Bed Partner “Gas-Lighting” as a Cause of Fictitious Sleep-Talking

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A case report highlighting a rare and striking, but perhaps under-recognized, cause of reported sleep-talking to a specialist sleep clinic, involving “gas-lighting” by the bed partner.

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REPORT OF CASE

A 67-year-old right-handed bus driver was referred to our neurological sleep clinic, with one year's history of sleep-talking noticed by his bed partner of 18 months. The somnolence occurred on most nights, beginning within ten minutes of falling asleep. There were up to 4 episodes per night, each ranging from minutes to hours in duration. The speech was elaborate and often related to ex-girlfriends, at times describing explicit sexual activities with them. The partner described the speech as “crude and vulgar,” and on one occasion he accurately recited the phone number of one of his ex-girlfriends, despite being unable to recall the number when awake. He had no recollection of these events, but was easily roused during the episodes. The nature of his speech had resulted in significant relationship stress, and he had been forced to spend many nights in a local hotel.

A psychiatric opinion at another centre did not reveal significant anxiety or depression. Despite this, a trial of the hypnotic and anxiolytic agents, clonazepam and temazepam, was suggested by the psychiatrist but this did not provide any symptomatic improvement. In fact, the content of his nocturnal speech reportedly deteriorated, and his partner described his discussing sexual affairs with friends and the sexual abuse of his children. The patient vehemently denied that the content of his reported speech had any factual basis.

He was known to snore. There had been one self-reported episode of sleep-talking in childhood, but there was no current history of sleepwalking, abnormal movements arising from sleep, daytime somnolence, or narcoleptic features.

His medical history included hypertension, hypercholesterolemia, chronic obstructive pulmonary disease, and leg cramps. He used tiotropium, antihypertensives, simvastatin, and quinine. He was an active smoker and drank two cans of beer per day. In an attempt to improve his symptoms, he had stopped smoking cannabis, but this had no effect.

The neurological examination was unremarkable. His body mass index was normal (24.6 kg/m²) and an Epworth Sleepiness Scale score did not suggest significant daytime

somnolence (5/24). An MRI brain revealed a right frontal white matter cyst, which was felt to be incidental. Nocturnal polysomnography demonstrated normal sleep latency and REM sleep onset. Significantly, his apnea-hypopnea index was 32.5 events per hour, with a 4% oxygen desaturation index of 32.8, diagnostic of clinically significant obstructive sleep apnea. No sleep-talking was witnessed while undergoing polysomnography. Nocturnal continuous positive airways pressure was commenced subsequently.

The working diagnosis at that time was that obstructive events in NREM sleep might be precipitating a NREM parasomnia, although it was recognized that certain features of his parasomnia were unusual, such as the onset within 10 minutes of sleep.

On review two months later, his sleep quality had improved. However, his partner reported ongoing nocturnal speech in the same manner. During this period, the patient's mounting curiosity and initiative led to the implementation of surreptitious nighttime electronic recordings. Via this method it became apparent that his partner was heard screaming and shouting at him without any audible evidence of sleep-talking as the trigger. This confirmed the patient's suspicion that his partner's reports were fictitious. He commented that his partner had taken advantage of these accusations to negotiate more favorable domestic financial arrangements for herself. He noticed further manipulative behavior in the form of purposeful misplacement of his phone book, chronologically correlating with his alleged recitals of ex-girlfriends' numbers. His partner adamantly refused the allegations of falsehood, and full psychiatric evaluation excluded morbid jealousy and psychotic illness.

DISCUSSION

We aim to highlight the rare but possibly under-recognized, psychological phenomenon of gas-lighting. This was first reported in 1969,¹ coined from the 1938 play *Gas Light*, in which a husband systematically torments his unsuspecting wife in order to infer insanity and provoke admission to a mental health unit.

Despite its recognition within a clinical context 45 years ago, there are only sparse descriptions in the medical literature.^{2–4}

Among the documented cases, the perpetrator devises ways to manipulate the opinions of medical professionals regarding their ostensibly unwell spouse. It draws similarities with the more widely recognized syndrome of Munchausen by proxy. The underlying motives are varied, including financial gain or emancipation from the “patient.”

The major differential diagnosis for sleep-talking is that of a NREM parasomnia, but in parasomnias of late onset (this patient presented in his seventh decade), the possibility of a REM sleep behavior disorder presenting as sleep-talking should be considered.⁵

We highlight this rare but striking phenomenon, which should be considered among the differential diagnoses of unusual or atypical presentations to sleep clinic. It is especially pertinent in this setting as the clinical assessment relies heavily on the bed partner account, and routine investigations are variably helpful in making a positive diagnosis.

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