follow-up period, she described fresh episodes of different sexual assaults taking place in various rooms in her home.

Discussion

Narcolepsy goes mostly undiagnosed. Many narcoleptics manage their condition by having naps and coffee, and avoiding situations in which sleepiness would be dangerous, such as highway driving. Many undiagnosed narcoleptics have illnesses in which dreams take place in the daytime when the subject is apparently awake. The intrusion of REM in this fashion may lead the patient to misremember but the patient can learn to gloss over associated incongruencies. Narcoleptics who are finally diagnosed will often describe events in their past which, by ordinary assessment of what is possible, cannot have taken place: astral travel is an example of this kind of event.

As set out in the patients' histories, they may, long before they are easily diagnosable, make detailed accusations of sexual attacks, or (if prevented by practical considerations) may wish they could do so.

That this type of false recollection is widespread is indicated by published case histories. A report emenating from Harvard (2) described post-traumatic stress disorder: after a horrific rape and torture the patient re-experienced the traumatic events in "daytime flashbacks and nightmares". She had "frequent episodes of paralysis while fully awake, during which she also had vivid hallucinations". The authors dismiss the diagnosis of narcolepsy, and when they tested her in their sleep laboratory they did not use the MSLT. Probably the authors preferred to think of the patient as a typical case of post-traumatic stress disorder rather than an atypical case of narcolepsy.

There is at present widespread interest in some supposedly linked things — early sexual abuse, post-traumatic stress disorder, and dissocation. The catch-all explanation of dissociation is currently offered for many phenomena observed which once would have been regarded as psychotic. The authors of the paper being cited refer to other accounts of post-traumatic stress disorder in which, though REM phenomena are obvious, the diagnosis of narcolepsy is not canvassed (3,4). Narcolepsy may not be the primary cause, but in a setting notorious for imprecision and fashion, narcolepsy has the unique advantage of being testable by laboratory assessment and genetic associations.

The patients we have been describing are obviously honest, describing consistently what they genuinely experienced, and setting their true perceptions before the listener. Their emotional responses are congruent. What they say has to be assessed by considering whether it is likely; and by asking questions which are calculated to elicit the narcoleptic tetrad. If what they are saying in their accusations is the result of narcoleptic experiences, then they are describing a selection of the phenomena which make up the tetrad of narcolepsy, or auxiliary symptoms of that state. They will describe the other symptoms if given the opportunity to do so by having the appropriate questions put to them in a non-leading form.

A sincere but false accusation may carry more weight than a denial. The accuser may gain credence as circumstances are artlessly detailed, while the accused person is limited to pathetically increasing the vehemence of his denials. A persistent false sincere accusation, persistently denied, damages both parties. In some cases, narcolepsy is the cause of such a stalemate. Narcolepsy can be diagnosed by having a trained practitioner ask the necessary questions, or by laboratory means, and where serious consequence may flow from an impasse, this disease should always be sought. Raising the possibility of narcolepsy does not provide an accused person with a spurious defence, but gives a narcoleptic accuser the possibility of reviewing the percepts which consistute the complaint. These patients make their accusations reluctantly and will be perfectly ready to admit to other members of the tetrad or to classical auxiliary symptoms. An accuser whose account is based on reality, on the other hand, will only manifest this set of phenomena as a coincidence, which would happen less than once in five hundred times.

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