

prompt but necessitate a thorough investigation of other medical, neurological, psychiatric, or pharmacological causes.

Josephine Elia, M.D.

Medical College of Pennsylvania, Philadelphia

American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV)*. Washington, DC: American Psychiatric Association

ALIEN ABDUCTION IN PTSD

To the Editor:

We would like to report a case of early childhood trauma presenting with a set of remarkable and unique dissociative symptomatology in the context of posttraumatic stress disorder (PTSD).

A 15-year-old male was referred to an inpatient unit for assessment of a possible psychotic disorder. He presented with a number of fears, including fear of alien abduction, drowning, water, heights, and insects, accompanied by panic symptoms, insomnia, reexperiencing flashbacks, and intrusive nightmares. Mental status examination did not reveal any psychotic symptomatology (i.e., formal thought disorder, hallucinations, or delusions), but this patient was guarded and mistrustful.

During the 2-week hospitalization the patient began to provide information about his "early childhood trauma." He recalled multiple contacts with aliens beginning at age 3 years. His conversation in relation to the aliens would consist of themes of physical and sexual abuse aboard a spaceship. Other stories consisted of invasion of his privacy and intrusion of objects into his body orifices on a large table with an overhead lamp. His reaction to these experiences was one of terror, intense fear, and helplessness. These traumatic events would be reexperienced in the form of nightmares and recurrent images and thoughts. Many of his descriptions were similar to the movie *Fire in the Sky*. In fact, his symptomatology was triggered by watching a commercial for this movie.

A review of the patient's childhood history revealed a number of early health problems including antenatal, perinatal, and neonatal difficulties. He had repeated hospitalizations for medical and surgical procedures, many of which were traumatic and disruptive to his emotional, cognitive, and social progress. At school entry he had separation anxiety disorder.

Between the ages of 5 and 8 years, after involvement in an unrelated near-drowning incident, this patient experienced several episodes of sexual abuse by a male neighbor occurring in the basement of the neighbor's house. This history, provided by the patient, was verified by his mother. However,

the frequency, nature, and exact duration of the abuse remain unknown. When he was 8 years old, his parents separated under traumatic circumstances which ended with his mother pointing an unloaded gun at his father. There was no contact with the father for 5 years after this incident (i.e., until age 13 years).

This patient's physical status and laboratory investigations were all normal. A computed tomography scan of his head and EEG were attempted on two occasions, but exposure to these resulted in the patient's reexperiencing the trauma in the form of flashbacks and numbing. He refused to have these done, even at a later stage.

Treatment was effective and consisted of a short-term course of alprazolam, individual and group therapy, and school and social interventions.

This male adolescent presented with a variety of responses to repeated early childhood trauma, ultimately leading to a delayed onset of PTSD in his teenage years (Terr, 1991). Several researchers have observed that numbing (loss of responsiveness in the wake of trauma) is a predictor of later PTSD symptomatology (Solomon et al., 1989). The development of dissociative defenses appears to occur more readily in childhood, and this has been linked to the hypnotizability of young children (Kirby et al., 1993).

It is possible this child went through a childhood sexual abuse accommodation syndrome which later manifested as a variety of other anxiety symptoms (Beitchman et al., 1992), since sexual abuse remained isolated in the child's world for years.

This child's schizotypal personality traits may have contributed to the incorporation of the trauma in his alien beliefs. The visual imagery was used defensively to detach himself from the immediate experience of terror, pain, and helplessness. Children exposed to multiple traumas are more likely to use dissociative defense mechanisms, which include spontaneous trance episodes and amnesia (Terr, 1991).

The alien beliefs were not bizarre or out of keeping with his culture, but rather symbolized the emotional and cognitive perspective of his traumatic childhood experiences. The child, in fact, suggested this at different times, and he was eventually insightful into his use of his alien beliefs as a coping strategy.

This case illustrates the importance of listening to patients and their symptom presentation in the context of cross-sectional, longitudinal, and sociocultural issues. It also cautions physicians against overdiagnosing psychotic disorders in such individuals.

Jatinder Takhar, M.D.

Sandra Fisman, M.B., B.Ch., F.R.C.P.(C)

University of Western Ontario, London, Ontario

- Beitchman JH, Zucker KJ, Hood JE et al. (1992), A review of the long term effects of child sexual abuse. *Child Abuse Negl* 16:101-118
- Kirby JS, Chu JA, Dill DL (1993), Correlates of dissociative symptomatology in patients with physical and sexual abuse histories. *Compr Psychiatry* 34:258-263
- Solomon Z, Mikulincer M, Benbenisty R (1989), Combat stress reaction: clinical manifestations and correlates. *Mil Psychol* 1:17-33
- Terr LC (1991), Childhood traumas: an outline and overview (review article). *Am J Psychiatry* 148:10-20

CPR AND PSYCHIATRIC TREATMENT

To the Editor:

We report a novel approach to group activity programming for adolescent inpatients and partially hospitalized patients. In 1993, one of the authors (S.F.) was conducting cardiopulmonary resuscitation (CPR) classes for staff members. Adolescent patients in the same unit expressed curiosity and enthusiasm about his CPR involvement. Thus he initiated basic CPR training (American Heart Association, 1992) for selected patients aged 12 to 18 with a variety of psychiatric diagnoses. The 4-hour course has proven to be highly successful as a combined educational and psychosocial exercise for groups of 6 to 10 adolescents. To our knowledge, this is the first report of the therapeutic use of CPR training on a psychiatric unit.

The multidisciplinary treatment team selects patients based on their ability to sustain attention and their willingness to participate. Introductory CPR reading material is distributed to participants the day before the training course because most of the patients lack previous CPR training. The course consists of 2 hours of lectures which include visual aids, followed by a written test and a hands-on demonstration of adult one-person CPR using a mannequin. Patients are assigned to help teach their peers the rescue sequence on the mannequin.

Some patients are interested in learning a skill that they may have seen practiced in television shows. Other patients have family members who have required CPR in the past. A few patients expressed an interest in obtaining CPR training as a prerequisite for future employment, e.g., as a swimming pool junior lifeguard. The ability to respond to an emergency is especially appealing to our patients, some of whom live with elderly grandparents or in crime-ridden neighborhoods. At least one patient has reported using the CPR training to save the life of a neighbor injured in an accident. Whatever the motivation to learn may be, the participants respond well to learning an "adult" life skill. All of the patients who participated succeeded in completing the course and certification. We have been impressed by

the patients' curiosity, initiative, pride in earning a CPR certification card.

The CPR course is a positive learning experience for adolescents who have often experienced chronic failure in academic institutions. The patients enjoy the action-oriented class and the increased sense of mastery and self-esteem they gain from the training. The educational material stimulates discussion and gives the instructor the opportunity to emphasize prevention: the importance of exercise, a healthy diet, and avoidance of smoking and substance abuse. In at least one California county, CPR training has become a part of the high school curriculum (M. Mueller, personal communicators, 1995). Teaching CPR to adolescent patients in the hospital setting confirms their access to mainstream education.

In this time of program-downsizing and cost containment, the CPR course provides a readily available, inexpensive, and safe group activity that promotes prosocial behavior, personal responsibility, and positive accomplishment. Psychiatric unit or other staff members who are certified CPR instructors may be readily available to teach CPR to adolescent inpatients or partially hospitalized patients.

We encourage other clinicians working with adolescents to explore the use of CPR training for the many benefits it may yield to the individual patients, their families, and the community.

Elizabeth M. Tully, M.D.

University of California, Davis

Stephen Frei

Sutter Center for Psychiatry, Sacramento, CA

Mark Giles

Sacramento, CA

American Heart Association, Emergency Cardiac Care Committee and Subcommittees (1992), Guidelines for cardiopulmonary resuscitation and emergency cardiac care, I: introduction. *JAMA* 268:2172-2183

The Letters column is a corner of the *Journal* which encourages opinion, controversy, and preliminary ideas. We especially invite reader comments on the articles we publish as well as issues or interests of concern to child and adolescent psychiatry. The Editor reserves the right to solicit responses and publish replies. All statements expressed in this column are those of the authors and do not reflect opinions of the *Journal*. Letters should not exceed 750 words, including a maximum of 5 references. They must be signed, typed double-spaced, and submitted in duplicate. All letters are subject to editing and shortening. They will be considered for publication but may not necessarily be published nor will their receipt be acknowledged. Please direct your letters to John F. McDermott, Jr., M.D., Editor, *Journal of the AACAP*, University of Hawaii School of Medicine, Kapiolani Medical Center, 1319 Punahou Street #633, Honolulu, HI 96826-1032.