

'I've been abducted by aliens'

Patricia Kinne, MD, and Venna Bhanot, MD

Ms. S is afraid to sleep at night because that's when the aliens come. Is she psychotic, or do her nocturnal experiences have another cause?

CASE 'I'm not crazy'

Ms. S, age 55, presents for treatment because she is feeling depressed and anxious. Her symptoms include decreased concentration, intermittent irritability, hoarding, and difficulty starting and completing tasks. She also has chronic sleep difficulties that often keep her awake until dawn.

Fatigue, lack of focus, and poor comprehension and motivation have left her unemployed. She and her teenage daughter live with Ms. S's elderly mother. Ms. S feels tremendous guilt because she cannot be the mother and daughter she wants to be.

Initially, I (PK) diagnose Ms. S with major depressive disorder and prescribe sertraline, 100 mg/d, which improves her mood and energy. However, her inability to stay organized results in her being "let go" from job training.

Ms. S reports similar difficulties in school as a child. I determine that she meets DSM-IV-TR criteria for attention-deficit/hyperactivity disorder (ADHD). Adding methylphenidate, 10 mg bid, improves her concentration and ability to complete tasks. It also reduces the impulsivity that has disrupted her relationships.

Despite a strong desire to normalize her sleep schedule, Ms. S continues to have dif-

ficulty falling asleep, so I add melatonin, 3 to 6 mg at bedtime. Her sleeping pattern is improved, but still variable. She also tries quetiapine, 25 mg at bedtime, but soon discontinues it due to intolerance.

As our rapport strengthens, Ms. S reveals that she has had multiple encounters with aliens beginning at age 3. Although she has not had an "alien experience" for about 5 years, she does not feel safe sleeping at night and instead sleeps during the day. Her efforts to stay awake at night strain her relationship with her mother.

How would you respond to a patient who claims she has been abducted by aliens?

- explain that there are no such things as aliens
- insist that she was dreaming
- issue a mental hygiene warrant and sign a certificate for immediate hospitalization
- explore the experiences in a supportive, respectful manner and rule out organic or substance-induced etiology

The authors' observations

Approximately 1% of the U.S. population report alien abduction experiences (AAE)—an umbrella term that includes alleged contact with aliens ranging from sightings to abductions.¹ Patients rarely report AAE to mental health professionals. In our society, claiming to be an "abductee" implies that one might be insane. A survey of 398



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To read more about sleep disorders, see "Sexual behavior during sleep: Convenient alibi or parasomnia," page 21-30

Clinical Point

A survey of 'abductees' found that 88% described at least some positive aspects of the experience

Canadian students that assessed attitudes, beliefs, and experiences regarding alien abductions found that 79% of respondents believed they would have mostly negative consequences—such as being laughed at or socially isolated—if they claimed to have encountered aliens.¹

Persons who have AAE may attend support groups of fellow “abductees” to accumulate behavior-consonant information (hearing other people’s abduction stories) and reduce dissonance by being surrounded by others who share a questionable belief.² A survey of “abductees” found that 88% report at least some positive aspects of the experience, such as a sense of importance or feeling as though they were chosen to bridge communication between extraterrestrials and humans.³

Data collected over 17 years from Minnesota Multiphasic Personality Inventory (MMPI) scores of 225 persons who reported AAE reveal common personality traits, including:

- high levels of psychic energy
- self-sufficiency
- resourcefulness
- a tendency to question authority and to be exposed to situational conflicts.¹

Other common characteristics include above-average intelligence, assertiveness, a tendency to be reserved and absorbed in thought, and a tendency toward defensiveness, but no overt psychopathology.¹

After Ms. S reveals her alien experiences, I reassure her in a nonjudgmental manner that we will explore her experiences and determine ways to help her cope with them.



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HISTORY Terrifying experiences

Ms. S elaborates on her alien experiences, relating a particularly terrifying example from her teen years. She was lying awake in bed, looking at the ceiling, where she saw a jeweled spider with a drill. As the spider descended from the ceiling and spread its legs, she recalled a noise like a dentist’s drill. As the spider neared her face, it grew larger and larger. Terrified, Ms. S was unable to scream for help or move anything except her eyes as the spider clamped its legs around her head and bored into her skull. She reported that although she could feel the drill go in, it wasn’t painful.

Other experiences included giving birth, undergoing examinations or probes, and communicating with aliens. Although she is very distressed by most memories, she feels she benefited from others. For example, as a child, Ms. S’s math skills improved dramatically after an AAE episode; she believes this was a gift from the aliens. Ms. S’s AAE memories are as vivid to her as memories of her college graduation. She had been reluctant to discuss these events with anyone outside her family out of fear of being perceived as “crazy.”

Ms. S says she was a shy child who had difficulty making friends. She was plagued with fatigue and worry about family members. She believed that aliens might attack her sisters and felt obligated to stay awake at night to protect them. Aside from alien experiences, Ms. S reports a happy childhood.

She has always been an avid reader. At age 8 or 9, after reading a book on alien abduction, she concluded that she had been abducted. Later, she joined a group of professed alien abductees. She feels accepted and validated by this group and has a forum for discussing her experiences without fear of ridicule or rejection.

Ms. S remains frightened by things that remind her of aliens. Although she wrote a summary of her alien experiences, she cannot draw a picture of an alien, and thoughts or images of the prototypical “grey” alien trig-

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Table 1**4 types of sleep paralysis-related hallucinations**

Intruder	Vague sense of a threatening presence accompanied by visual, auditory, and tactile hallucinations—noises, footsteps, gibbering voices, humanoid apparitions, and sensation of being touched or grabbed
Incubus	Breathing difficulties, feelings of suffocation, bodily pressure (particularly on the chest, as if someone were sitting or standing on it), pain, and thoughts of impending death
Vestibular-motor	Sensations of floating (levitation), flying, and falling
Other	Out-of-body experiences, autoscopy (seeing oneself from an external point), and fictive motor movements, ranging from simple arm movements to sitting up to apparent locomotion through the environment
Source: References 7,9	

ger panic. She also feels somewhat “different,” nervous, and distant from others.

What diagnosis do Ms. S’s symptoms and history suggest?

- seizure activity
- sexual abuse/trauma
- schizoaffective disorder
- schizotypal personality disorder
- sleep disorder

The authors’ observations

Reviewing AAE literature led me to consider several diagnoses, including:

- psychosis
- seizures
- false memory (sexual abuse, trauma)
- narcolepsy
- sleep paralysis.

A medical workup ruled out common organic causes of psychosis. Results were normal for brain MRI, ECG, comprehensive metabolic panel, thyroid function tests, complete blood count with differential, serum alcohol, urinalysis, and urine drug screen.

Electroencephalography (during drowsiness) revealed abnormal activity (occurrences of widely scattered bursts of nonspecific, round, sharply contoured slow waves in the left frontal region) only in the F7 electrode. In the absence of clinical symptoms and when found in a single lead, this is considered a normal variant.

Psychological testing—including MMPI,

Myers-Briggs Type Indicator (MBTI), and Wechsler Adult Intelligence Scale (WAIS III)—revealed no evidence of psychosis or personality disorder, and intelligence was within the average range. Mental status exam was normal. Aside from the alien experiences, Ms. S denied any memory of childhood trauma. Interviews did not reveal symptoms compatible with narcolepsy.

Diagnostic testing ruled out hallucinosis related to seizures. I also ruled out false memory related to sexual abuse or trauma, which is commonly found in patients who present with AAE.

Collaborative information from relatives did not uncover a history of psychosis. She and family members reported, however, that Ms. S’s father and 1 sister had periodic sleep disturbances with associated hallucinations. I began to suspect sleep paralysis.

What is the prevalence of sleep paralysis?

- 5%
- 17%
- 20%
- 30%
- 60%

The authors’ observations

Full-body paralysis normally accompanies rapid eye movement (REM) sleep, which occurs several times a night.⁴ Sleep paralysis is a transient state that occurs when an individual becomes conscious of this im-

Clinical Point

Ms. S’s symptoms suggested a diagnosis of psychosis, seizures, false memory, or a sleep disorder

Adverse Events with an Incidence $\geq 1\%$ in Intramuscular Trials—The following treatment-emergent adverse events were reported at an incidence of $\geq 1\%$ with intramuscular olanzapine for injection (2.5–10 mg/injection) and at incidence greater than placebo in short-term, placebo-controlled trials in agitated patients with schizophrenia or bipolar mania: **Body as a Whole**—asthenia; **Cardiovascular**—hypotension, postural hypotension; **Nervous System**—somnolence, dizziness, tremor.

Dose Dependency of Adverse Events in Short-Term, Placebo-Controlled Trials—Extrapyramidal Symptoms—In an acute-phase controlled clinical trial in schizophrenia, there was no significant difference in ratings scales incidence between any dose of oral olanzapine (5 \pm 2.5, 10 \pm 2.5, or 15 \pm 2.5 mg/d) and placebo for parkinsonism (Simpson-Angus Scale total score >3) or akathisia (Barnes Akathisia global score ≥ 2). In the same trial, only akathisia events (spontaneously reported COSTART terms akathisia and hyperkinesia) showed a statistically significantly greater adverse events incidence with the 2 higher doses of olanzapine than with placebo. The incidence of patients reporting any extrapyramidal event was significantly greater than placebo only with the highest dose of oral olanzapine (15 \pm 2.5 mg/d). In controlled clinical trials of intramuscular olanzapine for injection, there were no statistically significant differences from placebo in occurrence of any treatment-emergent extrapyramidal symptoms, assessed by either rating scales incidence or spontaneously reported adverse events.

Dystonia, Class Effect—Dystonia symptoms (prolonged abnormal contractions of muscle groups) may occur in susceptible individuals during the first few days of treatment. While these symptoms can occur at low doses, the frequency and severity are greater with high potency and at higher doses of first-generation antipsychotics. In general, an elevated risk of acute dystonia may be observed in males and younger age groups receiving antipsychotics; however, dystonic events have been reported infrequently ($<1\%$) with olanzapine.

Other Adverse Events—Dose-relatedness of adverse events was assessed using data from this same clinical trial involving 3 fixed oral dosage ranges (5 \pm 2.5, 10 \pm 2.5, or 15 \pm 2.5 mg/d) compared with placebo. The following treatment-emergent events showed a statistically significant trend: asthenia, dry mouth, nausea, somnolence, tremor.

In an 8-week, randomized, double-blind study in patients with schizophrenia, schizophreniform disorder, or schizoaffective disorder comparing fixed doses of 10, 20, and 40 mg/d, statistically significant differences were seen between doses for the following: baseline to endpoint weight gain, 10 vs 40 mg/d; incidence of treatment-emergent prolactin elevations >24.2 ng/mL (female) or >18.77 ng/mL (male), 10 vs 40 mg/d and 20 vs 40 mg/d; fatigue, 10 vs 40 mg/d and 20 vs 40 mg/d; and dizziness, 20 vs 40 mg/d.

Vital Sign Changes—Oral olanzapine was associated with orthostatic hypotension and tachycardia in clinical trials. Intramuscular olanzapine for injection was associated with bradycardia, hypotension, and tachycardia in clinical trials (see PRECAUTIONS).

Laboratory Changes—Olanzapine is associated with asymptomatic increases in SGPT, SGOT, and GGT and with increases in serum prolactin and CPK (see PRECAUTIONS). Asymptomatic elevation of eosinophils was reported in 0.3% of olanzapine patients in premarketing trials. There was no indication of a risk of clinically significant neutropenia associated with olanzapine in the premarketing database.

ECG Changes—Analyses of pooled placebo-controlled trials revealed no statistically significant olanzapine/placebo differences in incidence of potentially important changes in ECG parameters, including QT, QTc, and PR intervals. Olanzapine was associated with a mean increase in heart rate of 2.4 BPM compared to no change among placebo patients.

Other Adverse Events Observed During Clinical Trials—The following treatment-emergent events were reported with oral olanzapine at multiple doses ≥ 1 mg/d in clinical trials (8661 patients, 4165 patient-years of exposure). This list may not include events previously listed elsewhere in labeling, those events for which a drug cause was remote, those terms which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being acutely life-threatening. **Frequent** events occurred in $\geq 1/100$ patients; **infrequent** events occurred in 1/100 to 1/1000 patients; **rare** events occurred in $<1/1000$ patients. **Body as a Whole**—**Frequent**: dental pain, flu syndrome; **Infrequent**: abdomen enlarged, chills, face edema, intentional injury, malaise, moniliasis, neck pain, neck rigidity, pelvic pain, photosensitivity reaction, suicide attempt; **Rare**: chills and fever, hangover effect, sudden death. **Cardiovascular**—**Frequent**: hypotension; **Infrequent**: atrial fibrillation, bradycardia, cerebrovascular accident, congestive heart failure, heart arrest, hemorrhage, migraine, pallor, palpitation, vasodilatation, ventricular extrasystoles; **Rare**: arteritis, heart failure, pulmonary embolus. **Digestive**—**Frequent**: flatulence, increased salivation, thirst; **Infrequent**: dysphagia, esophagitis, fecal impaction, fecal incontinence, gastritis, gastroenteritis, gingivitis, hepatitis, melena, mouth ulceration, nausea and vomiting, oral moniliasis, periodontal abscess, rectal hemorrhage, stomatitis, tongue edema, tooth caries; **Rare**: aphthous stomatitis, enteritis, eructation, esophageal ulcer, glossitis, ileus, intestinal obstruction, liver fatty deposit, tongue discoloration. **Endocrine**—**Infrequent**: diabetes mellitus; **Rare**: diabetic acidosis, goiter. **Hemic and Lymphatic**—**Infrequent**: anemia, cyanosis, leukocytosis, leukopenia, lymphadenopathy, thrombocytopenia; **Rare**: normocytic anemia, thrombocytopenia. **Metabolic and Nutritional**—**Infrequent**: acidosis, alkaline phosphatase increased, bilirubinemia, dehydration, hypercholesterolemia, hyperglycemia, hyperlipemia, hyperuricemia, hypoglycemia, hypokalemia, hyponatremia, lower extremity edema, upper extremity edema; **Rare**: gout, hyperkalemia, hypernatremia, hypoproteinemia, ketosis, water intoxication. **Musculoskeletal**—**Frequent**: joint stiffness, twitching; **Infrequent**: arthritis, arthrosis, leg cramps, myasthenia; **Rare**: bone pain, bursitis, myopathy, osteoporosis, rheumatoid arthritis. **Nervous System**—**Frequent**: abnormal dreams, amnesia, delusions, emotional lability, euphoria, manic reaction, paresthesia, schizophrenic reaction; **Infrequent**: akinesia, alcohol misuse, antisocial reaction, ataxia, CNS stimulation, cogwheel rigidity, delirium, dementia, depersonalization, dysarthria, facial paralysis, hyposthesia, hypokinesia, hypotonia, incoordination, libido decreased, libido increased, obsessive compulsive symptoms, phobias, somatization, stimulant misuse, stupor, stuttering, tardive dyskinesia, vertigo, withdrawal syndrome; **Rare**: circumoral paresthesia, coma, encephalopathy, neuralgia, neuropathy, nystagmus, paralysis, subarachnoid hemorrhage, tobacco misuse. **Respiratory**—**Frequent**: dyspnea; **Infrequent**: apnea, asthma, epistaxis, hemoptysis, hyperventilation, hypoxia, laryngitis, voice alteration; **Rare**: atelectasis, hiccup, hypoventilation, lung edema, stridor. **Skin and Appendages**—**Frequent**: sweating; **Infrequent**: alopecia, contact dermatitis, dry skin, eczema, maculopapular rash, pruritus, seborrhea, skin discoloration, skin ulcer, urticaria, vesiculobullous rash; **Rare**: hirsutism, pustular rash. **Special Senses**—**Frequent**: conjunctivitis; **Infrequent**: abnormality of accommodation, blepharitis, cataract, deafness, diplopia, dry eyes, ear pain, eye hemorrhage, eye inflammation, eye pain, ocular muscle abnormality, taste perversion, tinnitus; **Rare**: corneal lesion, glaucoma, keratoconjunctivitis, macular hypopigmentation, miosis, mydriasis, pigment deposits lens. **Urogenital**—**Frequent**: vaginitis; **Infrequent**: abnormal ejaculation*, amenorrhea*, breast pain, cystitis, decreased menstruation*, dysuria, female lactation*, glycosuria, gynecostasia, hematuria, impotence*, increased menstruation*, menorrhagia*, metrorrhagia*, polyuria, premenstrual syndrome*, pyuria, urinary frequency, urinary retention, urinary urgency, urination impaired, uterine fibroids enlarged*, vaginal hemorrhage*; **Rare**: albuminuria, breast enlargement, mastitis, oliguria. (*Adjusted for gender.)

The following treatment-emergent events were reported with intramuscular olanzapine for injection at one or more doses ≥ 2.5 mg/injection in clinical trials (722 patients). This list may not include events previously listed elsewhere in labeling, those events for which a drug cause was remote, those terms which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being acutely life-threatening. **Body as a Whole**—**Frequent**: injection site pain; **Infrequent**: abdominal pain, fever. **Cardiovascular**—**Infrequent**: AV block, heart block, syncope. **Digestive**—**Infrequent**: diarrhea, nausea. **Hemic and Lymphatic**—**Infrequent**: anemia. **Metabolic and Nutritional**—**Infrequent**: creatine phosphokinase increased, dehydration, hyperkalemia. **Musculoskeletal**—**Infrequent**: twitching. **Nervous System**—**Infrequent**: abnormal gait, akathisia, articulation impairment, confusion, emotional lability. **Skin and Appendages**—**Infrequent**: sweating. **Postintroduction Reports**—Reported since market introduction and temporally (not necessarily causally) related to olanzapine therapy: allergic reaction (e.g., anaphylactoid reaction, angioedema, pruritus or urticaria), diabetic coma, jaundice, neutropenia, pancreatitis, priapism, rhabdomyolysis, and venous thromboembolic events (including pulmonary embolism and deep venous thrombosis). Random cholesterol levels of ≥ 240 mg/dL and random triglyceride levels of ≥ 1000 mg/dL have been reported.

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mobility, typically while falling asleep or awakening.⁵ These experiences can be accompanied by hypnagogic (while falling asleep) or hypnopompic (while awakening) hallucinations. An estimated 30% of the population has had at least one sleep paralysis episode.⁶ In one study, 5% of sleep paralysis patients had episodes that were accompanied by hallucinations.⁷

Although individuals cannot make gross body movements during sleep paralysis, they can open their eyes and are able to report events that occurred around them during the episode.⁸ Patients interpret sleep paralysis experiences in subjective terms. Common descriptions include intense fear, breathing difficulties, feeling of bodily pressure—especially on the chest—and sensations of floating, flying, or falling (Table 1, page 85).^{7,9}

During sleep paralysis episodes, individuals typically sense a threatening presence.⁶ Patients have reported beastly and demonic figures of doom: devils, demons, witches, aliens, and even cinematic villains such as Darth Vader and Freddy Kruger.⁶ Others have described this presence in terms of alien visitations or abductions.

Internationally, most alien experience reports come from countries dominated by Western culture and values. This suggests that a belief in aliens serves as a template against which people share ambiguous information, diffuse physical sensations, and vivid hallucinations of alien encounters that they experience as real events.¹⁰

A Harvard University study of 11 individuals who reported alien abductions found that all participants experienced a similar sequence of events:

- They suspected abduction after sleep episodes characterized by awakening, full-body paralysis, intense fear, and a feeling of a presence. Several reported tactile or visual sensations strikingly similar to descriptions of sleep paralysis, such as levitating, being touched, and seeing shadowy figures.

- They sought explanations for what they perceived as anomalous experiences.

- They “recovered” abduction memories in therapy (with the help of techniques such as hypnosis) or spontaneously (after reading books or seeing movies or television shows depicting similar episodes).⁴

Ms. S reported no daytime sleep attacks, cataplexy, or rapid onset of dreaming. Because her reported AAEs were spread out and the last occurred approximately 5 years ago, I decided against conducting a sleep study because it likely would be low yield and costly. I reached a diagnosis of sleep paralysis-familial type, chronic based on:

- an absence of organic or psychiatric dysfunction
- a familial pattern of sleep disturbances
- the temporal pattern and description of her symptoms (*Table 2*).¹¹

All of Ms. S’s episodes occurred at night or times of quiet restfulness. She usually slept on her back, which may be a risk factor for sleep paralysis.¹²

TREATMENT Reassurance, therapy

Effective treatment for Ms. S required helping her to understand that an organic condition was the foundation of her experiences. I began by conveying the sleep paralysis diagnosis and my understanding of the occupational and personal consequences that this condition had had for her. I explained the physiology of sleep paralysis and that memories or hallucinations (dreamlike mentation) are preserved in an extremely vivid fashion because her eyes are open. I acknowledged the realistic character of her experiences and the resulting symptoms of posttraumatic stress disorder (PTSD).

I refer Ms. S to a therapist for psychotherapy. The therapist begins by using trauma informed techniques to address Ms. S’s PTSD. As she improves, her therapy evolves into a combination of narrative and supportive psychotherapy, and then family systems therapy to address issues with her daughter and mother.

In a follow-up visit 1 year after beginning

Table 2

Diagnostic criteria for sleep paralysis

- A.** Patient complains of inability to move the trunk or limbs at sleep onset or upon awakening
- B.** Brief episodes of partial or complete skeletal muscle paralysis
- C.** Episodes can be associated with hypnagogic (preceding sleep) hallucinations or dreamlike mentation
- D.** Polysomnographic monitoring demonstrates at least 1 of the following:
 1. Suppression of skeletal muscle tone
 2. A sleep-onset REM period
 3. Dissociated REM sleep
- E.** Symptoms are not associated with other medical or mental disorders, such as hysteria or hypokalemic paralysis

Minimal criteria are A plus B plus E

Note: If symptoms are associated with a familial history, the diagnosis is sleep paralysis-familial type. If symptoms are not associated with a familial history, the diagnosis is sleep paralysis-isolated type

Severity criteria

Mild: <1 episode per month

Moderate: >1 episode per month but <1 per week

Severe: ≥1 episode per week

Duration criteria

Acute: ≤1 month

Subacute: >1 month but <6 months

Chronic: ≥6 months

REM: rapid eye movement

Source: Reference 11

treatment, Ms. S cites multiple improvements, with no recurrence of sleep paralysis episodes. She continues to take sertraline, which relieves her depression and anxiety, and methylphenidate to improve her attention and concentration. She has taken on more responsibility at home, cleaning, preparing meals, helping her daughter choose a college, and attending to her mother’s health issues. Ms. S still has difficulties with her sleep patterns, and her new psychiatrist is exploring the possibility of a bipolar component to her mood disorder.

Clinical Point

During sleep paralysis episodes, individuals often sense a threatening presence that some describe as alien visitations

continued

Clinical Point

No drugs are FDA-approved for treating sleep paralysis, but use pharmacotherapy to address anxiety and depression

The authors' observations

Like other traumas, AAE can induce symptoms of acute or chronic PTSD. The various psychoses, personality disorders, and dissociative disorders that could account for abduction experiences are characterized by delusions, so conduct ongoing assessment for these conditions in patients who report AAE. However, evidence suggests that serious psychopathology is no more common among "abductees" than among the general population.¹²

Persons reporting AAE exhibit physiologic reactivity as profound as that of survivors of combat or sexual assault.¹³ This reactivity confirms that the emotional power of the memory is as evocative and problematic as the physiologic reactions attributable to genuine (documented) traumatic events. Because patients have difficulty differentiating these hallucinations from actual events, they experience emotional pain and suffering. Fifty-seven percent of sleep paralysis patients who report AAE attempt suicide.¹⁴

Offer patients with AAE psychotherapy to deal with long-term effects of trauma and problems with mood, sleep, daily functioning, and/or relationships.

There are no FDA-approved medications for treating sleep paralysis. Pharmacotherapy can be used to address psychiatric symptoms such as the depression and anxiety Ms. S exhibited.

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Drug Brand Names

Methylphenidate • Ritalin Sertraline • Zoloft
Quetiapine • Seroquel

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Bottom Line

Assess patients who report alien abductions for psychosis, seizures, false memory, narcolepsy, and sleep paralysis. During sleep paralysis, patients may sense a threatening presence they interpret as intruders or aliens—and experience visual, tactile, and auditory hallucinations—that they perceive as real. Psychotherapy and pharmacotherapy can help patients manage the impact of these episodes.