'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 difficulty 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?

a) explain that there are no such things as aliens
b) insist that she was dreaming
c) issue a mental hygiene warrant and sign a certificate for immediate hospitalization
d) 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

Dr. Kinne is a fellow, department of child and adolescent psychiatry, University of Louisville, Louisville, KY. Dr. Bhanot is associate professor, department of psychiatry, West Virginia University, Charleston.

How would you handle this case?

Visit **CurrentPsychiatry**.com to input your answers and see how your colleagues responded

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

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.

Clinical Point

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

Want to know more?

See these articles at CurrentPsychiatry.com

Irrational beliefs: A ubiquitous human trait
FEBRUARY 2007

Psychosis: Is it a medical problem?
JANUARY 2007

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-

continued on page 85

continued from page 82

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?

a) seizure activity
b) sexual abuse/trauma
c) schizoaffective disorder
d) schizotypal personality disorder
e) 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?

a) 5%
b) 17%
c) 20%
d) 30%
e) 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-

continued on page 90

Clinical Point

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

continued from page 85

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 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.

continued

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

Clinical Point

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

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.

Clinical Point

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

References

1. Patry AL, Pelletier LG. Extraterrestrial beliefs and experiences: an application of the theory of reasoned action. *J Soc Psychol* 2001;141(2):199-217.
2. Newman LS, Baumeister RF. Toward an explanation of the UFO abduction phenomenon: hypnotic elaboration, extraterrestrial sadomasochism, and spurious memories. *Psychol Inq* 1996;7(2):99-126.
3. Bader CD. Supernatural support groups: who are the UFO abductees and ritual-abuse survivors? *J Sci Study Relig* 2003;42(4):669-78.
4. Clancy SA, McNally RJ, Schacter DL, et al. Memory distortion in people reporting abduction by aliens. *J Abnorm Psychol* 2002;111(3):455-61.
5. Girard TA, Cheyne JA. Individual differences in lateralization of hallucinations associated with sleep paralysis. *Laterality* 2004;9(1):93-111.
6. Cheyne JA. The ominous numinous: sensed presence and "other" hallucinations. *Journal of Consciousness Studies* 2001;8(5-7):133-50.
7. Cheyne JA, Newby-Clark IR, Rueffer SD. Relations among hypnagogic and hypnopompic experiences associated with sleep paralysis. *J Sleep Res* 1999;8:313-7.
8. Cheyne JA, Rueffer SD, Newby-Clark IR. Hypnagogic and hypnopompic hallucinations during sleep paralysis: neurological and cultural construction of the night-mare. *Conscious Cogn* 1999;8(3):319-37.
9. Cheyne JA. Sleep paralysis and the structure of waking-nightmare hallucinations. *Dreaming* 2003;13(3):163-79.
10. Spanos NP, Cross PA, Dickson K, et al. Close encounters: an examination of UFO experiences. *J Abnorm Psychol* 1993;102(4):624-32.
11. American Academy of Sleep Medicine. *International classification of sleep disorders, revised: diagnostic and coding manual*. Chicago, IL: American Academy of Sleep Medicine; 2001:166-9.
12. Holden KJ, French CC. Alien abduction experiences: some clues from neuropsychology and neuropsychiatry. *Cognit Neuropsychiatry* 2002;7(3):163-78.
13. McNally RJ. Applying biological data in forensic and policy arenas. *Ann N Y Acad Sci* 2006;1071:267-76.
14. Stone-Carmen J. A descriptive study of people reporting abduction by unidentified flying objects (UFOs). In: Pritchard A, Pritchard DE, Mack JE, et al, eds. *Alien discussions: proceedings of the abduction study conference held at MIT*. Cambridge, MA: North Cambridge Press; 1994:309-15.

Related Resources

- American Academy of Sleep Medicine. *International classification of sleep disorders, revised: diagnostic and coding manual*. Chicago, IL: American Academy of Sleep Medicine; 2001:166-9.
- Cheyne JA. Sleep paralysis and associated hypnagogic and hypnopompic experiences. http://watarts.uwaterloo.ca/~acheyne/S_P.html.

Drug Brand Names

Methylphenidate • Ritalin
Quetiapine • Seroquel
Sertraline • Zoloft

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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.