

PARADOXICAL INTENTION^{1,2}

A Logotherapeutic Technique

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It has frequently been questioned to what extent psychotherapy can be taught and learned, since the psychotherapeutic process consists of a continuous chain of improvisations. In addition, one must bear in mind the infinite diversity of patients which precludes the possibility of extrapolating from one patient to another. Thus the psychotherapist is faced with the seemingly impossible twofold task of always considering the uniqueness of each person as well as the uniqueness of the life situation with which this person has to cope. Nevertheless, it is precisely this *individualization* and *improvisation* which must be taught and must be learned.

The choice of an appropriate treatment method to be applied in any concrete case depends not only upon the *individuality* of the patient involved, but also upon the *personality* of the therapist. The difficulty of the problem lies in the fact that the last two factors must be considered as "unknowns," at least initially. To illustrate this point, I frequently tell my students that the choice of the therapeutic method to be used in a specific situation may be compared to the following algebraic equation: $\psi = x + y$, whereby ψ is the therapeutic method, x represents the individuality of the patient, while y stands for the physician involved.

This equation highlights the fact that the crucial agency in psychotherapy is not so much the method but rather the relationship between the patient and his doctor, or, to use a currently popular expression, the "encounter" between the therapist and his patient. This human relationship between two persons is what seems to be the most significant aspect of the psychotherapeutic process, a more important factor than any method or technique. However, we

¹ Read before the ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOTHERAPY, February 26, 1960.

² I wish to acknowledge the kind assistance of D. F. Tweedie, Jr., Ph.D., Chairman, Dept. of Psychology, Gordon College, Mass., in the editing of this manuscript.

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should not be disdainful of technique, for in therapy a certain degree of detachment on the part of the therapist is indispensable. In fact, the human element must on occasion be disregarded in order to expedite the treatment (1).

The therapeutic relationship develops in a polar field of tension in which the poles are represented by the extremes of *human closeness* on the one hand, and *scientific detachment* on the other. Therefore, the therapist must beware lest he be beguiled into falling prey to either extreme in which only one of these poles is considered. This means that the therapist must neither be guided by mere sympathy, by his desire to help his patient, nor, conversely, repress his human interest in the other human being by dealing with him merely in terms of technique (2). The therapist must beware of interpreting his own role as that of a technician of a *médicin technicien*. This would amount to reducing the patient (in the words of the famous French materialist LaMettrie) to an "*homme machine*."

The question has often been posed as to whether Logotherapy includes what might be justifiably spoken of as a therapeutic technique. In spite of the fact that this inquiry is frequently accompanied by a measure of doubt, Logotherapy does utilize a special psychotherapeutic procedure. This method was first set forth by the author in *The Doctor and the Soul* (3), originally published in 1946, and in a more detailed manner in 1956 (4).

In order to understand fully what takes place when this technique is utilized, we shall use as a starting point a phenomenon which is known to every clinically trained psychiatrist, namely anticipatory anxiety. It is commonly observed that such anxiety often produces precisely that situation of which the patient is afraid. The erythrophobic individual, for example, who is afraid of blushing when he enters a room and faces a group of people, will actually blush at precisely that moment.

In case histories which display anticipatory anxiety, the fear of some pathologic event (thus, ironically, precipitating it), one may frequently observe an analogous phenomenon. This is the compulsion to self-observation. For instance, in cases of insomnia, the patients often report in the anamnesis that they become especially aware of the problem of falling asleep when they go to bed. Of course this very attention inhibits the sleeping process.

In addition to the fact that excessive *attention* proves to be an intrinsically pathogenic factor with regard to the etiology of neu-

roses, we also observe in many neurotic patients that excessive *intention* may also be pathogenic. Many sexual neuroses, at least according to the findings and teachings of Logotherapy, may be traced back to the forced intention of attaining the goal of sexual intercourse—be it the male seeking to demonstrate his potency, or the female her ability to experience orgasm. The author has discussed this subject at length in various papers (5, 6, 7), pointing out that as a rule the patient seeks pleasure intentionally (one might say that he takes the "pleasure principle" literally). However, pleasure belongs to that category of events which cannot be brought about by direct intention, but, on the contrary, is a mere side-effect or by-product. Therefore, the more one strives for pleasure, the less one is able to attain it. Thus we see an interesting parallel in which anticipatory anxiety brings about precisely what the patient had feared, while excessive intention, as well as excessive self-observation with regard to one's own functioning makes this functioning impossible.

It is this twofold fact upon which Logotherapy bases the technique known as "paradoxical intention." For instance, when a phobic patient is afraid that something will happen to him, the logotherapist encourages him to intend or wish, even if only for a second, precisely what he fears.

The following clinical reports will indicate what I mean:

A young physician came to our clinic because of a severe hydrophobia. He had for a long time been troubled by disturbances of the autonomic nervous system. One day he happened to meet his chief on the street and, as the young man extended his hand in greeting, he noticed that he was perspiring more than usually. The next time he was in a similar situation he expected to perspire again and this anticipatory anxiety precipitated excessive sweating. It was a vicious circle; hyperhidrosis provoked hydrophobia and hydrophobia, in turn, produced hyperhidrosis. We advised our patient, in the event that his anticipatory anxiety should recur, to resolve deliberately to show the people whom he confronted at the time how much he could really sweat. A week later he returned to report that whenever he met anyone who triggered his anticipatory anxiety, he said to himself, "I only sweated out a liter before, but now I'm going to pour out at least 10 liters!" What was the result of this paradoxical resolution? After suffering from his phobia for four years, he was quickly able, after only one session, to free himself of it for good by this new procedure.

The reader will note that this treatment consists not only in a reversal of the patient's attitude toward his phobia—inasmuch as

the usual "avoidance" response is replaced by an intentional effort—but also, that it is carried out in as humorous a setting as possible. This brings about a change of attitude toward the symptom which enables the patient to place himself at a distance from the symptom, to detach himself from his neurosis. This procedure is based on the fact that, according to logotherapeutic teaching, the pathogenesis in phobias and obsessive-compulsive neuroses is partially due to the increase of anxieties and compulsions that is caused by the endeavor to avoid or fight them. A phobic person usually tries to avoid the situation in which his anxiety arises, while the obsessive-compulsive tries to suppress, and thus to fight, his threatening ideas. In either case the result is a strengthening of the symptom. Conversely, if we succeed in bringing the patient to the point where he ceases to flee from or to fight his symptoms, but on the contrary, even exaggerates them, then we may observe that the symptom diminishes and that the patient is no longer haunted by it.

Such a procedure must make use of the unique potentiality for self-detachment inherent in a sense of humor. Along with Heidegger's assertion that "sorrowful concern" (*Sorge*) is the essential feature permeating human existence, and Binswanger's subsequent substitution of "loving togetherness" (*liebendes Miteinandersein*) as the chief human characteristic, I would venture to say that humor also deserves to be mentioned among the basic human capacities.⁴ No animal is able to laugh.

As a matter of fact, when paradoxical intention is used, the purpose is to enable the patient to develop a sense of detachment toward his neurosis by laughing at it, to put it simply. A statement somewhat consistent with this is found in Gordon Allport's book, *The Individual and His Religion* (8, p. 92): "The neurotic who learns to laugh at himself may be on the way to self-management, perhaps to cure." Paradoxical intention is the clinical application of Allport's statement.

A few more case reports may serve to develop and clarify this method further:

I once received a letter from a young medical student who had in the past listened to my clinical lectures on Logotherapy. She reminded me of a demonstration of paradoxical intention that she had attended, and

⁴ In addition to being a constituent element in man's existence, humor may well be regarded as an attribute to deity. See: Psalms, 2:4; 37:13; and 59:8.

continued: "I tried to apply the method which you had used in the class-room demonstration to myself. I, too, suffered continually from the fear that, while dissecting at the Institute of Anatomy, I would begin to tremble when the anatomy instructor entered the room. Soon this fear actually did cause a tremor. Then, remembering what you had told us in the lecture that dealt with this very situation, I said to myself whenever the instructor entered the dissecting room 'Oh, here is the instructor! Now I'll show him what a good trembler I am—I'll really show him how to tremble!' But whenever I deliberately tried to tremble, I was unable to do so!"⁶

Another case, which was treated by one of my assistants, Dr. Kurt Kocourek, concerned a woman, Mary B., who had been undergoing various treatment methods for 11 years, yet her complaints, rather than being alleviated, had increased. She suffered from attacks of palpitation accompanied by marked anxiety and anticipatory fears of a sudden collapse. After the first attack she began to fear that it would recur and, consequently, it did. The patient reported that whenever she had this fear, it was followed by palpitations. Her chief concern was, however, that she might collapse in the street. Dr. Kocourek advised her to tell herself at such a moment: "My heart shall beat still faster! I will collapse right here on the sidewalk!" Furthermore, the patient was advised to seek out deliberately places which she had experienced as disagreeable, or even dangerous, instead of avoiding them. Two weeks later, the patient reported: "I am quite well now and feel scarcely any palpitations. The fear has completely disappeared." Some weeks after her discharge, she reported: "Occasionally mild palpitations occur, but when they do, I say to myself, 'My heart should beat even faster,' and at that moment the palpitations cease."

Paradoxical intention may even be used therapeutically in cases which have an underlying somatic basis:

The patient was suffering from a coronary infarct. Subsequently he developed anxiety as a psychic response to his somatic illness, and this anxiety became so intense that it became his main complaint. He began to withdraw from his professional and social contacts and finally could not bear to leave the hospital where he had been a patient for six months and where a heart specialist was at hand. Finally the patient was transferred

⁶ Once I encountered the most severe case of stuttering that I have seen in my many years of practice: I met a man who had stuttered severely all his life—except once. This happened when he was twelve years old, and had hitched a ride on a street car. When he was caught by the conductor, he thought that the only way of escape would be to evoke his sympathy, and so he tried to demonstrate that he was just a "poor, stuttering boy." But when he tried to stutter, he was utterly unable to do it!

to our clinic and logotherapeutic treatment was begun by Dr. Gerda Becker. The following is a brief summary of tape-recorded comments of the patient:

"I felt very anxious and the pain in my heart region began to trouble me again. Then I asked the nurse to call the doctor. She stopped in for a moment and told me to try to make my heart beat faster and to *increase* the pain and fear until she could return a little later. I tried this and when she came back after about a quarter of an hour, I had to confess to her that, to my great surprise, my endeavors had been in vain—I could increase neither the pain nor the palpitations but, as a matter of fact, both had disappeared! . . . Encouraged by this turn of events, I left the clinic for an hour or so and went for a walk through the streets—something that I had not attempted for more than six months. Upon entering a store I felt a slight palpitation but, as the doctor had suggested, I immediately started saying to myself, 'Try to feel even more anxiety!' Again it was in vain, I simply could not do it! I returned to the clinic happy over my achievement of leaving the hospital and strolling around alone." We invited the patient to visit us six months later and he reported that he was free of any complaints and had, meanwhile, resumed his professional work.

Now let us turn to the following case:

Mrs. H. R. had been suffering for 14 years when she came to the clinic. She was severely handicapped by a counting compulsion as well as the compulsion to check whether her dresser drawers were in order and securely locked. She did this by continually checking the contents of the drawers, closing them by a sharp rapping of her knuckles, and finally by attempting to turn the key in the lock several times. Eventually this condition became so chronic that her knuckles were often bruised and bleeding and the keys and locks on the bureau were ruined.

On the day of her admission, Dr. Eva Niebauer demonstrated to the patient how to practice paradoxical intention. She was shown how to throw things carelessly into her dresser and closet, to try to create as much disorder as possible. She was to say to herself, "These drawers should be as messy as possible!" The result was that two days after admission her counting compulsion disappeared and, after the fourth day, she felt no need to recheck her dresser. She even forgot to lock it—something that she had not failed to do for decades! Sixteen days after hospitalization she felt free of any complaints or symptoms, was very proud of her achievement, and was able to do her daily chores without compulsive repetition. She admitted that obsessive-compulsive ideas occasionally recurred but reported that she was able to ignore them, or, to make light of them. Thus she overcame her compulsion not by frantically fighting it (which

only strengthens it) but, on the contrary, by "making a joke of it"; in other words, by applying paradoxical intention.

A remarkable fact about this case is that after her symptoms had cleared up, the patient spontaneously, during a psychotherapeutic interview, revived some significant memories. She remembered that when she was five years old, her brother had destroyed a favorite doll and thereafter she began locking her toys in her dresser drawer. When she was sixteen, she caught her sister in the act of putting on some of the patient's best party clothes without her permission. From that time on she always carefully locked up her clothes. Thus, even if we take it for granted that her compulsions were rooted in these traumatic experiences, it is, nevertheless, the radical *change of attitude* toward her symptoms which was therapeutically effective. The bringing to consciousness of such psychic traumata cannot, at any rate, *in itself* be the appropriate treatment, inasmuch as a method which does not include such a procedure proved to be so efficient. This brings to mind a statement made by Edith Weisskopf-Joelson (9) in her article "Some Comments in a Viennese School of Psychiatry," which seems to me to be noteworthy: "Although traditional psychotherapy has insisted that therapeutic practices have to be based on findings on etiology, it is possible that certain factors might cause neuroses during early childhood and that entirely different factors might relieve neuroses during adulthood." Even psychoanalysts are more and more inclined to assume that traumata in themselves do not directly cause neuroses. The traumata merely provide the contents of the respective obsessions, compulsions, and phobias. In some cases, I would dare to say that even the opposite is true: The trauma does not cause the neurosis, but rather, the neurosis makes the trauma reappear. One illustration may serve to clarify this point. A reef which appears at low tide is not the cause of the low tide; rather, it is the low tide which causes the reef to appear. Be that as it may, the therapy that we use must be independent of the validity of the etiologic assumptions of any particular neurotic symptoms. Thus Weisskopf-Joelson's comment is pertinent. At any rate, it is interesting to note that more or less "free associations" leading back to the traumatic experiences which produced certain habits and symptoms may occur *after* therapy has brought relief.

Thus we see that paradoxical intention works even in cases in which either the actual *somatic* basis (the patient with the coronary

infarct) or the presumed *psychic* cause (the ease of H. R.) were not touched upon. Paradoxical intention is effective irrespective of the underlying etiologic basis; in other words, it is an intrinsically nonspecific method. According to the author's opinion, based upon clinical experience, in every severe case involving phobic symptoms, one has to reckon with an autonomic-endocrine or an anankastic substructure. This does not entail a fatalistic viewpoint, however, for a full-fledged neurosis is nothing but a superstructure built upon these constitutional elements; it may well be that it can be psychotherapeutically alleviated without necessarily removing, or even taking into account, the underlying basis. Such a therapy is palliative rather than causal. This is not to say that it is a symptomatic therapy, however, for the logotherapist, when applying paradoxical intention, is concerned not so much with the symptom in itself but, rather, the patient's *attitude* toward his neurosis and its symptomatic manifestations. It is the very act of changing this attitude that is involved whenever an improvement is obtained.

This nonspecificity helps to clarify why paradoxical intention is sometimes effective in severe cases. I wish to emphasize "sometimes"; for I do not wish to convey the impression that beneficial results were *always* obtained, nor that paradoxical intention is an universal panacea or a miracle method. On the other hand, however, I feel obliged to present the range of its applicability and the degree of its effectiveness accurately. I should like to add parenthetically that the percentage of cures or cases improved to a degree that has made further treatment unnecessary, is somewhat higher (75.7%) than the figures reported in the literature (10).

Paradoxical intention is also applicable in cases more complex than those involving monosymptomatic neurosis. The following will demonstrate that even instances of severe obsessive-compulsive character neurosis (in German clinical terminology referred to as anankastic psychopathic character structure) may be appropriately and beneficially treated by means of paradoxical intention.

The patient was a 65-year-old woman who had suffered for 60 years from a washing compulsion of such severity that she was admitted to our clinic for a period of observation in order that I might certify her for a leucotomy (which I expected to be the only available procedure for bringing relief in this severe case).⁶ Her symptoms began when she was four

⁶ In this connection I should like to stress my conviction that in some cases this operation is the only way to help. I have ventured to give such indications in a few cases and have in no instance regretted my decision.

years of age. When she was prevented from indulging her washing compulsion, she would even lick her hands. Later on she was continually afraid of being infected by people with skin diseases. She would never touch a doorknob. She also insisted that her husband stick to a very complicated prophylactic ritual. For a long time the patient had been unable to do any housework, and finally she remained in bed all day. Nevertheless, even there she persisted in scrubbing things with a cloth for hours, up to 300 times or more, and having her husband repeatedly rinse out the cloth. "Life was hell for me," she confessed.

In the hope of avoiding brain surgery, my assistant, Dr. Eva Niebauer, started logotherapeutic treatment by means of paradoxical intention. The result was that nine days after admission the patient began to help in the ward by mending the stockings of her fellow patients, assisting the nurses by cleaning the instrument tables and washing syringes, and finally even emptying pails of bloody and putrid waste materials! Thirteen days after admission she went home for a few hours and upon her return to the clinic, she triumphantly reported having eaten a roll with soiled hands. Two months later she was able to lead a normal life.

It would not be accurate to say that she is completely symptom free, for frequently obsessive-compulsive ideas come to her mind. However, she has been able to get relief by ceasing to fight her symptoms (fighting only serves to reinforce them) and, instead, by being ironical about them; in short, by applying paradoxical intention. She is even able to joke about her pathologic thoughts. This patient still kept in contact with the outpatient clinic, for she continued to need supportive Logotherapy. The improvement in her condition persisted, however, and thus the leucotomy, which previously had seemed unavoidable, had now become unnecessary.

The author has included a number of cases that were treated by his collaborators rather than by himself. This is not accidental. It serves to indicate that it is the method that works and not the personality of the creator of the method (though, as has been pointed out at the beginning, the personal factor must never be neglected).

The reader has undoubtedly noticed, with respect to the above-mentioned case reports, that paradoxical intention is particularly useful as short-term therapy, especially in phobic cases⁷ with an underlying anticipatory anxiety mechanism. The following is a remarkable instance of such short-term therapy that was successful

⁷ At least in some instances, paradoxical intention seems to be effective in cases of psychosis as well; for example, a patient at our clinic reported to one of the doctors at the first interview that she had read about paradoxical intention and had successfully applied it with reference to the "voices" she was hearing. She had taken her acoustic hallucinations for a neurosis!

in spite of long-standing pathologic manifestations. It is taken from a tape-recorded report of the patient, Mrs. Rosa L.

"... Once I had forgotten to lock the door and when I returned home it was open. That frightened me very much. After that, whenever I left the house, I couldn't get rid of the feeling that the door was still open. I would go back again and again to check. This went on for 20 years. I knew that the obsession was silly, for every time I went back the door would be locked, but I couldn't seem to keep from obeying the impulse. Life became unbearable. Since my interview with Dr. Becker, however, things have changed completely. Whenever I have the compulsion to check whether or not the door is locked, I say to myself: 'What if the door is open! Let them steal everything in the whole apartment!' and at that moment I am able to ignore the impulse and go calmly on my way."

Three months later we invited her back to report on her condition. She said: "I feel wonderful; not the slightest obsession. I can't even imagine how I could have had all those thoughts in the past years. *For twenty long years* I was tormented by them, but now they're gone and I'm very happy."

One should be careful to avoid the impression, held in many psychotherapeutic circles, that short-term therapy necessarily brings short-lived results. The following excerpts from another tape recording will illustrate this point:

"... There was practically not one minute during the day when I was free of the thought that I might break a store window. But Dr. Frankl told me to go right up to the window with the intention of smashing it. When I did this, the fear disappeared completely and I knew that I wouldn't go through with it. It all seems like a dream now; the fears and impulses to do these things have all vanished."

The noteworthy thing about this report is that it was given twenty years after the treatment!

In connection with short-term-therapy, I should like to quote Guthoil's statement (11) regarding "the more common illusions of freudian orthodoxy, such as that the length of therapy is synonymous with the depth of therapy; that the depth of therapy depends on the frequency of interviews; that the results of therapy are proportionate to the length and depth of treatment; that the durability of results corresponds to the length of therapy." Such a warning may point up the fact that paradoxical intention is not as superficial as it may first appear to be. Something is certainly happening at a deeper level whenever it is applied. Just as a phobic symptom

originates beneath the surface of consciousness, so paradoxical intention also appears to affect the deeper level. The humoristic formulations of its method are based on a restoration of basic trust in Being (*Urvertrauen zum Dasein*, 12, p. 41). What transpires is essentially more than a change of behavior patterns; rather, it is an existential reorientation (*existentielle Umstellung*).

It is in this respect that paradoxical intention represents a truly "logo"-therapeutic procedure in the truest sense of the word (13). Jorge Marcelo David, a logotherapist from Argentina, has pointed out that its use is based on what is called in logotherapeutic terms psychonoetic antagonism (or, sometimes, *Die Trotzmacht des Geistes*), and by which is meant the specifically human capacity to detach oneself, not only from the world but also from oneself. Paradoxical intention mobilizes this basic human potentiality for the therapeutic purpose of combating neuroses.

Of course one is bound to find individual differences in the degree to which this ability can be applied. It cannot be used indiscriminately, and the therapist must be aware of its limitation with regard to certain patients and situations (14). It would undoubtedly be desirable to establish criteria for evaluating the extent to which a specific patient is likely to mobilize his own psychonoetic antagonism.⁸ At any rate, such testing procedures have yet to be devised. The author himself insists that this ability is present in every human being, since it is an essential feature of being human.

With paradoxical intention one enters into the noetic dimension as the characteristic and constitutive dimension of human existence. Viewed from the point of view of logotherapeutic teachings, this dimension, the realm of the spiritual, covers more than merely rational or intellectual processes, although these are certainly included. Because of this inclusion, one can appreciate the statement that Gutheil made in his last paper, "Problems of Therapy in Obsessive-Compulsive Neurosis" (15), namely, that "new therapeutic means must be introduced. . . . Appeal to reason, fruitless though it may be in other cases, holds promise in cases of obsessive-compulsive neurosis, in which rationalization and intellectualization play so great a part."

This, in turn, leads to another question; namely, whether or not

⁸ Whether it would also be possible is another question inasmuch as, according to a statement of D. F. Twodlo, who is conducting logotherapeutic research, such "antagonism" is atypical for the neurotic patient's past and present experience, upon which, presumably, the criteria would be based.

paradoxical intention belongs to the persuasive methods, such as that of Paul Dubois, for example. As a matter of fact, paradoxical intention is the exact opposite of persuasion since it is not suggested that the patient simply suppress his fears (by the rational conviction that they are groundless), but rather, that he overcome them by exaggerating them! The essential dissimilarity of paradoxical intention and suggestive techniques has been brought to our attention by Polak (16).

Paradoxical intention can also be applied to cases of sleep disturbance, as mentioned before. The fear of sleeplessness increases sleep disturbance because anticipatory anxiety completes and perpetuates the vicious circle. In addition, it results in a forced intention to sleep which incapacitates the patient to do so. Dubois, the famous French psychiatrist, once compared sleep with a dove which has landed near one's hand and stays there as long as one does not pay any attention to it; if one attempts to grab it, it quickly flies away. But how can one remove the anticipatory anxiety which is the pathologic basis of forced intention? In order to take the wind out of the sails of this specific fearful expectation, we advise the patient not to try to force sleep, since the necessary amount of sleep will be automatically secured by the organism. Therefore, he can safely try to do just the opposite, to stay awake as long as possible. In other words, the forced intention to fall asleep, arising from the anticipatory anxiety of not being able to fall asleep, should be replaced by the paradoxical intention of not falling asleep at all! (Which in turn will be followed very rapidly by sleep.)⁹

In recent years the use of paradoxical intention has been increasingly reported in the literature. Authors from various countries, as well as those collaborating in the work of the Neurological Polyclinic of Vienna, have published the results of the clinical application of this technique. In addition to David (Buenos Aires), mention may be made of the assistants of Prof. Kretschmer (Psychiatric University-Clinic of Tübingen), Langen and Volhard, and Prill (Gynecologic University-Clinic of Würzburg) and Reh-

⁹It is noteworthy that this procedure, in cases of insomnia, has subsequently been worked out independently by two other workers in the field. One advises his patients to keep their eyes open as long as possible, while the other recommends to doctors who work with hospitalized patients that they let the patients punch a timeclock every quarter hour. He reports that after a very few fifteen minute intervals they succumb to increasing fatigue and sleepiness.

der (Hamburg). Prof. Bazzi (University of Rome) has even worked out special indicators to enable the psychiatrist to distinguish in which cases paradoxical intention should be applied and in which the autogenous training method of Schultz is indicated (17). At the International Congress for Psychotherapy, held in Barcelona, 1958, Ledermann (London) declared: "The results (of Logotherapy) are not to be denied. I have found the method helpful in cases of obsessional neurosis." Friek (Bolzano, Italy) goes still further by stating that there are cases of severe obsessive-compulsive neurosis in which a logotherapeutic procedure is the "only therapeutic way," and refers to some of his cases in which electroshock treatment had proved in vain, whereas Logotherapy alone served in the sense of an *ultima ratio*. Prof. Lopez-Ibor (University of Madrid) makes a similar statement.

In addition to my associates, Kocourek and Niebauer, who have published papers about paradoxical intention, there has been among my co-workers a psychoanalyst, whose training and orientation are strictly Freudian. For a year he treated nearly all of the cases of sexual disturbance in the outpatient ward of our clinic, and, inasmuch as short-term therapy was indicated, used logotherapeutic procedures exclusively. His experience is summarized in a paper, worked out in collaboration with me, which he read at a German Congress of Sexology.

We have previously stated that a compulsion to self-observation accompanies anticipatory anxiety, and in the etiology of a neurosis one often finds an excess of attention as well as intention. This is especially true in insomnia in which the forced intention to sleep is accompanied by the forced attention to observe whether the intention is becoming effective or not. This attention thus joins in perpetuating the waking state.

In reference to this phenomenon, Logotherapy includes a therapeutic device known as "*de-reflection*." Just as paradoxical intention is designed to counteract anticipatory anxiety, de-reflection is intended to counteract the compulsive inclination to self-observation. In other words, what has to be achieved in such cases is more than trying to "ironize" the trouble by using paradoxical intention and its humorous formulation; one should also be able to *ignore* the trouble to some degree. Such ignoring, or de-reflection, however, can only be attained to the degree in which the patient's awareness is directed toward positive aspects. De-reflection, in itself,

contains both a negative and a positive aspect. The patient must be de-reflected *from* his anticipatory anxiety *to* something else. This conviction is supported by Allport (8, p. 95) who once said: "As the focus of striving shifts from the conflict to selfless goals the life as a whole becomes sounder even though the neurosis may never completely disappear." Such goals may be discovered by a certain kind of analytic procedure which we call *Existenzanalyse* (18, 19, 20). In this way the patient may discover the concrete meaning of his personal existence (21).

Let us, in conclusion, review the indications of paradoxical intention from the perspective of what Logotherapy presents as the four characteristic patterns of response toward neurotic problems:

I. *Wrong Passivity*: By this is meant the behavioral pattern which may be observed in cases of anxiety neurosis or phobic conditions, or both. It is the withdrawal from those situations in which the patient, because of his anticipatory anxiety, expects his fears to recur. What we have to deal with in this case is the "*flight from fear*"—most commonly fear of collapsing on the street or having a heart attack.

II. *Wrong Activity*: This behavioral pattern is characteristic, in the first place, of obsessive-compulsive neurosis. 1. The individual, rather than trying to avoid conflict situations, *fights* against his obsessive ideas and neurotic compulsions and thus reinforces them. This struggle is motivated by two basic fears: (a) that the obsessive ideas indicate an imminent, or actual, psychotic condition, and (b) that the compulsions will someday result in a homicidal or suicidal attempt. 2. Another aspect of "wrong activity" may be observed in sexual neurosis, namely, a struggle *for* something, rather than *against* something: a striving for orgasm and potency. The underlying motivation is usually as follows: the patient feels that competent sexual performance is "demanded" of him either by the partner, by the situation, or by himself, in the event that he may have, so to speak, "scheduled" it for that moment. Due to this very "pursuit of happiness" the sexually neurotic individual founders, like the obsessive-compulsive neurotic, by responses that are inappropriate to the situation: pressure precipitates counterpressure.

In contrast to these negative, neurotic, "wrong" behavioral patterns, there are two positive, normal ones:

III. *Right Passivity*: This is the case when the patient, by means of paradoxical intention, "ironizes" his symptoms rather than try-

ing to either run away from them (phobias) or to fight them (obsessive-compulsions).

IV. *Right Activity*: Through de-reflection, the patient is enabled to ignore his neurosis by focusing his attention away from himself. He will be directed to *a life full of potential meanings and values with a specific appeal to his personal potentialities*.

In addition to this personal aspect, a social factor is involved as well. More and more we meet individuals who are suffering from what Logotherapy calls man's "existential vacuum" (2, 22, 23). Such patients complain of a feeling of a *total and ultimate meaninglessness* in their lives. They display an inner void or emptiness in which neurotic symptoms may abound. Filling this vacuum may thus assist the patient in overcoming his neurosis by helping him become aware of the full spectrum of his concrete and personal meaning and value possibilities, or, in other words, by confronting him with the "logos" of his existence.

SUMMARY

In the frame of Logotherapy of Existential Analysis (*Existenzanalyse*), a specific technique has been developed to handle obsessive, compulsive, and phobic conditions. This procedure, called Paradoxical Intention, is based on the fact that a certain amount of pathogenesis in phobias and obsessive-compulsive neuroses is due to the increase of anxieties and compulsions that is caused by the endeavor to avoid or fight them. Paradoxical Intention consists in a reversal of the patient's attitude toward his symptom, and enables him to detach himself from his neurosis. This technique mobilizes what is called in Logotherapeutic terms the Psychonoetic Antagonism, i.e., the specifically human capacity for self-detachment. Paradoxical Intention lends itself particularly as a useful tool in short-term therapy, especially in cases with an underlying anticipatory anxiety mechanism.

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