THE SPACEMAN

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Case Presentation

Ken is twenty years old and, at first impression, gentle, conscientious, likable. He is a college junior majoring in chemistry, "taking hard courses and doing well." Lately he has dropped out of school, unable to study ("my thoughts not clear, my past whipping by"). He began to talk to his classmates about extraterrestrials among us, or, alternatively, being an extraterrestrial himself. He was treated with Thorazine by a psychiatrist at his university before he returned to his hometown.

You note that Ken is extremely angry and afraid. He has guilt feelings and nightmares of his own execution, is counterphobic, and tends toward macho pursuits and Rambo-like vengeance fantasies. He reports that he is skilled in karate and that he exercises several hours a day. Ken does not use marijuana or other nonprescription drugs, and he says his friends regard him as a compulsive student.

Ken has a deficient sense of himself and is attracted to authoritarian

organizations ranging from the Marines to fundamentalist cults. His thought tends to be filled with symbolic imagery. He is impulsive and is likely to commit himself to three different paths in two days. The combination of rage, macho fantasy, and impulsiveness make him appear violently dangerous, although he has never attacked anyone.

In describing himself, Ken's phrasing and affect are often stagy. You remark on that to see how he responds, and he admits that his friends have noticed the same trait.

Ken has had no mature sexual experience. He appears slow to recognize that he is attractive. He is heterosexually oriented but expresses anxiety that others may doubt his masculinity.

At moments, Ken hates his mother and, far more, her mother. He describes his grandmother and her whole family as Nazis. He likes his father, and you gather that his father tends to remove himself from family stress. In your conversations with his mother, she appears to be concerned, responsible, and realistic, quite unlike Ken's description of her. In Ken's early years, her work required her absence from Ken for weeks at a time. Ken has one younger brother, whom he likes, but Ken disapproves of his pot smoking and irresponsibility. You sense Ken may have an infantile dependence on his parents—a dependence that he does not recognize.

Ken does not seem committed to his extraterrestrial fantasies. You suggest to him that they are ways of explaining to himself his feelings of alienation. He readily agrees, and he adds that they are also a way to keep people at a distance. Then, he offers that he thinks he can trust you and would like to try psychotherapy with you.

Formulations and Treatments

Judd Marmor (Psychoanalytic)

My initial reaction to the consultation is that I need considerably more information about Ken before I arrive at a definitive diagnosis and plan of treatment. In particular, I would like to know much more about his developmental history, from early childhood on. I need to know more about why he hates his mother and grandmother, in contrast to the positive feelings he has for his father. What kind of relationship did he have with them during his childhood and adolescence? What was his reaction to the birth of his brother, and what was the nature of their early interaction? Also, what kind of peer relationships did he have growing up, and why is it that he seems to be rather inhibited sexually? It is clear that he has an impaired self-image and feelings of masculine inadequacy. But how and why did this occur?

My first tentative impression, subject to revision when I get more

information about him, is that we may be dealing with a borderline personality disorder. My reasons for suspecting this diagnosis include his chronic anger, his impulsiveness, his histrionic tendencies, his emotional immaturity, his impaired self-image, and what appears to have been a transitory schizophrenia-like episode. I would not be too quick to fault the psychiatrist who first saw him for prescribing Thorazine—without receiving a report from that psychiatrist as to what his findings were at that time. With Ken's permission, I would be inclined to write to that psychiatrist for information. We must keep in mind also that we are seeing him after he was treated with Thorazine, which may well have produced a remission in his apparent psychotic break.

If further exploration of Ken's developmental background and personality patterns were to confirm my initial impression, I would be inclined to place him in a program of dynamic psychotherapy, seeing him face-to-face on a twice-a-week basis. The initial goal of such therapy would be to try to develop a strong working alliance in which Ken's fragile sense of trust can be strengthened. I would work toward helping him achieve a better understanding of how and why his difficulties have developed and of the way his perceptions, both of himself and of significant others, may have been distorted. Depending on how the situation evolves, it might well be that some family therapy sessions including his mother, his father, his brother, and his

maternal grandmother, if she is still alive, would also be indicated and useful. In any event, I tend to see Ken's therapy not as a short-term prospect, but as one that might well extend over a longer time. At the moment, I would see no indications for adjunctive psychopharmacological therapy, but I would not rule it out as a possibility, if subsequent circumstances indicated that kind of treatment.

Albert Ellis (Rational-Emotive)

I would suspect from the initial consultation that Ken is in the borderline personality range but would refrain from making a more definitive diagnosis until after I had had a few more therapy sessions. In using rational-emotive therapy, or RET (Ellis, 1962, 1988a; Ellis & Dryden, 1987), I find that the best mode of diagnosis is therapy itself, since the ways in which the client reacts to the first few therapy sessions usually tell much more about him than any amount of objective or projective tests.

I would take each of Ken's major symptoms and look for the main irrational beliefs—his core *masturbatory* philosophies—that probably lie behind them and that tend to produce them. I would hypothesize that his extreme anger stems from his absolutistic insistence that others (including his family members and therapists) *must* treat him in the manner that he considers fair and proper. I would guess that his fears and macho defenses

against them tend to be produced by his commands that he has to perform well and be competent and powerful. I would tentatively assume that his guilt feelings follow from his dogmatic demands that he do the right thing with regard to his responsibilities and his actions toward others. I would hypothesize that his deficient sense of himself and his need to join authoritarian cults originate in his *necessitizing* about his being all-powerful and having mighty associates and identities. I would guess that his impulsiveness largely stems from his low frustration tolerance, underlain by his beliefs that he must get what he wants when he wants it and that under no conditions should he be seriously balked or frustrated.

While checking out Ken's absolutistic demands on himself, on others, and on the universe, and while determining his specific "tyranny of the shoulds" (Horney, 1950), I would quickly begin to show him that he had better keep his goals, ideals, and purposes as his choices rather than as Jehovian demands. At the same time, I would give him unconditional acceptance, in spite of his failings and deficiencies, and show him how fully to accept himself. I would encourage him to use some of RET's shame-attacking exercises (such as deliberately acting foolishly or unmasculinely in front of others and managing to feel unashamed and unembarrassed while doing so). I would work with him behaviorally to help him do several things that he is irrationally afraid of doing—such as approaching attractive females and

trying to win their favor. I would also try to encourage him to stay in uncomfortable situations—such as returning to school—until he works on his low frustration tolerance and begins to feel, first, comfort and, later, enjoyment. I would particularly try to show him that although masculinity has certain advantages in our culture, it is hardly the be-all and end-all of human existence and that he can fully accept himself whether or not he is totally masculine and whether or not significant others approve of him.

Allen Frances (Integrative)

The patient's diagnosis is most likely paranoid disorder or paranoid personality, the choice depending on how seriously one takes his possibly delusional beliefs. In either case, many factors in his presentation resemble the profiles of individuals at risk to commit violent acts, and most especially murders or assassinations. The crucial initial problem is establishing a visible and enduring therapeutic relationship with an individual who is often suspicious, resentful, frightened, and likely to quit impulsively situations he regards as dangerous. Ken's reaction to the therapist's first interventions are encouraging: he accepts the confrontation concerning the extraterrestrial fantasies, volunteers that he likes the therapist, and wants to try therapy.

The psychotherapist should point out that the therapy will be uncomfortable for Ken and predict that he will at times feel angry and fearful

and want to stop. The therapist should educate Ken about what will be expected and about how to deal with feelings as they emerge in the treatment. Psychoeducation should also include as much about the patient's risk for violence as can be imparted without threatening the therapeutic alliance. Often patients like Ken have long been frightened by their violent impulses and fantasies and are relieved by the opportunity to discuss them openly.

The therapeutic relationship with a paranoid/dependent patient like Ken is usually most useful if the therapist maintains distance and avoids challenging the patient too directly or attempting too great a closeness. An unobtrusive and educational approach is usually best tolerated. Interviews should be conducted in large rooms, with easy exits for the patient, chairs at equal distances, and a willingness to end early if the patient becomes upset.

The ongoing treatment plan (Frances, Clarkin, & Perry, 1986) might combine varying proportions and sequences: direct advice (that guns be disposed of, that the grandmother be avoided, that decisions about joining cults be postponed); ventilation; exploration of cognitions that the world is inherently dangerous and that only the strong and heavily armed survive; behavioral exposure to anxiety-provoking situations in very gradual and easy-to-take steps; and again, in very gradual steps, psychodynamic exploration of his underlying wishes, fears, and defenses (particularly, that

his fears of being harmed by others constitute a projection of his own hostile impulses).

Which techniques are used, and in what order, would depend on the intuition of the therapist and on the patient's capacity to respond to gentle trials of each. Perhaps the most important agent of change in the treatment of patients like Ken is the corrective emotional experience that occurs in the interpersonal relationship with the therapist, so the choice of techniques should always be influenced by the effects they will have on that relationship. Family or group treatment is occasionally helpful. Medications to reduce violence have been and are being tested—most particularly lithium, Propanolol, and anticonvulsants. Results are encouraging but inconclusive. Medication for paranoid personality is unavailable; neuroleptics are often effective for patients with paranoid disorders, but these patients are more than usually noncompliant with the treatment regimen because of their general suspiciousness about medication and their specific intolerance of side effects. It is beyond our scope here to discuss the legal implications raised by treatment of Ken or the risks and countertransferences occasioned by such treatment, but these issues tire likely to be of considerable importance.

Milton V Kline (Psychoanalytic)

Since Thorazine was administered to Ken prior to some of the case

material reported, psychotic features that may have been present in the earlier, active phase of the illness may not be present now; but there are characteristic symptoms involving multiple psychological processes.

I am not able to ascertain from the material presented the degree of deterioration. Schizophrenic reactions always involve some deterioration from a previous level of functioning, so additional collateral information from the family and from observations, particularly by the psychiatrist at school, would be important in making this assessment.

I am not certain whether Ken's talk about the presence of extraterrestrials or, alternatively, of being an extraterrestrial himself is a fantasy, whether it represents a major dissociative disturbance, or whether it reflects an underlying, multiple-process schizophrenic illness. There appears to be some evidence of fragmented or bizarre thought content. And although there is no clear evidence of delusions of reference—in which events, objects, or other people are given consistently particular and unusual significance—nevertheless, there is some clear evidence of delusional thinking. I would like to use an approach that would lead to better insight into the content of Ken's thought.

It is essential to gain insight into the sense of self that this young man presents, into the nature of his ego boundaries and the losses that may have

been suffered in relation to his confused identity, into the meaning of his extraterrestrial delusion with regard to his sense of personal existence, and into his feelings and attitudes of self involving control by an outside force.

Ken manifests some disturbance in self-initiated goal-directed activity that at times may grossly impair work or other role functioning. This may take the form of inadequate drive, inability to follow the course of action to its conclusion, or regression to more primitive, primary-process cognitive associations.

I feel that this case is still in its early diagnostic phase and that a great deal has to be done to evaluate the degree to which familial patterns have played a role, particularly with reference to Ken's attitudes toward the mother, the grandmother, and his view of his grandmother's family as Nazis. A thorough assessment of familial influence is necessary. Earlier indications of Ken's paranoid attitudes or projections, particularly those typical of schizophreniform disorders, might then be assessed.

The thought process in this young man needs to be carefully evaluated. With sufficient additional information gained from one or two further consultations, I would suggest a hypnotic interview in which it would be possible to distinguish among (1) a disorder in the content of thought, (2) a dissociative disorder, or (3) a regression in cognitive functioning more typical

of schizophrenic illness. I would like to use hypnosis to explore the nature of the perception and the affect connected with the original extraterrestrial reference and thoughts.

Contraindications to the use of hypnosis must be assessed during initial interviews. However, earlier misconceptions that use of hypnosis with borderline or schizophrenic patients would lead to dissociation or deterioration have not been borne out. Within the framework of rapid and positive transference that occurs in a good hypnotic relationship, there are safeguards that permit assessment of unconscious material, both ideationally and affectively, without jeopardizing the patient's equilibrium. This assessment requires considerable experience in using hypnosis as a diagnostic and therapeutic modality, and it requires awareness of the parameters of hypnotic responsiveness and the characteristics of the positive transference that may emerge.

In this instance, let us assume that after taking a comprehensive psychodynamic history, conducting a careful evaluation, and establishing a hypnotic relationship, the therapist decides to proceed to assess Ken's thought content and the extent of his dissociation and regression. All three assessments can be accomplished in a unified consideration of the patient's productivity and responsiveness within the hypnotic interview.

Spontaneity of verbalization, and of images evoked and suggested, give the therapist a rapid, clear insight into the degree of regression, whether it is in the service of the ego or whether it holds potential for acting out and for fragmentation. In one part of the diagnostic procedure, the therapist seeks to elucidate images of subjects Ken has mentioned, such as Nazis in his family and extraterrestrials.

One might say to Ken when he is under hypnosis, "I would like you to think about what an extraterrestrial looks like. You will be able to visualize an extraterrestrial. Tell me, in any way that you wish, what it is that you see." After Ken has related what he has visualized, the therapist might say, "Tell what you feel, what feelings the images stimulated." The clinical process consists of evoking images, asking direct questions about the associated feelings, and establishing some link between these feelings and the presenting symptoms. Although still within the assessment period, one might make tentative interpretations and monitor both the patient's interpretations of the emerging material and his response to the therapist's interpretations, and then compare the two.

For example, if an image or association to that image suggests a familial significance, the therapist might interpret it in a subdued but direct way. For example, "That seems, perhaps, to be related to some of the feelings you described about your grandmother." The response to the interpretation could

be critically important. Part of this assessment would be to determine the degree to which alexothymia may be present— the degree of separation, detachment, or blocking of feelings, particularly unconscious feelings, that may hinder the structuring and attachment of words to describe these feelings. In patients of this kind, one often finds a special type of alexothymia; the words needed to relate unconscious feelings are so potentially conflicting that the intermediary process is one of establishing fantasies, hallucinations, or dissociative reactions as a defense.

It has been established that a disturbance of the kind Ken presents is the result of unconscious conflict. To plan a meaningful and effective therapy, it is necessary to understand the nature of Ken's inner conflict, its associations, and particularly the resistances and defenses that he has erected against it.

At various points in the hypnotic exploration, based on body posture, shifts, ideation, or verbal comments, the therapist should ask, "How do you feel, right at this moment?" According to the patient's response, the therapist might add a comment, perhaps an interpretative one, about the meaning of those feelings as they relate to the presenting symptoms. Based on the findings that would emerge, one might decide that this patient could better be treated either by a psychopharmacological approach with supportive psychotherapy or by a more intensive dynamic psychotherapy. The latter puts a good deal of pressure on the patient to feel, to come into contact with

unconscious feelings, and eventually to be able to experience an intensification of resistance and its meaning, which would lead to some clarification of defenses. In this form of therapy, direct challenges to the resistances may be used to confront the patient with the need to remember and, particularly, with the selective nature of his inability to remember important things.

One could also use the hypnotic relationship, which brings about a spontaneous transference, to intensify the transference and to use it to mobilize the unconscious therapeutic alliance.

When this is possible, the effect is dramatic. There is often an immediate drop in tension, a feeling of relief, a rise in true motivation, and the emergence of strong positive feelings for the therapist. The patient's unconscious frequently becomes unlocked, and some major communication that reveals the nature of the patient's disturbance may appear.

This young man may be in a partial remission due to the Thorazine and the support given in the initial therapeutic context. Therefore, my sole conviction about Ken is the need to explore the parameters, both of cognitive functioning and affect, with particular reference to fantasies and delusions. This approach is designed to lead to a differential diagnosis involving the possible contributions of schizophrenic disorder, characterological problems,

and conflicts that might make major use of dissociative mechanisms as defenses. I would consider using hypnotic procedures for such diagnostic exploration, and I would attempt to formulate a treatment plan based on the forthcoming information.

Because of the regressive components in the case of Ken, the clinical properties of hypnosis, particularly in relation to the analogues of multiple personality in psychotic states (Gruenwald, 1974), open avenues to rapid and comprehensive treatment in a case like this. In this case, regression must be considered a process that can generate and intensify the dynamic mechanisms of the patient's psychopathology and mobilize the development for the therapeutic transference. It is in this respect that Loewald (1979) has clarified the dual significance of the regressive experience for a patient—both as an expression of pathology and as a process of symptom formation—while simultaneously providing a state within which "restoration" may be achieved and from which a resumption of development may again proceed.

In Ken's case, the development of a classic transference neurosis would offer the matrix within which his pathognomonic regression would establish itself spontaneously under treatment circumstances. Such a transference crystallizes around certain core issues such as Oedipus conflicts, grandiose exhibitionistic or idealizing needs or wishes, or fantasies that belong to different developmental periods. It is this issue of different developmental

periods that becomes magnified during the hypnotic process through transferences to help deal with the fragmented ego states that constitute the core of borderline disorders (Kline, 1984).

Thus, within this process of regression, self-cohesion is lost and regained a number of times due to interactional effects of the regressive nature of hypnosis and the reintegrating effects of therapeutic transference. It is within such a sequence of events that reality testing continues to undergo change and, in effect, becomes the target of the therapeutic intervention (Balint, 1968).

This process is a reflection of the importance of positive anticipation in the recovery of patients in the grip of serious emotional disorders. Within the total integration of the past, the present, and the anticipation of the future, it is crucial that the patient be able to foresee the possibility of escape from the bind of his own dilemma and, as a consequence, to attain potential satisfaction and happiness. Just as primitive thinking in normal sleep and in a remembered dream solves many a problem, so do these primitive processes in hypnotic regression. Particularly with sensory and motor involvement, these processes offer a field for direct therapeutic activity and the successful reintegration of masses of life experience that had failed to integrate as a functional unity in the past (Sullivan, 1962).

Points of Contention and Convergence[1]

Judd Marmor

In general, I am more impressed by the areas of agreement among Ellis, Frances, Kline, and me than I am by the disagreements. We all recognize that Ken has a major personality disorder, possibly a borderline personality disorder, with evidence of psychotic ideation. Frances and Kline focused somewhat more strongly on the psychotic features than did Ellis or I, but we all recognize the need to get more information from and about Ken before arriving at a definitive diagnosis. Both Kline and I feel that, if possible, getting a report from the university psychiatrist who prescribed Thorazine for Ken would be worthwhile. Frances placed greater emphasis on Ken's paranoid features and the risk of violence than the rest of us did, and his therapeutic approach is therefore a more cautious one. Otherwise, however, it is not essentially different from the rest of ours in recognizing the need for establishing a meaningful and trusting therapeutic relationship with Ken and for trying gradually to uncover the experiential sources and nature of his psychopathology. Both Frances and I recognize that some adjunctive pharmacotherapy may be indicated; Ellis and Kline do not refer to that as a possible contingency.

The only recommendation about which I have serious reservations is

Kline's rather strong emphasis on the value of attempting one or more hypnotic interviews with Ken after a number of preliminary sessions. I believe that the risk of attempting hypnotherapy in a patient with Ken's unstable and paranoid personality would not be justified. The results that Kline hopes to achieve from such an interview or interviews can be equally well accomplished, and more safely, by the techniques the rest of us recommended. I say this without negative prejudice toward hypnotherapy. I have used it myself. But I believe the fragility of the transference relationship in this kind of patient is a contraindication for such therapy—certainly for the early use of it—until a genuine and strong patient-therapist relationship has been firmly established.

What I would emphasize about my own approach is its strong systems orientation (Marmor, 1982, 1983) and the flexibility (Marmor, 1974b, 1974c) that flows from it. I try to be alert not only to the intrapsychic mechanisms at play in Ken's psychopathology but also to the possibility of genetic and neurophysiologic factors that may be involved. I am interested in a historical reconstruction of his personality development, not because I consider it to be therapeutic per se, but because a better understanding of such past influences will help me interact more intelligently and meaningfully in the here-and-now therapeutic setting and during the corrective emotional experiences that I believe (as does Frances) are central to effective therapy (cf. Marmor, 1974a,

1975).

Finally, because I believe that his current life relationships are also of cardinal importance in the life-space system in which he operates, I am also prepared to explore and deal with the family system via family therapy sessions, if and when my understanding of the dynamics of that system indicates that approach would be helpful.

Albert Ellis

Regarding Judd Marmor's response, I agree that a psychotherapist could use much more information about Ken before arriving at a definitive diagnosis and treatment, but I personally would require much less developmental and early family history than he would. While I agree that Ken has an impaired self-image and feelings of masculine inadequacy, I would assume that these largely stemmed from his own constructs rather than from the standards and criticisms imposed by his family. His family and culture may well have taught him that masculinity is desirable, but his own commanding *must*abatory cognitions turned these learned preferences into rigid demands, and he thereby made himself disturbed.

Furthermore, I agree with Marmor that some family sessions might be useful—not mainly for diagnostic purposes, but for showing the family

members that they only contributed to Ken's disturbance and that they did not really cause it. I would particularly try to relieve them of the guilt they very likely have about Ken's condition. I would educate them about his irrational thinking and its partial biological causes, and I would try to enlist their help for Ken in using several RET methods.

I would be much more likely than Marmor to have Ken consult with a psychopharmacologist; to check for psychosis, possible endogenous depression, and violence proneness; and to see if psychotropic medication would be recommended. I agree with Marmor that Ken is suffering from a borderline personality disorder.

I would, of course, never recommend psychodynamic or psychoanalytic therapy for Ken, because I consider it (after practicing it for several years before I originated RET) woefully inefficient for almost all clients and harmful for most borderline personalities.

Like Marmor, and like other cognitive-behavioral therapists, I would try to help Ken see how his perceptions of himself and significant others may have been distorted. But I would go further than this and show him his own underlying rigid musts that tend to bring on his misperceptions. Thus, his view of his grandmother and her whole family as Nazis is probably a gross exaggeration that follows not only from his perception (which may be

accurate) of their bigoted behavior but also from his Jehovian command, "They absolutely must not be the way they are!"

Because Ken seems to be so seriously disturbed, I agree with Marmor that psychotherapy with him would probably extend over a longer period of time than is usual with RET. Clients like Ken tend forcefully and rigidly to hold onto their irrational beliefs, disturbed feelings, and behavior, so they had better be guided to change them by a forceful, directive therapist.

Turning to Allen Frances, I agree with his opinion that Ken may well have a paranoid personality. While I would carefully explore his propensity for violence, I would guess that he probably is not dangerous. I also agree that in his case, it is particularly desirable to win his trust, as we do in RET with unconditional acceptance of people like Ken in spite of their bizarre and sometimes hateful behaviors.

I agree with Frances that a psychoeducational approach is indicated with Ken, particularly regarding the dangers of his being violent, the difficulties he may encounter in therapy, and the disadvantages of cultism. Mostly, however, I would teach him the ABCs of RET: show him how Activating events (A's), such as his family's presumed Nazism, do not directly create emotional and behavioral Consequences (C's), such as his hostility and his inability to study. Rather, I would teach him that his Beliefs (B's) about the

Activating events (A's) more directly and more crucially upset him. I would show him how to Dispute (D) his irrational Beliefs (iB's) such as "I absolutely must be macho and act vengefully like Rambo, else I am a worthless wimp" (Ellis, 1962; Ellis & Dryden, 1987; Ellis & Grieger, 1986).

Psychoeducationally, I would also try to get Ken to use some of the RET self-help materials, including pamphlets and books. Those especially indicated would be *A new guide to rational living* (Ellis & Harper, 1975) and *How to stubbornly refuse to make yourself miserable about anything—Yes, anything!* (Ellis, 1988a). I would also recommend his listening to some of our effective RET cassettes, such as *Unconditionally accepting yourself and others* (Ellis, 1988b). I would encourage Ken to do the homework assignment of filling out several of our RET self-help reports (Sichel & Ellis, 1984), and I would review them with him.

I would risk much more closeness and directness than Allen would with Ken because I find that with borderline personalities, who tend to be vague and namby-pamby in confronting and disputing their irrational beliefs, my being very direct and forceful is often far more effective than keeping my distance. I would particularly experiment with vigorously challenging his ideas that he must be super-macho and that he immediately has to follow his impulsive desires. I would try to show him that underneath his feelings of great masculinity probably lie woeful feelings of inadequacy, and I would very

powerfully show him that he—and any human—can fully accept himself whether or not he performs well and whether or not he is adored by others.

I would use, as would Frances, ventilation of feelings with Ken, but only in conjunction with several RET techniques to help him change his hostile and disruptive emotions. Thus, I would use rational-emotive imagery (Maultsby, 1971; Maultsby & Ellis, 1974) to show him how to imagine some of the worst situations occurring (such as people despising him for being too weak), to let him get fully in touch with his inappropriate feelings (such as intense hostility and vengefulness) as he did so, and to get him to change these to appropriate feelings (such as keen disappointment and frustration). I would also use other RET emotive techniques, such as getting him forcefully to make rational self-statements—statements such as "My grandmother's behavior is too rigid and Nazi-like, but she is a fallible, screwed-up person who has a right to be wrong."

I also agree with Frances that behavioral exposure to anxiety-provoking situations would probably be useful with Ken. But I would experiment with implosive as well as gradual in vivo desensitization, if Ken were willing to try it. Thus, I would try to help him perform a series of RET shame-attacking exercises (Ellis, 1969, 1988a; Ellis & Dryden, 1987). These might consist of his deliberately letting himself lose several karate matches to weak opponents and working on himself not to feel ashamed when he publicly lost them.

I would not only explore Ken's defenses, as Frances would, but also show him the grandiose commands that underlie these defenses. Thus, if he masks his feelings of weakness by pretending to be an extraterrestrial, I would try to show him that he is probably demanding that he must be superhuman and that he is a weakling if he is only human. I would then try to help him to dispute and surrender this godlike demand and thereby have no need to continue to create the cover-up defense.

I quite disagree with Frances that "Perhaps the most important agent of change in the treatment of patients like Ken is the corrective emotional experience that occurs in the interpersonal relationship with the therapists, so the choice of techniques should always be influenced by the effects they will have on that relationship." Hogwash! For several reasons:

First, as I noted above, the therapist's giving Ken unconditional acceptance is one important aspect of teaching him how to accept himself fully. But merely giving him this kind of relationship—as Carl Rogers (1961) used to do—may well motivate him to accept himself because the therapist likes him. This is highly conditional self-acceptance and will likely disappear when significant others later dislike him.

Second, Frances implies that the corrective emotional experience that occurs in the client-therapist relationship occurs because of the emotional

aspect of the relationship itself. This may or may not be true. Thus, a number of my borderline clients have said that they disliked or did not particularly care for me. But they said I helped them considerably by teaching them how to look at themselves differently and how to become more effective; and they said their previous warmer therapists had hardly helped them at all.

Third, I discovered many years ago, when experimenting with Ferenczi's (1952) technique of being nice and warm to my clients, that they loved their therapy session and me. However, many of them, especially the borderline personalities, became more dependent and sicker. That was one important reason why I abandoned psychoanalysis and created RET.

Fourth, as several studies have shown, severe depressives and borderlines can significantly improve and stay improved when using cognitive and behavioral self-help materials, without the assistance of any therapist (Scoggin, Jamison, & Gochneaur, 1989).

Moving on to Milton Kline, I agree that Ken's low self-acceptance and weakened sense of identity underlie his extraterrestrial delusion and other symptoms. Ken and his therapist had better not only see this, as Kline indicates, but also actively do something to change it.

Kline asks for a thorough assessment of family influence on Ken's

attitudes. But to ascertain possible genetic influences, I would also want to know how seriously disturbed the close members of both his parents' families were.

Kline recommends a hypnotic interview with Ken to explore dissociative and schizophrenic disorders. Although I wrote a paper many years ago favoring the use of hypnosis with borderline personalities (Ellis, 1958), and although I have recently shown that hypnosis can be used effectively in conjunction with RET (Ellis, 1986), I would not risk using it in Ken's case. I say this because it could encourage dissociation, could help Ken believe that it is some kind of magical cure, could contribute to his dependency on me, and could sidetrack us from the main theme of helping him unconditionally to accept himself.

Kline states that, ''It has been established that a disturbance of the kind Ken presents is the result of unconscious conflict." This is a superficial psychoanalytic interpretation that has not been empirically established. Humans continually have conflicting desires, such as to have sex with a neighbor's wife and to act friendly toward the neighbor, without making themselves either neurotically or psychotically disturbed. They also add musts to their conflicts (and to their non-conflicts!) by which they disturb themselves—conflicts such as "I must have my neighbor's wife and not antagonize my neighbor!" or "I must not even think about having sex with my

neighbor's wife!" By seeking Ken's unconscious conflicts and ignoring his unconscious and conscious commands, Kline and other psychoanalytic therapists will, I predict, futilely prolong his therapy and most likely will do him much more harm than good. Want to bet?

I agree with Kline that Ken will probably resist therapy and that direct challenges to his resistance may be usefully offered. But the challenges I would give would be radically different from Kline's, since I would mainly challenge Ken's low frustration tolerance that often would be the main cause of his resistance. Thus, if he refused to remember important things, he would usually be motivated by the irrational beliefs—"I can't stand remembering them! It's too uncomfortable!"

On the whole, although I agree with many of the points made by Marmor, Frances, and Kline, I believe that they are all much too psychoanalytic and too little cognitive-behavioral. Therefore, I believe they all tend to encourage Ken to spend excessive time in therapy while obtaining relatively poor results. RET might well not work with Ken, but I think it at least has a good fighting chance!

Milton V. Kline

I can only state my rather complete concurrence with all that Judd Marmor has expressed from his point of view in the evaluation of the case of Ken. The questions he raises as well as the recommendations he offers are consistent with my feeling that dynamic psychotherapy, on an intensive level within a strong supportive therapeutic alliance, is essential in the treatment of Ken.

I am in essential agreement with the point that Albert Ellis clearly makes—that therapy is in itself the most effective diagnostic procedure. I have, however, some reservations about the therapeutic value of looking for core masturbatory philosophies and of very direct confrontation with major irrational beliefs in this case. I fear this approach may tend to impair the development of a strong working alliance and to dilute the transference—results that could prove to be counterproductive therapeutically. I am less than enthusiastic about direct behavioral approaches as the core treatment plan in this case.

Allen Frances makes a good case for establishing a strong transference. I am in agreement with the desire for a firm, positive therapeutic relationship that also gives the patient space and distance to avoid being threatened. And I agree with the psychoeducational approach suggested by Frances,

particularly with the avoidance of direct challenges to the patient. Perhaps the use of indirect rather than direct advice might be more consistent with my overall approach, but my views on this case are essentially in convergence with those of Frances.

While I have emphasized the selection of intensive dynamic psychotherapy using hypnosis in Ken's case, I do not feel that other therapeutic modalities would not be effective. Seemingly different therapeutic approaches may incorporate similar dynamic mechanisms that, in the final sense, contribute to recovery.

Notes

1 Allen Frances was unable to contribute to this section due to a serious illness in his family.

Authors

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