Viktor E. Frankl

On the Theory and Therapy of Mental Disorders

An Introduction to Logotherapy and Existential Analysis

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Viktor E. Frankl
(Translated by James M. Dubois)

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Translator's Notes and Acknowledgments

The original German book, *Theorie und Therapie der Neurosen*, was first published in 1956 and is now in its eighth edition. Of the six or more books that Viktor Frankl wrote that remain to be translated into English, this is the book that he most urgently wanted to see translated because it presents most systematically his overall theory of mental disorders and the way that logotherapy can be brought into the treatment of nearly all disorders, either as a primary or a secondary therapy. Because this is also one of his most difficult books, a separate editor's introduction has been written to make the book more accessible. Therefore, I limit myself here to a few passing remarks on the translation itself.

I have attempted to produce a translation that uses inclusive language by translating "man" (*der Mensch*) as "human beings," "human persons," or "people," and accordingly used the pronoun "they" instead of "he." Although I have taken this liberty in translation, I have at the same time faithfully replicated his reference to the specifically "human" (*menschliche*) and specifically "personal" (*personale*) dimensions of human nature.

In general, I have sought to be faithful to Frankl's psychiatric terminology. Thus, I did not translate the somewhat archaic term "organ neuroses" as somatoform disorders, nor did I abandon his use of the terms "pseudoneuroses" or "functional illnesses"—for these do not have exact equivalents in American psychiatry. (Also, all three of the terms just mentioned are still used by logotherapists in the German-speaking world.) In some cases where anglicizing a term would cause confusion (e.g., his term "psychopathic" has nothing to do with antisocial behavior), I have offered the closest diagnostic equivalent (in this case "personality disorder") and discussed it in a footnote upon its first appearance.

The biggest change in terminology occurs in the title of the book: The original referred to the theory and therapy of neuroses rather than mental disorders. This change was made with two aims in mind: first, to avoid putting off readers who have abandoned the term "neurosis"; second, to reflect the fact that most of the disorders the book addresses are not neuroses even according to Frankl's use of the term. That being said, nowhere in the text did I replace the term "neurosis" with the more generic term "mental disorder."

A glossary has been provided at the back of the book to provide definitions of medical terms. These terms are marked in bold the first time they appear in the text of the book.

Where an important German term is capable of being translated in a variety of ways, I have settled on the way I thought best and put the German term in parentheses the first time that it appears.

Translator's notes appear in italic font and are denoted with my initials—JMD. All other notes are Professor Frankl's.

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I dedicate this translation to the Frankl and Vesely families in gratitude for their invitation to undertake this work and in admiration of their deep commitment to seeing the work of Viktor Frankl live on.

Understanding Viktor Frankl's *Theory and Therapy of Mental Disorders*

James M. DuBois

This book provides a much-needed corrective to the way that Viktor Frankl is often understood. He is frequently viewed as a popular writer. This is not without good reason. His book *Man's Search for Meaning* (Frankl, 1962), sold over 9 million copies worldwide and he is cited in many popular books like *The 7 Habits of Highly Effective People* (Covey, 1989). Frankl is also frequently viewed as an existentialist or humanistic psychologist. This too is not without good reason. Gordon Allport introduced his writings to the United States and much like Allport, Maslow, Fromm, and Rogers, Frankl addressed the existential themes of human freedom, responsibility, values, spirituality, and death.[1] Yet to view Frankl simply as a popular, humanistic psychologist is to fundamentally misunderstand who he was as a person and what he represented.

Frankl was a physician and a professor of neurology and psychiatry at the University of Vienna. His view of psychiatric treatment went beyond existential counseling and included the medical tools of his day: hypnosis, electroconvulsive therapy, psychopharmaceuticals, and relaxation exercises. While the humanistic approach to psychotherapy is sometimes viewed as fundamentally opposed to standard psychiatric approaches, Viktor Frankl's theory of mental disorders allowed him to reconcile these two worlds—the worlds of lived experience and of medical science and practice.

[1] Gordon Allport wrote the preface to *Man's Search for Meaning* (Frankl, 1962). In his last line he calls logotherapy "the most significant psychological movement of our day."

This book, more than any other book he wrote, presents Frankl as a philosopher-psychiatrist, a theoretician immersed in medical practice. As the title suggests, it presents his overarching theory and therapy of mental disorders. And in this book we see that the two elements of theory and therapy are intimately related. No matter which disorder or treatment is discussed, Frankl's approach in *Theory and Therapy of Mental Disorders* (TTMD) develops along a consistent path:

Ontology → *Etiology* → *Classification* → *Therapy*

That is to say, Frankl's choice of therapy is matched to a disorder with a specific etiology or cause that reflects a fundamental human characteristic. In chapter 4 we read that a hormone replacement like hydrocortisone (therapy) may be prescribed to treat a "functional illness" marked by irritability and an inability to concentrate (classification) due to adrenocortical insufficiency (etiology); such mental disorders are only possible because different human dimensions interact—in this case, biological imbalances are affecting mental functions (ontology). In chapter 12 we read that the technique of dereflection (therapy) may be used to treat impotence (classification), which can arise from hyperreflection or an excessive focus on achieving an erection (etiology), which is a problem only because healthy human sexual relations depend on self-transcendence as a person engages another person (ontology). And in the Introduction we read that Socratic questioning (therapy) may be used in the psychotherapy of a noogenic depression (classification) that arises from a perceived lack of meaning in suffering (etiology), which is explained by the fact that human beings flourish only when their "will to meaning" is not thwarted (ontology).

These examples illustrate two things. First, Frankl's theory of mental disorders and his classification system cannot be fully understood or appreciated without first understanding his "metapsychology"—his philosophy of human nature and of psychological science. Second, some of Frankl's diagnostic terminology is foreign to American psychiatry. Accordingly, this introduction seeks to provide an overview of Frankl's metapsychology and to explain how Frankl's terminology relates to the more familiar terminology of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR).

Logotherapy as a Metapsychological Theory

In chapter 14 of TTMD, Frankl writes:

> Existential analysis is the attempt at a psychotherapeutic anthropology, an anthropology that precedes all psychotherapy, not only logotherapy. Indeed, every psychotherapy plays itself out against an *a priori* horizon. There is always an anthropological conception at its foundation, no matter how little aware of this the psychotherapy may be.[2]

While TTMD does not develop Frankl's psychotherapeutic anthropology at great length, it builds heavily upon it.[3] In what follows, we will briefly look at just three elements of this psychotherapeutic anthropology or metapsychology: the theory of knowledge; the dimensions of the human person; and the theory of meaning and values.

Theory of Knowledge

In his autobiography, Frankl recalls the concluding lines of a speech he delivered at the Fifth International Congress for Psychotherapy in 1961:

> As long as we do not have access to absolute truth, we must be content that our relative truths correct one another, and that we find the courage to be biased. In the many-voiced orchestra of psychotherapy we not only have the right, but the duty to be biased as long as we are conscious of it. (Frankl, 2000, p. 126)

In speaking of bias, Frankl refers to our need to see and articulate things from a definite perspective. Elsewhere he notes that the Latin term *perspectum* means "seen through." Seeing the world through a given lens, or from a given perspective entails that our knowledge is always limited, like the man who knows an elephant only from holding its trunk. But while it is true that all human knowledge is gained from a subjective perspective, the only thing that is subjective is the perspective through which we approach reality: "this subjectivity does not in the least detract from the objectiveness of reality itself" (1988, p. 59).

In writing this, Frankl was deeply influenced by the epistemology of the early phenomenologists. Sometimes phenomenology is understood as a tradition that is metaphysically idealistic and epistemologically

[2] As is common in Continental philosophy, Frankl uses the term "anthropology" to mean a philosophy of the human person.

[3] Frankl develops his metapsychology above all in the following seven works: *The Unheard Cry for Meaning* (1978), *Psychotherapy and Existentialism* (1985), *The Doctor and the Soul* (1986), *The Will to Meaning* (1988), the identically titled book in German albeit with different content, *Der Wille zum Sinn* (1991), and *Der leidende Mensch* (1990), which includes republications of *Homo Patiens* and *Der unbedingte Mensch.*

subjectivistic, denying that we can achieve genuine knowledge of the world. But this was neither the view of the early phenomenologists nor of Frankl. Frankl (1967) explains, "phenomenology, as I understand it, speaks the language of man's pre-reflective self-understanding rather than interpreting a given phenomenon after preconceived patterns" (p. 18). It deals with the "immediate data of [human] experience" (p. 18).[4] This is very much the simple, realist notion of phenomenology espoused by Scheler (1973) and Reinach (1914/1989).

Why is knowledge only gained from a specific perspective? In part, it is because different kinds of objects are given or present themselves in different manners: colors are seen, sounds are heard, logical conclusions may be deduced, scientific conclusions may be inferred, basic truths are to be intuited (like responsibility presupposes freedom), and the value of an object is felt or known intuitively (e.g., the value of a beautiful landscape or a beloved person). Similarly, different dimensions of the human person are disclosed in different ways. This fact would pose a serious limitation for someone who is working with a specific scientific approach that is geared to just one dimension. But, as noted above, Frankl's approach was based above all on the phenomenology of Max Scheler, who wrote: "what constitutes the unity of phenomenology is not a particular region of facts, such as, for example, mental or ideal objects, nature, etc., but only self-givenness in all possible regions" (1973, p. 145).

These epistemological assumptions explain what Frankl meant by being biased or speaking from a limited perspective. But they also help us to understand why he was so strongly opposed to reductionism. He wrote, "What we have to deplore . . . is not that *scientists are specializing* but that the *specialists are generalizing*" (1988, p. 21). Specialists understandably describe multidimensional phenomena like human persons from just one perspective. That is not only understandable, but unavoidable. However, such an approach becomes problematic when the specialist proposes that the phenomenon can be adequately comprehended from the one perspective (e.g., behavioral observation, EEGs, or dream analysis).

These underlying epistemological assumptions make Frankl different from most original thinkers and founders of movements. Given his broad notion of evidence and his insistence that objects never be reduced to what is given from one perspective, readers should not be shocked to find—as they will find in this book—that Frankl sometimes cites the work of behaviorists, Konrad Lorenz, Buddhist counselors, Goethe, Freud, and medical scientists in support of his own conclusions. While some of these

[4] While I have tried to use inclusive language in my translation of TTMD, I have not changed the language that Frankl or his translators used in his other English-language books.

systems do indeed contradict logotherapy (e.g., Skinner's [1976, 1990] radical behaviorism denies the existence of freedom and the unconscious mind), logotherapy is quite capable of integrating insights from these other systems because it works with a broad theory of knowledge and a multilayered view of the person.

However, Frankl's eclectic practice stands in sharp contrast to the multicolored pallet approach that American psychology textbooks typically espouse (i.e., presenting all major theories, perhaps with a few critical comments, but without guidance on how to pick and choose intelligently). DuBois (1993) has distinguished between theory-guided eclecticism, which coherently incorporates aspects of different theories and therapies into a larger system, with syncretism, which simply uses whatever seems appropriate at the moment without an overarching rationale. Syncretism is theoretically problematic insofar as it lacks internal consistency, and the power to explain and predict. Frankl avoids this theoretical problem to the extent that his metapsychology guides his eclectic practice.

To summarize, Frankl's theory of knowledge contributes two things to his theoretical goals and methodology:

1. His broad notion of evidence opens the possibility of gaining knowledge of the whole person and not merely of what individual sciences reveal.
2. His realist epistemology justifies eclectic psychotherapeutic theory and practice: the criterion for adopting various propositions and approaches is the object known (the human person), not the method of knowing.

The most basic element of Frankl's metapsychology is his theory of knowledge, but no less important to his theory of mental disorders is his view of human beings and the values they pursue.

Dimensions of the Human Being

According to Frankl, human beings are natural, integrated beings with three basic dimensions: the somatic, the mental, and the spiritual or noetic (1985, ch. 11). He refers to this as his "dimensional ontology."

The somatic level is the level of the body or soma, the biological level. In TTMD the somatic level receives a fair amount of attention as Frankl speaks of the influence of heredity and constitutional factors grounded in a person's endocrine and neurological functions, and as he discusses the treatment of endogenous disorders using psychotropic medications and other biologically based treatments.

The mental is the level of psychological processes. This is the level at which mental disorders are manifested, and accordingly it is the dimension with which most traditional psychological models are concerned. Like the somatic dimension, natural causal laws determine the psychological dimension. While the mental is not reducible to the biological, it is clearly determined by biological factors as well as laws of its own (e.g., principles of association or Gestalt perception).

The spiritual or noological dimension is the one that has received the least amount of attention from the fields of psychiatry and psychology. Frankl repeatedly lamented that the term spiritual has religious overtones in English, which the term German term *geistig* does not have (1988, p. 17). In this regard, the term noological is preferable, partly due to its unfamiliarity. While the noological dimension is like the mental insofar as it is immaterial, it is distinguished from the mental in several ways. First, it is the only dimension at which freedom and responsibility exist. While people are determined at the somatic and even psychological level, logotherapy recognizes the "defiant power of the spirit" (*Trotzmacht des Geistes*), the ability to take a free stance toward our fate and the things that determine us at any given time (1985, p. 133). Second, the conscience—the "organ" for perceiving meaning—operates at the noological level (1997, pp. 39ff). Its operations are natural to human beings, who are characterized by a "will to meaning." Third, the noological dimension is the properly human dimension; it is what distinguishes human persons from subpersonal animals (1985, p. 134). Fourth, Frankl posits that the person as a spiritual being cannot become ill; people become ill only in their somatic or mental dimensions (TTMD, ch. 10). Fifth, the noological dimension interacts with the somatic and mental dimensions. A perceived lack of meaning in life can contribute to the development of neuroses (like anxiety disorders or depression), just as a strong sense of meaning can be psychohygienic and provide resistance even to bodily illness (1985, TTMD). And although the spirit or person at the noological level cannot become ill, a biologically caused mental disorder like major depression may affect the operations of the spirit; for example, it may leave people unable to express themselves fully and unable to perceive values rightly (TTMD, ch. 2).

This dimensional ontology gives rise to three central features of logotherapeutic theory as developed in TTMD:

1. A conception of logotherapy as a therapy of the spiritual or noological dimension
2. A threefold view of causality, which has implications for the classification of mental disorders: disorders may be somatogenic, psychogenic, or noogenic depending on whether their cause is biological, mental, or spiritual
3. A view of human beings as capable of distancing themselves from psychosomatic events

Theory of Meaning and Values

At the center of logotherapy stands the idea that human beings have a "will to meaning." The topic of meaning is very large, has been the focus of many books by Frankl (1962, 1978, 1985, and 1988) but logotherapy scholars (Fabry, 1987; Wong & Fry, 1998; Riemeyer, 2002), but cannot be explored in great depth here. However, four elements of Frankl's theory of meaning are central to his theory and therapy of mental disorders.

First, Frankl maintains that "Man is always reaching out for meaning, always setting out on his search for meaning; in other words, what I call the 'will to meaning' is even to be regarded as man's 'primary concern' . . ." (1978, p. 31).

Second, the meaning we seek is not "the meaning in life"—some general abstract meaning—but always the meaning of my life, right here, right now. As Frankl put it,

> To look for the general meaning of man's life would be comparable to asking a chess player: "What is the best move?" There is no such thing as "the best move" apart from the one that is best within the context of a particular situation of a particular game. (1985, p. 67)

Third, we find meaning in our lives through the pursuit of three different kinds of values: creative, experiential, and attitudinal values. Creative values arise from producing new things in the world, for example, through work or parenting. Experiential values arise as we enjoy or participate in values, for example, the value of a beloved person or the value of beautiful music. Finally, attitudinal values arise from the free stances we adopt toward our fate or situation, for example, the way we face an incurable cancer or confinement in a concentration camp (1962; 1985, p. 127).

Fourth, although Frankl would never deny that human beings make value judgments or have affective responses to things, he is not talking about subjective properties when he speaks of values. For Frankl, the value of a possibility, an action, a person or thing is objective in the sense that it

is discovered. He speaks of this discovery as a kind of Gestalt perception (1988, pp. 62ff). A musical pattern or Gestalt is not a self-standing substantial entity, nor is it some mystical, other worldly property of sound waves. Yet musical patterns—for example, melodies and harmonies—are "discovered" by listening subjects, they are perceived against a background. It is similar with the perception of values.

When combined with his theory of knowledge and dimensional view of the person, Frankl's view of values yields three tenets of logotherapeutic practice:

1. The possibility of addressing issues that involve values and meaning without "imposing values" on patients; the therapist's role is that of a facilitator who helps patients to discover values and meanings that are unique to them[5]
2. The possibility of using the human capacity of self-transcendence—the ability to go beyond oneself to discover meaning in values—in therapy through dereflection and attitude modification
3. The possibility of logotherapy even in the face of incurable illness—for attitudinal values can always be actualized

While TTMD does not systematically develop any of the three aspects of Frankl's metapsychological theory that were just briefly presented—his theory of knowledge, dimensional ontology, and theory of meaning and values—it develops their implications for the theory and therapy of mental disorders more fully than any of his other writings.

Frankl's Theory of Mental Disorders

As readers approach the chapters in part I that lay out 10 categories of mental disorders, it is helpful to recall something that Frankl notes in his preface to the first edition, namely, that this book is based upon lectures that he delivered at the University of Vienna and in the United States, and under such conditions it is inevitable that there will be gaps and areas of overlap.[6] Understanding the origins of this book in course lectures helps us to understand why his treatment of various disorders is somewhat uneven:

[5] Throughout this introduction I frequently speak of "patients." This is largely because Frankl's focus in TTMD is on the care of psychiatric patients. Naturally, the terms "clients" or simply "persons" would be more appropriate in certain contexts.

[6] This includes areas of overlap with other books. While the overarching categorization schema and most of the cases in TTMD are unique to it, those familiar with his other books in English will recognize some of his stories, examples, and pithy remarks. In part, this is because some of his English-language books, e.g., *The Will to Meaning*, are not merely translations, but were written in English. Thus, it is only natural that he would incorporate into them some material from untranslated works.

they developed organically within a historical, educational context. To keep his lectures relevant to students, he regularly offered responses to some of the most influential movements of his day. Accordingly, almost half of the chapters in part I are primarily critical in nature; that is, his primary purpose is to add balance to, or to correct an error in, a dominant approach. What follows is an attempt to distill and explain the main *systematic* (rather than critical) contributions of the chapters in part I.

Chapter 1 of TTMD begins by presenting a dual-axis classification schema for mental disorders. However, before examining this original schema and discussing its merits, it will be best to begin with a survey of his actual division of mental disorders as developed in chapters 2 through 9; for as we will see, his actual categorization of mental disorders quickly deviates from his *a priori* dual-axis scheme.

Ten Categories of Disorders

Table 1 presents the 10 basic categories of disorders that Frankl discusses in part I. Readers will immediately notice that his classes differ significantly from the 16 classes found in the DSM. While this introduction seeks to provide a bridge from logotherapy to the DSM, it is important first to understand Frankl's classes on their own terms.

Endogenous Psychoses. Chapter 2 discusses endogenous psychoses or mental disorders that have a biological basis. Frankl clarifies that psychotic illnesses may be (though they need not be) triggered by critical psychological events, such as the experience of extreme stress or very sudden relief. Nevertheless, they remain primarily somatogenic.

Although the category of endogenous psychoses also includes schizophrenia and bipolar disorders, the primary focus of chapter 2 is on endogenous depression or what the DSM today calls "Major Depressive Disorder with Melancholic Features."

In this chapter Frankl reminds readers that by definition logotherapy is a therapy that engages the spiritual dimension of the person. But if that is the case and if endogenous depression has an organic basis, then what can logotherapy add to the understanding of its origins and treatment?

Frankl seems to have this question in mind as he observes that psychotic illnesses are capable of being shaped by many variables, including personality traits, the Zeitgeist, and free attitudes and responses of a person. Existential analysis, which is one aspect of logotherapy, seeks to reveal the person who may appear hidden behind psychotic symptoms. This then enables logotherapy to offer supplemental therapy of the sort described in

TABLE 1 Overview of Frankl's Classification of Mental Disorders

Frankl's Classification Terminology †	Description ‡	Illustrative Example from TTMD
Endogenous Psychoses (chapter 2)	Mental disorders with a biological cause	Major depression
Psychosomatic Illnesses (chapter 3)	Physical illnesses that are triggered by psychological factors, but are not caused by them	Asthma
Organ Neuroses (chapter 4)	Disorders involving physical symptoms that appear caused by a medical condition, but are in fact caused by psychological factors	Conversion disorder
Functional Illnesses or Pseudo-Neuroses (chapter 4)	Disorders that present with psychological symptoms typical of neuroses but have a physiological cause	Depersonalization secondary to corticoadrenal insufficiency (Addisonian pseudo-neurosis)
Reactive Neuroses (chapter 5)	Mental disorders that arise from a psychological reaction to the effects of a somatic or psychological disturbance	Phobic fear of sweating arising from anticipatory anxiety
Personality Disorders (*Psychopathie*) (chapter 5)	Constitutional, personality traits that resemble neurotic traits, but are typically milder. As constitutional, these traits are pervasive, inflexible and stable	Obsessive-compulsive (anankastic) personality disorder
Iatrogenic Neuroses (chapter 6)	Mental disorders caused or exacerbated by the therapeutic intervention	Phobic fear of psychosis due to physician's failure to share or explain diagnosis
Psychogenic Neuroses (chapter 7)	Mental disorders arising from psychological causes	Tic disorder in reaction to stressful family conflicts
Noogenic Neuroses (chapter 8)	Mental disorders arising from spiritual or existential causes	Adjustment disorder with depressed mood in reaction to divorce

TABLE 1 (CONTINUED) Overview of Frankl's Classification of Mental Disorders

Frankl's Classification Terminology †	Description ‡	Illustrative Example from TTMD
Collective Neuroses (chapter 9)	Pandemic unhealthy attitudes that are called collective due to prevalence and social influence. Because otherwise healthy people may have these traits, this is a "para-clinical" concept	Fatalism

† Because Frankl's categorization schema divides classes of disorders primarily according to etiology, rather than clinical presentation as in the DSM, (a) most of his classes have no direct counterpart in the DSM—even where modern psychiatry recognizes the etiology, and (b) the same DSM disorder (e.g., dysthymic disorder) may appear under more than one of Frankl's classes depending on etiology
‡ Frankl acknowledges that causal factors—e.g., heredity, environment, and spiritual resources—interact. Thus, his categories represent idealized diagnoses.

part II. While major depression should be treated pharmacologically, a supplemental psychotherapy may have three purposes:

1. To prevent secondary depression arising from psychogenic or noological causes (e.g., becoming even more depressed due to one's inability to work)
2. To console patients, to help them to live with the illness and perhaps find meaning in their suffering
3. To prevent suicide

Psychosomatic Illnesses. Chapter 3 is primarily dedicated to offering critical reflections on psychosomatic theories developed in the United States and Germany. In Frankl's view, both rest on a faulty understanding of the relationship between the spirit, mind, and body. American psychosomatic medicine too often identifies the mind with the body, whereas German psychosomatic medicine too often views the mind as determining all bodily states. In contrast to both approaches, Frankl insists that it is possible for a person healthy in mind to be infirm in body, just as it is possible for someone with mental illness to be physically healthy.

Because most of the chapter is critical in nature, his original systematic points can be easily overlooked. The first of these is definitional (and here he deviates significantly from the DSM). According to Frankl, psychosomatic illnesses are best understood as illnesses that are "triggered by," but not caused by, psychological factors. For example, an individual attack of

asthma may be triggered by a stressful event, but the etiology of the underlying disorder is not strictly psychological.

Second, Frankl suggests that we would do well to focus more on the psychohygienic role of psychosomatic interaction than on psychosomatic illnesses. He observes that psychological states may affect the status of our immune system, and thereby determine whether or not an infection will manifest itself. Thus, rather than reductionistically looking for psychological causes of bodily illnesses, we should inquire into why some people remain healthy despite being exposed to the same pathogens that cause illness in others. In this regard, his view of psychosomatic interactions anticipated much in the positive psychology movement (Snyder & Lopez, 2002), including studies of personal factors influencing resilience (Masten & Reed, 2002).

Organ Neuroses. Nowhere in TTMD are so-called organ neuroses discussed systematically or in any depth. In total, three sentences are dedicated to them—two in chapter 1, and one in chapter 4. However, Frankl clearly presupposes that the reader is familiar with such disorders and given his restrictive use of the term "psychosomatic disorders" it is necessary to acknowledge the few passages he dedicates to organ neuroses. He defines organ neuroses as the somatic effects of psychological causes. Although he does not provide any examples, it is clear that he is referring to somatoform disorders like conversion disorder.[7]

Thus, Frankl did indeed acknowledge that mental factors can do more than trigger physical symptoms; but when they do he speaks of organ neuroses rather than psychosomatic or somatoform disorders.

Functional Illnesses or Pseudo-Neuroses. Of all the chapters in TTMD, the terminology in chapter 4 will be the most foreign to readers. Without further explanation, most readers will find talk of Addisonian, Basedowian, and Tetanoid pseudo-neuroses to be gobbledygook. Frankl was well aware of this fact, and generally avoided discussing the phenomena presented in this chapter when speaking in the United States.[8] Nevertheless, it is this chapter more than any other that reveals Frankl to

[7] This interpretation is confirmed in the appendix to *Lehrbuch der Logotherapie*, 2nd Ed., which provides ICD-10 correlates to most logotherapeutic diagnoses (Lukas, 2002, p. 245).

[8] When lecturing on the theory and therapy of neuroses at the International University in California, one student who had read Frankl's original German book asked whether he was going to discuss pseudo-neuroses. Frankl replied that doing so would only confuse the class because the terminology and classification system used in the United States is simply too different from his own. Viktor Frankl, audiocassette, "Theory and Therapy of Neuroses: Lecture series at USIU, California, January–March 1974." Ordering information is available at www.viktorfrankl.org/e/audioE.html.

be an astute psychiatrist, well ahead of his time in exploring the use of psychopharmacological treatments.

The disorders he describes as pseudo-neuroses or functional illnesses would be categorized using the DSM as "Mental Disorders Due to a Medical Condition." Type I (Basedowian) functional illnesses involve so-called neurotic symptoms, such as agoraphobia, caused by hyperthyroidism. Type II (Addisonian) functional illnesses involve neurotic symptoms, such as depersonalization, caused by hypocorticalism. Type III (Tetanoid) functional illnesses involve neurotic symptoms, such as claustrophobia or twitching, that arise from disturbances of the central and peripheral nervous systems usually resulting from low levels of ionized calcium or more rarely magnesium.

Why Frankl calls these disorders "pseudo-neuroses" will be discussed below in the section addressing the ICD.

Reactive Neuroses. Two of the chapters in part I present classes of disorders for which logotherapy might provide the main therapy. Chapter 5 presents one of these—the class of so-called reactive neuroses. Reactive neuroses arise from the fight for or against something.

The range of specific reactive neuroses is extremely broad. Some reactive neuroses involve reactions to primary functional illnesses (e.g., the patient fears experiencing depersonalization), while others involve reactions to symptoms that are not per se pathological (e.g., a neurotic fear of blushing again).

Frankl, however, focuses on three primary patterns of neurotic reaction. The anxiety reaction pattern involves anticipatory anxiety in which an anxious reaction (say, stuttering or sweating excessively) is feared and fought against; this fear then gives rise to an anxious reaction, forming a vicious circle. The second pattern is the obsessive-compulsive reaction. It involves an obsessive-compulsive idea that is feared and fought against, which increases psychological tension, and increases the likelihood of compulsive behavior. Finally, the sexual reaction pattern involves a heightened self-scrutiny that arises as the patient's attention becomes fixed on a sexual reaction (e.g., potency or orgasm) thus taking the patient's attention off of the sexual stimulus (the partner) and interfering with a spontaneous sexual reaction.

Chapter 12 is dedicated entirely to the treatment of reactive disorders.

Iatrogenic Neuroses. Chapter 6 is dedicated to the discussion of iatrogenic neuroses, or those neuroses that arise in reaction to the intervention of the physician or therapist. While Frankl devotes a chapter to iatrogenic

neuroses and indeed gives them a unique name, they can be understood as a subset of reactive neuroses.

The special attention that he devotes to iatrogenic neuroses is best understood by recalling that Frankl lived and worked in Vienna, where Freudian psychoanalysis ruled supreme. While Frankl admired and claimed to be deeply indebted to Sigmund Freud, he never concealed his conviction that psychoanalysis often does more harm than good. Although the chapter contains sundry warnings and admonitions, it has two main themes.

First, by highlighting a symptom in therapy it is possible that anticipatory anxiety is provoked, which in turn serves to fixate the symptoms. For example, psychoanalysis may lead to a forced scrutinizing of neurotic symptoms, increasing anticipatory anxiety of the symptoms and fear that the symptoms are precursors of a psychotic illness. This can contribute to an anxious or obsessive-compulsive reaction pattern of the sort described in chapter 5.

Second, Frankl offers several recommendations to therapists to help them avoid triggering iatrogenic neuroses. Therapists should allow patients to speak and objectify their symptoms. They should validate the reality of their symptoms and avoid trivializing their symptoms—even when there is no organic cause. Above all, they should avoid premature diagnoses and stigmatizing patients, and be forthright and offer reassurances as appropriate. For example, when they appear concerned, patients with obsessive-compulsive disorders should be reassured that their symptoms are not precursors to psychotic disorders.

Psychogenic Neuroses. Given that Frankl called TTMD the theory and therapy of *neuroses*, and that he defines neuroses in the strict sense as mental disorders with psychological causes, it is ironic that in chapter 7—the only chapter devoted to psychogenic neuroses—he (a) gives very few examples of genuinely psychogenic disorders, and (b) devotes more time to showing how alleged psychological causes of neuroses either play no actual causal role (but rather are symptoms of disorders or merely shape disorders) or are at least presuppose specific causal conditions (just as a spark only causes fire when oxygen and fuel are available).

Thus, he gives an example of a woman whose marital conflict was allegedly to blame for her neurotic symptoms, whereas in fact she suffered from hyperthyroidism. The proof: her marital conflict remained even after she was successfully treated for hyperthyroidism and her neurotic symptoms disappeared. He warns us that psychological conflicts and traumas are ubiquitous, yet rarely pathogenic. In fact, they can be healthy in building "psychological immunity."

Frankl goes on to discuss the causal conditions that are necessary for a neurosis to take root, namely, constitutional variables like personality disorders or a family history. Following this brief discussion he writes, "All this might give us pause in taking psychogenesis all too literally—even with regard to neurotic illnesses in the narrow sense." Even though he qualifies this remark, it remains a shocking statement from a Viennese psychiatrist!

It is quite clear that in this chapter he is launching a shot across the bow of the psychoanalysis of his day, which viewed all neuroses as resulting from psychological conflicts and traumas. Nevertheless, Frankl maintained that the mind has an unconscious dimension, which includes both irrational and rational elements. And he maintained that disorders could arise from the unconscious processing of conflicts. In TTMD, he cites the case of a model who developed a tic in response to a scenario that unconsciously reminded her of the conflicting demands her mother and father placed on her. In his audiotaped lectures on the theory of neuroses he gives an even more striking example of a disorder that likely has its roots in unconscious conflicts: a man with a sexual fetish involving frogs and glue.[9] However, even here he hastens to add that while understanding the causes of such a disorder probably requires psychoanalysis, treatment did not.

Noogenic Neuroses. Whereas previous chapters have focused on psychological and somatic contributions to mental disorders, this chapter explores the role that spiritual factors can play in the origination of neuroses. It bears repeating that Frankl is not working with a religious notion of the spiritual; rather he uses the term to refer to persons as free, responsible, and oriented toward meaning. Because the psychological is so intimately bound up with constitutional variables,[10] and is subject to laws of its own, he finds it necessary to sharply distinguish the psychological from the free dimension of persons, which he calls the spiritual.

Frankl's intent in this chapter is not to "medicalize" existential problems. He insists that not all existential or spiritual crises are pathogenic or neurotic. Some crises are part of normal maturational processes. Others are unavoidable aspects of the human condition. (Elsewhere he speaks of the tragic triad of suffering, guilt, and death that are essential to every human life [Frankl, 1985].) And indeed, in the past people did not consult

[9] See note 5 above.

[10] At the very end of chapter 10, Frankl refers to personality (e.g., personality disorders), neurology (e.g., sympatheticotonia), and endocrine functions (e.g., hyperthyroid) as the key elements of constitution. Elsewhere in the book, he makes it clear that heredity may have a strong influence on all three of these.

physicians with their spiritual crises. But as Frankl observes (and he cites a good number of other psychiatrists who have made the same observation), increasingly people are turning to psychiatrists and therapists with problems that previously would have been referred to the minister. And therapists should not ignore existential problems, for while they need not be pathogenic, they can cause anxiety, depression, and other disorders.

Collective Neuroses. Chapter 9 presents a fundamental break from the rest of part I. After presenting results from several studies that purportedly show that the rate of psychiatric disorders has remained fairly constant across time, Frankl writes:

> In addition to neuroses in the narrower sense of the word, we understand neuroses in a wider sense, for example somatogenic, noogenic, and sociogenic neuroses. In the case of each of these, we are dealing with neuroses in the clinical sense. But there are also neuroses in a meta-clinical and neuroses in a para-clinical sense. To the latter belong collective neuroses. They are quasi-neuroses, neuroses in a transferred sense.

Thus, in speaking of collective neuroses he is not talking about a pandemic of clinical neuroses. These traits can contribute to mental illness, and when they do Frankl speaks of a sociogenesis of the disorder. But people who suffer from collective-neurotic traits need not become mentally ill or clinically neurotic. Rather, in speaking of a collective neurosis he refers to four dysfunctional traits that people widely possess and that characterize the age. While Frankl first published TTMD in 1956, I am unaware that his description of the traits changed significantly across the four-plus decades that he revised the book. Throughout his writings, and in chapter 9, he refers to the following traits as characterizing the collective neurosis of the present era:

- A provisional existential attitude: immersing oneself wholly in the present day without concern for the future
- A fatalistic attitude toward life: believing that one's life is fated or controlled by outside factors such as those posited in astrology
- Collectivist thinking: wishing to be absorbed by the crowd, and abandoning the view of self as free and responsible
- Fanaticism: ignoring the personhood of others and the validity of meanings espoused by others

Why, we may ask, does contemporary society suffer from these collective neurotic symptoms? Frankl suggests the following:

> All four symptoms of the collective neurosis—the provisional existential attitude, the fatalistic attitudes toward life, collectivist thinking, and fanaticism—can be traced back to a flight from responsibility and a fear of freedom. Freedom and responsibility however, constitute the spirituality (*Geistigkeit*) of human persons.

For whatever reason, Frankl found that people today "are spiritually weary; and this spiritual weariness is precisely the nature of contemporary nihilism." Perhaps more precisely, he might have said that spiritual weariness helps to explain the reductionistic attitudes that he has elsewhere labeled the nihilism of the age (1978, p. 61).

Nihilism remained a constant theme throughout the writings of Frankl. The reason for this is perhaps most clearly offered in *The Doctor and the Soul*, published in 1946, shortly after he was released from the last of the Nazi concentration camps where he was detained: "I am absolutely convinced that the gas chambers of Auschwitz, Treblinka, and Maidanek were ultimately prepared not in some Ministry or other in Berlin, but rather at the desks and in the lecture halls of nihilistic scientists and philosophers" (Frankl, 1986, p. xxvii). That is, Nazism was the fruit of disordered ideas that became widely held in society. No wonder then that Frankl would be concerned with disordered attitudes and thoughts beyond the clinical setting.

Categorization Scheme

We now turn to the general principles of categorization that Frankl develops in chapter 1. He begins by proposing two axes:

1. Phenomenology or symptomology (i.e., the way an illness presents)
2. Etiology (i.e., the cause or genesis of an illness)

Each axis is then further defined as either somatic or psychological. Frankl uses this schema to produce four important definitions. Neuroses in the strict sense can be defined as pheno-psychological, psychogenic illnesses. Psychoses are pheno-psychological, somatogenic illnesses. Organ neuroses are pheno-somatic, psychogenic disorders. Traditional medical disorders like heart disease or influenza are pheno-somatic, somatogenic (see table 2).

At this point it is easy to understand why this introduction first presented the categories of mental disorders before presenting the overarching categorization schema. Of the nine categories of clinical disorders,

TABLE 2 A Dual-Axis Categorization Schema

	Pheno-psychological	**Pheno-somatic**
Psychogenic	Neuroses	Organ neuroses
Somatogenic	Psychoses	Medical disorders

only two fit nicely into the schema; the remaining either fit ambiguously, poorly, or not at all. See table 3.

Frankl certainly did not deviate from his own schema unwittingly. He makes it clear that for heuristic and didactic purposes it is useful to distinguish between different categories of disorders. However, in the preface to the first edition of TTMD, he writes:

TABLE 3 The Fit of Classes with the Classification Schema

Class	**Fit**	**Comment**
(Endogenous) Psychoses	Good	Defined by the schema (making the adjective "endogenous" redundant)
(Psychogenic) Neuroses	Good	Defined by the schema (making the adjective "psychogenic" redundant)
Reactive neuroses	Ambiguous	In summary, Frankl calls them psychogenic; but elsewhere they appear "cryptogenic"—dependent on genetic and constitutional factors
Iatrogenic neuroses	Ambiguous	These are treated as reactive neuroses. However, in broadest sense, iatrogenic harms may be mediated through body (medications) or mind
Personality disorders	Ambiguous	Cause of constitutional personality disorders is unclear
Noogenic	Poor	Noogenic causes are not recognized in the schema
Psychosomatic illnesses	Poor	Notion of triggering is not included in etiology
Pseudo-neuroses	Antithetical	Technically fit definition of psychoses, yet are called pseudo-neuroses
Organ neuroses	Antithetical	Are called neuroses, yet do not fit definition because the symptomology is not psychological

> In fact there are no purely somatogenic, psychogenic, or neurogenic neuroses, but rather only mixed cases—cases in which a somatogenic, psychogenic, or noogenic aspect pushes into the foreground of the theoretical or the therapeutic field of vision.

Moreover, he explicitly states that the term neurosis can be used in a strict sense (as defined) as well as in a looser sense. In chapter 8, he writes "There are existential maturation crises that proceed according to the clinical pattern of a neurosis without being neuroses in the narrow sense of the word, namely, in the sense of a psychogenic illness."

Yet even as he uses the term neurosis in a looser sense, it is clear that he does not view it as synonymous with mental disorders in general. He views neuroses—even in the broader sense—as having a clinical pattern distinct from psychoses and personality disorders. Understanding what this clinical pattern is will require us to investigate the context of his practice of psychiatry.

The ICD-9: A Key to Understanding Frankl's Terminology

At least one reason why Frankl might present an idealized classification and then immediately deviate from it is to be found in the fact that he worked as a psychiatrist in a large clinic. Among other things, this meant he needed to communicate with colleagues and to write notes in patients' charts.[11] In Europe, the World Health Organization's *International Classification of Diseases* (ICD) is the standard diagnostic manual used by psychiatrists, and its language greatly influenced Frankl's. The ICD-9 was the current edition of the ICD from 1979–1998, the period during which most editions of TTMD were produced.[12] A quick look at the way that the ICD-9 defines psychoses and neuroses may be helpful.

The ICD-9 defines psychoses as:

> Mental disorders in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality. It is not an exact or well defined term. Mental retardation is excluded.

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[11] One might argue that not only his actual division of disorders, but the dual-axis schema itself was a concession to the standard diagnostic approach of psychiatry insofar as it leaves out noogenetic causes.

[12] The ICD-9 has been replaced by the ICD-10. However, the U.S. Center for Disease Control and Prevention (CDC) has published the classification system online at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD-9/ucod.txt.

The ICD-9 includes under this heading not only schizophrenia and related delusional disorders, but also melancholia and manic-depressive disorder—as does Frankl (in contrast to the DSM).

While the more recent ICD-10 abandoned the distinction between psychoses and neuroses (World Health Organization, 1992), the ICD-9 states that although the "distinction between neurosis and psychosis is difficult and remains subject to debate" it was retained "in view of its wide use." It offered the following definition of neuroses:

> Neurotic disorders are mental disorders without any demonstrable organic basis in which the patient may have considerable insight and has unimpaired reality testing, in that he usually does not confuse his morbid subjective experiences and fantasies with external reality. Behavior may be greatly affected although usually remaining within socially acceptable limits, but personality is not disorganized. The principal manifestations include excessive anxiety, hysterical symptoms, phobias, obsessional and compulsive symptoms, and depression. (ICD-9 at Code 300, Neurotic Disorders)

Thus, in the ICD-9 the difference between psychoses and neuroses was largely a matter of the severity of the psychological symptoms—that is, whether the patient maintains insight and the ability to distinguish fantasy from reality—rather than a difference in etiology.

This helps us to understand why Frankl would call functional illnesses "pseudo-neuroses" rather than psychoses: although they have an organic cause and psychological manifestations (thus fitting the definition of psychoses), the cluster of symptoms is milder than those typical of psychoses—that is, they present like a neurosis in the sense of the ICD-9, but because they have an organic basis they are "pseudo-neuroses."

Again, in the light of the ICD-9, we understand why Frankl spoke of noological neuroses. Although they are not psychogenic (an essential aspect of Frankl's definition of neuroses), they present like neuroses as described in the ICD-9.

By surveying the ICD-9 one realizes that Frankl's classification schema, while original, was also largely consonant with the dominant diagnostic framework used in Europe. The ICD-9 spoke of psychogenic (298.0) and endogenous (296.1) forms of depression, as well as both psychotic and neurotic forms of depression.[13]

[13] That being said, the ICD-9 warns readers that "Many well-known terms have different meanings in current use" (Intro to part 5. Mental Disorders). For example, the ICD-9's use of the term "reactive" is more in keeping with the DSM's use of the term "adjustment disorder" than with Frankl's

Frankl's Classification System and the DSM: A Bridge to American Psychiatry

Because many readers will be most familiar with the classification system used in the DSM, I have tried to present DSM corollaries to Frankl's diagnostic terminology in table 4. However, this table must be read with several caveats in mind.

First, I have not attempted to provide DSM correlates for his 10 classes or categories of disorders, but only for specific disorders. The reason is simple: Because the DSM's classification system is based primarily on presentation or symptomatology whereas Frankl's is based primarily on etiology, in most cases no correlates exist.

Second, I have not listed all of the disorders that Frankl has addressed throughout his writings, but only the main disorders he discusses in TTMD.

Third, the fact that the DSM has a correlate means only that the APA recognizes the same symptomological phenomenon. It in no way implies that the DSM explains the disorder in the same fashion. (For example, the DSM is not committed to recognizing a noological dimension.)

Finally, the table should not be taken to be authoritative. Diagnostics is an art, and others may disagree on how best to label the same disorder Frankl discussed.

Evaluation of the Classification System

Frankl's classification system is both sophisticated and original (especially when one considers the historical context of the book). But while individual disorders can be easily translated from Frankl's language into the contemporary diagnostic language of the ICD or DSM (see table 3), many of his overarching categories or classes cannot be translated (see table 1). Does this make his general categorization system obsolete?

In large part, the answer depends on whether the reader finds convincing his reason for speaking of a given category of disorders. Can therapeutic interventions cause anxiety or exacerbate depression? If so, then recognizing a category of iatrogenic disorders serves as a useful reminder

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reactive patterns. Moreover, the ICD-10 has moved further away from some of the traditional terminology Frankl used. Elisabeth Lukas (1997, 2002) explores how Frankl's categorization schema and vocabulary correlate to the ICD-10. She finds the ICD's approach lacking (insofar as it does not acknowledge iatrogenic harms or noological causes of disorders), but generally maintains that correlates can be found. My own research was greatly aided by her work.

TABLE 4 DSM Classifications for Frankl's Terminology of Disorders

Frankl's Terminology	DSM Classification ‡
Class: Endogenous psychoses	
Endogenous depression	296.2x Major depressive disorder, single episode; 296.3x Major depressive disorder, recurrent (Frankl often focuses on cases "with melancholic features"); 300.4 Dysthymic disorder
Schizophrenia	295.xx Schizophrenia
Class: Psychosomatic illnesses	
Asthma triggered (not caused) by stress or other psychological factor	316 Psychological factors affecting a medical condition
Class: Organ neuroses	
Various somatoform disorders	(485) Somatoform disorders, e.g., 300.11 Conversion disorder
Class: Functional illnesses or pseudo-neuroses	
Basedowian pseudo-neuroses (Masked hyperthyroidism)	293.84 Anxiety disorder due to a general medical condition (Hyperthyroidism). Axis III. ICD-9 Code: 242.9 Thyrotoxicosis without mention of goiter or other cause
Addisonian pseudo-neuroses (Masked hypocorticalism)	293.9 Mental disorder not otherwise specified due to a general medical condition (depersonalization disorder due to Addison's disease or hypocorticalism). Axis III. ICD-9 Code: 255.4 Corticoadrenal insufficiency
Tetanoid pseudoneuroses	293.84 Anxiety disorder due to a general medical condition (parathyroid tetany). Axis III. ICD-9 Code: 252.1 Hypoparathyoidism
Vegetative syndrome (including vagotonia & sympatheticotonia)	293.9 Mental disorder not otherwise specified due to a general medical condition (e.g., hypochondriasis due to a disorder of the autonomic nervous system). Axis III: ICD-9 Code: 337 Disorders of the autonomic nervous system. Note: the ICD-10 offers a direct correlate: F06.6
Class: Reactive neuroses	
Anxiety neuroses (phobias)	300.29 Specific phobia (specify type)

TABLE 4 (CONTINUED) DSM Classifications for Frankl's Terminology of Disorders

Frankl's Terminology	DSM Classification ‡
Obsessive-compulsive disorders	300.3 Obsessive-compulsive disorder
Sexual-neurotic patterns	(535) Sexual and gender identity disorders
Impotence	302.72 Male erectile disorder
Frigidity	302.73 Female orgasmic disorder; 302.71 Hypoactive Sexual Desire Disorder
Vaginismus	306.51 Vaginismus
Insomnia	307.42 Primary insomnia
Class: Iatrogenic neuroses	
Iatrogenic anxiety neurosis	Use diagnosis that best matches symptoms or 300.0 Anxiety disorder NOS (not otherwise specified)
Class: Psychogenic neuroses	
Neurotic depression	300.4 Dysthymic disorder
Class: Noogenic neuroses	
Noogenic mild vegetative syndrome	309.9 Adjustment disorder unspecified; or use other appropriate code to capture etiology like V62.82 Bereavement; V62.2 Occupational problem; V62.89 Religious or spiritual problem; V62.89 Phase of life problem
Noogenic anxiety neurosis	309.24 Adjustment disorder with anxiety; use appropriate 300.xx anxiety disorder matching symptoms; or use other appropriate code depending on etiology like V62.89 Religious or spiritual problem
Noogenic depression	309.0 Adjustment disorder with depressed mood; 300.4 Dysthymic disorder; or depending on etiology consider: 313.82 Identity problem, V62.82 Bereavement; V62.2 Occupational problem; V62.89 Religious or spiritual problem
Class: Personality Disorders (*Psychopathie*)	
Anankastic personality disorder	301.4 Obsessive-compulsive personality disorder

‡ DSM Legend: .x or .xx = the diagnosis requires further specification of subtype. Numbers provided in parentheses indicate DSM page numbers rather than codes; these are offered for class headings in contrast to specific disorders, which have codes.

to be vigilant as a therapist. Is there a free and responsible spiritual or noological dimension of the person that is not reducible to the psychological? Can neurotic symptoms like depression or anxiety arise from things like conflicts of conscience or a perceived lack of meaning in life? If so, then recognizing a category of noological disorders will help us to avoid reductionistic tendencies and to offer appropriate treatments. We might, for example, be slower to prescribe and quicker to engage in Socratic dialogues with patients.

The introduction of the DSM reminds readers that, an "official nomenclature must be applicable in a wide diversity of contexts. DSM-IV is used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems)." Undoubtedly, it is easier to get mental health professionals to agree that a clinical pattern of symptoms presents a specific disorder than it is to get them to agree on the cause of the disorder. Therefore, it is understandable that the DSM and ICD focus more on clinical presentation rather than etiology in classifying disorders.

Nevertheless, an argument could be made that an etiological classification system (of the sort Frankl presents) more easily translates into appropriate therapies, especially where a psychological syndrome or pattern may be due to any one of several factors. However, just as Engelhardt (1996) distinguishes between sets of ethical judgments that are appropriate to guide action among moral friends (say, members of one's political party or religion) versus society at large, so too we might need to distinguish between categorization systems appropriate among clinicians who share an etiological worldview and the larger body of mental health professionals.

Logotherapeutic Practice: Eclectic and Unique

Those who are familiar with the corpus of Frankl's writings will know that there is hardly a well-known technique that he did not use in his practice. In the introduction to TTMD he mentions the use of group therapy with alcoholism, and he draws numerous parallels between paradoxical intention and a variety of behavioral learning techniques; in chapter 2 we are urged to use psychotropic medications to treat endogenous depression; in chapter 7 we read about the use of dream interpretation to treat psychogenic neuroses and some noological neuroses; in chapter 12 Frankl describes the use of electroshock treatment, and even mentions a patient who was evaluated for a prefrontal lobotomy to treat her extreme obsessive-compulsive disorder; and in the same chapter he describes the use of autogenic training to supplement dereflection. In another book, *Die*

Psychotherapie in der Praxis he additionally discusses the use of suggestion, hypnosis, and relaxation therapy.

So what is distinctive about logotherapeutic treatment? Three techniques stand out:[14]

1. Paradoxical intention
2. Dereflection
3. Socratic questioning/modification of attitudes

The first two of these techniques are extensively discussed in TTMD. He explains the mechanisms behind them and illustrates them with numerous cases in both his introduction and in chapter 12.

Paradoxical intention makes use of the human capacity of "self-distancing." It is indicated when patients "defend against" symptoms—either by fight or flight (i.e., resistance or fear). Consider the example of a person who stutters, and copes with this by anxiously trying not to stutter. The person may be said to suffer from an anticipatory anxiety that makes the situation worse. Paradoxical intention would encourage him to try to stutter as much as possible, thus "taking the wind out of the sails" of the anticipatory anxiety. Frankl explains that this technique works by creating distance between the patient and his or her symptoms. The fact that paradoxical intention can also be humorous only aids this.

Dereflection mobilizes the human capacity for self-transcendence. It is indicated when patients fight for some positive state (e.g., sleep or an erection). Fighting for a positive state creates hyperreflection. This becomes problematic when the person's attention is focused on something that should happen naturally as a side effect. Sleep comes upon us when we do not strive for it; sexual responses are natural responses to a sexual partner. Dereflection promotes self-transcendence by helping the patient to practice "self-forgetting" in order to allow natural processes to produce the desired state.

While Frankl distinguishes between the techniques and argues that they have different mechanisms, they may be easily confused given that the same disorder—say, insomnia or impotence—is treated with paradoxical intention in one case and with dereflection in another. The reason for this is that the etiology of one and the same disorder can be understood in different ways. Insomnia can be understood as resulting from a hyperintention of sleep (in which case dereflection is indicated) or from an anxious fear of sleeplessness (in which case paradoxical intention is indicated).

[14] Distinctive does not mean exclusive. As noted above, Frankl seemed to take pride in the fact that several behavioral learning therapists observed how paradoxical intention seems to have anticipated techniques like implosive therapy, anxiety provoking and modification of expectations.

Likewise, impotence may arise from an undue focus on getting erect rather than on the partner (calling for dereflection) or from anxious anticipation of impotence (calling for paradoxical intention). Thus, knowing the diagnosis is insufficient to determine the treatment; one must first seek to understand the psychological dynamic behind the disorder or else experiment with the treatments.

Frankl illustrates the last technique, Socratic dialogue or attitude modification, in several cases he presents in TTMD. For example, in his chapter on medical ministry, he describes his interaction with a man who is contemplating suicide following the loss of his wife:

> We asked the severely depressed patient whether he had considered what would have happened had it been him who died before his wife. "What an unbearable thought," he answered, "my wife would have despaired." Upon which we simply replied, "Just look, your wife has been spared this, and you have spared her this, admittedly at the price of now having to mourn her passing." In this moment his suffering took on meaning: the meaning of a sacrifice.

Frankl's well-placed question allowed the patient to look upon his situation in a new light, to find meaning for the first time in a tragic situation.

In discussing the treatment of noological neuroses in chapter 10 he provides another example, this time of a woman who had become nervous and tearful due to a conflict. She felt she needed to choose between her faith (and raising her children in the faith) and her husband, who was an outspoken atheist. Frankl makes it clear that, as her therapist, he did not have the authority to make this decision for her. But in listening to her, he heard her use language that disclosed what her conscience told her, that she would be sacrificing her very self by abandoning her religion. He then probed her own language to help her to understand and resolve the conflict that gave rise to her nervous symptoms.

Interestingly, the therapeutic technique of Socratic dialogue or attitude modification is not really mentioned by Frankl in TTMD. In fact, he did not speak of it as a logotherapeutic technique in any of his other clinically oriented books (Frankl, 1982, 1986). I suspect that the reason for this is simple: he frequently heard the accusation that a therapist who believes in the spirit, believes in a hierarchy of values, and believes that patients need to find meaning in their lives will inevitably impose values and a worldview on patients (Klingberg, 2002). In *The Will to Meaning*, Frankl wrote, "a psychotherapist will not impose a value on the patient. The patient must be referred to his own conscience" (1988, p. 66). In *The Doctor and the Soul* he expands on this, explaining that "The physician should never

be allowed to take over the patient's responsibility; he must never permit that responsibility to be shifted to himself. . . . He must be content with leading the patient to an experience in depth of his own responsibility", (1986, p. 276). He offers the same admonitions in chapter 10 of TTMD. However, critics repeatedly overlooked this point.

But while Frankl may have hesitated to speak of Socratic dialogue as a central technique of logotherapy, his students and logotherapy colleagues have not. For example, Fabry (1987) presents "Socratic dialogue" and Lukas (1984, 2002) and Riemeyer (2002) present "modification of attitudes" (*Einstellungsmodulation*) alongside of paradoxical intention and dereflection as properly logotherapeutic techniques. They view it as just as important to the logotherapeutic toolbox as paradoxical intention and dereflection.

Because his students and colleagues have discussed this technique more systematically, they have also more explicitly discussed how the therapist can achieve the balanced aim of not imposing values on patients while also leading patients to healthier attitudes and the discovery of meaning. In an article entitled, "Key Words as a Guarantee Against the Imposition of Values by the Therapist," Lukas (1999) reminds logotherapists that a patient's voice of conscience (the power to discern one's unique meaning) is often heard in dialogues. Only the patient can resolve value conflicts or find meaning in a situation; yet they often find this difficult, they often don't hear the voice of their own conscience or see that which is in front of them. The therapist can help them in this process by listening for "cues" or "key words." In other, more difficult, cases in which patients "trample on all that is valuable in their surrounding," Lukas suggests that the therapist can engage in further Socratic dialogue, inquiring into why they believe their behavior is justified. Again, the aim is to allow the patient's conscience to work.

Fabry explains the meaning of the concept of a Socratic dialogue in the following terms:

> The Socratic dialogue takes its name from the Socratic concept of the teacher. The teacher's job was not to pour information into students but to make students conscious of what they already knew deep within. (1987, p. 135)

The idea that patients already know what is meaningful or helpful is in many cases accurate. However, in order to emphasize the transcendent nature of the discovery of meaning (which need not always first happen at an unconscious and undisclosed level), we might invoke a second educational metaphor, one Plato attributes to Socrates in the *Republic*:

> Education then is the art of doing this very thing, this turning around; it is knowledge of how the soul can most easily and most effectively be turned around. It is not the art of putting the capacity of sight into the soul; the soul possesses that already, but it is not turned the right way or looking where it should. This is what education has to do with. (518d)

Perhaps the best word for this process is *redirecting* (*Umstellung*), the term Frankl uses in chapter 2 when he discusses the need to assist patients in adopting an attitude toward their endogenous depression in order to prevent secondary depression.[15]

In the final chapter of TTMD, his summary, Frankl speaks of five spheres in which logotherapy is indicated:

1. As a specific treatment for noogenic neuroses, particularly to address problems related to meaning
2. As a nonspecific treatment of a variety of psychogenic, neurotic reaction patterns using paradoxical intention and dereflection. Here it may serve as a primary treatment, because it may address the root cause of the problem
3. As a "medical ministry" aimed at assisting patients with incurable somatogenic disorders to find meaning in their suffering even up to the end
4. As a nonmedical, preventive response to sociogenic phenomena that may become pathological
5. As a corrective response to reductionistic or subhuman models of medical practice in an effort to prevent iatrogenic neuroses

By "logotherapy" he seems to mean precisely the use of the three techniques listed above, perhaps most especially the technique of Socratic dialogue or attitude modification.

Assessment and Prospects

In the spirit of TTMD, which presents logotherapy's overarching theory and therapy of mental disorders, I would like to conclude this

[15] Of course, the analogy with Socrates is at once appropriate and problematic. Socrates lived his life in pursuit of wisdom, and the Oracle of Delphi proclaimed him the wisest man in Athens. At times Frankl reminds one of Socrates or of a wisdom writer in the Jewish tradition. Elisabeth Lukas has even gathered some of his "proverbs" in an article (1995), and recently published a book (2001) entitled *Wisdom as Medicine: Viktor Frankl's Contribution to Psychotherapy* (in German). Undoubtedly, finding just the right thing to say at just the right moment is therapeutic, but as Socrates might ask: Can it be taught?

introduction with an overarching assessment—not of TTMD, but of the present state and prospects of logotherapy.

Empirical Research and the Move from Ghettos to Mainstream Psychotherapy

Since at least the 1970s, Viktor Frankl and many logotherapists have seen a problem with logotherapy's development. On the one hand, logotherapy is very popular among the people. As noted above, *Man's Search for Meaning* has sold over 9 million copies. It has also managed to develop a relatively small but stable, international, and growing number of professionals who identify themselves as logotherapists. The Viktor Frankl Institute in Vienna lists on its website over 50 associations and institutes dedicated to logotherapy located in 24 countries.[16] Many of these organizations have developed diplomate programs that enable therapists to specialize in logotherapy. Logotherapy has also had a continuously published international journal since 1978.[17] Yet, on the other hand, logotherapy typically gets at most a paragraph or two in psychology textbooks, special courses on logotherapy are scarce in universities, and no doctoral program or medical residency program has ever existed that is dedicated to producing graduates specialized in this model.

One might say that, through the medium of Viktor Frankl's popular books, logotherapy continues to enjoy success as a form of personal enrichment or self-help. And it has developed what might be called an enduring presence in small professional circles. But within the field of mental health it does not enjoy the stature or influence that many believe it should have.

Why is this the case? I propose that there are two obstacles to moving logotherapy from the ghettos into the mainstream of psychotherapy, the latter being the more significant.

First, in 1978, in the inaugural issue of the *International Forum for Logotherapy* (*Forum*) Frankl wrote:

> You cannot turn the wheel back and you won't get a hearing unless you try to satisfy the preferences of present-time Western thinking, which means the scientific orientation or, to put it in more concrete terms, our test and statistics mindedness. . . . That's why I

[16] Interestingly, twenty of these institutes are in the German-speaking world; another twenty are in Latin American countries; only one exists in the English-speaking world.

[17] *The International Forum for Logotherapy,* published by the Viktor Frankl Institute of Logotherapy, Abilene, TX.

> welcome all sober and solid empirical research in logotherapy, however dry its outcome may sound. (Fabry, 1978/1979, pp. 5–6)

Yet despite this call from the founder of logotherapy, very little rigorous empirical research has been conducted on the model. From 1978–1999 nearly 440 articles were published in the *Forum*. Robert Hutzell, the journal's editor, reviewed these articles to determine how many "employed what would be considered scientific data gathering methods" (1999, p. 112). Scientific methods were taken to include descriptive methods (including clinical case studies), correlational methods, and formal experiments. He concluded that,

> Altogether, roughly 1/3 of the articles published to date in the *Forum* clearly utilize scientific data gathering methods of helping professionals. But the bulk of those articles are not rigorous, and less than 1 percent are true experiments. One might suggest that there certainly is room and need for increased numbers of rigorously designed research articles if logotherapy is to "get a hearing," as Frankl requested, from the academic community and modern researchers. (1999, p. 113)

Hutzell goes on to observe that the problem is not simply that the *Forum* prefers short articles of interest to a broad audience of professionals; for a review of the *Forum*'s Recent Publications of Interest to Logotherapists section revealed a similar lack of articles using a rigorous empirical design.

Hutzell's conclusions reinforced the findings of another review article, "Research in the Service of Logotherapy." In this article, Guttmann (1996a) concluded that the "use of the scientific method in its entirety is perhaps the weakest spot in all logotherapeutic research" (p. 28). He urged the use of control groups both to verify basic logotherapeutic claims and to compare logotherapeutic treatments to competing treatments. Both Hutzell (1999) and Guttmann (1996a) concede, however, that it is not easy to design rigorous studies that test constructs like self-transcendence, noogenesis, and the search for meaning.

However, a second significant problem exists. As we just saw, Frankl openly discussed the need "to satisfy the preferences of present-time Western thinking, which means the scientific orientation" (Fabry, 1978/1979, p. 5). But by no means is the "scientific orientation" restricted to methodology, that is, to a preference for experimental designs over case reports or phenomenological analysis. It often includes a "scientific worldview" with a reductionist metaphysics. This reductionist metaphysics is most acutely observed when the question of freedom arises. Consider, for example, a

quote from D. O. Hebb, a founder of cognitive neuropsychology and a former president of the American Psychological Association:

> Modern psychology takes completely for granted that behavior and neural function are perfectly correlated. . . . There is no separate soul or life-force to stick a finger into the brain now and then and make neural cells do what they would not otherwise. . . . One cannot logically be a determinist in physics and chemistry and biology, and a mystic in psychology. (Kalat, 1992, inside cover)

This view is not only common among neuropsychologists, but among behaviorists (Skinner, 1976, 1990) and philosophers (Searle, 1984; Honderich, 1993; Jaquette, 1994). In fact, Searle nearly paraphrases Hebb when he writes:

> If libertarianism, which is the thesis of free will, were true, it appears we would have to make some really radical changes in our beliefs about the world. In order for us to have radical freedom [freedom in Frankl's sense], it looks as if we would have to postulate that inside each of us was a self that was capable of making molecules swerve from their paths. . . . And there is not the slightest evidence to suppose that we should abandon physical theory in favour of such a view. (1984, p. 92)

Worldview clashes cannot be resolved by empirical research. Neuroscientists like Wilder Penfield (1975)—or neurologists like Frankl—are not less familiar with the basic facts of neurology than Hebb and Searle; they simply do not think these facts are incompatible with human agency or free will.[18] Scientific data should inform our philosophical positions, but rarely will they resolve them.

One might say that logotherapy not only has, but is a worldview. At the center of the worldview is Frankl's dimensional ontology, which is committed to the existence of a "higher" spiritual dimension, which means precisely a human dimension that is free and responsible. This worldview can accommodate the findings of science, not only because of its broad notion of evidence, but because Frankl viewed higher dimensions as more encompassing than lower dimensions. He wrote, "A 'higher' dimension

[18] Frankl's philosophy of free action is developed in chapter 2 of *The Unheard Cry for Meaning* (1978), "Determinism and Humanism: Critique of Pan-Determinism." In this essay Frankl espouses determinism—the fact that people are determined by biological and other causes; but he rejects pan-determinism, the view that denies that people can also rise above the variables that condition their behavior, at least in order to adopt a free attitude toward them.

just means a more inclusive and encompassing dimension. . . . It implies no more nor less than the recognition that man, by having become a human being, in no way ceases to remain an animal" (1988, pp. 26–27). But the converse is not true; a system that assumes that science is only compatible with a physicalist and pandeterministic worldview (which might include mental properties, but only as epiphenomena or supervenient properties) will not be able to account for the free action of persons. To the extent that psychology has a preference for such a view, logotherapy will not be able to satisfy it—even with extensive empirical research.

The Future of Logotherapy: A Theory and Therapy of Mental Disorders or an Interdisciplinary Worldview?

There are arguably at least two reasons to believe that logotherapy will continue to grow in popularity among professionals.

First, as van Pelt (1999) observed:

> In the USA we are witnessing a paradigm shift in medicine. While the practice of medicine has been dominated by the western 'scientific' method for many years, awareness is emerging that ancient healing practices can no longer be ignored, and they need to be invited back into the medical arena. For example, the Massachusetts Medical School has established a mindfulness mediation and Yoga program as a healing tool. . . . Harvard Medical School, through the initiative of Herbert Benson (author of *The Relaxation Response*), gives two yearly symposia on "Spirituality in Medicine." (p. 33)

Van Pelt goes on to discuss projects coming out of the National Institutes Health's National Center for Complementary and Alternative Medicine involving mind-body interaction.[19] And she argues that logotherapy's notion of "the defiant power of the spirit" may be more easily accepted by medical scientists than the idea of healing through prayer. So prejudices against the integration of spiritual concerns with medical science and practice may be slowly breaking down, and logotherapy may find that its language and approach—developed by a physician in secular terms—is amenable to many who are interested in this arena.

A second prospect for growth among professionals is at an interdisciplinary level. Apart from the fields of psychiatry, psychology and counseling, logotherapy has been integrated into the fields of nursing (Coward &

[19] Information on this center is available at http://nccam.nih.gov/.

Reed, 1996; Starck, 1981), social work (Bennett, 1974; Guttmann, 1996b), pastoral counseling (Dickson, 1975; Leslie, 1985), religious studies (Bulka, 1977; Fabry, 1975; Pacciolla, 1993; Zsok, 1999), philosophy (Kovacs, 1985; Loewy, 1994; Seifert, 1995), and education (Schlederer, 1965; Dienelt, 1998).[20]

In fact, today we see that many of the directors of institutes that offer specialized training in logotherapy (which is very common in Germany and Austria) have terminal degrees in fields other than psychology or medicine, including theology and philosophy.

Nevertheless, we cannot ignore the role of prejudices. In his autobiography, Frankl tells us a story about his doctoral degrees. He writes,

> I wanted to indicate that I was qualified to speak both as a medical man and as a philosopher, yet I wanted to down play the fact that I had a doctorate in each field. So I said: "Ladies and gentlemen, I have both medical and philosophy doctorates, but usually I do not mention this. Knowing my dear colleagues in Vienna, I expect that instead of saying Frankl is twice a doctor, they would say he is only half a physician." (2000, pp. 37–38)

While he presented this story as a joke in his book, he actually did believe a prejudice existed and to this day most people who read his works do not know he had a doctoral degree in philosophy (personal communication). My point here is that Frankl recognized that even when they are unfounded, prejudices do affect the attitudes and behaviors of people, and at least sometimes, they should be taken into account in the way that we present ourselves.

If logotherapy develops primarily as a worldview—a view of human nature and values—that is relevant to ten different fields, will it be viewed as a viable model of psychotherapy or rather as one-tenth of a model of psychotherapy?

Is logotherapy's current interdisciplinarity a strength or a weakness? Our answer will depend on how we conceive of logotherapy, or rather on what we want to see it become. Is it primarily a worldview that can be adapted to many fields, including religious studies and the ever-growing field of self-help? Or is it primarily an approach to psychiatry or psychotherapy?

Regardless of what form logotherapy adopts as it moves into the 21st century, the publication of TTMD in English will go some way toward

[20] A thorough bibliography documenting primary and secondary literature in logotherapy is published online by the Viktor Frankl Institute, Vienna: www.viktorfrankl.org/e/bibE.html.

strengthening the argument that it is at least relevant to psychiatric and psychotherapeutic practice today.

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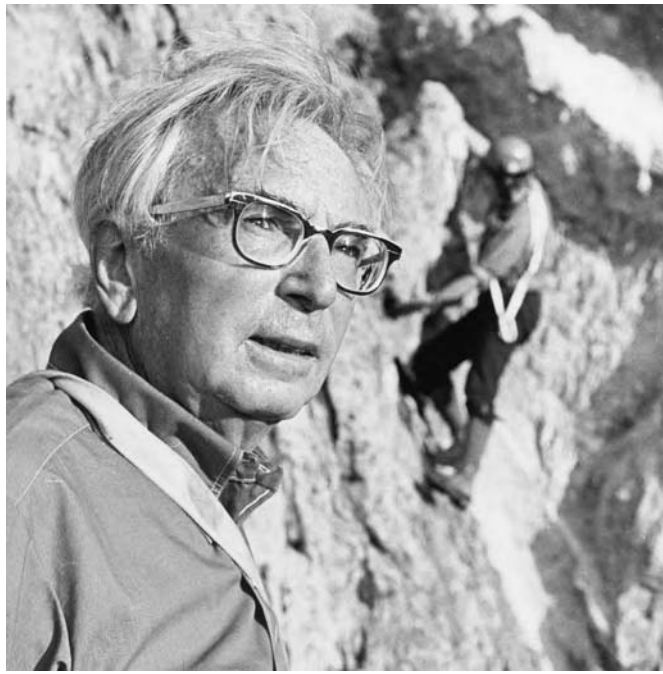
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Viktor Frankl, at age 70, climbing in Moedling, a mountainous region close to Vienna, Austria in 1975. Photo by János Kalmár.

Viktor Frankl's Prefaces

Preface to the First Edition

The present book is based on lectures that I delivered under the titles "Theory of Neuroses and Psychotherapy" and "Theory and Therapy of Neuroses" at the University of Vienna. They were expanded using manuscripts from lectures that I delivered elsewhere.

Under such conditions repetitions and areas of overlap are unavoidable. But from a didactic point of view, this is not wholly undesirable.

On the other hand, under such conditions gaps are no less unavoidable; for through the "wide land of the soul" (Arthur Schnitzler) there are many paths. That which is really successful is neither arbitrarily selected nor the only possible path. Rather it will cover ground that enables the theory and therapy of neuroses to be understood in new and fruitful ways. *Videant collegae.*

This theory and therapy of neuroses moves up a heavenly ladder that stands on the clinical floor but nevertheless reaches the metaclinical space. For heuristic reasons and didactic purposes one must act as though there are distinct branches off of this Jacob's ladder.[1] In fact there are no purely somatogenic, psychogenic, or neurogenic neuroses, but rather only mixed cases—cases in which a somatogenic, psychogenic, or noogenic aspect pushes into the foreground of the theoretical or therapeutic field of vision. Such a *reservatio mentalis* is to be read between the lines.

[1] *Frankl alludes to Genesis 28:12, in which Jacob had a dream of a ladder that rested on the earth and extended to heaven, with angels ascending and descending.—JMD.*

Preface to the Fourth Edition

Compared to the previous edition, this edition contains both cuts and additions. The main addition has been to produce a proportionate and extensive introduction that reflects the current level of logotherapeutic research and practice. This introduction is based on a seminar, "Theory and Therapy of Neuroses" that I held during the winter semester of last year in my Chair of Logotherapy at the United States International University in San Diego, California. . . .

It remains only for me to thank my assistants and students from that period, from whom I was able to gain a good deal of case material that demonstrates logotherapy in practice.

—Vienna/San Diego, Winter of 1974/75

Preview

Introduction: What Is Logotherapy?

The introduction offers several central tenets of logotherapy and presents 16 cases that illustrate logotherapy in practice. In so doing, the Introduction anticipates material from part 2, which explains treatments for the mental disorders described and categorized in part 1.

- Logotherapy goes beyond psychoanalysis and behaviorism by considering the specifically human phenomenon of self-transcendence. Self-transcendence means that human beings are always directed toward something other than themselves, for example, a meaning to be fulfilled or another person.
- People become existentially frustrated when they feel their lives are meaningless. Existential frustration or despair can be expressed in several disordered behaviors including substance abuse, suicide, and criminality. The correlation between a feeling of meaninglessness and a number of dysfunctional behaviors has been empirically demonstrated using logotherapy tests.
- Some neurotic behaviors can be treated using paradoxical intention. Paradoxical intention makes use of the human capacity of "self-distancing." This technique is indicated when neuroses arise from patients' fight against their symptoms or flight from their symptoms.
- Other neurotic behaviors can be treated using dereflection. Dereflection makes use of the human capacity of self-transcendence. This technique is indicated when neuroses arise from patients' fight for some positive state.

Introduction: What Is Logotherapy?

Before we state what logotherapy actually is, it is recommendable first to state what it is not: *it is not a panacea!* The determination of the "method of choice" in a given case is analogous to two unknowns: $\Psi = x + y$, where x stands for the unrepeatability and uniqueness of the patient's personality and y for the no less unrepeatable and unique personality of the therapist. In other words, a given therapy does not allow itself to be applied in every case with the same expectation of success, nor can every therapist use all methods equally effectively. And what holds for psychotherapy in general holds especially for logotherapy. To put it briefly, our analogy permits itself to be expanded upon with the following formulation: $\Psi = x + y = \lambda$.[1]

Paul Johnson once ventured to say, "Logotherapy is not a rival therapy against others, but it may well be a challenge to them in its plus factor." What this plus factor is, however, is revealed by N. Petrilowitsch when he claims that logotherapy, in contrast to all other psychotherapies, remains not on the level of neuroses, rather it goes beyond them into the sphere of specifically human phenomena.[2] In fact, psychoanalysis sees in neuroses the result of psychodynamic processes and accordingly attempts to treat neuroses so as to bring new psychodynamic processes into play, that is, transference.[3] Grounded in learning theory, behavioral therapy views

[1] *While the Greek symbol psi (Ψ) is well known, the symbol lambda (λ) is less well known. It is typically transliterated as "l"—the first letter of logotherapy; hence Frankl uses this symbol to denote logotherapy.—JMD*

[2] N. Petrilowitsch, "Über die Stellung der Logotherapy in der klinischen Psychotherapie," *Die medizinische Welt* 2790, 1964.

[3] The following lines in a letter of December 31,1913, from Schnitzler to the psychoanalyst Theodor Reik are instructive: "Into the darkness of the soul go more roads, I feel it ever more strongly, than the psychoanalysts dare dream (and interpret). And very often a path leads through the middle of the illuminated inner world, where they—and you—believe all too soon that it must return into the realm of shadows." See Four Unpublished letters of Arthur Schnitzler to the Psychoanalyst Theodor Reik, *Modern Austrian Literature, Vol. 8,* Nr. 3/4, 1975, p. 240.

neuroses as the product of learning processes or conditioning processes and accordingly tries to influence neuroses by bringing about a kind of unlearning or reconditioning. In contrast, logotherapy enters into the human dimension and in this manner is enabled to incorporate the specifically human phenomena that it encounters there into its techniques. Indeed, we are here dealing with no more and no less than the two fundamental anthropological[4] characteristics of human existence: first, self-transcendence,[5] and second, the capacity of self-distancing (*Selbst-Distanzierung*)—which distinguish human existence precisely as human.[6]

Self-transcendence marks the fundamental anthropological fact that human existence is always directed toward something that is not itself — toward something or someone, namely, either a meaning to be fulfilled or an interpersonal existence that it encounters. Human beings become genuinely human and are entirely themselves only when, rising in devotion to a task in service to a cause or out of love for another person, they go beyond and forget themselves. It is analogous to the eye, whose task to see the world can be achieved only to the extent that it cannot see itself. For when does the eye see something of itself? Only when it is ill. When I suffer from a cataract and see a cloud, or suffer from glaucoma and my sight is surrounded by a rainbow colored light, then my eye sees something of itself, then it perceives something of its illness. To that same extent my ability to see is hindered.

Without bringing self-transcendence into the picture that we draw of human nature, we will confront the mass neuroses of today without understanding. Today people in general are no longer sexually but rather existentially frustrated. Today people suffer less from a sense of inferiority than from a feeling of meaninglessness.[7] In fact, this feeling of meaninglessness usually goes along with an "existential vacuum."[8] And it can be demonstrated that this feeling that life no longer has any meaning is spreading. Alois Habinger was able to demonstrate in a longitudinal study of 1000 students that the feeling of meaninglessness more than doubled in a few years (personal communication). Kratochvil, Vymetal, and Kohler have shown that the feeling of meaninglessness is in no way restricted to the capitalist nations that it invaded "without a visa." We have L. L. Klitzke

[4] *Reflecting common German usage, "anthropology" in Viktor Frankl's sense means a philosophy of the human person.—JMD*

[5] See Viktor E. Frankl, "Selbst-Transzendenz" in *Handbuch der Neurosenlehre und Psychotherapie* (Munich: Urban und Schwarzenberg, 1959).

[6] See Viktor E. Frankl, *Der unbedingte Mensch* (Vienna: Franz Deuticke, 1949), p. 88.

[7] See Viktor E. Frankl, "The Feeling of Meaninglessness," *The American Journal of Psychoanalysis*, 32, 85, 1972.

[8] See Viktor E. Frankl, *Pathologie des Zeitgeistes* (Wien: Franz Deuticke, 1955).

and Joseph L. Philbrick to thank for showing that it is already being observed in developing nations.[9]

If we ask ourselves what may have caused or produced the existential vacuum, the following explanation offers itself: in contrast to animals, instincts and drives do not tell human beings what to do. And in contrast to earlier times, traditions no longer tell them what to do. Neither knowing what they must do, nor knowing what they should do, people also no longer really know what they want to do. And the consequence? Either they want only that which others are doing, and that is conformism. Or, in contrast, they do only that which others want—want from them—and then we have totalitarianism. Beyond this, however, a further apparent consequence of the existential vacuum is a specific neuroticism, namely, the "noogenic neurosis," which arises from feelings of meaninglessness or doubts about a meaning in life or despair that no such meaning exists.[10]

Whereby it should not be said that this despair in itself is pathological. To inquire about the meaning of one's life, indeed, to put this meaning into question is a human achievement rather than a neurotic ailment. At the least, spiritual maturity manifests itself in this: an offer of meaning is no longer uncritically and unquestioningly, that is, unreflectively, accepted from the hands of tradition; rather meaning is sought to be independently and autonomously discovered and found. Thus, the medical model is from the outset inapplicable to existential frustration. If it is a neurosis at all, then existential frustration is a sociogenic neurosis. It is a sociological fact, namely, the loss of tradition, which has made contemporary persons so existentially insecure.

There are also masked forms of existential frustration. I will mention only the frequent cases of suicide specifically among academic youth,[11] drug addiction, widespread alcoholism, and increasing adolescent

[9] See L. L. Klitzke, "Students in Emerging Africa—Logotherapy in Tanzania," *American Journal of Humanistic Psychology, 9,* 105, 1969.

[10] See Viktor E. Frankl, "Über Psychotherapie," *Wiener Zeitschrift für Nervenheilkunde 3,* 461, (1951). There are already 10 scientific works in which it unanimously emerges that 20 percent of patients present with noogenic neuroses. For the relevant investigations we are indebted to Frank M. Buckley, Eric Klinger, Gerald Kovacic, Dietrich Langen, Elisabeth S. Lukas, Eva Niebauer-Kozdera, Kazimierz Popielski, Hans Joachim Prill, Nina Toll, Ruth Volhard, & T. A. Werner. See Eric Klinger, *Meaning and Void* (Minneapolis: University of Minnesota Press, 1977).

[11] Among American college students, suicide is the second most common cause of death (following traffic accidents), as J. E. Knott of Rhode Island College reports. Among the remaining people of similar age suicide ranks fifth. See *Österreichische Ärztezeitung*, 29, Jahrgang, Heft 10, 25. Mai 1974. Thankfully our numbers do not include unreported cases of suicide. For we doctors must think not only therapeutically, but also preventatively—and in the matter of suicide, publicity is not unqualifiedly a good. A school psychologist of the Viennese city board of education, Kraft, reports on an experiment carried out in Switzerland: in one Canton the media came to an agreement not to report on suicide for 1 whole year, whereupon the suicide rate in this Canton sunk to one tenth. See *Die Presse*, 14–15 November, 1981.

criminality. Today it is easy to demonstrate how much existential frustration is at work here. The degree of existential frustration can now be quantified using the PIL-Test developed by James Crumbaugh, and recently Elisabeth S. Lukas has made a further contribution to exact and empirical logotherapy research using her LOGO-Test.[12]

Regarding suicide, Idaho State University examined 60 students who attempted suicide, and in 85 percent it was found that "life meant nothing to them." It was then determined that among those students who suffered from a feeling of meaninglessness 93 percent were in excellent physical condition, actively engaged in social life, had excellent semesters in their studies, and were on friendly terms with their families (personal communication).

Now let us consider drug addictions. William J. Chalstrom, the director of a Naval Rehabilitation Center, asserts that "more than 60 percent of our patients complain that their lives lack meaning."[13] Betty Lou Padelford was able to demonstrate statistically that it was not, as the psychoanalytic view claims, a "weak father image" that was at the basis of the drug addiction, rather from the 416 students she tested it was possible to demonstrate that the degree of existential frustration was significantly correlated with the "drug involvement index": the average index score for those not existentially frustrated was 4.25 while for those existentially frustrated it was

[12] See Elisabeth S. Lukas, "Zur Validierung der Logotherapie" in Viktor E. Frankl, *Der Wille zum Sinn*, (Bern: Hans Huber, 1982). For a similar article in English, see Elisabeth Lukas, "Validation of Logotherapy," *International Forum for Logotherapy,* 4, 2, 1981: 116–125. In addition to Lukas's LOGO-Test, there are to-date nine other logotherapeutic tests, namely James C. Crumbaugh and Leonard T. Maholick's PIL (Purpose in Life) test published in "Eine experimentelle Untersuchung im Bereich der Existenzanalyse. Ein psychometrischer Ansatz zu Viktor Frankls Konzept der noogenen Neurose," in *Die Sinnfrage in der Psychotherapie,* Nikolaus Petrilowitsch (Ed.) (Darmstadt: Wissenschaftliche Buchgesellschaft, 1972); James C. Crumbaugh's SONG (Seeking of Noetic Goals) and MILE (the Meaning in Life Evaluation Scale) tests published in "Seeking of Noetic Goals Test," *Journal of Clinical Psychology,* July 1977, vol. 33, no. 3, 900–907; Bernard Dansart's Attitudinal Values Scale Test, published in "Development of a Scale to Measure Attitudinal Values as Defined by Viktor Frankl," a dissertation at Northern Illinois University, De Kalb, IL, 1974); R. R. Hutzell and Ruth Hablas's Life Purpose Questionnaire test, presented in a lecture held at the *First World Congress of Logotherapy* in San Diego, California; Walter Boeckmann's *S.E.E.* test (*Sinn-Einschätzung und — Erwartung/*Measurement and Expectation of Meaning) published in *Sinn-orientierte Leistungsmotivation und Mitarbeiterführung. Ein Beitrag der Humanistischen Psychologie, insbesondere der Logotherapie nach Viktor E. Frankl, zum Sinnproblem in der Arbeit* (Stuttgart: Enke, 1980); and three tests still being developed thanks to Gerald Kovacic (University of Vienna), Bruno Giorgi (Dublin University), & Patricia L. Starck (University of Alabama).
For an updated list of logotherapy tests visit the Online Bibliography published by the Viktor Frankl Institute of Vienna at www.viktorfrankl.org.—JMD.

[13] *Frankl cites this as a personal communication, but provides no date. Presumably many of the other quotes he cites without reference are also based on personal communications or excerpts from articles that authors sent to him.—JMD*

8.90—that is, it more than doubled.[14] These research results are consistent with those of Glenn D. Shean and Freddie Fechtman.[15]

It is clear that any drug rehabilitation program that regards existential frustration as an etiological factor and uses a logotherapeutic intervention promises success. Thus we find that according to the *Medical Tribune*, of 36 drug addicts who were treated by the University Neurological Clinic of Vienna during an 18-month period only 2 were clearly drug-free—which translates into 5.5 percent.[16] In the German Republic, of "all drug-addicted youth who are treated by physicians, less than 10 percent [can] expect a recovery."[17] In the United States the average is 11 percent. However, Alvin R. Fraiser, of the California-based Narcotic Addict Rehabilitation Center uses logotherapy and has a recovery rate of 40 percent.

It is similar with alcoholism. In severe cases of alcoholism it has been determined that 90 percent suffer from a fundamental feeling of meaninglessness.[18] It is no wonder then that James C. Crumbaugh, using psychometric tests, measured the results of group logotherapy in cases of alcoholism, and comparing them with the results of other methods of treatment, was able to demonstrate that "only logotherapy showed a statistically significant improvement."[19]

Regarding criminality, W. A. M. Black and R. A. M. Gregson of a university in New Zealand, discovered that criminality and a purpose in life stand in an inversely proportionate relationship to each other. Prisoners who are repeat offenders distinguish themselves from the average citizen with scores of 85 versus 115 on Crumbaugh's Purpose in Life Test.[20]

As the behavioral researchers from the school of Konrad Lorenz were able to show, aggressiveness that is redirected toward harmless objects—say, toward the television screen—and is supposed to be abreacted, in reality is just provoked and, like a reflex, in that manner simply further built up. Carolyn Wood Sherif of Pennsylvania State University summarizes: "There is a substantial body of research evidence that the successful execution of aggressive actions, far from reducing subsequent aggression, is the best way to increase the frequency of aggressive responses

[14] Betty Lou Padelford, Dissertation, United States International University, 1973.
[15] Glenn D. Shean and Freddie Fechtman, "Purpose in Life Scores of Student Marijuana Users," *Journal of Clinical Psychology, 27*, 112, 1971.
[16] *Medical Tribune*, vol. 3, no. 19, 1971.
[17] *Österreichische Ärztezeitung*, 1973.
[18] See Annemarie von Forstmeyer, *The Will to Meaning as a Prerequisite for Self-Actualization*, Dissertation, Case Western University, 1968.
[19] See James C. Crumbaugh, "Changes in Frankl's existential vacuum as a measure of therapeutic outcome," *Newsletter for Research in Psychology, 14,* 3, 1972.
[20] W. A. M. Black & R. A. M. Gregson, "Purpose in Life and Neuroticism in New Zealand Prisoners," *British Journal of Social and Clinical Psychology, 12,* 50, 1973.

(Scott, Berkowitz, Pandura, Ross, and Walters). Such studies have included both animal and human behavior."[21]

Professor Sherif of the United States reported that the traditional impression that athletic competition is a substitute war or battle is false. Three groups of teenagers in a closed camp had built up aggressions toward each other through athletic competition, instead of dispersing them. But the main point is this: only once were the mutual aggressions of the camp inmates brushed aside, and that was the time when the young people needed to move a wheelbarrow that was stuck in the clay earth, which was supposed to be used to deliver food to the camp. The "devotion to a task" that was meaningful even if taxing had literally allowed their aggressions to be "forgotten."[22]

Thus we are confronted with the possibility of a logotherapeutic intervention, which as such (that is, as logotherapeutic) aims to overcome the feeling of meaninglessness by setting in motion the process of finding meaning. Indeed, within 6 months Louis S. Barber was able to raise the level of fulfillment of meaning as measured with the PIL Test from 86.13 to 103.46 by creating a "logotherapeutic environment" in the rehabilitation center for criminals that he directs. And while the average relapse rate in the United States is 40 percent, Barber could demonstrate a rate of 17 percent.[23]

After discussing the many and diverse appearances and forms of expression of existential frustration, we must ask ourselves how the state is created—that is, what is the ontological precondition that enables, let us say, the 60 students who were examined at Idaho State University to attempt to commit suicide without any psychophysical or socioeconomic explanation? In short, how must human existence be constituted so as to make something like existential frustration possible? In other words, as Kant put it, we are inquiring into "the condition of the possibility" of existential frustration, and we will not go wrong if we assume that human beings are so structured—that their condition is such—that they simply cannot manage without meaning. In short, the frustration of a human being can only be understood if we understand human motivation. And the ubiquitous presence of the feeling of meaninglessness may serve as an indicator

[21] Carolyn Wood Sherif, "Inter-group Conflict and Competition: Social-Psychological Analysis." Lecture, Scientific Congress, XX, Olympiad, Munich, 22 August 1972.
[22] See Viktor E. Frankl, *Anthropologische Grundlagen der Psychotherapie* (Bern: Hans Huber, 1974).
[23] The prisoner Otto B. also confirms this possibility in the following excerpt from a letter written to me from the Stein Prison: "One can turn the worst situation into something meaningful—if one wants to!" And former prisoner Frank W., who organized a logotherapy group while still "in highest-security prison in all of Florida—only a few hundred meters from the electric chair," writes to tell me that "all of the original 12 in the group have maintained contact—only one returned—and he is now free."

when the concern is to find the primary motivation—that which human beings in the end desire.

Logotherapy teaches that human beings are fundamentally permeated with a "will to meaning."[24] This, logotherapy's motivational theory, permits itself to be operationally defined even before it is empirically verified and validated, insofar as we offer the following clarification: we will call the will to meaning simply that which is frustrated whenever a person succumbs to the feelings of meaninglessness and emptiness.

James C. Crumbaugh and Leonard T. Maholick have dedicated themselves to the empirical foundations of the theory of the will to meaning, as did Elisabeth S. Lukas with 1000 participants.[25] Increasingly more statistics are known that support the legitimacy of our motivational theory. Out of the many studies of recent times I will cite the results of only one research project that was undertaken by the American Council on Education together with the University of California. Among 189,733 students at 360 universities, 73 percent—that is, the highest percentage of all—were interested in one single goal: "developing a meaningful philosophy of life." The report was published in 1974. In 1972 it had been only 68.1 percent.[26]

One might also refer to the results of a 2-year statistical study that was published by the highest authority in psychiatric research in the United States, the National Institute of Mental Health, that produced the finding that of 7,948 students at 48 American high schools, about 16 percent had the goal "to make a lot of money," while the largest group—78 percent—wanted one thing: "to find a meaning and purpose to my life."

Now if we turn to the question of what we can do to reduce existential frustration, that is, the frustration of the will to meaning, or to treat noogenic neuroses, then we must discuss bestowing meaning. Properly speaking, meaning cannot be bestowed, and least of all can the therapist give meaning—that is, give meaning to the life of the patient or provide the patient with this meaning along the way. Rather, meaning must be found, and it can only be found by oneself. Indeed, this function is performed by the conscience. In this sense we have described the conscience as "the organ of meaning."[27] Thus, meaning cannot be prescribed; but what we may well do is describe that which occurs in people whenever they go in

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[24] See Viktor E. Frankl, *Der Unbedingte Mensch* (Vienna: Franz Deuticke, 1949).

[25] See James C. Crumbaugh & Leonard T. Maholick, "Eine experimentelle Untersuchung im Bereich der Existenzanalyse: Ein psychometrischer Ansatz zu Viktor Frankls Konzept der 'noogenen Neurose'" in Nikolaus Petrilowitsch (Ed). *Die Sinnfrage in der Psychotherapie* (Darmstadt: Wissenschaftliche Buchgesellschaft, 1972). See also Elisabeth S. Lukas "Logotherapie als Persönlichkeitstheorie," Dissertation, University of Vienna, 1971.

[26] See Robert L. Jacobson, *The Chronicle of Higher Education.*

[27] See Viktor E. Frankl, "Logotherapie und Religion" in Wilhelm Bitter & Ernst Klett (Eds.), *Psychotherapie und religiöse Erfahrung* (Stuttgart, 1965).

search for meaning. It turns out that the discovery of meaning results from a Gestalt perception—precisely in the sense of Max Wertheimer and Kurt Lewin, who spoke of the "demand quality" present in certain situations. It is just that in a meaning-Gestalt we are not dealing with a "figure" that jumps out of a "background" before our eyes. Rather, what is in each case perceived in the discovery of meaning is, against the background of reality, a possibility: the possibility of changing reality in one way or another.

Now it appears that the plain and simple person—that is, not one who was exposed to indoctrination for years, be it as a student in a classroom or as a patient on the analytic couch—has always known the way to find meaning, the way that life permits itself to be filled with meaning. That is, primarily by doing a deed or creating a work, that is, creatively. But also through an experience, that is, insofar as we experience something—something or someone. And to experience someone in his or her entire unrepeatability and uniqueness means to love him or her. However, life proves to be unconditionally meaningful, and it remains meaningful—it has and it keeps its meaning—under all conditions and in all situations. From the power of a prereflective ontological self-understanding,[28] from which an entire axiology[29] can be distilled, the average person on the street can provide testimony of what the human person is capable of not least in the fact that even when—indeed, precisely when—confronted with an unchangeable fact, the human person can still preserve his or her humanity precisely by overcoming the situation.[30] What counts then is the stance and the attitude with which the person confronts the unavoidable blow of fate. Thus, the person is allowed and equipped to wrest and win meaning from life even up to his or her last breath.

This *logo-theory* was originally intuitively developed within the framework of logotherapy—originally called the theory of "creative, experiential, and attitudinal values"[31]—has in the meantime been empirically verified and validated. Thus, Brown, Casciani, Crumbaugh, Dansart, Durlak, Kratochvil, Lukas, Lunceford, Mason, Meier, Murphy, Planova,

[28] *Under the influence of the phenomenologists, Frankl frequently speaks of ontology. An ontology is an account of what sorts of things exist or of the kind of being that a specific entity possesses. Some use the term synonymously with "metaphysics."—JMD*

[29] *An axiology is a theory of value. Under the influence of Scheler, Frankl views values as existing within a hierarchy. Moreover, values in his sense are objective in the sense that they are discovered, not merely created.—JMD*

[30] Thanks to a prereflective ontological self-understanding, the common person on the streets knows that every individual situation presents a question that must be answered, so that the person properly cannot ask about the meaning of his or her existence, because "it is life itself that poses the question to the person: the person is not to ask, but rather is asked by life, the person must answer life—that is, is respons-ible to life."

[31] See Viktor E. Frankl, "Zur geistigen Problematik der Psychotherapie," *Zentralblattt für Psychotherapie, 10,* 33, 1938.

Popielski, Richmond, Roberts, Ruch, Sallee, Smith, Yarnell, and Young were able to demonstrate that the discovery and the fulfillment of meaning are independent of age, level of education, and sex, but also of a person's religious or secular inclination, and, among those who are religious, independent of the faith one professes. The same is true of IQ.[32] Finally, Bernard Dansart with the help of a test he developed was able to validate empirically the introduction of the concept of "attitudinal values."[33]

How do the applications of this logo-theory look in practice? In this connection I would like to cite the case of a nurse that was presented to me in the context of a seminar I held for the Department of Psychiatry at Stanford University. This patient suffered from an inoperable cancer, and she knew it. Crying, she entered the room where the Stanford psychiatrists were gathered, and with a voice choked with tears she spoke of her life, of her gifted and successful children, and of how difficult it was going to be to take leave from them all. Up to this point, to be quite frank, I had found no opportune moment to bring logotherapeutic reflections into the discussion. But at this point it was possible to transform that which was in her eyes the most negative—that she must leave behind that which was most valuable to her in the whole world—into something positive, to interpret it or understand it as something meaningful. I simply asked her what a woman would say who had no children. I can imagine that such a woman would despair precisely because nothing and no one is there who she must "leave behind" when it comes time to take leave from the world. In this moment the patient's face lit up. Suddenly she was aware that what matters is not whether we must take leave—for sooner or later we must all do that. Rather, what matters is precisely whether something exists from which we must take leave, something that we can leave behind in the world, with which we fulfill a meaning and fulfill ourselves on that day when our time has run out. It can hardly be described how relieved the patient was after the Socratic discussion took a Copernican turn.

I would now like to contrast the logotherapeutic style of intervention to the psychoanalytic with a quote from a work by Edith Weisskopf-Joelson (an American representative of psychoanalysis, who today embraces logotherapy): "The demoralizing effect of the denial of a meaning in life, above all of deep meaning that potentially dwells in suffering can be illustrated in the case of a psychotherapy that a Freudian lavished upon a woman who was suffering from an incurable cancer." Weisskopf-Joelson lets K. Eissler speak for himself:

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[32] Viktor E. Frankl, *Der unbewusste Gott* (Munich: Koessel Verlag, 1974).

[33] See Bernard Dansart, "Development of a scale to measure attitudinal values as defined by Viktor Frankl," Dissertation, Northern Illinois University, 1974.

> She compared the fullness of meaning of her earlier life with the meaninglessness of the present phase; but even now, when she could no longer work in her career and needed to lie down for many hours in the day, her life was nevertheless meaningful, she believed, insofar as her existence was important to her children, and she herself had fulfilled such an important task. However, were she ever to be brought to the hospital without envisioning ever being able to return home, and were no longer capable of leaving bed, she would become a lump of useless, decaying meat, and her life would lose all meaning. In fact, she was prepared to endure all pain just so long as it was somehow meaningful. But she asked why would I want to sentence her to endure her suffering during a time when her life no longer had any meaning? To which I responded that in my view she committed a serious error, for her whole life was meaningless and at every point had been meaningless, even before she became ill. I told her that the philosophers had always tried in vain to find a meaning in life; and so the only difference between her earlier and her present life consisted in that she was still able to believe in a meaning in life during the earlier phase, whereas in the present phase she was no longer in any condition to do so. In reality, I enjoined her, both phases of her life were wholly and completely meaningless. The patient reacted perplexed to this disclosure, purported not to understand me, and broke out into tears.

Eissler did not, for example, give the patient the belief that even now suffering can have a meaning; rather he took from her the belief that her whole life could have had even the least meaning. But let us ask not only how a psychoanalytic, but also how a behavioral therapist confronts cases of human tragedy like one's own imminent death or the death of another. One of the most representative practitioners of behavior modification grounded in learning theory informs us that in such cases "the patient should make telephone calls, cut the lawn, or wash dishes, and these activities should be praised by the therapist or otherwise rewarded."[34]

How should a psychotherapy that derives its conception of human nature from experiments with rats deal with the fundamental anthropological fact that persons, on the one hand, in the midst of an affluent society commit suicide, and, on the other hand, are prepared to suffer as long as that suffering has meaning? In front of me lies the letter of a young psychologist who described to me how he tried to raise the spirits of his dying

[34] J. Wolpe, in *American Journal of Psychotherapy, 25,* 362, 1971.

mother. "It was a bitter acknowledgement for me," he wrote, "that nothing that I had learned in 7 long years of study could I use to help lighten the hardness and the finality of my mother's fate"—nothing, but that which he learned during his subsequent logotherapeutic training "about the meaning of suffering and about the rich harvest in the shelter of the past." And in view of this, he had to vouch that these "partly unscientific, but nevertheless wise arguments possessed the greater weight in the final, human analysis."

By now, it may have become clear that only a psychotherapy that ventures to go beyond psychodynamic and behavioral research and to enter the dimension of specifically human phenomena, in other words, that only a rehumanized psychotherapy will be capable of understanding the signs of the time and taking a position on the needs of the time. In other words, it may have become clear that in order simply to diagnose an existential frustration or even a noogenic neurosis we must see humans as beings that—through the power of self-transcendence—are constantly in search for meaning. However, with regard to therapy and not just diagnosis, and in fact not the therapy of noogenic neuroses, but the therapy of psychogenic neuroses, we must, in order to exhaust every possibility, fall back on the no less distinguishing capability of self-distancing, which is seen not least of all in a sense of humor. A human, humanized, or rehumanized psychotherapy thus presupposes that we get a glimpse of self-transcendence and get hold of self-distancing. However, neither is possible if we see human beings as animals. No animal concerns itself about the meaning of life, and no animal can laugh. This is not to say that human beings are only human and are not also animals. The human dimension is in fact higher than the animal dimension, and that means that it encompasses the lower dimension. The recognition of specifically human phenomena in human beings and the simultaneous acknowledgement of subhuman phenomena in them thus is not a contradiction, for between the human and the subhuman exists a relationship not of exclusivity but—if I may say so—of inclusivity.

Now, it is precisely the intention of the logotherapeutic technique of paradoxical intention to mobilize the capability of self-distancing in the context of the treatment of psychogenic neuroses, whereas the other fundamental anthropological fact, namely self-transcendence, lays the foundation for another logotherapeutic technique—dereflection. In order to understand these two methods of treatment we must, however, proceed from logotherapy's theory of neuroses.

We distinguish here between three pathogenic reaction models. The first can be described in the following manner. The patient reacts to a

given symptom with the fear that it could reappear, that is, with anticipatory anxiety, and this anticipatory anxiety in fact results in the resurfacing of the symptom—an event that simply reinforces in the patient his or her original fear.

Now, in certain situations the thing that the patient has so much anxiety about reappearing can be anxiety itself. In such cases our patients speak quite spontaneously of a "fear of fear." And how is this anxiety of theirs motivated?

Ordinarily they fear fainting, or a heart attack, or having a stroke. But how do they react to their fear of fear? With flight. They avoid, say, leaving the house. In fact, agoraphobia is the paradigm of this first neurotic reaction pattern (see Figure 1).

Why should this reaction model be called "pathogenic"? In a lecture I held at the invitation of the American Association for the Advancement of Psychotherapy, I formulated it in the following manner: "Phobias and obsessive-compulsive neuroses are partially due to the endeavor to avoid the situation in which anxiety arises."[35] Nevertheless, this interpretation that the flight from anxiety through the avoidance of the anxiety-provoking situation is decisive for the perpetuation of the anxiety-neurotic pattern of reaction—this interpretation of ours—has in the meantime been

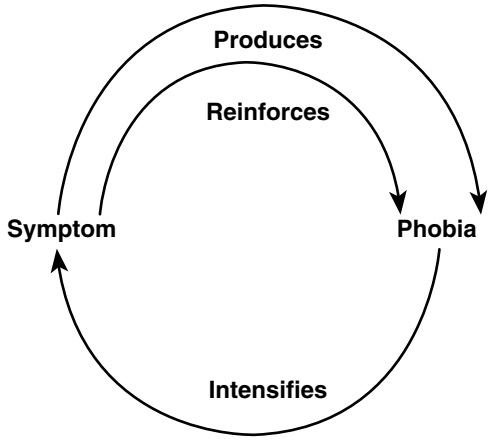


Figure 1

[35] Viktor E. Frankl, "Paradoxical Intention: A Logotherapeutic Technique," *American Journal of Psychotherapy, 14*, 520, 1960.

repeatedly confirmed by behavior therapists. I. M. Marks states, "the phobia is maintained by the anxiety reducing mechanism of avoidance."[36] Logotherapy clearly anticipated much that would be set upon a solid experimental basis by behavioral therapy. Already in 1947 we presented the following:

> As you know, in a certain sense and with some justification, one can also conceive of neuroses as conditioned reflex mechanisms. Above all, analytically oriented methods of psychiatric treatment are primarily concerned with consciously illuminating the primary conditions of the conditioned reflex, namely, the external and internal situation of the first appearance of a neurotic symptom. In contrast, we are of the opinion that the genuine neurosis—the manifest, already fixated neurosis—is caused not only by the primary condition, but also through its secondary effects. However, the conditioned reflex is built up—as we now attempt to understand the neurotic symptom—through the vicious circle of anticipatory anxiety! Accordingly, if we want, so to speak, to decondition a well-established reflex, then it is important to eliminate the anticipatory anxiety, indeed, using the principle we described as paradoxical intention.[37]

The second pathogenic pattern of reaction is not to be observed in cases of anxiety neuroses, but in cases of compulsive neuroses. Our patients are under the pressure of the compulsive presentations that storm in upon them and they react to these presentations by attempting to suppress them. Thus, they attempt to exercise a contrary pressure. This contrary pressure, however, only raises the level of the original pressure. Once again, the circle is closed, and once again our patients are enclosed in this vicious circle (see Figure 2). What characterizes the compulsive neurosis, however, is not a flight—as in the case of the anxiety neuroses—but rather a fight, a fight against the compulsive presentations. Once again we must ask ourselves what motivates and causes this. And it turns out that the patient either fears that the compulsive presentations could be more than a neurosis, insofar as they signal an impending psychosis, or the patient fears that he or she could convert the criminal content of a compulsive presentation into action, that is, by doing something to someone else or to him or herself. One way or another patients suffering from an

[36] I. M. Marks, "The origins of phobic states," *American Journal of Psychotherapy, 24,* 652, 1970.
[37] Viktor E. Frankl, *Die Psychotherapie in der Praxis.*

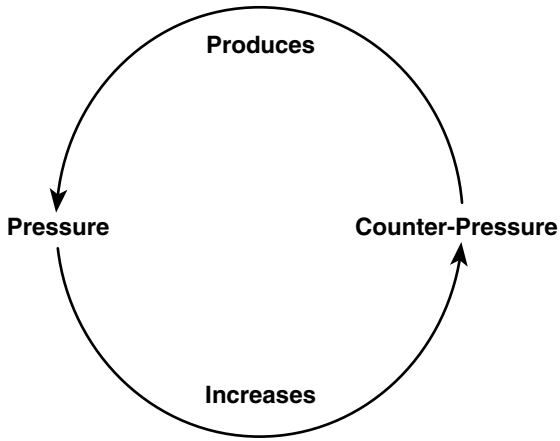


Figure 2

obsessive-compulsive neurosis do not have fear of fear itself, but rather a fear of themselves.

Now, it is the task of paradoxical intention to burst open, to break up, to unhinge both circular mechanisms. This happens insofar as the wind is taken out of the sails of the patient's fear, or as one patient once put it, "the bull is taken by the horns." Whereby one must consider that people with anxiety disorders are afraid of something that could happen to them, whereas people with obsessive-compulsive disorders are also afraid of something that they could do. Both will be taken into account if we define paradoxical intention in the following way: the patient will be directed to wish (in the case of anxiety neuroses) or to resolve to do (in the case of compulsive neuroses) precisely that which the patient fears so much.

As we will see, paradoxical intention concerns itself with an inversion of the intentions that characterize both patterns of reaction, namely, the avoidance of fear or of compulsion through the flight from the former or the fight against the latter. But that is precisely what the behavioral therapists of today consider decisive. For instance, subsequent to his hypothesis that a phobia is maintained by the anxiety reducing mechanism of avoidance, I. M. Marks makes the following recommendation: "The phobia can then be properly overcome only when the patient faces the phobic situation again."[38] And paradoxical intention offers itself to this end. In an article coauthored with S. Rachman and R. Hodgson, Marks

[38] L.c (op. cit.).

likewise emphasizes that the patient must be talked into and convinced to confront that which disturbs him most.[39] Also in a work coauthored with J. P. Watson and R. Gaind he recommends therapeutically that patients must confront the object of their fears as directly and quickly as possible and no longer may avoid such objects.[40]

That logotherapy implemented these therapeutic recommendations long ago, in the form of paradoxical intention as described in 1939, is today acknowledged by leading behavioral therapists: "paradoxical intention proceeds from an entirely different starting point," write H. Dilling, H. Rosefeldt, G. Kockott, and H. Heyse of the Max Planck Institute for Psychiatry, "but its effects might possibly be explained with simple principles of learning psychology." Subsequently the authors acknowledge that with paradoxical intention "good and in part very quick results were produced," they interpret these results according to learning theory insofar as they "assume an extinction of the conditioned pairing of the triggering stimulus and anxiety. In order to produce new, more appropriate ways of reacting to specific situations, the avoidance behavior with its constantly reinforcing effect must be given up and the person must acquire new experiences with the anxiety-triggering stimulus."[41] This task is accomplished precisely by paradoxical intention. Arnold A. Lazarus likewise confirms its success and explains it from the point of view of behavioral therapy in the following way: "When people encourage their anticipatory anxieties to erupt, they nearly always find the opposite reaction coming to the fore—their worst fears subside and when the method is used several times, their dreads eventually disappear."[42]

I practiced paradoxical intention as early as 1929,[43] but first described it in 1939,[44] and published it under that name only in 1947.[45] Its similarity to other behavioral therapy methods of treatment that later came on the market—such as anxiety provoking, exposure in vivo, flooding, implosive therapy, induced anxiety, modeling, modification of expectations, negative practice, satiation, and prolonged exposure—is undeniable and did not remain hidden from a few behavioral therapists. According to Dilling,

[39] "The treatment of chronic obsessive-compulsive neurosis," *Behavioral Research and Therapy, 9,* 237, 1971.
[40] "Prolonged Exposure," *Brit. Med. J., 1,* 13, 1971.
[41] "Verhaltenstherapie bei Phobien, Zwangsneurosen, sexuellen Störungen und Süchten," *Fortschr. Neurol. Psychiat. 39,* 293, 1971.
[42] Arnold A. Lazarus, *Behavior Therapy and Beyond* (New York: McGraw-Hill, 1971).
[43] Viktor E. Frankl, *Psychotherapie in Selbstdarstellungen* (Bern: Hans Huber, 1973).
[44] Viktor E. Frankl, "Zur medikamentösen Unterstützung der Psychotherapie bei Neurosen," *Schweizer Archiv für Neurologie und Psychiatrie, 43,* 26, 1939.
[45] Viktor E. Frankl, *Die Psychotherapie in der Praxis* (Vienna: Franz Deuticke, 1947).

Rosefeldt, Kockott, and Heyse, "although it was originally not conceived according to learning theory, underlying the method of paradoxical intention may be a mechanism similar to the forms of treatment called flooding and implosive therapy."[46] And regarding the last mentioned form of treatment, I. M. Marks likewise refers to "certain similarities to the paradoxical intention technique"[47] as well as to the fact that this technique of ours "closely resembled that now termed modeling."[48]

If anyone can make a claim of priority with regard to paradoxical intention, in my opinion it is only the following authors. I am indebted to Rudolf Dreikurs for the reference to an analogous "trick" that was described by him,[49] and even earlier by Erwin Wexberg, who ad hoc coined the term "anti-suggestion." And in 1956 it was brought to my attention that H. v. Hattingberg likewise pointed to an analogous experience:

> Whoever, for example, has succeeded in consciously wishing the appearance of a nervous symptom—one that he had up to this point anxiously fought against—can, through this volitional attitude, cause the anxiety and finally even the symptom to disappear. It is thus possible to drive out the devil with Beelzebub. Such an experience is admittedly practically attainable only for some. However, there is hardly an experience that would be more instructive for the inhibited.[50]

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[46] Op. cit.

[47] *Fears and Phobias* (New York: Academic Press, 1969).

[48] "Treatment of Obsessive-Compulsive Disorders" in Hans H. Strupp et al. (Eds.) *Psychotherapy and Behavioral Change* (Chicago: Aldine Publishing Company, 1974). Additionally, Professor L. Michael Ascher, assistant to Wolpe at the Behavioral Therapy University Clinic of Philadelphia, finds it noteworthy that most psychotherapeutic systems have developed methods that exponents of other systems were not at all able to use. The logotherapeutic technique of paradoxical intention is however an exception, namely, insofar as many psychotherapists from the most different of camps build this technique into their own systems. "In the past two decades, paradoxical intention has become popular with a variety of therapists impressed by the effectiveness of the technique." See his "Paradoxical Intention," in *Handbook of Behavioral Interventions* in A. Goldstein & E. B. Foa (Eds.) (New York: John Wiley, 1980). Ascher in fact thinks that behavioral therapeutic methods that are simply "translations of paradoxical intention into a theory of learning" have been developed, which holds true in particular of the so-called implosion and satiation methods. Professor Irvin D. Yalom of Stanford University also holds that the logotherapeutic technique of paradoxical intention has "anticipated" the so-called symptom prescription method introduced by Milton Erickson, Jay Haley, Don Jackson, & Paul Watzlawick. See "The Contributions of Viktor Frankl" in *Existential Psychotherapy* (New York: Basic Books, 1980). With regard to the therapeutic effectiveness of paradoxical intention, which according to Ascher has made this technique so popular, I will point to a case of "incapacitating erythrophobia"—to choose only one example—which, despite its 12-year history, Y. Lamontagne was able to cure in four sessions. See his "Treatment of Erythrophobia by Paradoxical Intention," *The Journal of Nervous and Mental Disease, 166,* 4, 178, 304–306.

[49] *Das nervöse Symptom* (Vienna: Verlag Moritz Perles, 1932).

[50] *Über die Liebe* (Munich-Berlin, 1940).

Neither should one assume that paradoxical intention, if it really should be effective, should not have had its predecessors and precursors. Consequently, the service that one can credit logotherapy with is simply that it extended the principle into a method and built it into a system.

Thus it is all the more remarkable that the first attempt to prove experimentally the effectiveness of paradoxical intention was undertaken by behavioral therapists. It was Professors L. Solyom, J. Garza-Perez, B. L. Ledwidge, and C. Solyom from the psychiatric clinic at McGill University who, in cases of chronic obsessive-compulsive neurosis, selected two equally pronounced symptoms, and then treated the one—the experimental symptom—with paradoxical intention, while the other—the "control" symptom—remained untreated. In fact, it was found that only the treated symptoms disappeared, and this within a few weeks. And in no case were these symptoms replaced with new ones.[51]

Among the behavioral therapists it was once again Lazarus who was struck by "an integral element in Frankl's paradoxical intention procedure," namely, "the deliberate evocation of humor. A patient who fears that he may perspire is enjoined to show his audience what perspiration is really like, to perspire in gushes of drenching torrents of sweat which will moisturize everything within touching distance."[52] The fact is—as we already hinted at when discussing the mobilization of the capacity for self-distancing—that the humor with which the patient must formulate the paradoxical intention belongs to the essence of this technique, and thus is the technique contrasted to the behavioral therapy techniques that we enumerated.

How right it is that we have time and time again pointed to the significance of humor for the success of paradoxical intention was again recently demonstrated by a behavioral therapist. Iver Hand of the London Maudsley Hospital was able to observe patients suffering from agoraphobia who,

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[51] "Paradoxical intention in the treatment of obsessive thoughts: A pilot study," *Comprehensive Psychiatry, 13,* 291, 1972. Likewise, Ascher has done much to provide experimental proof of the therapeutic significance and effectiveness of paradoxical intention. In general, it turned out that the technique of paradoxical intentional is as valuable as the various behavioral therapeutic interventions. However, in cases of insomnia and of neurotic urinary dysfunction the logotherapeutic method was superior. Regarding insomnia, Ascher's patients had originally needed an average of 48.6 minutes to fall asleep. After ten weeks of behavioral therapeutic treatment they needed 39.36. However, after 2 weeks were devoted to the use of paradoxical intention, this time was reduced to only 10.2 minutes. See L. M. Ascher & J. Efran, "Use of Paradoxical Intention in a Behavioral Program for Sleep Onset Insomnia," *Journal of Consulting and Clinical Psychology, 46,* 547–550, 1978. Similarly, Ralph M. Turner & L. Michael Ascher, "Controlled Comparison of Progressive Relaxation, Stimulus Control, and Paradoxical Intention Therapies for Insomnia," *Journal of Consulting and Clinical Psychology, 47,* no. 3, 500–508, 1979, report that "Paradoxical intention significantly reduced sleep complaints in contrast to placebo and waiting list control groups."

[52] Op. cit.

gathered in groups with those whom they had avoided until then because their anxiety provoking situations would have been confronted, spontaneously and jokingly exaggerated their fear to themselves and with each other. As he wrote, "They used humor spontaneously as one of their main coping mechanisms."[53] In short, the patients "discovered" paradoxical intention—and thus were their reaction "mechanisms" interpreted by the London research team!

We now want to turn to paradoxical intention as it is practiced according to the rules of logotherapy. Indeed, this should be expounded with the help of case studies.[54] We should refer readers to the cases discussed in my books, *Die Psychotherapie in der Praxis*, *Der Wille zum Sinn*, and *The Doctor and the Soul*. But in what follows we will focus on previously unpublished material.

Adolph M. Spencer from San Diego, California, wrote to me:

> Two days after I read your book, *Man's Search for Meaning*, I found myself in a situation that provided the opportunity to put logotherapy to the test. Namely, at the university I participate in a seminar on Martin Buber, and during the first meeting I spoke plainly, as I thought I had to say just the opposite of what everyone else was saying. Then I suddenly began to sweat terribly. And as soon as I noticed this, I started to worry that the others might notice it, and then I really began to sweat. Suddenly I recalled the case of a physician who consulted you about his fear of breaking out into a sweat, and I thought that my situation was rather similar. I do not, however, think much of psychotherapy, and least of all of logotherapy. Thus all the more my situation appeared to me as a unique opportunity to put paradoxical intention to the test. But what was it that you had advised your colleague? For a change he should once wish and attempt to show the people just how proficiently he can sweat—"until now I've sweat perhaps a total of 1 liter, but now I will produce 10 liters!" it says in your book. And while I continued to speak in the seminar, I told myself, "Spencer, go on and sweat for your colleagues! But do it right—that's nothing—you need to sweat a

[53] Lecture to the Montreal Logotherapy Symposium, sponsored by the American Psychological Association during its 1973 annual conference.

[54] *Where I write "case studies," Professor Frankl actually refers to "casuistry." This term usually refers to the application of general ethical principles to specific cases, as in Talmudic or Jesuit analysis of focal cases. Because the term casuistry is generally unfamiliar and because he is not speaking of ethical, but rather of psychological principles, I use the more familiar terms "case studies" and "cases" to replace the terms "casuistry" and "casuistic material."—JMD*

> good deal more!" And not more than a few seconds elapsed when I observed that my skin was becoming dry. Inside I had to laugh. I was not prepared for paradoxical intention to work, and certainly not so quickly. I said, hell, there must be something to this paradoxical intention; it worked even though I am skeptical about logotherapy.

We take the following case from a report from Mohammed Sadiq:

> Mrs. N., a 48-year-old patient, suffered from tremors to the extent that she was no longer able to hold a cup of coffee or a glass of water without spilling some of it. She could also neither write nor hold a book steady enough to read. One morning it so happened that we were sitting alone facing each other, and she began to shake again. At that I resolved to give paradoxical intention a try, in fact, with genuine humor. So I began, "Mrs. N., what would you think of a tremor competition?" She replied, "What do you mean?" I said, "We want to see who can tremble faster and longer." She said, "I didn't know that you also suffered from tremors." I said, "No, no, by no means; but if I want to, I can tremble." And I started to tremble just as she did. She said, "Yeah, you can do it faster than I can." And, smiling, she began to speed up her shaking. I said, "Faster! Go Mrs. N.! You've got to tremble faster." To which she said, "But I can't! Stop, I can't continue." And she had really grown tired. She stood up, went to the kitchen and came back—with a cup of coffee. She drank the whole cup without spilling a drop. Since then whenever I catch her trembling, all I need to do is say, "Now, Mrs. N., how about a tremor competition?" To which she would reply, "All right, all right"—and that has helped every time.

George Pynummootil from the United States reports the following:

> A young man came to my office with a nervous eye twitch that started every time he needed to speak with someone. When people would ask him what was the matter he would grow more nervous. I transferred him to the care of a psychoanalyst. But after a whole series of visits he returned to my office to report that the psychoanalyst had not found the cause, much less helped him. At that point I recommended that the next time he had to speak with someone he should try to wink and blink as much as possible to show his dialogue partner just how well he could do

that. I thought that I must have gone crazy to recommend such a thing for something like that could only make his condition worse. And he left. For a few weeks I did not see him. But then one day he returned again just to tell me excitedly what happened in the meantime. Because he thought very little of my suggestion, it had not occurred to him to try it. But his nervous twitch grew worse, so when one night he recalled what I had said, he said to himself, "I've tried everything there is, and nothing has helped. What could possibly happen, why not try what he suggested." And the next day when he encountered the first person to come along he attempted to blink his eyes as much as possible—and to his great surprise he was simply not able to do it even in the least. The nervous twitch never made itself felt again.

A university assistant wrote to us:

I needed to interview at a place after I applied for a post that I was very keen on because I would then have been in the position to permit my wife and children to follow me to California. I was very nervous and I tried terribly to leave a good impression. But whenever I would get nervous my legs started to quiver, in fact, to the degree that those present must have noticed it. And that's what happened this time. Only this time I said to myself, "alright, this time I'm going to make these darned muscles quiver so much that I can't sit, so that I've got to jump up and dance around the room so long that these people think I've snapped. These darned muscles are going to quiver like they've never quivered before—today I'm going to set a quiver record." Now, the muscles did not twitch once during the whole interview, I got the position, and my family will soon be here in California.

Two examples from Arthur Jores fit in well here:[55]

A hospital social worker came to Jores, "who complained that she would turn red whenever she had to go to the physician's office to talk to him. Together we tried paradoxical intention and a few days later I received a happy letter that it was working great." On another occasion a medical student came to Jores, "for whom it was extraordinarily important to do well on the preliminary medical

[55] Arthur Jores, *Der Kranke mit psychovegetativen Störungen* (Göttingen: Vandenhoeck), p. 52.

exam in order to keep his stipend. He complained of test anxiety. Paradoxical intention was also used with him, and what do you know, he was completely at peace during his exam and passed with a good grade."

We have Larry Ramirez to thank for the following case:

The technique that has helped me most often and worked most effectively in my counseling sessions is that of paradoxical intention. One such example I have illustrated below. Linda T., an attractive 19-year-old college student, had indicated on her appointment card that she was having some problems at home with her parents. As we sat down, it was quite evident to me that she was very tense. She stuttered. My natural reaction would have been to say, "relax, it's alright" or "just take it easy," but from past experience I knew that asking her to relax would only serve to increase her tension. Instead, I responded with just the opposite, "Linda, I want you to be as tense as you possibly can. Act as nervously as you can." "O.K.," she said, "being nervous is easy for me." She started by clenching her fists together and shaking her hands as though they were trembling. "That's good," I said, "but try to be more nervous." The humor of the situation became obvious to her and she said, "I really was nervous, but I can't be any longer. It's odd, but the more I try to be tense, the less I'm able to be." In recalling this case, it is evident to me that it was the humor that came from using paradoxical intention which helped Linda realize that she was a human being first and foremost, and a client second, and that I, too, was first a person, and her counselor second. Humor best illustrated our humanness.

J. F. Briggs held a lecture for the Royal Society of Medicine, from which we have taken the following:

I was asked to see a young man from Liverpool who stuttered. He wanted to take up teaching, but stuttering and teaching do not go together. His greatest fear and worry was his embarrassment by the stuttering so that he went through mental agonies every time he had to say anything. I remember a short time before having read an article by Viktor Frankl, who wrote about a reaction of paradox. I then gave the following suggestion, "You are going out into the world this weekend and you are going to

> show people what a jolly good stutterer you are." He came up the following week and was obviously elated because his speech was so much better. He said, "What do you think happened! I went into a pub with some friends and one of them said to me, 'I thought you used to be a stutterer,' and I said, 'I did — so what!' It was an instance where I took the bull by the horns and it was successful."

Another case of stuttering concerns a student at Duquesne University, who wrote to me the following:

> For over 17 years I stuttered heavily. There were times when I was completely unable to speak. I was under treatment repeatedly, but had no success. Then one day a professor gave me the assignment to discuss your book, *Man's Search for Meaning*, in our seminar. So I read the book and came across your paradoxical intention. At that moment I decided to try it in my own case, and you know, it worked wonderfully on the very first try. There was no trace of stuttering. Then I set out to put myself in precisely those situations in which I had always stuttered, but again the stuttering disappeared as soon as I applied paradoxical intention. However, a few times I did not apply it, and immediately the stuttering returned. I see in this evidence that it really was paradoxical intention that freed me of the stuttering.

Irony is not lacking from one report, for which I thank Uriel Meshoulam, a logotherapist at Harvard University. One of his patients was drafted by the Australian military and was convinced that he would not be enlisted because he stuttered so heavily. As he was being evaluated for military fitness, he tried three times to show the physician how heavily he stuttered, but was completely unable to stutter at all. In the end he was found unfit for military service, but due to high blood pressure. The report concludes, "To this day, the Australian army probably doesn't believe he stutters."

The application of paradoxical intention to stuttering has been discussed often in the literature. Manfred Eissenmann dedicated his dissertation to this topic at the University of Freiburg im Breisgau (1960). J. Lehembre published his experiences with children and emphasized that only once did it lead to symptom substitution, which is in agreement with the observations of L. Solyom, Garza-Perez, Ledwidge, and C. Solyom,

who did not identify one case of symptom substitution following the use of paradoxical intention.[56]

Jores once treated a patient who lived in the firm conviction that she always had to have plenty of sleep. She was now married to a man who had great social obligations so that it sometimes happened that she would get to bed very late. She reported that she always tolerated this very badly. In some cases, she would get a migraine at night, around one o'clock, or at the latest the next morning. It was possible to overcome these migraines that were coupled with staying up later than usual by using paradoxical intention. The patient was instructed to say to herself, "so, now for once you want to have a good, proper migraine headache." After that, according to Jores, the migraines disappeared.

This case leads us to the application of paradoxical intention to sleeping disorders. Sadiq, whom we have already cited, once treated a 54-year-old patient who had become dependent on sleeping pills and was brought to a hospital.

> Around 10 o'clock in the evening she came out of her room and asked for a sleeping pill. She said, "May I please have my sleeping tablets?" I replied, "I'm sorry, today we ran out of them, and the nurse forgot to order new pills on time." She replied, "Now how am I supposed to be able to sleep?" I suggested, "Today it's going to have to happen without sleeping pills." Two hours later she appeared again. She said, "It's simply not working." I said, "And what if you laid down again and for a change tried not to sleep, but rather, tried to stay up the whole night?" She said, "I've always thought that I am crazy, but it seems to me that you're crazy too." I said, "You know, sometimes I have fun being crazy, or can't you understand that?" She said, "Did you really mean what you suggested?" I said, "Naturally I meant it. Try it just once! We want to see if you can stay awake the whole night. Well?" She said, "O.K." The next morning when the nurse entered her room to bring her breakfast the patient was still not awake.

By the way, there is an anecdote that is worth mentioning in this context. It is taken from the well-known book by Jay Haley, *Strategies of*

[56] J. Lehembre, "L'intention paradoxale, procédé de psychotherapie," *Acta neurol. Belg. 64,* 725, 1964. See also L. M. Ascher, "A review of literature in the treatment of insomnia with paradoxical intention," unpublished paper. Ascher did not observe substitute symptoms following the use of paradoxical intention. He also speaks against any reduction of paradoxical intention to suggestion: "Paradoxical intention was effective even though the expectations of the clients were assumed to be in opposition to the functioning of the technique."

Psychotherapy.[57] During a lecture by the famous hypnotist, Milton Erickson, a young man stood up and said to him, "Perhaps you can hypnotize other people—but definitely not me." At that Erickson invited the man to take a place at the podium, and then he said to him, "You are completely awake . . . you are staying awake . . . you are becoming more and more awake . . ." and promptly the subject fell into a deep trance!

It remains the distinction of R. W. Medlicott, a psychiatrist from New Zealand, to be the first to have applied paradoxical intention not only to sleep but also to dreams. He had previously had great success with paradoxical intention—even, as he stresses, in the case of a patient who was a psychoanalyst by profession. However, he had a patient who regularly suffered from nightmares, who in fact always dreamed that she was being followed and in the end was stabbed down. Then she would scream out loud and her husband would be woken up. Medlicott instructed her to put all her efforts into dreaming this dream to the end, until even the knife stabbing came to an end. And what happened? There were no more nightmares, but her husband's sleep was disturbed just as it had been before. The patient no longer screamed out loud while she slept, but now she laughed so loud that her husband still couldn't sleep peacefully.[58]

A reader from the United States reported something similar.

> Thursday morning I awoke depressed and thought I would never get healthy again. In the course of the morning I started to cry and was simply in despair. Then I thought of paradoxical intention and I said to myself, "We want to see once and for all how depressed I can become. I'll cry so that the entire apartment is flooded with tears." And I imagined that my sister would come home and complain, "Dammit, did we really have to have this flood of tears?" At which I laughed so hard that I became afraid. So nothing remained but for me to say to myself, "Your laughing will become so bad that your neighbors will all come running to see who is laughing so hard." During all this I stopped being depressed, and I invited my sister to go out with me. As I said, that was Thursday and today is Saturday and I feel like a million dollars. You know, I think the paradoxical intention worked two days ago like an attempt to cry and at the same time to look in the mirror.

[57] Jay Haley, *Strategies of Psychotherapy* (New York: Grune & Stratton, 1963).
[58] R. W. Medlicott, "The management of anxiety," *New Zealand Medical Journal, 70,* 155, 1969.

And she may not be so wrong about that. Both—the paradoxical intention and self-mirroring—are vehicles of the human capacity for self-distancing.

Repeatedly it has been observed that paradoxical intention was effective even in severe, chronic, and enduring cases, and that it did this even when the treatment was brief. Thus, cases of obsessive-compulsive disorder were described that had persisted for 60 years until paradoxical intention led to a marked improvement.[59] The therapeutic success that can be attained with this technique is astonishing and remarkable at least when we contrast it to the ubiquitous pessimism with which today's psychiatrists face severe and chronic obsessive-compulsive disorders. Thus, L. Solyom, Garza-Perez, Ledwidge, and C. Solyom refer to the results of 12 investigational studies from seven different nations that showed that obsessive-compulsive disorders are impervious to treatment in 50 percent of all cases.[60] The authors maintained that the prognosis for obsessive-compulsive disorder is worse than every other form of neurosis, and that behavioral therapy has brought about no change, for only 46 percent of the cases published by behavioral therapists improved. However, D. Henkel, C. Schmook, and R. Bastine, in reference to experienced psychoanalysts, point out that "particularly severe obsessive-compulsive disorders proved to be untreatable despite intensive therapeutic efforts," while paradoxical intention, which stands in contrast to psychoanalysis, "shows clearly the possibility of a short-term influence on obsessive-compulsive disorders."[61]

Friedrich M. Benedikt showed in his dissertation that for the application of paradoxical intention in severe and chronic cases a tremendous personal effort is required.[62] However, in this context, we would like to repeat that "the therapeutic effect of paradoxical intention stands or falls with whether the physician also has the courage to demonstrate its application,[63] as previously demonstrated in a concrete case."[64] Behavioral therapy in fact also recognizes the significance of such actions as it actually coined a term and speaks of "modeling."

That paradoxical intention can provide a brief and helpful treatment even in long-enduring cases can be illustrated with the following cases. Ralph G. Viktor and Carolyn M. Krug, of the University of Washington, applied this technique in the case of a man, who had been an extreme

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[59] K. Kocourek, Eva Niebauer, & Paul Polak, "Ergebnisse der klinischen Anwendung der Logotherapie," in Viktor E. Frankl, Victor E. V. Gebsattel, & J. H. Schultz (Eds.) *Handbuch der Neurosenlehre und Psychotherapie* (München-Berlin: Urban & Schwarenberg, 1959).
[60] Op. cit.
[61] D. Henkel, C. Schmook, & R. Bastine, *Praxis der Psychotherapie, 17,* 236, 1972.
[62] See Friedrich M. Benedikt, *Zur Therapie angst- und zwangsneurotischer Symptome mit Hilfe der paradoxen Intention und Dereflexion nach V.E. Frankl* (Munich, 1968).
[63] Viktor E. Frankl, *Die Psychotherapie in der Praxis* (Wien: Franz Deuticke, 1961).
[64] Benedikt, op. cit.

gambler since he was 14 years old.[65] They actually instructed him to gamble 3 hours daily even though in doing so he lost so much that he was without money for 3 weeks. And what did the therapists do? They coldbloodedly recommended that he sell his watch. One way or another, it was the first time in more than 20 years ("after twenty years and five psychiatrists" as the publication says) that the patient was freed of his passion for gambling.

Max Jacobs discusses the following case.[66]

> Mrs. K. had suffered from severe claustrophobia for at least 15 years when she sought him out in South Africa, one week before she needed to fly home to England. She was an opera singer and frequently needed to fly around the world in order to meet her performance duties. Nevertheless, her claustrophobia was focused precisely on airplanes, elevators, restaurants and . . . theaters.

"Frankl's technique of paradoxical intention was then brought in," the narrative continues. In fact, Jacobs instructed the patient to seek out situations that triggered her phobia and to wish what she had always feared, namely, to choke. She needed to say, "Right here on the spot I am going to choke—let it give me all it's got!" Additionally, the patient was instructed in progressive relaxation and desensitization. Two days later she was able to go to a restaurant, to ride in an elevator and even a bus. Four days later she was able to visit a movie theater without fear and she awaited her return flight to England without anticipatory anxiety. From London she reported that she was even up to riding the subway for the first time in years. Fifteen months after her short treatment the patient reportedly remained free of symptoms.

Jacobs next describes a case that concerned an obsessive-compulsive, rather than an anxiety, neurosis. Mr. T. had suffered with his neurosis for 12 years and even submitted himself to psychoanalysis and electroshock therapy without success. Above all, he feared choking while eating, drinking, or even crossing the street. Jacobs instructed him to do just what he always feared: "Using the technique of paradoxical intention, he was given a glass of water to drink and told to try as hard as possible to make himself choke. He was instructed to try to choke at least 3 times a day." Along with

[65] Ralph G. Viktor & Carolyn M. Krug, "Paradoxical intention in the treatment of compulsive gambling," *American Journal of Psychotherapy, 21,* 808, 1967.
[66] Case published in Arnold A. Lazarus, *Clinical Behavior Therapy* (New York: Brunner-Mazel, 1972).

this, he was given relaxation exercises. Through the course of 12 visits he reported that he was completely free of symptoms.

Time and again people ask about the conditions and requirements for training in logotherapeutic methods. However, the technique of paradoxical intention precisely confirms that occasionally it is sufficient to make oneself familiar with the technique by becoming familiar with the literature. Indeed, among those psychiatrists and psychologists who use paradoxical intention most successfully and insightfully are some who have never come into contact with me. As they know paradoxical intention only from our publications, we know of their successes and experiences only from their publications. But it is also interesting to realize how the different authors modify and combine paradoxical intention with other techniques. This realization only strengthens our conviction that psychotherapy—that is, not only logotherapy—depends on the constant willingness to improvise. Where it is possible to provide training in the form of clinical demonstrations, this improvisation is not only something that must be learned, it is something that can be learned.

It is astonishing how frequently lay people successfully use paradoxical intention on themselves. In front of me lies a letter from someone who suffered from agoraphobia for 14 years, who was in orthodox psychoanalytic treatment for 3 years without success. For 2 years a hypnotist treated her, during which time her agoraphobia was a little better. For 6 weeks she even had to be admitted. Nothing really helped. After all this, the patient wrote, "Nothing has really changed in 14 years. Every day of those years was hell." Then once again things hit the point where she went outside but wanted to turn back. She was terribly overcome with agoraphobia. Then she recalled what she had read in my book, *Man's Search for Meaning*, and she said to herself, "I'm going to show the people all around me on the street how well I can panic and collapse." And suddenly she was calm. She continued on her way to the supermarket and did her shopping. But at the checkout she began to sweat and tremble. She said to herself, "I'll show the checkout clerk just how much I can sweat. He'll stare at me!" Only on the way home did she notice how calm she had become. And so it went. In a few weeks, with the aid of paradoxical intention she was able to overcome agoraphobia so much that she sometimes could not believe that she ever suffered from it. "I have tried many methods, but none gave me the quick relief your method did. I believe in paradoxical intention, because I have tried it on my own with just a book." For amusement's sake, let us add that this suffering woman—now well—had the ambition to complete her knowledge of paradoxical intention, knowledge gained from reading only one book. In the end, she ran an ad in the *Chicago Tribune* for a week.

She included the ad with her letter. The ad read: "Would like to hear from anyone having knowledge of or treated by paradoxical intention for agoraphobia." But no one responded to the ad.

That lay people can use paradoxical intention, indeed even on themselves, is understandable if we consider that it draws upon coping mechanisms that—as the previously cited observations of Hand show—already exist in the person. And thus we are able to understand cases like the following. Ruven A. K. from Israel, who studies at the International University in California, was drafted into military service at the age of 18. "I was looking forward to serving in the army. I found meaning in my country's struggle for survival. Therefore, I decided to serve in the best way I could. I volunteered to the top troops in the army, the paratroopers. I was exposed to situations where my life was in danger—for example jumping out of the plane for the first time. I experienced fear and was literally shaking and trying to hide this fact made me shake more intensively. Then I decided to let my fear show and shake as much as I can. And after a while the shaking and trembling stopped. Unintentionally, I was using paradoxical intention and surprisingly enough it worked."

But paradoxical intention is not just discovered by individuals *ad usum proprium*. The principle that underlies it was discovered in prescientific psychiatry. J. M. Ochs delivered a lecture to the Pennsylvania Sociological Society at Villanova University, "Logotherapy and Religious Ethnopsychiatric Therapy" (1968), in which he represented the view that ethnopsychiatry uses a principle that was later systematized by logotherapy. In particular, the folk medicine of the Ifaluk people was decidedly logotherapeutic. "The Shaman of Mexican-American folk psychiatry, the *curandero*, is a logotherapist." Ochs also refers to Wallace and Vogelson, who apply general principles borrowed from folk medicine that also play a role in modern psychiatry. "It appears that logotherapy is one nexus between the two systems."

Such hypotheses become plausible when we directly compare the following two reports. The first concerns a 24-year-old schizophrenic who suffered from auditory hallucinations. He heard voices that threatened and mocked him. Our informant dealt with him during a hospital admission. "The patient left his room in the middle of the night to complain that the voices would not let him sleep. He was encouraged to ignore the voices but that was impossible." It continues in the following dialogue.

Doctor: "What if you tried something else?"

Patient: "What do you mean?"

Doctor: "Go lay down and pay attention as closely you can to what the voices say—don't miss a single word. Do you understand?"

Patient: "Are you serious?"

Doctor: "Yes, I'm quite serious. I don't understand why you shouldn't savor these g_d-damned voices for a change."

Patient: "But I thought . . ."

Doctor: "Go try it once—then we can talk more about it. . . ."

Forty-five minutes later he had fallen asleep. In the morning he was very excited because the voices had left him in peace the rest of the night.

Let us now consider the counterpart. Jack Huber once visited a clinic led by Zen psychiatrists.[67] The motto that led the work of these psychiatrists read, "Emphasis on living with the suffering rather than complaining about it, analyzing it, or trying to avoid it." One day a Buddhist nun was admitted who was in a severe state of confusion. She was in a state of anxiety because she believed snakes were crawling all over her. European doctors, psychiatrists, and psychologists had already given up on the case when the Zen psychiatrist was brought in. "What's going on," he asked. "I'm terribly afraid of the snakes—they're crawling all over me." The Zen psychiatrist deliberated a while, and then he said, "Unfortunately, I need to go now, but I'll be back in a week. During this week I want you to observe the snakes very carefully. The next time I visit you, you will need to describe precisely every single movement." A week later the nun was finally normal again and attended to her duties. "Well, how is it going?" asked the Zen psychiatrist. "I observed the snakes as closely as possible, but that didn't work for long, because the more that I did it, the more they took off."

There is a third pathogenic reaction pattern to discuss. While the first is characteristic of anxiety neuroses and the second of obsessive-compulsive disorders, the third concerns a mechanism that we encounter in cases of sexual neuroses, that is, in disturbances of potency or orgasm. And in these cases we observe once again, as in obsessive-compulsive disorders, that the patient fights. We said that obsessive-compulsive patients fight against the compulsion; but in the case of sexual neuroses, patients do not fight against anything, rather they fight for something. They do so insofar as they fight for sexual pleasure in the form of potency and orgasm.

[67] Jack Huber, *Through an Eastern Window* (New York: Bantam Books, 1968).

But unfortunately the more one is concerned with pleasure, the more it escapes a person; that is, it escapes direct capture. For pleasure is neither the actual goal of our actions nor a possible goal; rather it is much more an effect, a side effect that arises on its own whenever we live out our self-transcendence (that is, whenever we either love another or devote ourselves to something). But as soon as we intend only pleasure rather than the partner, the will to pleasure gets in the way of itself. The self-manipulation is miscarried. The path to pleasure and self-actualization leads over the path of self-giving and self-forgetting. Whoever takes this path to be a detour is tempted to choose a shorter route and to aim for pleasure as a direct goal. Only this shorter route turns out to be a dead end.

And once again we observe how patients get caught in a vicious circle. The fight for pleasure (or for potency or orgasm), which forces a hyperintention of pleasure, not only kills pleasure, but also brings with it an equally forced hyperreflection (see Figure 3). One starts to observe oneself during the act and to watch the partner. Spontaneity is completely lost.

If we ask ourselves what triggers hyperintention in cases of impotence, then we repeatedly find that the patient sees the sexual act as a performance that is demanded of him. In other words, the sexual act has the character of a duty. Already in 1946, we indicated that the patient "feels almost obligated to execute the sexual act," and indeed this "compulsion toward sexuality can be a compulsion of the self or a compulsion of the situation."[68] However, the compulsion can also result from his partner (a "vivacious," sexually demanding partner). The significance of this third factor has in the meantime been confirmed in animal experiments. Konrad Lorenz was able to bring a female Siamese fighting fish to swim up to a male energetically, rather than to coquettishly swim away from him during mating, upon which the male-fighting fish, so to speak, reacted humanly: his mating apparatus was shut down reflexively.

In addition to the three instances enumerated above, in which the patient feels driven to sexuality, there are two new factors. First of all, there is the value that our performance-oriented society places on sexual performance. The peer pressure, that is, the dependence upon what the individual's peer group regards as "in"—this peer pressure leads to a forced intention to be potent and to achieve orgasm. But it is not only hyperintention that is fostered in this manner by a collective standard, but also hyperreflection. What spontaneity remains untouched by peer pressure is taken from people of today by pressure groups. We mean the sexual

[68] Viktor E. Frankl, *Ärtzliche Seelsorge* (Wien: Franz Deuticke, 1946).

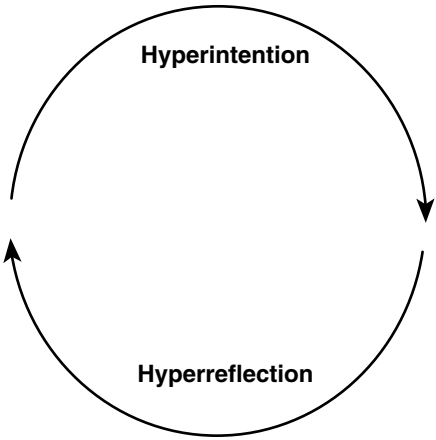


Figure 3

pleasure and enlightenment industries. The sexual pressure to consume, which they aim for, is marketed to the people by "hidden persuaders," and the mass media have surrendered to this. What is paradoxical is that the young people of today also give in to being strung along in this fashion by industrial capital and to being carried along by the sexual wave without noticing who is manipulating them. Those who take a stand against hypocrisy should also do it where pornography is presented as art or enlightenment in order to justify a business trade.

The situation has also intensified insofar as an increasing number of authors observe an increase of impotence among young people and trace this increase back to modern women's liberation. Thus, J. M. Stewart reports on "impotence at Oxford." The young women, it says, run around *demanding* their sexual rights and the young men fear that they will be regarded as poor lovers by women who have so much experience.[69] Further, George L. Ginsberg, William A. Frosch, and Theodore Shapiro published a study under the title, "The New Impotence," in which they speak explicitly of the fact that "the young man of today is demanded insofar as this study showed that in these new cases of impotence the initiative to have sex came from the females."[70]

In logotherapy we counter hyperreflection with a dereflection. To treat the specific hyperintention that is so pathological in cases of impotence we

[69] J. M. Stewart, *Psychology and Life Newsletter, 1,* 5, 1972.
[70] George L. Ginsberg, William A. Frosch, & Theodore Shapiro, "The New Impotence," *Arch. Gen. Psych. 26,* 218, 1972.

have developed a special technique, which dates back to 1947.[71] We recommend that the patient be encouraged "not to engage in sex, but rather to acquiesce to fragmentary acts of tenderness, like a mutual sexual foreplay." We also encourage "the patient to explain to his partner that for the time being the doctor has strictly forbidden coitus. In fact, the patient does not need to stay with this for any given amount of time; but now that he is relieved of the pressure from the sexual demands that his partner had confronted him with, he should approach the object of his desire ever more closely while running the risk of being turned away by his partner—in compliance with the purported prohibition on sex. The more he is refused, the more he success he has."

William S. Sahakian and Barbara Jacquelyn Sahakian are of the opinion that the research findings of W. Masters and V. Johnson have completely confirmed our own.[72] In fact, the treatment method developed by Masters and Johnson in 1970 is similar in many ways to the one we published in 1947 (just described above). However, in what follows, our presentation will once again be case based.

Godfryd Kaczanowski reports on a married couple that consulted him.[73] They were married for just a few months. The man had become impotent and was severely depressed. They married out of love and the man was so happy that he had only one goal: to make his wife as happy as possible, indeed, sexually as well, insofar as he wanted to bring her to the most intensive orgasm possible. After a few sessions he was led by Kaczanowski to the insight that precisely this hyperintention his partner's orgasm was what had thwarted his potency. He also recognized that if he would "give himself" to his wife, he would give her more than an orgasm (which would automatically appear once he no longer aimed for it). In accordance with the rules of logotherapy, Kaczanowski prescribed a prohibition on coitus until further notice, which evidently freed the patient of his anticipatory anxiety. As expected, it turned out a few weeks later that the patient ignored the prohibition on coitus, his wife resisted it for a while, but then gave up, and since then their sexual life has been 100 percent normalized.

Similarly, we find a case from Darrel Burnett that concerns frigidity rather than impotence. "A woman suffering from frigidity kept observing what was going on in her body during intercourse, trying to do everything according to the manuals. She was told to switch her attention to her

[71] Viktor E. Frankl, *Die Psychotherapie in der Praxis* (Wien: Franz Deuticke, 1947).
[72] William S. Sahakian & Barbara Jacquelyn Sahakian, "Logotherapy as a Personality Theory," *Israel Annals of Psychiatry, 10,* 230, 1972.
[73] Godfryd Kaczanowski, "Logotherapy: A New Psychotherapeutic Tool," *Psychosomatics, 8,* 158, 1967.

husband. A week later she experienced an orgasm." Just as hyperintention was overcome through paradoxical intention with Kaczanowski's patients, namely, through the prohibition against coitus, hyperreflection was overcome through dereflection with Burnett's patients, which could only happen when the patients found their way back to self-transcendence.

Sometimes our "trick" can only be played when neither partner is let in on the secret. Just how creative one must be in such situations is illustrated in the following report from Myron J. Horn, a former student of mine:

> A young couple came to see me regarding the man's impotence. His wife repeatedly told him that he was a lousy lover and that she was beginning to think about being with other men in order to be finally really satisfied. I then ordered them to spend at least one hour naked in bed every day for one week. They could do whatever they pleased, only one thing was forbidden under all circumstances, namely, coitus. A week later I saw them again. They tried to follow my advice, but "unfortunately" they had coitus three times. I acted irritated and insisted that this coming week at least they should follow my instructions. Only a few days passed and they called me, but just to report that they were unable to follow my instructions; in fact, they were having coitus now several times a day. A year later I learned that this success was lasting.

But it is also possible that we sometimes need to let the partner in on the "trick," but not the patient. A participant in a logotherapy seminar led by Joseph B. Fabry at the University of Berkeley used our technique, under Fabry's direction, on her own partner, who was a professional psychologist, and as such directed a sexual counseling center. (He was trained under Masters and Johnson.) This sex counselor, it turns out, had become impotent himself. It was reported to us that, "using a Frankl technique, we decided that Susan should tell her friend that she was under a doctor's care who had given her some medication and told her not to have intercourse for a month. They were allowed to be physically close and do everything up to actual intercourse. The next week Susan reported that it had worked." But then there was a relapse. However, Fabry's student was inventive enough to resolve her partner's impotency problem alone this time. "Since she could not have repeated the story about doctor's orders she had told her friend that she had seldom, if ever, reached orgasm and asked him not to have intercourse that night but to help her with her problem of orgasm." That is, she assumed the role of a patient in order to lead her partner to assume the role of the practicing sex counselor thus to bring him to self-transcendence. In this way dereflection was also achieved and

the pathological hyperreflection was dissolved. "Again it worked. Since then no further problem with impotence has occurred."

Gustave Ehrentraut, a Californian sex counselor, once treated a patient who had suffered from premature ejaculation for 16 years. At first, he was treated using behavioral therapy, but after 2 months he had not made any progress. Then he reports, "I decided to attempt Frankl's paradoxical intention. I informed the patient that he wasn't going to be able to change his premature ejaculation, and that he should, therefore, only attempt to satisfy himself." Ehrentraut then recommended that the patient make coitus as short as possible, and this paradoxical intention had the effect of lengthening the time of coitus fourfold. Since then there has not been a relapse.

Another Californian sex counselor, Claude Farris, sent me a report in which paradoxical intention is applied to **vaginismus**. Sexuality was strictly taboo for this patient, who was raised in a Catholic cloister. She sought treatment for severe pain during coitus. Farris now instructed her not to relax the genital region, but to tense her vaginal muscles so hard that her husband would be unable to penetrate the vagina. One week later the couple returned again to report that for the first time in their married life coitus was pain free. No relapse was reported. But what is remarkable about this report is the idea of using paradoxical intention to bring about relaxation.

In this connection, an experiment of David L. Norris, a California researcher, should be mentioned, in which Steve, a test subject, was instructed to relax as much as possible, which he was unable to do because he was too actively aiming for this goal. Norris could observe this precisely because the test subjects were connected to an electromyogram that consistently registered 50 micro amps. Until Steve learned from Norris that he would never in his whole life bring himself to really relax. Then Steve blurted out, "To hell with relaxation, I don't care a whistle about it." And then the electromyogram's indicator suddenly dropped to 10 micro amps. "With such speed," reported Norris, "that I thought the unit had become disconnected. For the succeeding sessions Steve was successful because he was *not* trying to relax."

Something analogous can be seen in the diverse methods, to say nothing of sects, of meditation, that are no less "in" than relaxation. An American professor of psychology wrote to me the following. "I was recently trained in doing Transcendental Meditation but I gave up after a few weeks because I feel I meditate spontaneously on my own, but when I start meditation formally I actually stop meditating."

Preview

Part I. The Theory of Neuroses and Psychotherapy

Part I is devoted to developing a categorization scheme for, and a description of psychotic, psychosomatic, and neurotic disorders.

- Chapter 1 presents Viktor Frankl's categorization of mental disorders.
- Chapters 2–9 are devoted to examining a variety of disorders. While these disorders present different symptoms, the chapters are divided primarily according to the etiology of the disorder. Thus, the chapters discuss disorders caused by various somatic, psychological, spiritual, and sociological causes. Frankl's purpose in these chapters is not to describe comprehensively the variety of mental disorders that exist, so much as to illuminate the fundamental mechanisms that underlie various kinds of mental disorders.
- Frankl's terminology is to some extent unique, but much of it draws from the terminology of the *International Classification of Diseases*, 9th Edition (ICD-9). This is the standard classification manual used in Europe, whereas the *Diagnostic Statistics Manual* is the standard manual used in the United States. The editor's introduction bridges Frankl's terminology and these standard diagnostic manuals.

Part I
The Theory of Neuroses and Psychotherapy

. . . tu laborem et maerorem consideras, ut ponas ea in manibus tuis

Preview

Chapter 1. The Theory of Neuroses as a Problem

This chapter develops a categorization system that yields definitions of key psychological terms.

- An illness may be categorized using two axes: (1) phenomenology or symptomology (i.e., the way the illness presents), and (2) etiology – the cause or genesis of the illness. Each axis can be divided into somatic vs. psychological. Thus, diseases are characterized as either pheno-psychological or pheno-somatic (depending on whether their symptoms present as psychological or somatic), AND as either psychogenic or somatogenic (depending on whether their cause is primarily psychological or somatic).
- These divisions are useful, but there are always borderline and mixed cases. There are also cases in which other causes play a prominent role, e.g., spiritual or sociological causes.
- Several definitions follow from this approach:
    - Neuroses in the strict sense can be defined as pheno-psychological, psychogenic illnesses. (Note: Throughout the book the term "neurosis" is frequently used in a looser sense to refer to neurotic symptoms arising from bodily, spiritual, or sociological causes.)
    - Psychoses are pheno-psychological, somatogenic illnesses. (Note: Frankl's use of the term "psychotic disorder" is thus much broader than the use of the term in the *Diagnostic Statistics Manual*, and includes Major Depressive Disorders (endogenous depression). His usage is consistent with the ICD-9.)
    - Psychosomatic illnesses are pheno-somatic illnesses that are "triggered" but not caused by psychological factors. Such may be the case, for example, with individual attacks of asthma, but not with asthma per se.
    - Functional illnesses (or pseudo-neuroses) are similar to neuroses in appearance but are somatogenic. (These present differently from illnesses traditionally denoted as psychoses and have vegetative or endocrine disturbances as their cause.)
    - Reactive neuroses are those that arise from patients' psychological reactions to the effects or symptoms of a somatic or psychological disturbance.

- Iatrogenic neuroses are neuroses whose etiology is attributable to the actions of a physician or health professional.
- Noogenic neuroses are pheno-psychological disorders that arise from spiritual causes, such as a crisis of conscience or an existential crisis.

Chapter 1
The Theory of Neuroses as a Problem: Toward a Definition and Classification of Neurotic Disorders

Cullen (1777) coined the term "neurosis." It would be misleading, however, if one relied upon Cullen for a definition of neurosis. For since that time, as Quandt and Fervers suggest, the concept has undergone a change in meaning. And one could say that the different meanings have multiplied with time. Thus we can understand that both Bumke and Kurt Schneider have recommended doing away with the term. Kloos also is prepared to plead the same; he finds the concept vague and moreover unnecessary. However, he himself adds that the term appears to be ineradicable.

In general it appears that there are two tendencies in scholarly literature regarding the demarcation of the concept of neurosis: an inflationary and a deflationary. The most prominent representative of the latter tendency is Werner Villinger, who speaks out against an overextension of the concept, that is, against an expansion of its territory. Taking the opposite view would be authors like Rümke, who draws the line so broadly that he does not view neurosis as an illness or a nosological phenomenon, but rather as a syndrome, that is, a purely symptomological phenomenon.

We would like to adopt a moderate position by distinguishing between neuroses in the proper, narrower sense of the word and neuroses in a broader sense. Thus, we can distinguish genuine neuroses from **pseudo-neuroses**, which is not to say that we must always add the prefix "pseudo"—we can leave it out without further ado.

At least as a working hypothesis, that is in a more or less heuristic manner, we suggest that we proceed using the definition that we are justified in calling neurotic every illness that is psychogenic.

As soon as we assume this point of departure, a schema of possible forms of human illness suggests itself effortlessly. As nosological principles of division we employ the following:

1. Symptomology or phenomenology
2. Etiology of the illness under consideration

That is, we divide illnesses, on the one hand, according to the appearances of the illness (that is, the symptoms or phenomena that it produces), and on the other hand, according to how they developed. We thus distinguish between pheno-psychological and pheno-somatic, and somatogenic and psychogenic illnesses (see Figure 4).

To begin with, we encounter psychosis as an illness that has psychological symptoms (pheno-psychological), yet is brought forth by somatic causes (somatogenic). That is not to say that one has scientifically investigated the supposed somatic causes of psychosis. (If one likes, one could speak of psychoses as "crypto-somatic" illnesses.) In contrast, Kurt Schneider calls it the scandal of psychiatry that the somatic illness that underlies endogenous psychoses is still unknown. But it is not to be assumed that a somatogenic illness cannot be treated psychotherapeutically.[1]

Above, we have demarcated the borders, and where there are borders there are also borderline cases. Only one must not succumb to the temptation to prove or refute anything using borderline cases, for with the aid of borderline cases anything can be proven or refuted, and that also means that nothing can be proven or refuted. Jürg Zutt once rightly observed that

		SYMPTOMOTOLOGY	
ETIOLOGY		**Pheno-psychological**	**Pheno-somatic**
	Somatogenic	Psychosis	"Ordinary" illness
	Psychogenic	Psychoneurosis	Somatic neurosis

Figure 4

[1] See the section below, "The Psychotherapy of Endogenous Depression."

some living creatures are such that one cannot say whether they belong to the kingdom of plants or animals without some deliberation. Nevertheless, it would not occur to anyone to contest on these grounds the fact that there is an essential difference between plants and animals. Heyer expresses something similar when he notes that from the existence of hermaphrodites nobody claims the right to deny the essential difference between man and woman.

It should also not be contested that the psychological and the somatic (that is, not only the psychogenic and the somatogenic) represent an inner unity in the human person—the psychosomatic unity of the essence of the human being. However, one cannot overlook that unity is not the same as identity or wholeness. That is, however closely bound together the psychological and the somatic are in human nature, nevertheless we are dealing with two essentially different kinds of being, and the only thing that they share in common is that they are kinds of one and the same being. But between these kinds of being there exists an unbridgeable gap. We can never get past the fact that something like the physical lamp that I see in front and above me is bright and round, while the psychological perception of this lamp, or the equally psychological presentation (*Vorstellung*) of it (as soon as I close my eyes) is nothing less than it is bright and round. A presentation can, for example, be vivid but never round.

It is a question itself how one can preserve and rescue the unity of the human person in theory, in our view of human nature, in the face of this unbridgeable gap between the psychological and the somatic as essentially different kinds of being. In my view, this is only possible within the framework of a dimensional-ontological view of the psychophysical problem. For as long as we speak of these forms of being in terms of layers or levels—that is, somewhat in the sense of Nicolai Hartmann or Max Scheler—then the danger continues to exist that the essence "human being", so to speak, falls out into a physical and a spiritual essence, as if this essence, as if the human being were "put together" out of body and soul (and spirit). But if I, for example, take the drinking glass that is sitting here in front of me on the table and project an image of it onto the level of the tabletop, then we get a circle; and if I project an image of the glass from the side angle, then the resulting image is a rectangle. Nevertheless, it will not occur to me to make the assertion that the glass is put together out of a circle and a rectangle. Just as little am I entitled to say that the human person is put together out of body and soul (and spirit). And for precisely this reason the bodily and the mental may not be viewed as self-standing levels or layers, but rather as dimensions of the unified-wholistic essence of the human being. Only then can this unity and wholistic nature be adequately

anthropologically comprehended. Only then can we understand the compatibility of the incommensurable, and the unity of the essence of the human being despite the manifoldness of its constitutive dimensions.

Thus we hold fast to the idea that despite the unity of the essence of the human being there is a difference in principle between its constituents, the somatic and the psychological. (Shortly, we will have to discuss the spiritual (*Geistige*)—a constituent that is essential to the human being.) And it matters not that between psychogenesis and somatogenesis there are only differences of degree. My teacher, Oswald Schwarz took care to draft the following schema (see Figure 5).

In this schema, the verticals indicate different illnesses with a greater or lesser degree of psychogenic or somatogenic contribution. An illness is thus always more or less psycho- or somatogenic. The position of a disease in the above framework is one of difference, and the vertical position of a given disease is shifting. But the diagonal line exists as a sharp and fixed boundary; it represents the boundary between the psychological and the somatic spheres as such, each as an ontological region, each as an anthropological dimension.

By the way, it holds true that an illness may be to some extent always both: it may reveal a psycho- as well as a somatogenic component, only in varying proportions. So what is most important for us physicians, as therapists, from a pragmatic point of view, is not the extent to which the etiology is psychogenic or somatogenic, but rather what presents itself as primary at the time, psychogenesis or somatogenesis. The old wise saying, *qui bene distinguit, bene docet* (he who distinguishes well, speaks well), can be modified to apply to our demand for a targeted therapy: *qui bene distinguit, bene curat* (he who distinguishes well, cures well).

Now, we do not deny that one can sometimes justifiably speak of a primary psychogenesis or somatogenesis on grounds that in a given case the psychological and the somatic causal components join together in a causal ring such that the somatic is always conditioned by the psychological and the psychological is conditioned by the somatic. Such a denial would be unjustifiable insofar as a causal ring can only be spoken of

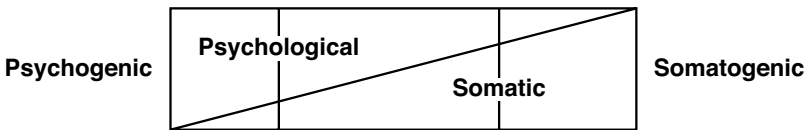


Figure 5

in a cross-sectional view of the event of illness; whereas a longitudinal view quickly shows that in reality we are dealing with a causal-spiral, that is, it shows that in individual, concrete cases it can indeed be determined where the circular event took its starting point, whether in the psychological or the somatic realm, even if later it comes to a mutual determining of the psychological and the somatic. (This position is not open to the objection that our question about primary causes reminds one of the question of what came first, the chicken or the egg; for in an individual, concrete case, in the case of the chicken sitting before me now and of the egg lying in front of me, I could very well decide which was there first.) The causal ring presents only a projection of the causal spiral, that is, the subtraction of a dimension—in the case before us, the dimension of time.[2]

If we return to the point of departure of our deliberations, then we can define neurosis as a psychogenic illness, but more than this, as a primary psychogenic illness. At least this definition will hold true of neurosis in the narrower sense—that is, not of pseudo-neuroses.

If we, so to speak, zoom in on the lower, right-hand section of Figure 4, then we find that with organ neuroses—as psychogenic, pheno-somatic illnesses—we are always dealing with the effects of the psychological in the somatic realm. If we now contrast a pseudo-neurosis (that is, a neurosis not in the proper sense, but rather in a broader sense) with the case of a genuine, organ neurosis, then we would need to distinguish between an "effect" and a mere "triggering (*Auslösung*)." (This distinction between effect or cause, on the one hand, and mere triggering, on the other, is important not only in relation to neuroses, but also psychoses: Psychoses as somatogenic (pheno-psychological) illnesses can under certain conditions—despite its principle somatogenesis—very well be triggered by psychological factors.)

There are, namely, also illnesses that are only triggered by the mental—not properly caused or even properly conditioned by the mental, not psychogenic in the narrow sense of the word. Illnesses that are not caused by the mental but merely triggered, we will call psychosomatic illnesses (see Figure 6).

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[2] See H. J. Weitbrecht, *Kritik der Psychosomatik* (Stuttgart, 1955), pp. 87–88: "The idea of psychosomatic simultaneity which is today widely viewed as the philosopher's stone, concretely leads to a dubious simplification of the body-soul problem . . . prescinding from the triviality that with everything mental something bodily comes into play, even if it is only as a support. Out of a desire for an apparent knowledge of the whole, the fullness of the problems of succession, of the flow of events in time, of the compensation and decompensation of the reciprocal relationships between the rows of bodily and mental phenomena, is left out of consideration. . . . From the discovery of a mere stirring up of the bodily-mental layer on the organic, to the repercussions of a bodily-mental execution on the supporting level, there are numerous forms of possible relationships."

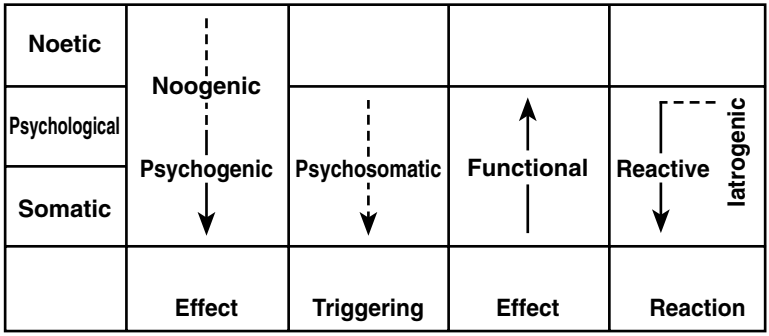


Figure 6

It is also possible that we are dealing with a genuine effect, but not—as in cases of genuine organ neuroses—with the effect of the psychological in the realm of the somatic, but rather the opposite, with an effect of the somatic in the realm of the psychological. As we already know, such illnesses—the pheno-psychological and somatogenic, according to our Figure 4—are by definition psychoses. In a certain context, which we now refer to as pheno-psychological, somatogenic illness, we are dealing nevertheless primarily with disruptions of vegetative and endocrine functions that sometimes progress monosymptomatically, and whose one symptom is precisely psychological; in this context it would naturally be out of the question to call such illnesses psychotic. Compare the case that Hans Hoff has in mind when he speaks of "inborn or acquired anomalies of autonomous (vegetative) reactions," in which "the patient swings in the sympathetic or parasympathetic direction" and in which "anomalies of the endocrine glands play a role." Thus, we consciously prescind from psychoses, and we may do this, for we intend only to speak of neuroses and pseudo-neuroses, or neuroses in the narrower and broader senses. Now, conditions that are similar to neuroses, in which we deal with the effects of the somatic in the psychological realm, we will refer to as functional illnesses (or pseudo-neuroses).

When a given patient somehow manages to react psychologically to the effects of (vegetative and endocrine) somatic functional-disturbances (as we just denoted them), then we are dealing with a psychological repercussion of an originally somatic disturbance. And these repercussions, these reactions, we refer to as reactive neuroses. Whereby we certainly must add that with reactive neuroses we sometimes find a neurotic reaction to something psychological, which is not somatogenic—precisely in the sense of functional illnesses—but rather psychogenic.

Now it can be that at the same time "behind" a reactive neurosis or a neurotic reaction a doctor stands, insofar as the occasion of the neurotic reaction was a thoughtless or unconsidered statement of the doctor. In such cases—so to speak, a subgroup of reactive neuroses—we speak of iatrogenic neuroses.

And it can be that at the same time "beyond" the psychogenesis of a psychogenic neurosis (now we are no longer speaking of merely organic neuroses) the proper cause of the illness is not to be sought in the psychological realm, rather in a realm that essentially lays above the psychological: namely, in the noetic realm, in the realm of the spirit (*Geistigen*). In such cases, where in the end a spiritual problem, a conflict of conscience or an existential crisis provides the etiological foundation of a neurosis, we speak of noogenic neuroses.[3]

In the spiritual realm we are dealing with a dimension that we have until now left out of sight as we spoke of the somatic and the psychological dimensions of human nature, and possible dimensions of being ill. This third, spiritual, dimension belongs to full human nature—to its "wholeness" (see above)—not merely as an added proper dimension, but rather it is, even if not the only, still the proper dimension of human nature insofar as the human person as such is only constituted in those (spiritual) acts in which he or she, so to speak, is lifted out of the somatic-psychological level and into the spiritual.

[3] The term "noetic neurosis," as well as the expression "existential neurosis" (von Gebsattel), we would decline to use for the simple reason that the noetic or the existential per se can never be neurotic, and consequently, neurosis cannot be noetic or existential; existential frustration, for example, can indeed be pathogenic (it need not be, it is thus only possibly pathogenic), but it is not pathological.

Preview

Chapter 2. Endogenous Psychoses: On Psychoses Caused by Somatic Disorders

This chapter is devoted to examining endogenous mental illnesses, or pheno-psychological, somatogenic disturbances. Although such a category also includes schizophrenia and bipolar disorders, the primary focus of this chapter is on endogenous depression or what the *Diagnostic Statistics Manual* today calls "Major Depressive Disorder with Melancholic Features."

- Psychotic illnesses may be, but need not be, triggered by critical psychological events, such as the experience of extreme stress or very sudden relief. Nevertheless, they remain primarily somatogenic.
- Psychotic illnesses are capable of being shaped by many variables, including personality traits, the Zeitgeist, and free attitudes and responses of a person.
- Existential analysis seeks to reveal the person who may appear hidden behind psychotic symptoms.
- Logotherapy posits that in every person suffering from a psychosis, there is an uninjured spirit, a person with some residual freedom.
- By definition, logotherapy is a therapy that engages the spiritual dimension of the person. The logotherapeutic treatment of psychoses involves two key elements. First, encouraging patients to distinguish between themselves and their illness processes, thus distancing themselves from such processes. Second, encouraging patients to engage their illness, for example, by accepting the illness or by choosing not to act on delusional beliefs (e.g. paranoid beliefs or the belief that life has no value).
- Psychotic illnesses such as endogenous depression require a two-pronged treatment. On the one hand, drug therapy is indicated to treat the underlying somatic cause or at least to treat the symptoms. On the other hand, psychotherapy is indicated to assist patients in adopting adaptive attitudes toward their illness and to prevent secondary depression (i.e., depression about the fact that they have the illness of depression).
- In-patient treatment may be indicated when patients are suffering from extreme self-reproach (due to their inability to work or otherwise perform) or when they are at risk of committing suicide.

- Suicidal thoughts are not as dangerous as suicidal intentions. Suicidal intentions suggest that the patient has already adopted an intention to act on suicidal thoughts. Patients should be asked whether they have suicidal intentions. If they deny having suicidal intentions, they should be asked why they choose to live rather than to kill themselves. Those who have difficulty providing convincing reasons why they should live are at risk of committing suicide and may need to be involuntarily committed.

Chapter 2
Endogenous Psychoses: On Psychoses Caused by Somatic Disorders

What follows is not really meant to introduce new material; rather the old will be newly organized and the new integrated with the old. We have already introduced a division of human illnesses according to two principles of division: symptomatology and etiology. We then distinguish between pheno-psychological and pheno-somatic illnesses—according to whether their symptoms are psychological or somatic—and regarding etiology, between somatogenic and psychogenic illnesses. According to this schema of division, psychosis falls under the pheno-psychological, somatogenic illnesses.

The somatogenesis of psychoses certainly may not be presented in a strictly cross-sectional manner; rather it also encompasses—as soon as a longitudinal view is taken—hereditary genesis.

Just as the interrelations discovered by so-called, self-described psychosomatic medicine do not suffice to cast doubt on the somatogenesis of "illness in the banal sense of the word," just so little does the "scandal of psychiatry" described by K. Schneider (see above) change anything about the principal somatogenesis of psychotic illnesses, and despite all the qualifications that must be discussed individually, we maintain the somatogenesis of such illnesses. Under such "scandalous" conditions, there is nothing to prevent us from speaking of "cryptosomatic-genesis" so that the child has a name.[1]

[1] *The scandalous condition that he refers to here and above is that frequently the underlying somatic cause of a disease is not known or understood.—JMD*

Such principal somatogenesis certainly does not exclude a partial psychogenesis. Only "partial" must be understood structurally, not quantitatively. Somatogenesis and psychogenesis, as well as noogenesis and sociogenesis, which remain to be discussed, cannot be quantified. What matters much more is the significance attached to each factor, and this significance is localized in different dimensions of human nature. For even psychosis extends into different dimensions of human nature, and psychiatry must follow them into all of these different dimensions. We do not have to add all the individual elements and moments; rather we have to dimensionalize them. Above all, there is one thing we must not do: contaminate them, insofar as we mix up the individual dimensions. This occurs, however, through the confusions that will be discussed in what follows.

Cause and Effect

What we call a "secondary rationalization" is a well-known phenomenon to us psychiatrists. We confront it, for example, when a paranoid schizophrenic patient interprets the hallucination of a bodily feeling in a certain direction, say he regards himself as possessed by a devil as we saw in earlier times, or say he believes he is under the influence of hypnosis as we saw over the past few decades, or say he incorporates radar into his delusional explanatory system as we now sometimes see. But do we not also see that the relatives of our patients also secondarily rationalize? We hear, for example, that a broken engagement is to blame for the schizophrenia of a daughter, or the more or less excessive masturbation of a son is to blame for his psychosis. In all of these cases we deal with a confusion of *post et propter hoc* (of "after this" and "because of this"), whereby what is always overlooked is that the constant *hoc* ("this") was an effect. To stay with our last example, excessive masturbation was not the cause, but rather was already an effect of the illness. In other words, we are dealing with not only a pathogenic, but much more with a pathognomic factor. But psychiatrists cannot properly throw stones in this regard, for we ourselves are not always free of the tendency toward secondary rationalization. For how often do our causal needs play a trick on us? In particular, it is the oft cited and pathogenically incriminating traumas, complexes, and conflicts that often are precisely not to be evaluated as pathogenic but rather only as pathognomic.[2] That psychological traumas and complexes surface at all, or that someone is not able to cope with his conflicts, certainly belongs to the symptomatology, but not to the etiology of the relevant psychosis.

[2] *That is to say, they do not cause the given pathology, but are signs of it.—JMD*

Let us consider the example of those suffering from endogenous depression. As we tried to show elsewhere, they experience and live through the tension that is proper to being human, between what is and what should be, to an exaggerated degree. The patients bring the difference between their "should" and "is" under the enlarging and distorting view of the magnifying glass of their endogenous depression. The distance between what is and what should be is experienced as though it were an abyss. But in itself, the tension between what is and what should be—the "existential tension" (*Daseinsspannung*), as we also call it—in itself, the distance between what is and what should be is irresolvable and unalterable. As long as the human person is conscious, there will be a negative balance of his being against his should. It is in no way as if this exaggerated existential tension, this is–ought abyss gives rise to endogenous depression, but rather the endogenous depression gives rise to the abyss (in the sense of pathognomy). It is not the existential tension that makes the person ill; rather it is the illness of endogenous depression that allows the patient to perceive the tension in a distorted and enlarged manner.

And what is endogenous depression in itself? Despite everything else, it remains somatogenic—a "somatosis." Indeed, it may be best characterized as a vital depression. However, it may also be permissible to speak of an ebb of *biotonus* or vitality.[3]

Now what is the case when a reef appears at low tide? No one will say that the reef is the cause of low tide, but rather, through the ebbing tide it is merely exposed. But is it otherwise with the abyss between what is and what should be? Is it not merely made apparent, merely exposed through endogenous depression, through this vital ebb? Thus it is valid to say: just as little as the reef is caused by the ebbing tide, is a psychosis caused by a psychological trauma, a complex or a conflict.

To remain with the analogy of the ebbing tide, as the tide continues to ebb, the reef gains mass. Something analogous is seen with the vital ebb called endogenous depression. For example, we know an endogenously depressed patient, who during World War I helped out by replacing drafted men as postal carriers, and decades later on the occasion of an endogenous-depressive phase he admitted during his medical history that he stole a post bag at that time. Now it is well known that real guilt hardly ever presents itself in the self-accusations of endogenously depressed patients. Actually, upon closer questioning, it turned out that the theft was of an old, empty sack—without mail! That this little misdeed even came to

[3] *Frankl cites Ewald as using the term "biotonus" which means "vital energy" or vitality.—JMD*

mind is already the effect of the endogenous depression, but not a cause of it. Neither the great subjective guilt nor the small objective guilt was in this case pathogenic; they were only pathognomonic.

Causing versus Triggering (*Auslösung*)

Prescinding from the reversal of the relationships between effect and cause which we just discussed, psychiatry no less often succumbs to the error of ignoring the distinction between genuine psychological causation on the one hand, and mere psychological triggering on the other. Illnesses that are not caused, but rather only triggered by the mental do not deserve the label "psychogenic," rather we are dealing with a "pseudo-psychogenesis."

Now it is trivial to point out that psychological illnesses, and thus also psychoses, can for example be triggered by excitement. Only it is important to note that such excitement need not be of a frightening nature; rather excitement of a joyful kind can also trigger a psychological illness. In any case, we are dealing with a kind of effect of psychological stress. On the other hand, one should not overlook the fact that not only extreme strain, but also relief—for example, very sudden relief—can play a role in the psychological triggering of an estimable pathogenic factor. In this regard, I will simply mention the characteristic situation of the release from the concentration camps or a prisoner of war camp.[4]

Nevertheless, it belongs to the essence of psychotic illnesses that under certain conditions they do not first require a triggering. And speaking of concentration camp imprisonment, we know a patient who became manic in the Dachau camp, but who after his release—despite the joyful surprise of an extraordinarily favorable chance to emigrate—became heavily depressed in the sense of a melancholic phase. All this speaks of the complete independence of a genuine psychosis from fate, or if you like, of the fated nature of psychotic processes themselves. In this regard, the statistical investigations of J. Hirschmann have sufficiently clarified the relative stability of the *Umwelt* of psychoses, indeed, even neuroses.[5]

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[4] See *The Doctor and the Soul* p. 81, (German Edition, 1946), "The sudden release, the release of mental pressure, means . . . a danger. In terms of character, the threat it poses is none other than the mental counterpart of Caisson's disease." *Note: A caisson is a structure used in underwater work. Caisson's disease thus refers to decompression syndrome.—JMD*

[5] See also Max Malzacher, Joerg Merz, & Daniel Ebnoether, "Einschneidende Lebensereignisse im Vorfeld akuter schizophrener Episoden," *Arch Psychiatr Nervenhk 230,* 227, 1981. After examining a population of 70 patients experiencing their first schizophrenic psychosis, Malzacher and his colleagues from the research department of the University Psychiatric Clinic Zurich were not able to confirm the triggering function of drastic life events for schizophrenic psychoses postulated by Brown & Birley.

Finally, there is also the triggering of psychotic illnesses—far removed from any causality!—a well-known and recognized fact in the somatic realm. We recall the typical triggerability of psychotic hallucinations through somatic complications like *typhus abominalis* or *commotio cerebri*. But not only such pathological, but also physiological processes can act as triggering factors from the somatic realm. Let us just mention that puberty presents itself as a typical time for the manifestation of schizophrenia (it is owing to this prevalence that this condition was once called premature dementia), while menopause is worth mentioning as the most typical time for endogenous depression. Both puberty and menopause suggest a triggering stemming from the endocrine system; nevertheless, it will not occur to anyone to characterize endogenous depression as merely an endocrine disorder.

It is obvious that precisely in cases of menopausal triggered endogenous states of depression a cotemporal triggering by psychological factors also comes into question. We are thinking of the "eleventh hour" panic (*Torschluss-panik*) and the existential balance—the balance of that which life owes to a person, and of that which a person owes to life. When this balance turns out to be negative—even only if subjectively or apparently—then, if you like, we are dealing less with psychological triggering of an endogenous-depressive psychosis, and much more with a combination of an endogenous and psychotic depression with a psychogenic and neurotic depression.

If we ask ourselves wherein exists the final and proper difference between triggering and causation, then we see that in one sense triggering is itself a cause, even if not the primary cause, but rather, so to speak, a secondary cause. But triggering is not the only secondary cause in this sense, but also what one generally calls a condition. To condition something likewise does not yet mean to effect or cause something. Now, it is well known that there are so-called necessary and sufficient conditions. We could say that while the primary cause can be interpreted as a sufficient condition, triggering—insofar as it can be understood as a kind of condition—as a secondary cause, is not only not a sufficient condition, but also not a necessary condition. We need to create for it a new term: a merely possible condition!

Psychological Pathogenesis and Psychological Pathoplasty

Pathoplasty is the shaping of disease. Frankl's discussion of pathoplasty follows.

Thematic Pathoplasty

In the broadest sense of the word "psychogenic" means "contents," for example, the content of a delusion—a fact that has long been conceded or has been maintained for a long time. In any case, such psychogenic material (in the broadest sense) enters into the theme of delusional ideas.

It is to the credit of psychoanalysis that it analytically investigates factors that contribute to the theme of delusional thought processes, often with the intention of pursuing them back to infancy.[6] Quite correctly, for it is self-evident that the individual as the temporal Gestalt that it is literally unfolds and rolls out in life in such a manner that an overview of the elapsed life affords an insight into the individual, the individual as such.

Individual Pathoplasty. But this holds true not merely of the pathological, it is normal that this or that content of consciousness predominate according to the individual. And in cases of later illnesses we would speak of these predominant contents of consciousness in their totality as the premorbid personality. The thoughts of the patient circle around them as a theme—"as a needle that gets stuck in the groove of a record," as one patient so perfectly put it. So it is that one patient cannot get over his guilt, whereas with another it is less his guilt—his moral debt—but rather his debts, his financial debts. In the first case we are dealing with a delusion of sin, in the former with a fear of poverty. If hypochondriacal delusions come to the fore, then this leads again to a fear of illness.

Collective Pathoplasty. Now it is self-evident that the choice of delusion, as we would like to call it, depends not least on a collective fund of thought. Today, it is conditioned by the collective thinking of our time. And it is in this sense that one has rightly spoken of a sociogenesis within the etiology of psychoses. This happens in a para-clinical sense, in the same sense in which we speak of a collective neurosis. We are right to speak of collective psychoses insofar as we understand by that nothing more than the total sociogenic and collective elements and moments as they time and again find their way into the individual psychosis, that is, psychosis in the clinical sense.

To trace their path would be the task of a pathology of the Zeitgeist (spirit of the age). However, psychoses themselves would always be the expression and reflection of such pathology; for the predominating ideas are directed by time, by the Zeitgeist, by the illness of the Zeitgeist—they

[6] *The emphasis appears in the German original. Here as elsewhere, Frankl is at pains to make clear that — although he is an outspoken critic of the reductionistic tendencies of psychoanalysis—he finds much to praise in the work of Freud and his successors.—JMD*

are always directed by time and change with time. In other words, we continually observe changes in the dominance of pre–dominating ideas.

So we know that the typical, masked (*larvierte*) endogenous depression in the 1920s was ordinarily masked under the images of scrupulous obsessive-compulsive presentations, while today they are predominantly hypochondriacal presentations of fear, they develop under a phobic model and for this reason as a matter of diagnostic etiquette fall under the label "vegetative depression." Who should be surprised that in such a time endogenous depressive thoughts seldom revolve around the theme of guilt,[7] but rather around the foreground content of bodily health and the capacity for career work.[8]

Stylistic Pathoplasty

Psychological pathoplasty, and in this sense (but only in this sense) "psychogenesis," makes itself noticeable and valid not only thematically, but also stylistically with regard to the whole "lifestyle" (Adler). And what matters most to us is that the style of being (*Daseinsstil*) of the premorbid personality can be pursued into its psychotic caricature.

In this regard, we owe much not only to the individual psychology of A. Adler, but also to what L. Biswanger contributed with his Daseinsanalysis to the "style analysis" of psychoses. That is said without denying that the initiate will know how Daseinsanalysis amounts to an ontologizing of individual psychology's theory of the "tendentious apperception."

Personal Pathoplasty. Beyond everything individual and personal we now see that psychosis is more than a mere form of illness; it is always also a way and possibility of being human. With reference to endogenous depression, special existential analysis[9] has found that the illness of endogenous depression per se presents itself as neither more nor less than a vital slump (*Baisse*). However, we must ask, how does existential analysis in general present people who suffer from depression? As creatures who are responsible to their should for their being. Earlier we heard that persons suffering from endogenous depression experience this existential tension overly intensely in a specific manner. Now, the vital slump in itself would produce no more nor less than a feeling of vague insufficiency. However, that the person affected by this illness would not merely crawl into a corner like a wounded animal, but would experience his or her insufficiency as guilt

[7] H. Kranz, "Fortschritte der Neurologie," *Psychiatrie usw. 23,* 58, 1955.
[8] A. von Orelli, *Schweizer Archiv für Neurologie, 73,* 217, 1954.
[9] Viktor E. Frankl, *Ärtzliche Seelsorge, I* (Auflage: Wien 1946).

over against his or her conscience or God—all this lies not in the illness of endogenous depression, but is rather the contribution of the human person to the illness. It corresponds to and arises from an interaction of the human in the one who is ill and what is ill in the human. It extends far beyond the mere vital slump, beyond a psychosomatic event; what we are dealing with is rather an ingredient of the person, something personal and as such something transmorbid, for the person is spiritual and as such, is beyond being healthy or ill.

Existential Analysis of Psychoses

The task of existential analysis is to point toward and to illuminate the personal dimension of psychosis. It attempts to allow the person to be seen through the veil of the episode, to transcend the image of illness to reach an image of the person. The image of illness is merely a caricature and a shadow image of the real person, a mere projection of the person into the clinical level from the dimension of the person that is essentially beyond neuroses and psychoses. Existential analysis pursues the phenomena and symptoms of neurotically and psychotically ill existence in this metaclinical space.

Now in this space existential analysis discovers and awakens something. What it discovers is a humanity that is uninjured and incapable of being injured. Existential analysis tries to teach us how to make this visible even through the veil of neurotic derangement and psychotic madness.[10]

Like other, formerly unconscious contents, so too can unconscious religiosity be raised up into consciousness precisely in and through the psychosis. So too can something genuine and original be manifested in psychosis that remains latent in normalcy, covered and hidden by the average and mundane.

In general, it also remains obvious that a functionally reliable psychophysical organism is the condition for the unfolding of the human spirit. It is just that we cannot forget that the psychophysical, as much as it may condition the spiritual, nevertheless cannot cause or produce the spiritual. Moreover, it cannot be overlooked that it is always the psychophysical organism alone that is affected with a psychotic illness. After all, a psychophysical functional disturbance has the effect that the spiritual person—who stands behind, and as we will see, also somehow stands above the psychophysical organism—cannot express him or herself, cannot be divulged. It is this—and nothing more nor less—that psychosis means for the person. We also read in R. Allers, "illness hinders the person in his or

[10] It is the enduring achievement of H. Baruk to have made the first advances into the region.

her self-divulging." And in this context, the author does not neglect to point out explicitly that this holds true even "in conditions of severe abnormality, for example, a high degree of mental retardation resulting from insufficient development of the brain or with highly advanced dementia resulting from damage to the brain."[11]

The human spirit is dependent upon the service of its body. Indeed, more than this, this body can terminate its service; analogous to talk of a *potentia oboedientialis*, I have spoken of an *impotentia oboedientialis*.[12]

As soon as the person cannot be discerned, because the psychosis has barricaded the person and kept him or her from my view, I can no longer provide therapy, and an appeal to the person will fail. Thus we find that logotherapeutic treatment is considered only in cases of clinically light to moderate cases of psychosis.

The Interpretation of Meaning and the Search for Meaning

It is well known that one distinguishes between the discovery of meaning (*Sinnfindung*) and the bestowal of meaning (*Sinngebung*). The attempt to interpret the meaning of a hallucination, which was discussed above, can be understood as the discovery of meaning. Only we cannot forget that in interpreting a hallucination we are dealing with a meaning for me as a physician; but we need to ask whether a psychosis itself contains a meaning, not for me as a physician but for the patient. In our opinion, psychosis does in fact have a meaning for the patient, only this meaning is not given, rather remains to be given; the meaning of the psychosis remains to be given by the patient him or herself. It is the patient who has to give his or her illness meaning. Above all, he or she must find it, must search for it.

Now we remind ourselves that existential analysis aims not merely to discover, but also to awaken something. What it discovers is the uninjured humanity, which is also beyond injury. Three existential traits (*Existentialien*) constitute (not merely characterize) human existence as such, as human: the spirit, freedom, and responsibility. And as soon as

[11] *Frankl provides no reference for this quotation.—JMD*

[12] See Viktor E. Frankl, "Dimensionen des Menschseins," *Jahrbuch für Psychologie und Psychotherapie, 1,* 186, 1953. One who sees only the biological, psychological and the sociological determining factors of the human person, but not the spirit's power of defiance (*Trotzmacht des Geistes*), is like one who looks at a car and only sees the gearshift, but not the clutch. The human person can distance him or herself from the three "gears" of instinct, heredity, and the environment, and through the spirit's power of defiance the person can also "disengage" vital and social influences. That this power of defiance is not always necessary is a different matter altogether. Fortunately, the human person must not use it unflinchingly, for the person asserts him or herself *thanks* to his or her heredity and environment, and *through the power* of instincts at least as often as *in spite* of these.

existential analysis attempts to find the spirit even in psychotic human existence, it also seeks to awaken freedom and responsibility.

In fact, inherent to psychotic existence is a degree of freedom—freedom against being subdued by the psychosis—and a last remnant of responsibility—responsibility to overcome the psychosis, to shape the fate that is called psychosis; for this fate remains malleable and awaits to be shaped.

Positing and Appealing

Existential analysis posits (*ekphoriert*) an uninjured spirit that is incapable of being injured, and which stands behind the psychosis, and it appeals (*appelliert*) to a freedom that also stands behind the psychosis—a freedom to engage the psychosis to some extent, whether this means resisting it or reconciling oneself with it. In other words, existential analysis, insofar as it is psychotherapy or becomes logotherapy, posits not only the spirit, but it appeals to this spirit—it calls to the defiant power of the spirit. In so doing, we are aware of how much contemporary psychiatry abhors the expression "appealing." But has not W. von Baeyer said, "The physician's pedagogy of the mentally ill appeals to freedom and responsibility"?[13] Has not J. Segers said that "certainly it takes moral courage to appeal to a responsible freedom" and that "we must, however, reach this level within the sanitorium"? Has not E. Menninger-Lerchenthal indicated that "melancholy sometimes does not advance to the core of a personality, in which a person's fundamental attitude is anchored"? It is our view that a human person who is suffering from an endogenous depression can, as a spiritual person, defy this affect of the psychophysical organism and keep him or herself out of the events of the organic illness. In fact, with endogenous depression we are dealing with a psychophysical affect, for the psychological and the physical are equally involved. Hand in hand with psychophysical depression go somatic anomalies of menstruation, secretion of stomach acids, and the like. The individual is endogenously depressed with the stomach, the skin and hair, with the body and soul, but never with the spirit. Rather it is the psychophysical organism alone that is affected, but never the spiritual person, who as such, as spiritual, is unable to be affected by disease. Whether *ceteris paribus* the one person distances him or herself from endogenous depression, while another allows him or herself to fall into this depression is not determined by the endogenous depression, but rather by the spiritual person. And so we see how

[13] W. von Baeyer: Lecture to the first meeting of the Deutschen Gesselschaft für Psychiatrie und Neurologie, on April 1 and 2, 1955, in Bad Nauheim.

psychophysical parallelism is contrasted to a psychonoetic antagonism. It is our aim to invoke the latter.

Existential Analysis of Psychosis

L. Binswanger's Daseinsanalysis[14] focused much less on the possibility of calling upon or appealing in such a manner. Not that this should be weighed against it in a comparison of Daseinsanalysis and existential analysis. The main concern of Daseinsanalysis is not psychotherapeutic, at least according to M. Boss, who wrote, "Daseinsanalysis has nothing to do with psychotherapeutic praxis." Whereas existential analysis tries to assist in the treatment of neuroses, Daseinsanalysis has the merit of having contributed to our understanding of psychosis. (In this sense, Daseinsanalysis and existential analysis are not opposed to each other, but are complementary.) For the sake of this understanding, Daseinsanalysis needs to focus on the unity of "being-in-the-world" (M. Heidegger), while existential analysis turns toward the diversity within the unity; the unity must be analyzed into the dimensional multiplicity of existence and facticity, of person and organism, of the spiritual and the psychophysical, in order to be able to appeal to the person or to call upon the defiant power of the spirit. If we were to allow the spiritual person to be incorporated into a noo-psycho-physically neutral Dasein, then to whom should such an appeal or call be addressed? The addressee would be unknown. Whose power of defiance should be called upon? Against which apparent power should it be played? In this picture of the human being it is no longer possible to distinguish between the spiritual person and the organic process of illness. Endogenously depressed human beings could no longer distance themselves from themselves. The human being would be uniformly endogenously depressed, for the psychotic person whose "that's how it is and nothing can be done about it" way of being-in-this-world (*Nun-einmal-so-und-nicht-anders-in-der-Welt-Sein*), which Daseinsanalysis so successfully and meritoriously attempts to illuminate, would in this manner of being-in-this-world be so thoroughly determined and governed, the psychotic person would be so through and through caught in his or her way of being-in-this-world, that one would have to speak of an infiltration, absorption, and diffusion of such a Dasein.[15] In the framework of Daseinsanalysis, the psychotic

[14] *Binswanger's "Daseinsanalyse" is often translated in English as existential analysis. I've used the term Daseinsanalysis because there is precedence for doing so in English and in order to distinguish this term from Frankl's Existenzanalyse—also translated as existential analysis.—JMD*

[15] *Although the language in this paragraph is somewhat awkward, Frankl's phrases faithfully reflect the Heideggerian philosophy he is engaging here. This philosophy provided much of the impetus behind Binswanger's Daseinsanalysis.—JMD*

person has no way out of the psychotic skin of the "that's how it is and nothing can be done about it" way of being-in-this-world.

If we have at the outset demarcated the purview of psychoanalysis inasmuch as it claims to contribute to the understanding of the psychogenic dimension of psychosis, then we must remind ourselves that psychoanalysis understands itself as a form of dynamic psychology. In contrast, Daseinsanalysis would correspond with a psychology that could be characterized as static, while logotherapy, in contrast to both, must be characterized as an "appealing" psychotherapy. For logotherapy a biological fact such as psychosis is for all that far from being a biographical fact. For while Daseinsanalysis focuses on the unity in diversity of "body-soul-spirit," logotherapy in contrast focuses on the opposite, the diversity in and despite of the unity of human nature; indeed it focuses on the spirit in a facultative antagonism with the body-soul that we—in contrast to psychophysical parallelism (which is an obligatory one)—characterize as a psychonoetic antagonism. The logotherapeutic thesis of the fatefulness of psychosis is not fatalistic. It is true that logotherapy recognizes no genuine psychogenesis of psychosis, but rather a "pseudo-psychogenesis," namely, a psychological pathoplasty. Nevertheless, it recognizes that psychotherapy is strictly indicated in cases of psychosis, naturally, only within the framework of a simultaneous somatic therapy.

Logotherapy with Psychosis

It has already been stated that psychogenesis exists in the genesis of psychoses only in the sense of a psychological pathoplasty. We further noted that, in this sense, there is also a noogenesis, that is, also a pathoplasty stemming from the spirit. Now it is self-evident that where there is a spiritual pathoplasty, there must also exist a spiritual psychotherapy — even for psychoses. But by definition, what we call "logotherapy" is a psychotherapy of the spiritual. This is where existential analysis shifts into logotherapy.

Logotherapy must make two points. Just as with the psychotherapy of neurosis, the patient must be brought to and encouraged to objectify the processes of the illness and to distance him or herself from them.[16] In other words, the patient should learn to stare into the face of things like fear and compulsions . . . and laugh in their face (the method of paradoxi-

[16] Logotherapy in cases of psychosis (a "logotherapy of psychosis" does not really exist) is essentially a therapy of what remains healthy, a treatment of the attitudes of what remains healthy in the one who is sick over against what has become sick in the human. For what remains healthy is incapable of becoming sick, and what has become sick is incapable of being treated by psychotherapy (not merely by logotherapy), rather it is much more amenable to somatotherapy.

cal intention). However, it is also the case that representing the illness as a fated occurrence and accepting it as fateful actually puts the patient in the position of being better able to actualize the facultative psychonoetic antagonism to the extent that the primary illness of all psychogenic neurotic reactions and the secondary superstructures and substrates are again exposed and reduced to their actual fateful core.

But the logotherapeutic treatment of psychoses must be concerned with more than this. It must not only objectify, but also subjectify the illness. It must prompt the patient to personalize the psychosis, to leave his or her stamp or image on it. In other words, we must ensure that an exchange occurs between the human in illness and the ill in the human.

Implicit Pathoplasty

The exchange between the human who is ill and what is ill in the human takes place in the form of a reconciliation. To take just one of many examples that are common for clinicians: one of our schizophrenic patients admitted that she did indeed hear voices; but she preferred this to being hard of hearing. H. J. Weitbrecht explains, "Nobility and downfall appear to be tragically interwoven;" one could add, "not seldom comically."

Now this concrete case in which a person seeks to shape her hard fate—acoustic hallucinations, a fate that we said is fundamentally malleable and awaits to be shaped—illustrates that this shaping can be achieved without the affected person being able to give the least account of what is going on in front of him or her. In other words, this achievement does not happen reflectively, it happens more implicitly; the exchange (in this concrete case, the reconciliation) is a thoroughly silent one. Everything proceeds unspoken—naturally, for the psychotic person precisely cannot do one thing: express him or herself. Precisely the expressive (and beyond that, the instrumental) function that serves the spiritual person, and which arises from the psychophysical organism, is disturbed.

Thus, existential analysis shows that, and to what extent, the fate called psychosis "remains malleable" and logotherapy shows that, and to what extent, "this fate awaits to be shaped." Now, however, we discover that this fate called psychosis is always already shaped, for the person was always at work, the person was always in the game, has always contributed to the shape of the illness, for the illness encounters and happens to a human being. An animal would have fallen prey to the ill affectivity; an animal would have to allow itself to be driven by the impulses of the illness. Only a human being can confront all that. And the person has confronted it all along, he or she has already done so as soon as we are faced with a delusion of becoming a pauper or a delusion of sin, as the case may be.

It is just that such an implicit pathoplasty should not be confused with the common assertion that the delusion presents the psychological reaction to a somatic process. For our part, the talk is not of psychological reactions, but rather of spiritual acts, namely, personal stances and attitudes toward psychosis. How much these spiritual acts and personal stances and attitudes are to be distinguished from mere psychological reactions can be clearly seen from the fact that respective personal stances and attitudes can, must, and will be taken toward the delusion itself.

It is imperative to distinguish sharply between the somatic, the psychological, and the spiritual. In individual cases a delusional jealousy truly is a psychological reaction to a somatic process; but that a paranoid person who is jealous in this manner—as in a concrete case known to us—would not be carried off by his delusion to carry out a murder, but rather goes and comforts and pampers his wife who has become suddenly ill—this is a spiritual change of attitude that must be fully attributed to the spiritual person, who was sane in this regard.[17]

Human Dignity and Life Worth Living

We spoke of the meaning of psychosis for me as a physician and said that it is to be discovered. Then we spoke of the meaning of psychosis for the patient, and said that the patient must bestow meaning on the psychosis. Now for the third and final counterpart, we must speak of the value of the patient to us. Was too little said about "lives not worth living"?[18] And ultimately, was not the life of psychotic patients meant by that? Now even if the prognostically most unfortunate psychotically ill person has lost all value of usefulness, he or she maintains his or her dignity, for the value rank of the suffering person (*Homo patiens*) is higher than that of the skilled person (*Homo faber*). The suffering person stands higher than the efficient person. And if this were not so, then it would not be worthwhile to be a psychiatrist. I don't want to be a psychiatrist for the sake of a depraved "psychological mechanism" or for the sake of a ruined mental "apparatus," not for a broken machine, but rather only for the human who is ill, who lies behind and stands above everything else.

[17] In this achievement, the fact that that no consequences were drawn, so to speak, from the delusion, testifies to the defiant power of the spirit. In the case before us, it is testified to by that alone, and not by some sort of insight into delusion as delusion or into jealousy as an illness, that is, not in a so-called insight into the illness.

[18] *The phrase "lives not worthy of living" was used frequently by the Nazis when speaking of those who were targeted for extermination, above all, the mentally ill. — JMD*

Psychotherapy of Endogenous Depression

Cryptosomatic Genesis and Somatic Simultaneous-Therapy. When one speaks of endogenous depression, it means that the endogenous depression as such, as endogenous (as opposed to being an exogenic, reactive, or psychogenic depression), is precisely not psychogenic, but rather somatogenic. Only one must remember that by somatogenesis we mean a primary somatogenesis, and it is clear that this provides latitude for the psychological pathoplasty that is intertwined with the somatic pathogenesis and completes the clinical picture. Psychotherapy is to be inserted into this latitude that is left open by the somatogenesis.

From the principal, even if merely primary, somatogenesis of endogenous depressed states it follows that its psychotherapeutic treatment cannot be a causal therapy. However, we must also bear in mind that somatotherapy, at least to the present day, is equally unable to act as a causal therapy.[19]

Not only the causes of the respective illness, but also the effects of the corresponding treatment are, as regards the mechanism whereby they are realized, hardly understood. One need only think of all the speculation with regard to the effective mechanism of electroshock.

Now, just as psychotherapy or somatic therapy makes little claim to be, or little intends to be, a causal therapy, it has great reason to be an active therapy.

Nevertheless, regarding such activity, a somatopsychological simultaneous therapy is to be recommended. For this reason, we would like to bring drug therapy into our considerations and reflections through a case analysis. We do so from a therapeutic point of view; from the point of view of diagnosis, we are dealing with an instance of masked endogenous depression.

Fritz T., 32 years old, is being treated elsewhere for anxiety disorder and carcinogenic phobia. In particular, he fears contracting a brain tumor. For this reason, he visited many doctors, among them well-known specialists, who conducted diverse tests, including an encephalograph, and underwent a wide variety of treatments. His case history showed that he did in fact have an uncle who suffered from a brain tumor and finally committed suicide. The patient himself suffered from a noticeable vasomotor related chronic headache. Despite all this, the picture did not strike us as a vasovegetative depression; rather we were looking in the direction of a vegetative depression, which is the typical characterization of those cases of

[19] *Frankl's point is that most medical interventions, e.g., pharmaceutical psychiatric treatments, control symptoms rather than cure disease by eliminating the cause (e.g., a genetic anomaly).—JMD*

endogenous depression in which specific vegetative problems are in the foreground rather than the usual hypochondriacal complaints. For, as we said earlier, whereas earlier scrupulous obsessive-compulsive ideas masked endogenous depression, more recently there has been a shift in symptoms such that scrupulous, in contrast to hypochondriacal themes, moved to the background. The hunch that this was a case of vegetative depression was confirmed as we looked for the typical characteristics of endogenous depression in the patient's medical history, which include: daily mood swings that are exacerbated in the morning and in remission in the evening, previous episodes, and corresponding heredity. In the case before us, the first two aspects were not difficult to establish. How was he to be treated? We would like to begin by illustrating the pathogenesis structure using a schema (see Figure 7).

The vegetative, masked, recidivistic, endogenous depression as such, as endogenous, is accompanied by a typical anxiety readiness. This anxiety readiness is itself contentless. Like every anxiety readiness it seeks out, and always finds, a content. In this concrete case, it related to the patient's headaches and immediately pounced upon a detail of the family medical history, namely, the brain tumor of his uncle. The brain tumor then became the concrete object of anxiety, the object of a phobia, that upon which the vague contentless anxiety became focused, whereby the headache and the illness of the uncle formed a kind of condensation nucleus.[20] Now this anxiety that a brain tumor could be causing the headaches leads understandably to a forced self-observation regarding the headache, and this self-observation alone is likely to exacerbate the symptoms—and in this fashion the vicious circle is completed.

It is time to consider somato-psychological simultaneous therapy. Corresponding to the vicious circle presented above, therapy must assume the form of a concentric attack against as many targets as possible. Above all, it must open fire against the endogenous-depressive substructure using a

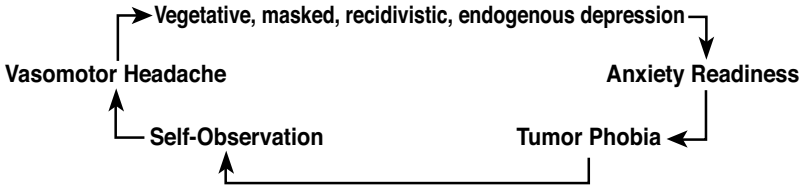


Figure 7

[20] *A condensation nucleus is a small particle upon which water vapor condenses to form drops of water or ice crystals.—JMD*

suitable medication. The following considerations will illustrate how such a case should be approached from the psychological side.

Pychotherapeutic Treatment of Endogenous Depression

Outpatient (Poliklinische) Care and Inpatient Treatment. In view of the primary somatogenesis of endogenous depression, it is clear that psychotherapy is appropriate only in mild cases. That is not to say that the psychotherapeutic treatment of endogenous depression must be limited to ambulatory, outpatient care. In other words, we should not act as though the range of cases in which psychotherapy is appropriate fully overlaps with those appropriate for outpatient care. It is not as though the indication of hospitalization and psychotherapy exclude each other.

Now, we know that hospitalization may be indicated either for the sake of treatment or due to the illness itself. Classical shock treatment as well as the use of medication—at least when medicines are used in very high doses—require an inpatient setting, if they are to be administered *lege artis*. It is well known that in such cases simultaneous psychotherapy should not go untried.

With regard to the illness itself, there are two reasons why we admit a patient. First, because an endogenous depressive state so typically goes hand in hand with a tendency toward self-reproach; second, because they often precipitate a no less characteristic suicidal tendency.

In cases of excessive self-reproach, the point of hospitalization is to create a distance between the patient and a milieu that brings with it a whole host of obligations, be they family related or professional in nature. We are dealing with obligations that bring about an interminable confrontation of the patient with what we like to call a "Triad of Failure." They are in reality three insufficiencies from which the patient suffers terribly:

1. An inability to work
2. An inability to feel pleasure (*Genussunfähigkeit*)
3. An inability to suffer (*Leidensunfähigkeit*)[21]

The patients' inability to work becomes the content and object of reproach that they themselves offer, but which they also hear from their surroundings, which only adds fuel to the fires of self-reproach.

[21] *Elsewhere, Frankl has distinguished between emotions that have biological causes vs. those that have a reason (i.e., are intentional or about something). See Viktor E. Frankl,* The Will to Meaning: Foundations and Applications of Logotherapy *(New York: Meridian, 1988), p. 37. He makes the same distinction below in chapter 5. Although those suffering from endogenous depression may feel melancholic (a biologically caused suffering), their ability to suffer for a reason is hampered.—JMD*

Analogously, admonitions like the following have a similar effect: "they should pull themselves together and take control of their self-reproaches." Such admonitions can produce an undesired, paradoxical effect insofar as the failure following such an attempt by the patient can be registered as a personal inadequacy and thus their subjective guilt balance sheet is put further into debt.

The same holds true of the well-meaning suggestion that "the patient should amuse him or herself," whereby one indirectly addresses the patient's inability to feel pleasure, rather than his or her inability to work.

With regard to the danger to the patient arising from a suicidal tendency, not merely hospitalization, but involuntary commitment is indicated. Now insofar as it is desirable to determine the degree of the threat of suicide, which either makes it advisable and appropriate to commit the patient to confined institutional care, or rather, to discharge the patient from the institution, we have specified a standard method that has always proven useful (not only for ourselves). It puts us in the position to construct a diagnosis of persisting suicidal danger or to diagnose the concealment of a suicidal tendency.

To begin with, we ask our patients whether they (still) entertain the idea of killing themselves. Without exception—in cases in which the truth is spoken as well as when the patient is concealing an actual intention to kill him or herself—this question is answered in the negative. At which point we ask a second question, even if it might sound brutal: *why do you not (or no longer) want to take your life*? And now it regularly turns out that those who really have no intention of killing themselves can immediately produce a series of reasons why they should not throw away their lives: that they now believe their illness can be cured, that they need to consider their family or to think about their professional obligations, that they are bound by their religion, and so forth. Whereas those who have merely tried to hide their suicidal intentions reveal that they have no answer to the second question; they react characteristically with embarrassment for they are at a loss for arguments that speak against suicide, which is why the patient is unable to provide a motive for refraining from attempting suicide in the future. When patients are already institutionally confined, they typically begin to insist on being discharged or to swear that absolutely no suicidal intentions stand in the way of such a discharge.

At this point it must be noted that our investigation seeks out proof of masked or manifested suicidal *intentions*, not merely suicidal thoughts. For in contrast to suicidal *thoughts*, suicidal intentions already imply that the patient has taken a stance toward the suicidal thoughts; the thoughts themselves, prior to any stance toward them, are actually insignificant.

What we are concerned with is rather the answer to the question, "which conclusion does the patient draw from the thoughts that stir within?"—whether they identify with them, or rather distance themselves from them. That such a distancing—as a way and possibility of taking a stance toward an organic illness event at least in the sense of a facultative power—is possible, and in fact can be actualized insofar as it allows itself to be actualized therapeutically, is a clinical fact that unfortunately all too often is in danger of being forgotten.

We ourselves try to stop the transition from suicidal thoughts to suicidal intentions or even suicide attempts insofar as we play against each other the two tendencies discussed in connection with endogenous depression: we play the tendency toward self-reproach against suicidal tendencies. In the right circumstances, we let it slip into our discussions with the patient what great risk we would take upon ourselves were we to treat the patient on an outpatient basis. We try to get the patients to see what they would have on their conscience if they would allow themselves to give in and attempt suicide. We paint the picture of the handling physician or the nurse being jailed, and so forth—whereby we have already advanced to the territory of the psychotherapeutic treatment of endogenous depression.

Prevention of Secondary (Pfropf) Depression

As already mentioned, our own undertakings in no way pretend to be a form of causal therapy. However, that is not to say that our own system is not concerned with specific and targeted therapy. It may indeed be specific and targeted insofar as it is addressed to the spiritual person of the patient. In fact, the psychotherapeutic treatment of endogenous depression must be focused on the personal stance of the patient toward the organic illness. For psychotherapy is not most properly concerned to influence the illness as such, but rather what we must be concerned with is the attitude of the patient toward his or her illness, or perhaps a change in the attitude. In other words, the readjustment or redirecting (*Umstellung*) of the patient. However, properly speaking this readjustment serves primarily a prophylactic purpose insofar as it may prevent a secondary, supplementary depression, which is appended to the primary, original depression.

We often see cases in which patients would not despair nearly so much, that is, would not suffer nearly as much from endogenous causes, if they would not additionally despair over their despairing mood; that is, they are psychogenically depressed over their endogenous depression. Indeed, we know cases in which the patients cried because they were so tearful. However, this does not represent a causal nexus in the sense of cause and effect, but rather in the sense of a motivational connection, that is, in the

sense of a reason and consequence. Such people—as well as isolated cases of compulsive crying or emotional incontinence accompanying arteriosclerosis cerebri—perceive their tearfulness, but not without becoming so upset by it that instead of merely taking note of it, they react by crying (this time, more psychogenically). While the primary tearfulness nevertheless corresponds to a necessary, organic event, the secondary crying arises from an unnecessary, "extravagant" sadness.

Prevention of secondary, psychogenic depression in cases of depression that are primarily endogenous is advisable today more than ever for one main reason, which has been noted by Edith Weisskopf-Joelson of the University of Georgia. She observed that the worldview attitude that underlies all of today's psychohygenic theories puts into the foreground an interpretation of life that maintains that the reason why human beings exist is to be happy, and every moment of despair is a symptom of maladaptation. Such an appraisal of human life, she continues, may in some circumstances be blamed for the fact that the load and burden of unavoidable misfortune is only increased by the despair over a moment of despair.[22]

Targeted Psychotherapy of Endogenous Depression

Enough said about the psychohygenic dimension of all psychotherapeutic undertakings and efforts with endogenously depressed patients. Let us now turn to the real psychotherapeutic question. In the first place, it is advisable to ensure that the attempted psychotherapy itself will not produce iatrogenic harm, which can happen so easily in such cases. Above all, every attempt to admonish to the patient to pull him or herself together is thoroughly wrongheaded.

To attempt therapy according to the model of individual psychology can also be contraindicated. For, according to the ubiquitous individual psychological interpretation, patients want to tyrannize their kinfolks with their depression, thus the possible insinuation can easily provoke a suicide attempt. This is not unlike an analogous psychotherapeutic error with a different sort of psychotic illness, namely, with schizophrenia when it is erroneously diagnosed as a neurosis and treated with hypnosis: florid hypnotically suggested and hallucinated ideas can be provoked.

The direction in which a targeted therapy of endogenous depression should move is rather the following. We need to encourage the patient, not to pull him or herself together, but rather just the opposite: to submit to the depression, that is, to accept the depression precisely as endogenous.

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[22] Edith Weisskpf-Joelson, "Some comments on a Viennese School of Psychiatry," *The Journal of Abnormal and Social Psychology*, November, 1955.

In other words, we need to encourage patients to objectify and, in this manner, to distance themselves from their depression, insofar as this is possible; and in mild to moderately severe cases this is possible.

Above all, we need to remind patients repeatedly that they are ill, genuinely ill. In this manner we fight the patients' tendency toward self-reproach insofar as they by nature are inclined not to understand their condition as an illness, but rather as merely hysterical, or they morally accuse themselves of "letting themselves go." And now we require of patients above all else that they, and also their environment, demand nothing else of them. As people who are genuinely ill, they must be relieved of all duties. In order to reinforce this message, it is sometimes recommendable to have the patient committed, or at least to bring the patient into an open hospital environment, because this is the best way to demonstrate that we regard them as genuinely ill.

Naturally, we must add that they are not mentally ill in the narrow sense of the word, but rather have a mood disorder, whereby we take the wind out of the sails of any phobic fear of psychosis.

We follow up by adding that their mood disorder occupies an exceptional position, that it has an exceptionally good prognosis. For, we explain to them, that we can never predict with 100 percent certainty that a banal illness like a simple angina will heal itself without the least complications or residual effects (for it is possible that such patients would still suffer from polyarthritis or residual endocarditis), their own illness is the only one that we can predict with absolute certainty will heal itself spontaneously. And they will not overturn this law of nature that has been known and recognized since the advent of psychopathology. We tell the patients that this is simply the truth, and we can't help it if it is also "coincidentally" comforting to them—therefore we do not need to be silent about it or to withhold this information from them.

We need to tell these patients verbatim, that we can guarantee them that they will emerge from their illness—at least from the present phase of it—completely as the person they were in their healthier days. Until that day of healing, the treatment can do nothing more than mitigate the condition, to relieve and lessen the particularly excruciating symptoms. Other than that—we must expressly emphasize—the present phase will subside and be cured on its own, that is, even without treatment, for it is not we who will make them healthy again, rather they will become healthy once again of their own power, at least as healthy as they once were—not better and not worse. That is, under certain conditions they will be just as grave or nervous as they used to be.

And in conclusion, we do not neglect to impress upon them that despite their (symptomatic) skepticism, they will become healthy again, no matter what, even if they do not believe it and do nothing to achieve it, in fact, even if they "stand on their heads." For from the outset the endogenously depressed patient will not believe, will not be able to believe, our favorable prognosis, for this skepticism is one of their symptoms, just as is their pessimism. They will always "find a hair in the soup" and will not be able to find a good word to say about anyone, themselves or others. They will always accuse themselves of cooperating too little. But however much the patients either consider themselves not to be really ill, but in accordance with the self-reproach typical of their illness consider themselves depraved, or alternatively, consider themselves to be ill, but incurably so—in the end, they will nevertheless cling to the words of their physician and to the hope that springs from them.

However, we must make an effort to go psychotherapeutically beyond the disordered feeling that is concomitant with endogenous depression to provide some degree of insight into the disorder. We know that endogenously depressed patients are incapable of perceiving value or a meaning in themselves, or in others, or in the world. All the more must we repeatedly remind them that their value blindness, their inability to find a value in itself or a meaning in life, stems from their mood disorder. Indeed, more than this, the fact that they doubt proves that they suffer from an endogenous depression and that a good prognosis is justified.

These patients must be encouraged to refrain from making further judgments about the value or lack of value, the meaning or meaninglessness of existence, based on their sorrow, their fear, and their disgust for life. For such judgments are all dictated by their disordered affective life, and the thoughts that stem from them cannot be correct.

Above, the point was made that we need to emphatically and expressly point out to our patients that, and in what sense, they are ill, genuinely ill. Apart from assisting them to see past their pathonomonic disordered mood to enable of a genuine insight into the disorder, the real purpose is raising and maintaining in consciousness how free from all duties they are. For this reason, in ordinary and even milder cases of endogenous depression, we plead for a reduction of job-related work to a half day, but not that it be discontinued altogether. This measure is justified because, as we see time and again, work often presents the only possibility of diverting the patients from their brooding. Therefore, we naturally recommend working in the afternoon, and we instruct patients not only not to work in the mornings, but also to stay in bed as much as possible. Given the spontaneous remission in afternoons and the exacerbation of anxiety in mornings that is so

typical of cases of endogenous depression, these patients would react to morning work with a deepened sense of insufficiency, whereas in the afternoon they are more likely to see in it what they should: a diverting task that, at least when successful, can mitigate their feelings of professional inadequacy.

There are only two obligations that we do not relieve patients of. In fact, to the contrary, we must demand two things of them: trust in their physician and patience with themselves.

We require trust—that means trust in the face of a 100 percent favorable outcome that their physician can present them with. They must simply bear in mind that their own case is likely the only case they are familiar with, whereas their physician is familiar with thousands of cases of this nature, which were followed through their course. We must now ask these patients, who are they to trust: themselves or the specialist? And we continue that, whereas they cling to hope based on their diagnosis and prognosis, we specialists don't merely hope, rather we are able to be convinced of our favorable prognosis for them.

And we require patience—patience precisely with regard to the favorable prognosis their illness has, patience in waiting for spontaneous healing, patience in waiting for the clouds to pass which obscure their view of the value horizon so that they may turn their sights toward what is valuable and filled with meaning in being. And thus they will be in a position to allow their endogenous depression to pass like a cloud that indeed can hide the sun, but which does not cause us to forget that there nevertheless is a sun. Similarly, endogenously depressed patients must fasten on to the idea that their mood disorder is indeed capable of hiding from them the meaning and value of existence, so that they may not be able to find anything in the world or in themselves that makes their life worth living—but also that their value-blindness will pass and that they will catch a glimmer of what Richard Dehmel once beautifully expressed: "Behold! The pain of time is but the play of eternal bliss."

Does all this mean that we are able to heal even one case of endogenous depression using this psychotherapeutic method? By no means. We set unpretentious goals. We are satisfied with lightening the load of our patients, not even permanently, but—depending on the severity of the illness—for a few days or even hours. For the true and ultimate value of such a "supportive" psychotherapy is to keep patients' heads above water for the duration of their illness, to help them to navigate through the depressive phase.[23]

[23] As mentioned earlier, such is not a causal therapy, but it is nevertheless an active and targeted therapy.

Nevertheless, such a psychotherapy is concerned above all with one of the most gratifying psychological treatments that a psychiatrist can undertake, and such patients are among the most thankful one will ever encounter in praxis.

We are aware of the banality—to put it bluntly—of most of the advice and points we are in a position to offer to our endogenously depressed patients along the way. But nevertheless, he who cannot muster the courage to offer such banality may often destroy his own success—and that of his patients as well.

Preview

Chapter 3. Psychosomatic Illnesses: Critical Remarks on Psychosomatic Medicine

This chapter is devoted to evaluating psychosomatic medicine in the light of a proper understanding of the relationship between psychological and somatic factors.

- Properly understood, psychosomatic illnesses are those illnesses that are triggered by, but not caused by, psychological factors. For example, psychological states do not cause asthma but may trigger an individual attack.
- Trends in both American and German psychosomatic medicine can be criticized on several grounds. Both rest on a faulty understanding of the relationship between the spirit, mind, and body. American psychosomatic medicine too often identifies the mind with the body, whereas German psychosomatic medicine too often views the mind as determining all bodily states. In fact, it is possible for a person healthy in mind to be infirm in body, just as it is possible for someone with mental illness to be physically healthy.
- A proper understanding of mind-body interconnections does not support the view that illnesses have primarily psychological causes, but rather promotes an understanding of why some people remain healthy despite being exposed to the same pathogens that cause illness in others.

Chapter 3
Psychosomatic Illnesses: Critical Remarks on Psychosomatic Medicine

Psychosomatics is a slogan and a trend. The extent to which it is a slogan, and like every slogan can be misused, can be illustrated with a story told by a prominent American psychohygienist. After a radio lecture on psychosomatics, he received a letter from a listener in which the listener offered to share with him the name of a drug store where he could buy a bottle of psychosomatic medicine.

On the other hand, the extent to which psychosomatics is not only a trend, but also a genuine novelty can be seen in the moment when we define a psychosomatic illness as one that is triggered by the mental, in contrast to psychogenic illnesses that are mentally conditioned and caused. For example, if in the case of a bronchial asthma we were to ask, insofar as we can understand it to be a psychosomatic illness, what is triggered by the mental, the answer would be: the individual attack. That someone suffering from a bronchial asthma or from attacks of angina pectoris sometimes has attacks when he becomes excited, or has them only when he becomes excited, is trivial and nothing we did not already know. After all, that does not imply that bronchial asthma or angina pectoris as such, as a whole—that is, not the individual attack, but the respective underlying ailment—is psychosomatic or even psychogenic.

In 1936, R. Bilz published a book entitled *Psychogenic Angina*. With that term, he did not refer to angina pectoris, but rather to angina in the old, common sense of the word—a sore throat. But it is not right to say that even this kind of angina can be psychogenic, although occasionally it may

well be understood as psychosomatic in the above sense of the term. For it is known that its viral cause is ubiquitous, that it generally remains **saprophytic**, and only occasionally becomes pathogenic. When it does become pathogenic in no case does this depend solely on its virulence but on the status of the immune system of the affected organism. However, the status of the immune system is for its part merely an expression of the general "biotonus" (Ewald). When the latter is decreased, then so too is the *élan vital* (Bergson) decreased, and we have—if I may modify Janet's expression "*abaissement mental*"—an *abaissement vital* (that is, a drop in vitality), and concomitant with it, a lowering of the organism's ability to ward off and fight against a virus. Now, to stay with the example of *angina tonsillaris*, all this can occur through a common cold. However, sometimes it can be triggered by agitation, that is, by the mental. In other words, the status of our immune system depends, among other things, upon the state of our emotions. Decades ago, Hoff and Heilig were able to demonstrate experimentally that subjects who were hypnotized and then had different emotions suggested to them such as joy or fear, accordingly had higher or lower levels of **agglutination** in their serum against typhus bacilli. Decades later there was another experiment, namely, the mass experiment of the concentration camps. In the time between Christmas of 1944 and the New Year of 1945, a wave of deaths occurred that could in no way be explained by changed or worsened work or living conditions or by the appearance or addition of new infectious diseases, but rather by the fact that the prisoners had, in stereotypical fashion, always clung to the hope that they would "be home for Christmas." Now, Christmas came but one was not at home, instead one had to abandon all hope of returning home in the foreseeable future. Precisely this sufficed to produce a drop in vitality, which meant the death of so many. In this fashion they confirmed the words of the Bible: "Hope deferred makes the heart sick" (Proverbs 13:12).[1]

The following case illustrates all this still more dramatically and drastically. At the beginning of March 1945, a fellow concentration camp inmate told me that on February 2, 1945 he had a remarkable dream. A voice that appeared to be prophetic told him that he could ask it something, for it could tell him everything. And he asked the voice when the war would end for him. The voice replied, on March 30, 1945. Now, as March 30 drew nearer it appeared that this "voice" would not be correct. On March 29, my comrade became feverish and delirious. On March 30 he became unconscious. He died on March 31. Spotted fever snatched him away. Indeed, on March 30—the day that he became unconscious—the war had

[1] *The original cites Proverbs 13:3, but apparently 13:12 is indicated: "Hope deferred makes the heart sick, desire fulfilled is a tree of life."—JMD*

ended "for him." We would not be in error if we were to assume that the disillusionment that the actual unfolding of events prepared for him had weakened his biotonus, his immune system, his organism's powers to resist and fight, such that the infection that lay dormant in him was now given free play.

Thus, one could summarize things by saying that the psychophysical state of the concentration camp inmates was dependent upon their attitudes. Meusert has provided us with the knowledge of analogous experiences in the realm of so-called **dystrophy** as it arises among prisoners of war. And Nardini, the American military psychiatrist, reported on his experience with American soldiers in Japanese prisoner of war camps, and observed how greatly the chance of surviving imprisonment depended upon the individual's view of life, that is, on his mental attitude toward the concrete situation. Finally, Stollreiter-Butzon was able to show in his work published a few years ago how much the course of a transverse lesion of the spinal cord (with regard to complications and concurrent illnesses) depended upon the stance and attitude of the individual toward his or her illness.

Repeatedly it turns out that it is not the often cited complexes and conflicts, and so forth, that are pathological per se. It does not lie in a conflict or a complex whether or not it will become pathological, but rather in the total psychological state of the patient. For all the incriminated complexes and conflicts are nearly ubiquitous and already for that reason cannot be pathological per se. But psychosomatic medicine claims more than this. It does not claim merely that complexes and conflicts are pathogenic, it also assesses the specificity of such pathogenesis. That is, it asserts nothing less than that certain illnesses can be more or less thoroughly and clearly classified with certain complexes and conflicts. However, in this regard, they so to speak, "write up the bill without the innkeeper" insofar as they once again fail to consider the whole somatic structure of the patient. Thus, we can say that, on the one hand, psychosomatic medicine has never really addressed the question why a specific complex or conflict ever became pathological for this patient; on the other, it has bypassed the question why a given patient ever came down with this illness. Wolfgang Kretschmer rightly wrote, "One cannot psychologically derive the specificity of why a conflict, for example, can only lead to anorexia nervosa."

As it turns out, the proper set of problems regarding psychosomatic connections just begins precisely where psychosomatics "stops" insofar as it provides us no answer to our questions. For it is clear to the expert that we are confronted once again with the old problem of organ selection (*Organwahl*), which is more general than the problem of symptom

selection (*Symptomwahl*). Now, Freud was compelled to appeal to the somatic insofar as he introduced the concept of the "somatic cooperation"; whereas Adler no less recognized the somatic substructure (*Substruktion*) of all "organ selection" in his study of organ inferiority.

In this regard, Adler spoke of an "organ dialect" in which a neurosis expresses itself. Now, we could say the language of the people (Volksmund) also expresses itself in organ dialect—we need only think of sayings such as "to have something on your heart" or "I can't stomach him," or "it's hard to swallow."[2]

The professional literature contains an unusually instructive experimental contribution by an Italian author that is relevant to our last point. He placed a series of subjects under hypnosis and suggested that they were insignificant employees who worked for a tyrannical boss, and that they could not revolt against him, rather they needed to "just swallow" what he did. He then viewed their stomachs through an X-ray machine and found they had all become aerophagic: they showed a marked increase of air in their stomachs. That is, they not only figuratively, but also literally swallowed something, namely, air. Thus, it is no wonder that real employees who suffer under tyrannical bosses occasionally come to their doctors and complain, for example, about pressure around their heart (caused by diaphragmatic elevation) or similar complaints.

In such cases, where the affected organ—in our case, the stomach—"cooperates" in the characteristic sense as the symbolic expression of a neurotic event, we can also speak of a "symbolic cooperation" of the affected organ (as I did in my book, *Psychotherapie in der Praxis*).[3]

Prescinding from somatic cooperation in general and from symbolic cooperation in the previous special sense just discussed, there is also a "social" cooperation. I am thinking in particular of the "cooperation" of social insurance, the welfare payments that the patient is presented with. For it is not unusual that a neurosis is cultivated or at least fixated with an eye toward income. Just as Freud spoke of "secondary motives for illness" or of "the prize of illness," so too in connection with what I have described as social cooperation one could speak literally of a financial prize of illness that plays a large role in the etiology of neuroses, or in general, in psychogenesis.

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[2] *These sayings are slight variations on the original, which would lose their ability to illustrate his point if translated literally.—JMD*

[3] Viktor E. Frankl, *Psychotherapie in der Praxis* (Wien, 1947).

Critique of American Psychosomatics

Above all, there are three aspects of American psychosomatics that make us voice reservations and criticism:

1. It rests too heavily on overly simplistic statistics
2. It rests too heavily on test results
3. It restricts itself all too much to a psychoanalytic mode of interpretation

On the First Criticism—American Psychosomatics Rests Too Heavily on Simple Statistics

As an illustration of this direction of research I turn to a work from Grace and Graham, whose title remarkably reads, "The specificity of the relation between attitudes and diseases." In this study, the authors report on 127 patients with 12 different illnesses, whom they interviewed, and then scored the interviews. Thus they arrived at the conclusion that certain illnesses correlated with certain mental attitudes and stances, and in fact, as the title of the study suggests, in a specific pattern of coordination. For example, it turned out that the common denominator suggested by the mental stances and attitudes of all patients with, say, rhinitis vasomotoria, diarrhea, and so forth—that this common denominator was in one case "The patients wanted nothing to do with their problems" and in another case "The patients wanted to be free of their problems," and so forth. Now as long as one reads from left to right, that is, first looks at the given "disease" and then at the respective coordinated "attitude," then one is not struck by what would immediately strike one if one rather read the lists from top to bottom; namely, that the list of illnesses contains a great variety while the list of mental attitudes contains nearly identical entries, as the above example illustrated. For it is clear that "wanting to have nothing to do with his problems," on the one hand, and "wanting to be free of them," on the other, are practically the same. Thus, the evaluation of the results of statistical psychosomatic research results depends not least upon the way we read them.

By the way, the assertion that there is a connection between ulcers, which are regarded as the psychosomatic illness par excellence, and character traits is strongly contested by Kleinsorge. That one can fight against the mischief of one-sided statistical research in psychosomatics using its own weapons, namely, through the use of statistical tools, can be seen in the study of the English author, Kellock, who compared the childhood experiences (whose traumatizing influences people are so generally

convinced of) of 250 ulcer patients with a control group of 164 healthy people. He found not the least difference between them.[4]

On the Second Criticism—American Psychosomatics Rests Too Heavily on Test Results

Regarding psychosomatic research that rests upon the results of testing, we may consider a study conducted by the Department of Oral Pathology of a Boston college, whose results showed a correlation between neurotic tendencies and cavities. These findings were the result of testing done on a total of 49 persons.

In this context, it seems appropriate to ask how reliable individual test methods are. Manfred Bleuler has already warned against the overestimation of tests in clinical-psychiatric practice. Regarding clinical-psychiatric diagnostics, Richard Kraemer asserts that a skilled examination generally achieves the same results as test studies. Only one should not imagine that such an examination must last only God knows how long and must only be conducted in an in-patient setting. Langen, using precise statistical methods, was able to demonstrate the final diagnosis made by subjects after a long period of observing patients correlated highly with their first impression: they were consistent in 80 percent of the cases of psychosis, and nearly 100 percent of the cases of neurosis.

But there exists a fundamental limit to testing. It appears where one attempts, for example, to determine with the help of tests how intense the suicidal tendencies of individual patients are (which has actually happened). Such does not help the psychiatrist either theoretically or practically. For how strong a suicidal tendency is in an individual case is not what is really relevant; what is relevant is rather what conclusion the patient draws from his or her suicidal tendency, impulse, or compulsion. In other words, the stance the patient takes as a spiritual person toward his or her suicidal tendency as a psychological-organic fact. To conduct tests while bypassing this is to "write up the bill without the innkeeper." For a suicidal tendency per se does not kill, but rather the human being kills him or herself. But there is a kind of test or rather a procedure to achieve a

[4] See also Scharch & Hunter who found that, in a randomly selected population, it was impossible to observe any personality differences between migraine patients and people who did not suffer from migraines, which also speaks against the etiology offered by the psychoanalytic camp (i.e., that migraines are "self-punishment for hostile impulses" and "repressed anger"). See David M. Scharch & John E. Hunter, "Personality Differences Between Randomly Selected Migrainous and Non-Migrainous People," *Psychotherapy: Theory, Research and Practice 16,* 297, 1978. In a study on hypertension (which also relates to migraines), Kidson & Kochrane were able to empirically demonstrate that the apparent differences arose from the fact that the patients in treatment already had neurotic personality traits.

glimpse of the stance and attitudes of the spiritual person toward the psychophysical processes of the illness. I am thinking of the method I proposed to uncover the concealment of suicidal tendencies, discussed in chapter 2. Time and again, with the help of this differential-diagnostic method it is possible to distinguish between the mere concealment of suicidal tendencies and freedom from them. No psychiatric clinician needs to be told how important such a differential diagnosis can be when considering whether to commit a patient or whether to discharge a patient who has already been committed.

On the Third Criticism—American Psychosomatics Restricts Itself Too Much to a Psychoanalytic Mode of Interpretation

The third aspect of American psychosomatics that we critically emphasized pertains to the fact that it restricts itself to psychoanalytic interpretation. I would like to offer just two examples. N. Fodor asserts that thrombotic hemorrhoids are the price the adult pays for his or her anal birth fantasies. Or, Byschowski explains that obesity could present an ego-defense just as it sometimes is a protection against exhibitionist wishes and against masculine attacks.[5]

Excursus. Let us return to our critique of psychosomatics in general and consider the following. First, the psychological and the physical or the somatic indeed form a unity in the human being. But this in no way means that unity is the same as identity, that is, that the psychological and the physical are one and the same. Second, this intimate psychosomatic unity in the human being does not yet form the whole. The noetic, the spiritual, belongs much more essentially to the whole insofar as the human person is not merely, but by nature a spiritual being. That is, the spiritual dimension is constitutive of the human person insofar as it represents (not the only, but nevertheless) the proper dimension of the human being's existence.

Insofar as psychologism represents a scientific process that ignores the spiritual as a unique dimension, American psychosomatic medicine has not yet even reached the level of psychologism, much less overcome it. Rather, it has remained captive of a somato-psychologism, something standing firmly on this side—certainly not on the other side—of

[5] Let us now give a practitioner a chance to speak: "And so those analytical techniques in particular, in which one tries to use exposure of the roots of abnormal childhood development to arrive at an improvement of the effects of this developmental failure, have largely failed in the treatment of asthma. In fact, this is the most certain way to drive away a patient." See Felix Mlczoch, "Zur Konzeption des Asthma bronchiale," *Therapiewoche 26,* 7630, 1976.

psychologism; for it claims not only the unity, but also the identity of the psychological and the somatic; in fact, this school of thought, and F. Alexander in particular, holds that "psychological and somatic phenomena are two aspects of the same processes."

Thus it becomes evident that American psychosomatic medicine has not overcome psychologism, but has rather fallen short of it. On the other hand, German psychosomatic medicine has surpassed it—as it for the most part gravitates toward, or is derived from, the great personality of a Viktor von Weizsäcker. Of this psychosomatic orientation we must say that it—in the sense of the earlier discussed relationship between the somatic, psychological and noetic, or of unity, identity and wholeness—has not overcome the psychological, but rather bypassed it. So, in summary—and in anticipation of what follows—we might say that German psychosomatic medicine is in fact noosomatic medicine.

Critique of German Psychosomatic Medicine

According to German psychosomatic medicine, the history of an illness can only be understood in reference to a life history, that is, every detail of a case history is determined by the life history, so that we can justifiably speak of a biographical determinism. In other words, only those who allow things to "make them sick" become sick.[6]

It is also true that irritation can give rise to illness. In this vein, Kleinsorge and Klumbies were able to show that worry, that is, irritation has the same activity on an electrocardiogram as a coronary spasmogen, while joy is recorded electrographically like a nitrite.

However, there are not only anxiously excited and happily disposed people, but also happily excited people. For example, we are indebted to Fervers for pointing out that attacks of *angina pectoris* also arise after intense joy, and he mentions in this context "the unanticipated return of a son from Russian captivity."

Let me offer yet another, tragicomic example of the pathogenic effects of joyful excitement. In our ward there lay a patient who, decades ago, was a celebrated soccer star. Coincidentally, the soccer world championship was broadcast on the radio at the time of his stay at our clinic, and our veteran soccer player would naturally not be held back from listening to the broadcasts of the individual games. In doing this, he was excited to greater or lesser degrees—but to the greatest degree when his native team, the

[6] *The word play behind this saying is somewhat lost in English. I use the term "make them sick" in the colloquial sense of being mortified (kränken).—JMD*

Austrians, had won a game; in fact, after one Austrian victory he suffered severe cardiac collapse.

So, it is understandable that those who allow things to "make them sick" are ill; but it would be false to claim that *only* they are ill. For it is also evident that those who rejoice also fall ill—and what kind of meaning should this have from the perspective of biography? Such a meaning can only be an artificial construction.

Moreover, how symptomatology is to be completely determined by biography is above all not evident when we are dealing with inborn malformations and their consequences, and with hereditary illness (Weitbrecht).

It is similar in the case of accidents: that every single instance of an accident has a biographical significance is completely far-fetched.[7] Naturally, there is that which we call "accident proneness," as Adler emphasized decades ago. But this does not imply that every accident proceeds from such proneness.

If poisoning too were only to be understood on the basis of a life history, then every intoxication would be an "auto-intoxication" in that involuntary, humoristic sense in which a doctor once, with regard to a patient who had attempted to take her life by breathing in illuminating gas, involuntarily committed her using the diagnosis of "auto-intoxication through illuminating gas."

Certainly, various things in human existence have a biographical value and, insofar as they have such a value, also have the value of personal expression. For biography in the final analysis is nothing more than the temporal explication of the person: in lives that unfold in the various existences that unroll, persons explicate themselves; they unfold themselves and are unrolled like a carpet, and only in so doing reveal their unrepeatable pattern. Persons reveal themselves in their biography, they open themselves, their essence, their unique being, only through biographical explication, while they hold themselves closed to a direct analysis.

In this sense, every biographical detail, indeed every detail of a life history, acquires a biographical value, and precisely thereby also the value of personal expression—but only to a certain degree, and only within certain limits. This limitation corresponds to the contingency of human persons, who are absolute only potentially, while remaining contingent in fact; for as much as the human person is in essence a spiritual essence, it remains a finite essence. From this it also follows that the spiritual person does not necessarily come through—through the psychophysical layers. The spiritual person is not always visible through the psychophysical

[7] See Mueller-Eckhard: "There are no accidental accidents." Or V. Weizsaecker: "A wounding is no accident."

layers, nor always effective. Of course, the psychophysical organism is the totality of organs, of tools, or in other words, a means to an end; and this end is a double end, corresponding to both functions of the organism with regard to the spiritual person: its expressive and instrumental function. The organism is a means to this double end in the service of the person. But this means, this medium, is (as far as its expressive function goes) completely opaque (*trübe*) and (as far as its instrumental function goes) completely inert. Precisely because of this opacity, the spiritual person is not always visible through the medium of the psychophysical organism, and because of the inertness is not always effective. In other words, this tool in the service of the person does not possess a perfect usefulness—the *potentia oboedientialis* is somehow broken, has developed a flaw (*Knick*) of sorts (to make use of my theological source's word, the now deceased Dr. Leopold Soukup). So that one could at certain times speak of an *impotentia oboedientialis*.[8] In any case, it cannot be said that the psychophysical organism, or all the incidents of illness it experiences, are representative of the spiritual person which stands behind it and makes use of it in one way or another. It is certainly not able to do the latter in all conditions and under every circumstance. For such a spiritual person is not completely effectual through the psychophysical organism, and for precisely this reason is it also not always visible through the psychophysical organism;[9] precisely because this medium is inert it is also opaque. Insofar as the organism—not the least in instances of illness—is a mirror in which the person is reflected, this mirror is not spotless. In other words, not every spot on it can be ascribed to the person that is reflected in it.

And so, there is something with which psychosomatic medicine has not reckoned: the psychophysical organism. Only a transfigured body would be representative of the spiritual person; the body of the "fallen" person on the other hand stands as a broken and therefore distorting mirror.

Not only a healthy, but also a sick spirit can live in a healthy body—to this I can testify as a clinical psychiatrist, just as I am able, as a clinical neurologist, to give testimony that conversely a healthy spirit can live in an infirm (e.g., in a crippled) body. Under no condition may every *insanitas corporis* (bodily illness) be automatically attributed to a *mens insana* (unhealthy mind) or be derived from an *insanitas mentis* (mental illness). Not every illness is noogenic. Whoever asserts this is a spiritualist or—with regard to bodily illness—a noosomaticist (*Noosomatiker*).

[8] The potentia oboedientialis, *or "obedience potency," is the body's state of being ready to submit to the authority of the spirit. The* impotentia *he speaks of is the body's inability to respond to the demands of the spirit under certain conditions of illness.—JMD*

[9] Likewise, we do not consider taking an aphasiac [*i.e., one who cannot speak—JMD*] at his word.

As long as we remain conscious that the human person is not able to realize everything that it desires as a spiritual person through or in itself as a psychophysical organism, then we—in view of such *impotentia oboedientialis*—will preserve ourselves from tying every bodily illness to a spiritual failure. Whereby in any case, we prescind from the extremes of noosomatic medicine, such as the assertion that falling ill to carcinoma is not only an unconscious suicide, but is also an unconsciously self-imposed death penalty arising out of some kind of guilt complex.[10]

Certainly everything, including every illness, has a meaning. But this meaning does not lie where psychosomatic research is looking for it: sick *persons* are the ones giving their illness this meaning, specifically, in the confrontation of it as destiny, in the confrontation of their self as a spiritual person with the illness as something affecting the psychophysical organism. In the confrontation with the destiny of illness, in the attitude toward this destiny, the sick person, the *homo patiens*, fulfills a meaning, indeed, the profoundest meaning. Not in the "that" but in the "how" of suffering lies the meaning of suffering.[11]

Concluding Considerations

At the outset we spoke among other things of psychogenic angina (Bilz); we discussed it as a psychosomatic illness. I am acquainted with an instructive and illustrative double case of psychosomatic tonsillitis, affecting a clinician and his assistant: both get it, if at all, on a Thursday. The assistant gets it on a Thursday when he has to give a scientific lecture

[10] I could if necessary also imagine that a headache is "identical" to worry; what I cannot however imagine is that aspirin, which makes the headache go away, is identical with joy.

[11] The well-known American psychiatrist, Freyhan, wrote "A large number of psychosomatic disturbances show themselves to be the expression of a masked endogenous depression, whose broad biological-physiological etiology can be demonstrated through corresponding therapy results. Also, research on the relation between life events and the outbreak of illnesses has not to date been able to produce any proof for a preponderance of psychogenesis in psychosomatic illnesses. The few existing longitudinal studies rather point to a minor influence of life events and circumstances." See Fritz A. Freyhan, "Is psychosomatic obsolete?" *Comprehensive Psychiatry, 17,* 381, 1976. Skolnick says on this point that "Indeed, the childhood background of mentally ill persons often shows negative factors: these persons often come from broken marriages, dysfunctional families, they must have suffered from a dominating, or frigid, or completely possessive mother, they had a violent or a completely unapproachable father. Normally it is argued that these circumstances lead to abnormal development. However, most children who have experienced early suffering and disturbances in their development nevertheless grow into completely normal adults. A study of the Institute for Human Development of the University of California assumed from the outset that children of broken families have difficulties as adults, and that children who had a happy, successful childhood become happy adults. However, in two thirds of all cases this was not so. The traumatic effects of stress in childhood were overestimated. But not only that, study subjects with a problem-free childhood had also been misjudged: many of them were anything but happy, satisfied, worry-free or even mature personalities as adults." See Lene Skolnick, "Kinder sind hart im Nehmen," *Psychologie heute 5,* 44, 1978.

on the immediately following Friday—something which always upsets him to a certain degree. The clinician, however, gets his tonsillitis—if he gets it—likewise on Thursday, simply because he always has his lecture on Wednesdays. And that day he is always still free of tonsillitis. Now, we have every right to assume that on this day the infection is already there, but simply dormant. The colleague simply cannot afford to be sick on his lecture day, and so the outbreak of the illness, which was in process, is delayed.

We could also substitute the history of an illness with the history of literature in our discussion of psychosomatics. Goethe labored for seven years on the manuscript of Faust II. In January 1832, he tied up this manuscript and put his seal upon it; in March 1832 he died. We are certainly not misled in the assumption that Goethe had lived a large part of these seven years, if I may put it so, beyond his biological means. Here was not a suffering, but rather a dying that was fully due, indeed way past due; but it was delayed until his life work was completed.

So with this I have shown that psychosomatic medicine does less to help us understand why someone falls ill than it helps us to understand why someone remains healthy.[12] At least in the cases just presented there is more justification in speaking not of psychosomatic illness, but rather of psychosomatic health. With regard to this, psychosomatic medicine can give us truly valuable directives. But precisely with this, it slides out of the sphere of necessary treatment of illness into the sphere of potential illness prevention. For it is indeed clear that where there is a triggering by the spiritual, there must also be a protection by the spiritual. But with this, psychosomatic medicine becomes a concern for psycho-hygiene.[13]

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[12] Consider the case of a colleague who, in a severely exhausted, overworked condition, was called to take part in an Alpine rescue expedition that was leaving in a few hours. As soon as he had fulfilled his medical duty he collapsed, and had difficulty getting himself to safety on the rock. That he at all collapsed is only too understandable, even without psychosomatic medicine. However, that the collapse did not come even a second earlier than when this colleague had fulfilled his task—this can only be explained psychosomatically. Similarly, we can add the following. All in all, it is not only evident that the state of the immune system depends on emotional states, but also that emotional states depend on motivation. But just how decisive motivation can be precisely in extreme human situations becomes apparent in the experiences suffered in prisoner of war camps. For instance, a number of psychiatrists could demonstrate that in Japan, North Korea, and North Vietnam, those prisoners of war had the best chance of survival who were directed to some meaning to which they were committed. This was moreover confirmed to me by the three American officers who had survived the longest prisoner of war terms in North Vietnam (up to 7 years) and, as chance would have it, were my students at the U.S. International University in California. There they spoke extensively in my seminar, and the unanimous conclusion was that it was the orientation toward meaning that had ultimately kept them alive!

[13] In the meantime, my student Professor Hiroshi Takashima from Tokyo has contributed to the clarification of the problematic from the logotherapeutic point of view in his book *Psychosomatic Medicine and Logotherapy* (New York: Psychosomatic Medicine, 1977).

Preview

Chapter 4. Functional Illnesses or "Pseudo-Neuroses": On Mental Disorders Due to a Medical Condition

This chapter examines special mental disorders that meet Frankl's definition of psychoses (i.e., they are pheno-psychological, somatogenic disorders), yet present like neuroses. These may be called functional illnesses or "pseudo-neuroses."

- There are three main types of functional illnesses:
    - Type I (Basedowian) functional illnesses involve neurotic symptoms, such as agoraphobia, caused by hyperthyroidism.
    - Type II (Addisonian) functional illnesses involve neurotic symptoms, such as depersonalization, caused by hypocorticalism.
    - Type III (Tetanoid) functional illnesses involve neurotic symptoms, such as claustrophobia or twitching, involving irritability of the central and peripheral nervous systems usually resulting from low levels of ionized calcium or more rarely magnesium.
- While Viktor Frankl's terminology in this chapter is unusual within English-language literature and some of his prescribing advice is outdated, his use of psycho-pharmaceuticals was innovative and his fundamental insights are timeless. Today, the disorders he describes as "functional illnesses" are listed in the *Diagnostic Statistics Manual* as "Mental Disorders Due to a Medical Condition." Although psychotherapeutic techniques may be used in simultaneous therapy (described in chapter 3), patients with such disorders should be treated by a physician or therapist with current knowledge of psychopharmaceuticals.

Chapter 4
Functional Illnesses or "Pseudo-Neuroses": On Mental Disorders Due to a Medical Condition

We assumed at the outset that "neurosis" is defined as a psychogenic illness. In particular, organ neuroses (*Organneurose*) are the effect of a psychological cause in the sphere of the somatic. But there is also the opposite: the effect of the somatic in the psychological. Strictly speaking, we are dealing with psychoses that by definition would qualify as somatogenic and pheno-psychological. But what we are about to discuss are clinical pictures similar to neuroses. Their symptomatology is therefore, so to speak, a micropsychological one. In any case, claustrophobia can hardly be put in the same category as anxious melancholy. But its etiology is also a microsomatic one, so much so that in the relevant cases there is no structural change of organs or organ systems, but rather, mere functional disturbances, which is why we could also characterize these illnesses as functional.

The organ systems that are predominantly affected are the vegetative[1] and the endocrine. And their functional disturbances could also, and this is in fact what is essential, appear as mono-symptomic, whereby the respective symptom may be psychological. From this it follows that the vegetative and endocrine functional disturbances,[2] insofar as they run

[1] *Here and elsewhere in this book, Frankl uses the term "vegetative" to refer generally to things related to the autonomic nervous system.—JMD*

[2] Viktor E. Frankl, "Die Leib-Seele-Geist-Problematik vegetativer und endokriner Funktionsstörungen," in E. Speer (Ed.), *Die Vorträge der 2. Lindauer Psychotherapiewoche 1951*, (Stuttgart 1952).

their course according to the clinical picture of a neurosis, are masked. In contrast to authentic neuroses, to neuroses in the narrow sense of the word that, as stated, can be defined as psychogenic illnesses, we will therefore speak in the following of somatogenic illnesses, which therefore must be characterized as **pseudo-neuroses**.

Naturally, the mental builds upon and is superimposed upon most such pseudo-neuroses. In other words, its somatogenesis is merely primarily somatogenic. Therapeutically, it is of particular relevance what comes first, the psychogenesis or the somatogenesis.

Insofar as we now allow ourselves to be led by practical points of view, we could distinguish the following as the most important groups of somatogenic pseudo-neuroses.

	Psychological Symptom	Physical Diagnosis	Therapy of Choice
Type I: **Basedowian** group (masked hyperthyroidism)	Agoraphobia	Basic metabolic rate >	Dihydroergotamine
Type II: **Addisonian** group (masked hypocorticalism)	Depersonalization, psychodynamic syndrome	Blood pressure <	Deoxycortone
Type III: **Tetanoid** group	Claustrophobia, **globus hystericus**, difficulty breathing	Chvostek + K: Ca > 2	Calcium, Dihydrotachysterine, o-Methoxyphenyl-glycerinether

With regard to what we have called the microsomatic etiology of such types of illness, it is understandable that we must in each case first look for the somatic cause. In other words, the respective functional disturbance of a vegetative or endocrine sort allows itself in certain circumstances to be demonstrated only with the help of a laboratory. In this vein, it is not always the case that the result is objectifiable. It is known, for instance, how relatively little reliability there can be with results such as a Chvostek's sign (*der Chvostek*) or even a potassium-calcium quotient. Just as there are exceptions in the **tetanoid** group, in the Type I (**Basedowian**) group there need not be an elevation of the basal metabolic rate, just as there need not be a lowering of blood pressure in the **Addisonian** group. Nevertheless, it is shown over and again, also in such diagnostically impoverished cases, how well they respond to the therapy of choice presented above.

Type I (Basedowian) Pseudo-Neuroses

Let us begin by considering a case. The patient in question has suffered for the past 5 years from the most extreme claustrophobia. For half a year she saw a psychoanalyst who is not a doctor. Finally she stopped going to her simply because there was no therapeutic success. To the contrary, the depression had even gotten worse. Physically, the patient exhibited finger tremors and fluttering of the eyelids. Her thyroid was diffusely enlarged, and her basic metabolic rate was at 44 percent. The patient received dihydroergotamine parenterally. Already on the next day she reported that the injections "worked wonders." "I would not have thought," she said, "that I would come so far so quickly." After a few further injections she remained permanently anxiety free and remarked, among other things, that the terrible dreams from which she had suffered earlier now have a "good ending." "The psychoanalyst had indeed interpreted the dreams, but they had remained terrible," she said mockingly.

Naturally, in the presence of such therapeutic success, one must be open to the possibility that we are dealing with the power of suggestion. Certainly, the result of suggestion is not an insult to anybody's honor, but it is nevertheless misleading, in fact, misleading for the clinician. For the practitioner it is neither necessary nor possible to exclude the power of suggestion from the outset or during the treatment, nor to rule it out afterwards, during the review of the treatment results. The clinician must be aware of this possibility. However, the cases we used to present those somatogenic pseudo-neuroses that are of greatest clinical importance were only selected if they were first treated unsuccessfully with other medications and then later only responded to the appropriate medication, or conversely, if they were treated with other medications after the fact, and only responded well to the appropriate medication. Likewise, the respective patients themselves were unaware, during all of this, of what medication they were receiving at a given time; some even believed that they were receiving something different than what they in reality received. We intentionally allow the patients to believe that they receive the medication that, according to their reports and assertions, had served them well. But the opposite situation can also arise, insofar as the patient—with or without justification—is afraid of the results of some particular injection and falls into a marked anticipatory anxiety about the side effects of the medication; if such an antisuggestion is present, then the therapeutically beneficial effect (unexpected by the patient) of the appropriate medication is demonstrated all the more powerfully.

Now what follows are two atypical cases that despite being atypical still belong to the sphere of Type I pseudo-neuroses. The first of these two

cases is to be characterized as atypical insofar as its symptomatology was a mixed one, so that it was a combination of the first (Basedowian) and the second (Addisonian) syndromes. Therefore, the therapy had to be a combined one, and had to attack the pathogenic factors concentrically. Because these factors also included the psychological reaction of the patient as well as her reactive neurosis, it is also self-evident that under such conditions an adequate multicausal therapy could only consist of a somato-psychological simultaneous therapy.

Judith K. (Vienna Neurological Policlinic)[3] was a 37-year-old patient who suffered from extreme agoraphobia. She was uncommonly anxious in childhood, afraid of fire and of earthquakes. For 13 years she had not gone out on the street by herself, for fear of fainting or dizzy spells, but she also avoided any kind of gathering, something that—together with the symptom of having a "choking feeling in the throat"—actually seems to suggest claustrophobia more than agoraphobic. For 4 years the patient was unable to live alone in her apartment. She complained, otherwise, of pressure in the area of the heart, diarrhea, a frequent urge to urinate and chilliness, and was sensitive to weather and the foehn. She had already seen prominent experts, was once hypnotized, underwent a **narcoanalysis** (*Narkoanalyse*), and received multiple electroshocks in a mental clinic. But all these measures were without effect. Recently she lost 22 kilograms. She presently weighs 47 kilograms. Her basal metabolic rate once measured + 50 percent. Her EKG suggested a low degree of myocardial injury. Therapeutically it was necessary to provide somatopsychological simultaneous therapy, that is, to combine the psychotherapeutic guidance of the patient with a targeted medication. The latter was meant to serve psychotherapy by preparing a foundation upon which psychotherapy could build. Now the present case bears, as noted above, not only agoraphobic, but also claustrophobic marks, and we generally categorize the latter as belonging to the third (the tetanoid) group of pseudoneurotic illnesses, just as we claim that agoraphobic conditions often conceal or (for the one who can read them) betray as their monosymptomic psycho-correlate a Type I (Basedowian) syndrome.[4] Now, precisely because a case of this kind also points in the tetanoidal direction, we felt obliged to prescribe myoscain E in addition to the dihydroergotamine, since we have been able to

[3] *The term "Poliklinik" in German typically denotes an outpatient or ambulatory care center. However, I have stayed with the less familiar term polyclinic to ensure that readers understand it refers to the neurological department of the well-known Vienna General Policlinic (where Arthur Schnitzler was on staff), and because—as becomes apparent through the cases—the Vienna Neurological Policlinic had a small inpatient ward. (I thank Franz Vesely for these historical tidbits.)—JMD*

[4] Naturally none of this should be so construed as to imply that every agoraphobia is a somatogenic pseudo-neurosis as we mean it.

show that this o-methoxyphenyl-glycerinether is able to dampen the anxiety of "functionally" disturbed cases.[5] The effect of this twofold medicinal treatment, which was augmented by psychotherapy (according to the method of paradoxical intention), was the following: On the 13th day of inpatient treatment the patient—who for 13 years had not been able to leave the house alone—managed to go from the town where she lived to the clinic without accompaniment. On the 17th day, for the first time in 20 years, she went to the theater alone. On the 18th day she went to a café alone for the first time in her life. (She was only "afraid of being afraid," she admitted, but this soon disappeared.) In the fourth week of her stay at the clinic she rode on the back of a motorcycle with her husband through the city. She also rode alone in a packed streetcar (whose crowdedness, for claustrophobic reasons alone, should have made her tremble). As she was released from the clinic after an inpatient treatment lasting a total of 4 weeks she felt "as if I was born again." Without needing to take any further medication, the patient remained without complaints, even during periodic checkups. During one visit she reported that—after a 4-year hiatus—she had also resumed sexual relationships with her husband. We mention this only in order to show how mistaken it would have been to construe the etiology of such a neurosis on the basis of a sexual abstinence, when in reality precisely the opposite is true: the sexual hiatus was not the cause but rather a mere effect of the pseudo-neurosis, just as the sexual rehabilitation of the patient was a side effect of our therapy.

Let us now consider a second case which was also atypical because it concerned a Type III (tetanoid) syndrome, but nevertheless the therapeutic effect was attained using the therapy generally indicated with Type I pseudo-neuroses (namely, dihydroergotamine).

Margarete is a 39-year-old patient at the Vienna Neurological Policlinic who reported having suffered for many years from increasing anxiety, which overcomes her in closed spaces. She also cannot stand any kind of close-fitting clothing. Four weeks ago she had received an injection at the dentist's, whereupon she was suddenly overcome by tremendous anxious excitement. She experienced palpitations of the heart that persisted even with prescribed medications (Chinin, Digitalis, and Luminal). Finally, the patient complained of feelings of apprehension and globus hystericus. While the latter is routinely often misinterpreted in the hysterical sense, we hold the view that it is to be diagnostically interpreted as pointing in the tetanoid direction just as much as the feeling of being cramped and of apprehension. Regarding apprehension, our patients habitually speak

[5] Viktor E. Frankl, "Zur Behandlung der Angst," *Wiener medizinische Wochenschrift 102,* 535, 1952.

of not being able to breathe deeply. Now, as far as the present case is concerned, it came out that there was in fact a potassium-calcium quotient of 21:9, something suspiciously pointing in the tetanoid direction, while the basal metabolic rate only came to + 4 percent. We had therefore every right to suspect an illness that could be categorized as part of the tetanoid group of masked, vegetative, endocrine functional disturbances, and accordingly we prescribed a potassium medication, but also administered myoscain E. However, all of these therapeutic measures were devoid of any therapeutic effect. On the other hand, it became clear that doses of DHE 45 worked very well. It is notable that immediately after each injection, for half an hour, the patient was terribly tired and complained of dizziness and nausea. Had it been merely a case of the power of suggestion, then it would have been an antisuggestion, that is, the patient could have at most expected a further deterioration. Now, not only can there be no talk of this, but soon the objective condition improved as well as did the tachycardia. Additionally, the patient underwent a logotherapeutic treatment (paradoxical intention), which was specifically directed at the anticipatory anxiety. As the patient came to us, her condition had been one of a high degree of anxious agitation for she was afraid of going crazy. To the diverse complaints, which we had interpreted as a functional illness (in our sense), the patient reacted with a psychotophobia (that is, a fear of becoming psychotic). But now we could no longer speak of a mere functional illness; we rather had to let the picture show itself in its totality as a reactive neurosis. Now within a few weeks of her stay at the clinic, the patient was completely free of complaints, and she remained so across the many years that have gone by since her inpatient treatment.

We have intentionally chosen two atypical cases in order to warn against deriving a schematic praxis from a theoretical schema.

Finally, it is worth mentioning that clinical experience suggests that pseudo-neurotic agoraphobia and claustrophobia can be categorized as Type I (Basedowian) or Type III (tetanoid) pseudo-neuroses insofar as we have succeeded even in cases in which there was neither the one nor the other manifest phobia to help us produce a differential diagnosis and thereby to know which therapy is indicated. We succeeded with the help of a test question. We searched, so to speak, for a latent agora- or claustrophobia, by asking the patients what would make them tremble more: to stand alone in the middle of an open space or to sit in the center of a row of a theatre filled to capacity. The claustro- or agoraphobic readiness, as tested in this manner, is so significant an indication of the correlative pseudo-neurosis that we are able to establish the appropriate therapy of choice.

Type II (Addisonian) Pseudo-Neuroses

Let us consider another case. Dr. S, a physician, complains of stomach pains, has diarrhea, and for some time now has had to stick to a diet that excludes black bread, fruit, and vegetables. It is well known that such diets often lead to a deficiency of the vitamin B complex, both in the sense of a reduction in the variety of B vitamins and a resorption disorder. As is characteristic, he also does not tolerate well heat or sun. Finally, he admits to frequently desiring salty foods, which is also characteristic. And now we come to the description of the depersonalization symptoms. The patient complains that nothing ever really happens to him. He never has the feeling of "being there," rather he experiences himself as if he were "without essence"—"as if a cord had snapped within me," he said. "I appear to myself as in a dream—my field of consciousness is too narrow and self-consciousness is completely gone. I do not come back to my own self. I have to ask myself, 'why am I myself, and not the person that I am watching right now?' Everything appears to me as distant, and I appear to myself as foreign. My voice sounds so foreign. It is as if my limbs did not belong to me, as if I stood over my body, or didn't have any body at all, but were rather a pure spirit."

To all of this are added iatrogenic problems. First, as so often happens, barbiturates are prescribed as routine medication, which we know will lower a blood pressure that is already low in most cases. (In this case the Riva-Rocci blood pressure reading was a mere 95 millimeter Hg.) But not only is the arterial hypotonia lowered, but also the "hypotonia of consciousness," as it was called by J. Berze, which is another way of understanding depersonalization. Additionally, the doctor who originally treated the patient unthinkingly, not to mention thoughtlessly, spoke of a "splitting," whereupon the patient immediately began to develop a reactive psychotophobia. Now, for our part, the therapy consisted of a daily dose of Percorten (desoxycorticosterone pivalate). After only a few days the patient felt wonderful: "Everything is normal—everything is once again so near, bright and clear, like normal." (In an analogous case, an English student described the subjective therapeutic effect of Percorten in the following manner: "It cleared my brain. My thinking capacity is better.") Also "consciousness and memory are sharpened." In the next months he became completely free of all complaints, and he remained so even after he stopped taking Percorten.

In other cases we administer deoxycortone parenterally. We did this with a young pharmacist who, because of her severe depersonalization experiences, was given a total of three 5 milligram doses of Cortiron administered intragluteally at weekly intervals. As she asserted, the effect

of the first two injections lasted five days and consisted in rendering "everything decidedly more immediate and clear." Now, precisely in cases of such parenterally administered medication it must be remembered that we must boost the adrenal cortex without spoiling it. Practically, this means that it is not harmless when we are considering using simultaneously extended release injections; for these forms of administering the medicine resemble arrows that, once shot, can no longer be controlled. Now, when does the adrenal cortex, once it is stimulated, function fairly normally? Usually in mild functional cases it generally suffices to bring about a spontaneous fitness in the form of an overall change of attitude, which is achieved particularly well through athletic training. To illustrate this point, let us consider a case shared with us by our colleague J. M. David of Buenos Aires.

The case concerns an Argentinian officer of 30 years, who for 6 years not only suffered from the most severe depersonalization, but also from a complete psychoadynamic (*Psych-adynamischen*) syndrome: diminished powers of concentration and memory.[6] He had already seen five doctors and undergone psychoanalysis for 2 years, acetylcholine, and ten electroshocks. He now receives Percorten parenterally combined with vitamin B, and undergoes short-term therapy using logotherapy to address existential frustration. After three injections of adrenocortical hormones we see amazing results. Regarding the depersonalization, the patient feels fantastic. However, when he goes for a country holiday he forgets to take along the prescribed oral adrenocortical medication and promptly experiences a severe relapse. However, in the course of the next few weeks he begins to play sports regularly, and he is soon doing fine without any kind of medication.

The following case, it seems to us, is also instructive in many respects. It has to do with a young patient, a foreigner, who in her homeland had been treated for 6 years, 6 hours each week, by a psychoanalyst, and then had to terminate the treatment for undisclosed reasons. (When she told her psychoanalyst that she needed to stop therapy, the therapist explained that it was impossible to terminate the therapy, since the analysis had actually not even yet begun, but had rather miscarried because of resistance from the patient.) When we saw her we diagnosed hypocorticalism with depersonalization in the foreground and prescribed the medication Desoxycorticone. According to the report of the general practitioner treating the patient, "the patient immediately felt better not only with

[6] Viktor E. Frankl: "Psychodynamie und Hypokortikose," *Wiener klinische Wochenschrift, 61,* 735, 1949; and "Über ein Psych-adynamisches Syndrom und seine Beziehungen zu Funktionsstörungen der Nebennierenrinde," *Schweizerische medizinische Wochenschrift, 79,* 1057, 1949.

regard to depersonalization, but also physically." (The patient was bedridden at the time we began our treatment.) He continued, "She has gained weight, is no longer of delicate health, has finished a dissertation, and needs no more treatment."

Once again it becomes clear that in order to be able to diagnose a neurosis, we must first exclude a somatogenic pseudo-neurosis; this is necessary, but it is only possible for a medical doctor with full clinical training.[7] As much, however, as the exclusion of a somatogenic pseudo-neurosis is the necessary condition for the diagnosis of an authentic (psychogenic) neurosis, this necessary condition is still not nearly a sufficient condition; for merely because a somatogenic pseudo-neurosis can be ruled out, we cannot by a long shot diagnose a (psychogenic) neurosis. In other words, it is not permissible to arrive at the diagnosis of a neurosis *per exclusionem* (i.e., by process of elimination).

The following case serves to illustrate this warning. Over the past five years, Cecilia D. has bounced from one neurological psychiatric clinic to the other and been subjected to all possible measures—both diagnostic and therapeutic, from a lumbar puncture to an encephalogram, from narcoanalysis to electroshock. Finally, it was determined that "something organic is out of the question; it has to do with a conversion hysteria." Given this diagnostic label, the patient was transferred to our department. But just from hearing the patient's history, it seemed to us that everything pointed toward the thalamus as the source of the problem. The X-ray examination revealed a chronic increase in endocranial pressure, and the results of the opthalmoscopic exam indicated a *chorioiditis centralis peracta*. In this roundabout way we proceeded from a suspected location (near the thalamus) to a specific diagnosis of toxoplasmosis. Indeed, the Sabin-Feldmann test and the toxoplasma reaction came out positive.

Type III (Tetanoid) Pseudo-Neuroses[8]

Once again, let us use concrete examples to lead us into the phenomenology of this third group of somatogenic pseudo-neuroses.

K., a medical student, was sent by those in authority to our department for psychotherapy. For four years, he has suffered from "nerve cramps"—cramplike states, lasting up to an hour, accompanied with paresthesia in the form of tickling and tension, but also sometimes with rigidity of the

[7] See T. Reichert & R. Hemmer, *München med. Wochenschrift 98*, 543, 1956. Of 584 cases of cerebral tumors confirmed by means of operations, 33 were treated according to the diagnosis of a neurosis.

[8] K. Nowotny & P. Polak in Vienna have been particularly helpful in clarifying and distinguishing these in contrast to authentic neuroses.

extremities, which the patient described while forming slight but typical "paw position" with his hands. He further reports that at times of attacks, he "breathes funny" and we have every reason to suspect that in those cases he hyperventilates. Vague stomach complaints complete the picture. Objectively, the Chvostek's signs are positive, the potassium-calcium quotient runs around 22:10, amounting therefore to significantly more than 2. After trying a calcium injection, the patient reports an "outstanding effect"; as soon as he receives Myoscain E, he becomes and remains free of attacks.

As stated at the outset, dihydrotachysterine is also indicated in cases of pseudo-neuroses, namely in those cases accompanied with anxiety. The following case serves as case-based evidence for this.

Irene Z., 32 years old, complains of panic attacks. She cannot ride alone in the streetcar (a typical claustrophobic reaction). She also complains of a choking sensation in her throat and of difficulty breathing. She has cramps in her arms. Objectively, the Chvostek's sign is positive, while the potassium-calcium quotient amounts to 2.9. She shows marked relief in response to Myoscain E with regard to her anxiety: the patient comes for the first time without someone to accompany her. She then is given Calcamin—naturally with an eye on her calcium level—and is free of complaints after a few weeks. Months later there is a relapse: the patient had neglected to regularly take the Calcamin. Later, she misses doses of Calcamin, and nevertheless remains free of complaints—for 2 years. After these 2 years, she experiences a second relapse. The patient comes to our department because for the past few weeks she again has feelings of apprehension, choking sensations, and cannot breathe deeply. She shows prompt improvement in response to Myoscain E, but she also responds well to a trial injection of calcium. For years now she is permanently free of complaints, feels well, and can ride alone in a crowded streetcar without having the slightest amount of fear.

Type IV Pseudo-Neuroses: Vegetative Syndrome

G. V. Bergmann coined the phrase "vegetative stigmatization," and Siebeck the expression "vegetative instability." Today we speak of vegetative dystonia, a concept that Wichmann introduced in 1934. In psychotic, namely endogenous, states of depression, vegetative symptoms stand in the foreground so much that we rightly speak of vegetative depression. In contrast to the scrupulous masking of the masked endogenous depression in the previous generation, today we encounter predominantly vegetative ailments and reactive hypochondriac complaints.

Insofar as we are dealing with neurotic or pseudo-neurotic states, we prefer to speak noncommittally of **vegetative syndrome**s, and not of a vegetative dystonia. From the therapeutic point of view, however, it is necessary to differentiate the vegetative syndromes. In this sense, it is completely justified when, for example, W. Birkmayer contrasts sympatheticotonic and vagotonic syndromes. It is well known that F. Hoff also argues for such a distinction, and F. Curtius explicitly says, "The types of **vagotonia** and **sympatheticotonia** have clinically demonstrated themselves, despite a number of limitations, to an exceptional degree." That in isolated cases we repeatedly encounter an overlapping of the two vegetative symptom patterns is quite natural and does nothing to alter the diagnostic possibility and therapeutic necessity of ascertaining which respectively is more important: the sympatheticotonia or the vagotonia.

It appears to us that the recognition of sympatheticotonic or vagotonic states is most important where there are vegetative attacks, and in particular vegetative heart attacks. In this regard, we are tremendously indebted to the research of K. Polzer and W. Schober, who have rendered great service to the elaboration of sympathetico-vasal (*sympathikovasaler*) and vasovagal forms of attack. We have no hesitation in venturing the assertion that every day, and in every consultation, the worst kind of injustice is done to patients who are stigmatized and labeled as neurotic, or even hysterical, and who in reality have been merely misdiagnosed, since they are sick with vegetative attacks.

As was initially stressed, we have allowed ourselves to be led by practical, clinical perspectives, when we selected the three groups of Type I, Type II, and Type III pseudo-neuroses. But it is obvious that not only functional disturbances of the endocrine and vegetative nervous system can occur under the appearance of neuroses, but also organic lesions and afflictions of the central nervous system. The most classic example is the so-called pseudo-neurasthenic prodromal stage of progressive paralysis. That organ systems other than the nervous system can also fall ill in the sense of a pseudo-neurotic masked functional disturbance is known to the clinician.

Preview

Chapter 5. Reactive Neuroses: On Neuroses Arising from the Fight for or against Something

This chapter examines reactive neuroses, or those neuroses that arise from the fight for or against something. Some of these reactive neuroses involve reactions to primary functional illnesses (e.g., the patient fears experiencing depersonalization), while others involve reactions to symptoms that are not per se pathological (e.g., a neurotic fear of blushing again).

- There are three primary neurotic reaction patterns:
    - The anxiety neurotic reaction pattern involves anticipatory anxiety in which an anxious reaction (say, stuttering or sweating excessively) is feared and fought against, and this fear then gives rise to an anxious reaction, forming a vicious circle.
    - The obsessive-compulsive neurotic reaction pattern involves a compulsive idea that is feared and fought against, which gives rise to compulsive behavior as a neurotic reaction.
    - The sexual neurotic reaction pattern involves a heightened self-scrutiny that arises as the patient's attention becomes fixed on seeking a sexual reaction (e.g., potency or orgasm) thus taking the patient's attention off of the sexual stimulus (the partner) and interfering with a spontaneous sexual reaction.
- The specific logotherapeutic treatment of reactive neuroses is alluded to in this chapter; it is more fully developed in chapter 12 on paradoxical intention and dereflection.

Chapter 5
Reactive Neuroses: On Neuroses Arising from the Fight for or against Something

First we saw that neuroses allow themselves to be defined as psychogenic illnesses. Then it became evident that they are to be distinguished from pseudo-neuroses, which do indeed progress according to the clinical pattern of neuroses, but must be characterized as somatogenic. To these we can now contrast neuroses that are psychogenic only in the broader sense of the term, that is, they are neuroses only in the broader sense of the term.

If somatogenic pseudo-neuroses are the psychological effects of somatic causes, then it becomes repeatedly apparent that there are psychological repercussions of these effects, there are neurotic reactions, which we can also characterize as reactive neuroses; for the reactions in question are psychological, and thus the corresponding illnesses are psychogenic.

Now, there are also typical reactions within the neurotic reactions we are considering. The common denominator of these reaction patterns is anticipatory anxiety.

As is well known to the unprejudiced clinician, anticipatory anxiety is not seldom the actual pathogen within the etiology of a neurosis insofar as it fixates a symptom that itself is fleeting and harmless by focusing the attention of the patient on the symptom.

The so-called mechanism of anticipatory anxiety is familiar to the practitioner: the symptom generates a corresponding phobia, the phobia in question reinforces the symptom, and the symptom, reinforced in this way, confirms patients still more in their fear of a return of the symptoms (see Figure 8).

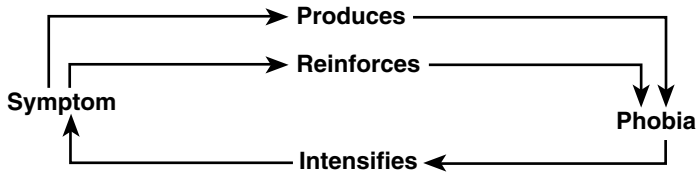


Figure 8

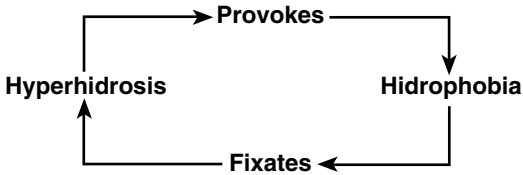


Figure 9

Patients lock themselves into the vicious circle that arises; they weave themselves into it, as if into a cocoon.

A concrete case may serve to illuminate all this. A young colleague comes to us. He suffers from severe hidrophobia (that is, a fear of sweating). By nature he is vegetatively unstable. One day he extends his hand to greet his supervisor and notices that he had begun to sweat to a noticeable degree. The next time he is in a similar situation he anticipated the outbreak of sweat, and the anticipatory anxiety itself drove the sweat of anxiety into his pores, whereby the vicious circle was closed: the hyperhidrosis provoked the hidrophobia, and the hidrophobia reinforced the hyperhidrosis (see Figure 9).

If neuroses can arise from a circular process, then their therapy must correspond to the movement of forceps (*Zangenbewegung*). We must mount a concentric attack, with both the symptom and the phobia as points of attack. In other words, in the sense of a somatopsychological simultaneous therapy, the one arm of the therapeutic forceps—that which can penetrate and force open the neurotic circle—is brought to bear on the vegetative instability as the somatic pole, and the other arm of the therapeutic forceps is applied to the anticipatory anxiety as the psychological pole (see Figure 10).

This example of anticipatory anxiety makes clear that fear makes real that which it fears. In other words, as the wish is proverbially father to the thought, so is fear mother to the event, namely, the event of an illness.

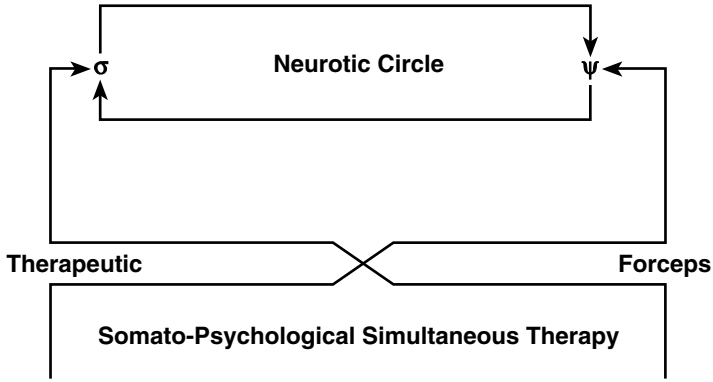


Figure 10

At the least, this is true of anticipatory anxiety. Often the hour of a neurosis strikes only when the anticipatory anxiety takes control of the process.

Anxiety Neurotic Reaction Pattern

In anticipatory anxiety, what exactly is anticipated with the most anxiety? First, it must be mentioned that our neurotic patients apparently agree with F. D. Roosevelt, who in the context of one of his famous "fireside chats" is to have said, "The only thing we have to fear is fear itself."[1] Indeed, anxiety itself belongs to those things that tend to be feared most by patients. In the special case of anticipatory anxiety we could also speak of anxiety anticipation. The patients themselves, however, commonly speak of a fear of anxiety.[2] They have the anxious anticipation of the return of an anxiety attack that they once experienced.

The fear of anxiety constitutes a potentiating phenomenon, like the one we encounter with endogenous depression, which despite its endogenous character often has a reactive element, not in the sense of an exogenic component, but rather a reaction to the depression as endogenous. The unfounded sadness of the respective patients gives them ground for an additional sadness.[3]

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[1] The Columbia World of Quotations (1996) *attributes this to Roosevelt's first inaugural address, March 4, 1933—JMD.*

[2] There is not only a fear of anxiety, but also a shame of anxiety. In one case known to us, the patient was ashamed of his anxiety because he could not understand how he, who was "after all so religious," could nevertheless be anxious. In reality his anxiety spoke not against his religiousness, but rather for a hyperfunctioning of the thyroid.

[3] We come up against analogous potentiating phenomena also outside of the clinical sphere. Who has not gotten irritated at their own irritation? We are indebted to Hans Weigel for the most recent discovery in this field, namely that of "the conscience that is guilty for not having a guilty conscience" (*Unvollendete Symphonie*, novel, Innsbruck, 1951).

Ultimately, it is not really anxiety itself that our patients are afraid of. If we search for the reason why these patients fear anxiety, it repeatedly turns out that they are afraid that the anxious agitation could have damaging "consequences" for their health. Above all there are three things that their anxiety fixes upon: That they could, out of pure agitation, collapse on the street; that they could collapse from a heart attack; or that they could collapse from a stroke. In other words, behind the fear of anxiety there stands, depending on the case, a collapse phobia, an infarct phobia, or a stroke phobia.

All these give patients a reason for their fear of anxiety. But what is the result of this fear of anxiety? Out of a fear of anxiety, the patients begin a flight from anxiety. In other words, they run away from the anxiety, paradoxically, by staying at home; for we are dealing with the first of the reaction patterns to be discussed, namely, the agoraphobic reaction pattern.

Let us consider another case, that of Marie (Vienna Neurological Policlinic). She was treated and her case history written down by Dr. Kocourek. The mother of the patient had suffered from a washing compulsion. She herself has been in treatment for a vegetative dystonia for the last 11 years. In spite of this she has become increasingly nervous. In the foreground of the symptoms stand attacks of palpitations. These are accompanied by anxiety and "a collapselike feeling." After the first attacks of palpitations and anxiety, there arose an anxiety that all this could happen again, whereupon the patient also started having palpitations. In particular, she was afraid of collapsing on the street or of having a stroke. To the anticipatory anxiety was joined a compulsive self-observation, that is, the patient constantly watched herself, looking for these problems. For example, she was constantly checking her pulse. The family life of the patient was described as a good one. Her physical exam showed the thyroid to be enlarged. She also had tremors and twitching of the eyelids. The patient was treated with two tablets of Myoscain E three times a day, and was instructed by Dr. Kocourek to tell herself: "My heart should no longer beat. I will attempt to collapse on the street." The patient was directed, as an exercise, to search out all situations that are unpleasant for her, rather than avoiding them. She was given penicillin as a preventative measure. Two weeks after being admitted, the patient reports, "I feel very well and have almost no more palpitations. The palpitations don't bother me any more, for nothing can happen to me. The spells of anxiety have vanished completely. I am almost completely healthy." After the patient was discharged, she reported 17 days later, "If once in a while I have palpitations, I tell myself 'my heart should beat even more.' The palpitations stop, whereas earlier they would always get worse because I would think to

myself, 'Oh my God, something's going to happen to me.' I had always believed that I would have a stroke. I had never known what I had. On the street I would always be afraid that I would collapse. I actually don't have any more fear."

And so it has shown itself that fear of anxiety, whose reason we had tried to find, does indeed have a reason: a fear of collapse, of infarction, or of stroke stands as its "reason." Only we must remember that fear of anxiety is a secondary anxiety insofar as it is related to a primary anxiety that patients have at the outset, whereas they develop the fear of the anxiety only later. In contrast to the secondary anxiety, the primary anxiety has no reason, but rather a cause.

The difference between reason and cause is explained with the example of the fear of heights. This fear can be traced back to the anxiety and fear that the affected persons experience because of insufficient education or insufficient equipment. The fear of heights can also be traced back to an insufficiency of oxygen. In the one case there is a fear of heights, and in the other an "illness of heights." The former has a reason and the latter a cause. The one is something psychological, and the other something somatic. But the distinction between psychological reason and somatic cause also becomes clear through a further example: an onion is no reason for crying; but it can be the cause of a secretion of tears. Conversely, tickling is no reason for laughing (joking would be a reason), but rather the cause that is able to release a laugh reflex.

What is the somatic cause of the primary anxiety of our patients? We were able to demonstrate that it is not uncommon that hyperthyroidism underlies agoraphobia. This however does not mean that the hyperthyroidism is in and of itself capable of giving rise to anxiety neurosis—for instance in the sense of a somatic pseudo-neurosis. Actually, the somatogenic result and accompanying symptom of hyperthyroid illness proves to be no more than a mere readiness for anxiety, and the reactive anticipatory anxiety must first be joined to this vegetative readiness for anxiety. Only then does the full anxiety neurosis unfold—now in the sense of a reactive neurosis.

With this we have in fact arrived at the discussion of the neuropathic foundation of neuroses, whose constitutional foundation we have yet to discuss. We agree with M. Villinger that there are "important reasons for opposing the overexpansion of the concept of a neurosis," and together with him regret that "in contrast to a deflation in the realm of psycho- and neuropathy stands a marked inflation in the realm of the neurosis." For in agreement with H. Kranz, we consider "personality disorder" (*Psychopathie*) to be a "concept worth keeping," despite its age (it was coined in 1891 by

Koch);[4] and it is the same with the concept of neuropathy. The expression of a neuropathy can be a sympatheticotonia, or a vagotonia—concepts whose legitimacy we also have no reason to call into question (F. Curtius; F. Hoff; W. Villinger). The correlation between sympatheticotonia and hyperthyroidism is known: the two overlap.

Let us consider an example. Mrs. W. is 30 years old. She came to us seeking treatment of phobias. It became clear that behind these phobias stood an obsessive-compulsive personality disorder.[5] However, in addition to the personality disorder, there was also a neuropathic disposition in the form of a sympatheticotonia or a hyperthyroidism: enlarged thyroid, exothalamus, tremors, tachycardia (pulse 140), weight loss (5 kg), and a basal metabolic rate of + 72 percent. The personality and the neuropathic dispositions are the constitutional foundation of the neurosis. To this is linked a dispositional foundation. Two years ago the patient had a goitrous tumor surgically removed, an experience that carried with it a vegetative disruption. This finally resulted in a vegetative disequilibrium, which provided a conditional foundation. Two months later the patient drank a strong espresso, contrary to normal habit, and experienced a vegetative anxiety attack. Now we come upon a significant medical history report: "After the first anxiety attack, I would immediately experience anxiety again at the mere thought of it." From this we see that the vegetative anxiety attack had empowered a reactive anticipatory anxiety. Now, an existential analysis of the case posits that beyond the personality disorder and the neuropathic foundation (that is, beyond the constitutional, dispositional and the conditional foundation), there is also an existential background relevant to the neurosis. The patient verbalizes it in the following manner: "I am in a place where spiritually nothing happens. I hang in midair, everything appears to be meaningless. What had helped me most was having someone to care for, but now I am alone. I want to have a reason for living again." These words are no longer the medical history of a patient. What we now hear is far more a person's cry for help. We speak in similar contexts of existential frustration. This is how we identify the frustration of the will to meaning, as the demand for as meaningful an existence as is possible, which is so characteristic of human persons. Existential frustration is not pathological, but rather only pathogenic—and it is not necessarily

[4] *The term that Frankl uses here is "Psychopathie." In German, this term never meant psychopathy in the sense of being antisocial. It rather referred to constitutional personality traits that resemble neurotic traits. While the term was once somewhat common in the German language, it has been replaced by the term Persönlichkeitsstörungen or personality disorders in the ICD.—JMD*

[5] *The actual term Frankl uses is anankastic personality disorder. The term "anankastic" is somewhat archaic in English, but loosely denotes what the DSM today calls an obsessive-compulsive personality disorder.—JMD*

pathogenic. Whenever it nonetheless becomes pathogenic, whenever the futile demand for meaning in life makes a person ill, then we call such an illness a noogenic neurosis. In the case above, however, the neurosis is not noogenic, but rather reactive. Nevertheless, we see that all the circular formations we have been discussing are only able to run wild in what we have characterized as an existential vacuum; and what the patient was attempting to describe in the words cited above is nothing other than an existential vacuum. If the psychological weeds (*Vakatwucherungen*) are to be removed, then the existential vacuum must be filled. Only when this happens can the therapy be completed and the neurosis completely conquered. What must be risked and accomplished is entry into the spiritual dimension, the inclusion of the spiritual in the theory and therapy of neuroses. And this may involve making clear to the patient that even her existence is not devoid of concrete and personal meaning, that is, we may provide logotherapy, as we call a psychotherapy that begins with the spiritual.

Should our falling back upon neuropathic structure imply that we are laying down our therapeutic weapons and falling into a therapeutic nihilism or a fatalism? We are still a long way away from seeing fate in a fact such as sympatheticotonia or vagotonia. As upset as one person suffering from sympatheticotonia may be, another one, coming from the identical neuropathic structure, is not upset, but is rather stimulated. He is somehow awake—even to the periphery of his field of vision. This was observed by E. Bachstez and W. Schober (of the Vienna Neurological Policlinic), who "remarkably often found a particularly large field of vision in patients who were over-stimulated, alarm ready, sensitive and easily excitable with a strong dilation reaction (*Erweiterungsreaktionen*)." Analogously, the one person suffering from vagotonia is cramped and reserved—to the point of holding back his stool, in the sense of a spastic constipation—while another is reserved only in the sense that he rests in himself. Goethe's words in *Wilhelm Meisters Wanderjahre* thus prove themselves: "By nature we possess no flaw that cannot become a virtue, no virtue that cannot become a flaw." For, what is done because of sympatheticotonia or vagotonia, how they are incorporated into a life, what kind of life is built upon them, depends on the spiritual person and not on the sympatheticotonia or the vagotonia of the psychophysical organism. In particular, neither a neuropathic constitution nor a personality disorder need be clinically manifest. As long as it is not, then we in fact do not have the right to speak of more than a mere constitutional neuro- or psycho-instability.

Turning again to the secondary anxiety, we should still note that it is not only a reactive anxiety (the first of several forms). In the form of the fear of anxiety, reactive anxiety is a reflexive anxiety, that is, it allows itself

to be distinguished from a transitive anxiety, such as a phobic anxiety, that is, the anxiety of something specific. In any case, in time anxiety always seeks—and also always finds—a concrete content and object; it concretizes itself, it condenses itself around the content and the object as its nucleus.

Whereby the content and the object can also alternate. Consider the following. Gisela R., a premenopausal patient, turns to us because of her astraphobia (she is afraid of lightning). In fact, her house had burnt down after being struck by lightning. To the question of why she is afraid in winter—when there is no lightning—the patient responds, "Because I don't suffer from a fear of lightning, but from a fear of cancer." A few years earlier, the mother of the patient had died of cancer. Cancer and lightning had become the condensation nuclei of an alternating phobia.

Likewise, the opposite can be the case and reflexive anxiety can turn into transitive anxiety: a patient was afraid of his supervisor, finally he was afraid of speaking in front of the supervisor, then he was afraid of speaking at all, then he was afraid of being afraid. Consider an analogous case. A patient suffers from serious erythrophobia (i.e., fear of blushing) with the following history. First she blushes when her mother speaks of a certain young man. Then she blushes if the discussion is about other young men. Later she blushes for other reasons. Finally she blushes not only in front of her mother, but also whenever she is afraid of blushing.

We do not encounter somatogenic pseudo-neuroses in the context of hyperthyroidism alone, but also in hypocorticalism, which arises not from an overfunctioning of the thyroid, but from an underfunctioning of the adrenal cortex. The consequence and accompanying symptom is what we call the psycho-adynamic (*psych-adynamische*) syndrome, in which depersonalization is prominent. This also leads to something over and beyond the somatogenic pseudo-neuroses, namely, to reactive neuroses.[6] Again, it is the case that patients with anxiety react to something unusual, to something uncanny that happens to them, that is, they react to the depersonalization. But they react to all of this not like patients with hyperthyroid, that is, with fear of the effects of their condition, but rather with fear of the causes that could stand behind their condition. Most patients are afraid that these symptoms are harbingers or signs of a mental illness, that they

[6] See H. Kranz, *Deutsche Zahnärztliche Zeitschrift, 11,* or *Prosthetik und Werkstoffkunde, 5,* 105, 1056: "Alienation—and depersonalization experiences—are always highly unsettling"; "a lasting disturbance of our sense of self (*Ich-Bewusstseins*) can become a source of considerable and abnormal responses to an experience."

are perhaps even the early symptoms of a psychosis. We call this a psychotophobia (*Psychotophobie*). Such patients already envision themselves lying on stretchers and ending up in straitjackets.

Once again we encounter an amplification phenomenon. Since Haug's work in this area, it has been known that depersonalization can be provoked by a forced self-scrutiny—even in healthy people. We see that just as anxiety is heightened to a fear of anxiety through the circle of reactive anticipatory anxiety, so also is depersonalization increased as soon as it is sucked into the circle of a compulsive self-scrutiny and reactive psychotophobia.

This does not mean that only depersonalization can become the point of crystallization for a psychotophobia. In the following case it becomes apparent, rather, that psychotophobia can arise in other circumstances.

Mr. Matthew N., 40 years old, comes to us in a state of high excitement that has persisted for the last weeks. He had been incarcerated for 2 weeks in connection with a black marketing affair (this case occurred in the immediate postwar period). There was great celebration upon his release, and the patient—contrary to habit—drank heavily. Thereupon, he suffered an apparent vegetative attack, which was accompanied by a feeling of anxiety. The patient tried to overcome this feeling of anxiety by smoking a cigarette, also contrary to habit, upon which his feeling of anxiety only grew and he fell into a vegetative state of emergency. Now, we have heard that anxiety seeks and finds a content and an object, so it is not surprising that it suddenly occurred to the patient that an uncle of his had had a mental illness, that another uncle had committed suicide and that he himself had one night witnessed someone, apparently mentally ill, run through the streets in his pajamas and finally kill himself. From now on, the patient feared that his unexplained anxiety attack could be the har-binger or even the manifestation of a mental illness, and that he may—because of this attack—attempt to kill himself. In other words, the patient developed a psychoto- and suicide phobia, and to the previously discussed somatic vicious circle of "anxiety–nicotine–anxiety" is added a psychological vicious circle: the readiness for vegetative anxiety—reactive psychoto- and suicide-phobia—anxious excitement (see Figure 11).

In this case, not only mental illness, but also suicide, stands as the focal point of a phobia.

Here is another case. Mrs. B. is lactating, and one day suffers a vegetative attack. Subjectively, **paresthesia** stands in the foreground. The patient speaks of a "sensation of wooden limbs." Her medical history puts us on the trail of the "endocrine gland," so much so that we started to suspect

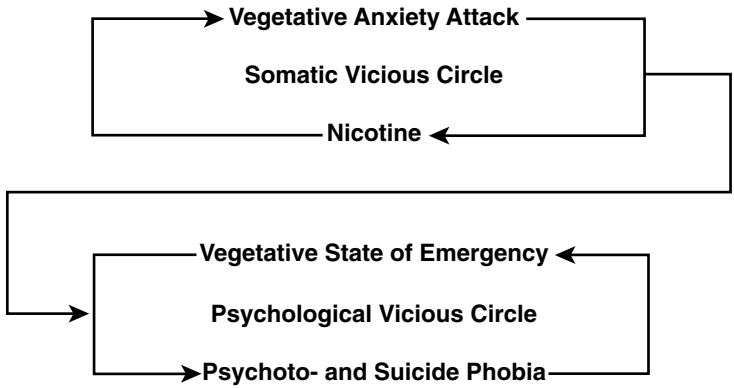


Figure 11

tetanus.[7] In fact, the Chvostek sign proved to be highly positive. That tetanoid pseudo-neuroses accompany the tendency for vegetative anxiety is not unknown; we have already pointed to the correlation between the two states in our discussion of claustrophobia. In this concrete instance, no actual vegetative anxiety developed. It appears rather that the unusual, uncanny feeling that came over the patient caused her to fear that her condition could degenerate, that she could crack (psychotophobia) and do something crazy. (We speak in analogous situations of a criminophobia.) She fears doing something either to herself (in the sense of the fear of suicide) or to the one literally closest to her—her child. We speak here of a fear of homicide. From all of this there arises in the patient the fear of being alone with her child, a claustrophobia, not directly, but rather indirectly. In this case as well we encounter, alongside the psychological circle (anxiety readiness—anticipatory anxiety—anxiety readiness) a somatic circle. For one of the medical history reports expresses the following, "Out of pure fear I have begun to breathe strangely." We are not mistaken when we propose that the patient has begun to hyperventilate and that the hyperventilation heightens and intensifies the anxiety; even the healthiest of persons will have the urge to hyperventilate once they maneuver themselves into a tetanoid metabolic state (see Figure 12).

In such cases, we are no longer dealing with fear of anxiety; rather, we encounter something new: a patient's fear of him or herself. This fear of self can take many forms: fear that their condition could be the harbinger or manifestation of a mental illness (i.e., psychotophobia); or fear that

[7] See Beichel, *Endokrinologische Spurenkunde*.

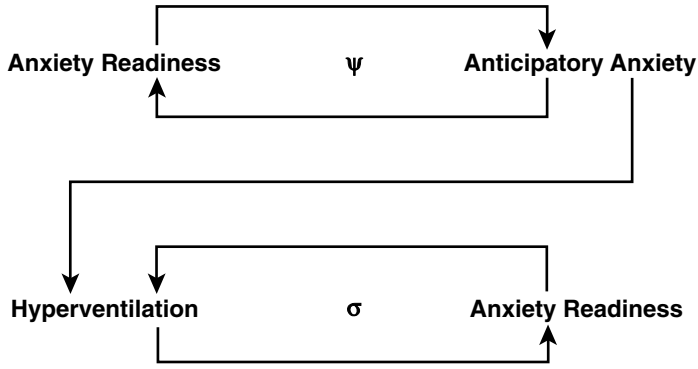


Figure 12

they could do something drastic either to themselves (i.e., fear of suicide) or to another person (i.e., fear of homicide or of committing a crime).

Obsessive-Compulsive Neurotic Reaction Patterns

Reactive phobias must by no means start only in the somatic sphere; they could also originate in the psychological dimension. In other words, among the constitutional foundations of neuroses we recognize not only neurological foundations but also personality disorders, above all, the obsessive-compulsive personality disorder onto which this or that expression of a patient's fear of him or herself is grafted. This results then in compulsive ideas, and the reaction of the patient consists in the fear that he or she could translate the senselessly arising compulsive ideas into action or reality.

Mr. G. (Vienna Neurological Policlinic) was afraid that he could have a stroke, that he could get cancer, that he could throw his child out the window, or throw himself in front of a train, etc. What the reaction of the patient consists of is that he struggles against the compulsions, that he fights against them—precisely in contrast to people with anxiety disorders, who run away from anxiety attacks. In other words, we now encounter the compulsive neurotic reaction pattern: while people with anxiety disorders flee from anxiety, those with obsessive-compulsive disorders fight against it:

Anxiety attack →Fear of the anxiety →Flight from the anxiety →Reactive anxiety neurosis

Compulsive idea →Fear of the compulsion →Struggle against the compulsion →Reactive compulsive neurosis.

However, pressure elicits counterpressure, and the counterpressure strengthens the pressure. And it is likewise true that the interior pressure that the patient endures is increased to a maximum interior tension in a manner no different from the way that anxiety is raised to a fear of anxiety.

Just as the neurotic anxious reaction adds itself to the neuropathic constitution, so does the compulsive-neurotic reaction build upon a constitutional personality disorder; but the reactive compulsive neurosis also allows itself to be subtracted from the obsessive-compulsive personality disorder. In other words, the neurotic reaction to the obsessive-compulsive personality disorder is reversible—it can be cancelled out. In the place of struggling and fighting against the compulsions, that is, in the place of improper activity, need only arise correct passivity, and this passivity can go so far that the compulsions fall into a kind of atrophy of inactivity.[8]

It all comes down to whether patients learn how to deal correctly with the anxiety attacks or the compulsions—and ultimately with themselves. The more patients readjust themselves in this sense, that is, the more the pathogenic struggle and fight against the compulsions cease, the more we see a reduction in compulsive symptoms to the fateful core. And the core *is* fateful, for it is known that the electroencephalogram of people with obsessive-compulsive disorders has shown itself as abnormal: according to Silverman in 48.4 percent, according to Leonardo in 53 percent, according to Hill and Waterson in 75 percent, and (in the case of obsessive-compulsive personality disorders) according to Rockwell and Simons, in 100 percent of the cases. Apart from this, taking only recent literature into account, von Dytfurth has investigated the relationships between compulsive neurosis and the brain stem, and substantiated the hypotheses of other authors in this regard. Moreover, Peter Hays is of the opinion that a hereditary component is also at work: "Genetic predisposition is almost a *sine qua non*."[9]

We are however neither fatalists nor brain mythologists and are far from seeing fate in a personality disorder. Just as little are we therapeutic nihilists. Rather, we believe that a targeted psychotherapy is completely possible and necessary, even in the realm of personality disorders. We have in mind a kind of mental orthopedics. That the patient struggles against the

[8] The improper activity of people with neuroses consists in the struggle against lust (see the section below on sexual neuroses) or in the fight against a compulsion; improper passivity can be seen when people fear and run away from anxiety.

[9] Peter Hays, "Determination of the Obsessional Personality," *American Journal of Psychiatry, 129,* 217, 1972.

compulsions—this is what must be halted. Only we must consider that the struggle against the compulsion has a ground, namely, the fear of the compulsion. It can be rendered objectless by showing the patient the relative immunity to psychoses that belongs to a compulsive-neurotic character type, and thereby demonstrating that there is practically no danger that the neurosis will turn into a psychosis. In other words, it is a fact that people with obsessive-compulsive disorder who suffer from psychotophobia are afraid of something that they have no reason to fear. All this of course holds not only of the psychotophobic, but also of the criminophobic fears of our patients.

To illustrate this with a concrete example, we turn again to the instructive case of Mr. Matthew N. Because of his fear of psychosis and suicide, our approach takes the following form. We tell the patient to his face that he has always been pedantic and scrupulous, and ask him whether he has not always been in the habit of checking to see whether the gas lines or the hall door are definitely closed. As soon as the surprised patient answers our question in the affirmative we explain to him the following: "Look here, any person can become mentally ill, even those without a genetic predisposition. Only one group of persons is an exception to this, is immune to psychotic illness, and that is people who have a compulsive-neurotic character, who are inclined to have or even have various compulsive fears. And what you have reported, which we call repetition- and control-compulsion, are typical compulsive fears. So I must rob you of your illusions: you could not possibly be psychotically ill—precisely not you!" When you speak with patients thus, then you practically hear the weights crashing as they fall from their heart. Within 48 hours the condition subsided, and years later the patient reported, at a coincidental meeting, that he has remained completely unburdened by this problem.

Consider the case of a theater actor who was afraid of having a stroke or a brain tumor and of having outbursts on the stage, and so forth. Two years ago he injured himself upon entering the stage, and three weeks later he was to play the same role, and experienced a dizzy spell. Upon appropriate questioning he admits to having had anticipatory anxiety. His arterial blood pressure was low, which we mentioned to him to reassure him that he was not in danger of having a stroke. But more importantly he was told the dizzy spell was explained by the hypotonia. Now we ask the patient whether he has not always been pedantic and scrupulous. He responds affirmatively and is correspondingly enlightened (see above). In addition to this, he is instructed to tell himself immediately before his next appearance on the stage, "Yesterday I twice began to scream on the stage

and the day before three times; today I am going to go crazy four times, and now I'm going to go crazy."

In the following case, the attending doctor was able to limit treatment to paradoxical intention. William (Vienna Neurological Policlinic) was 40 years old. Seventeen years ago he was suddenly smitten with the fear of going crazy. An unfounded fear overcame him, a feeling till then unknown to him, and in response to this newly experienced feeling he told himself, "this is how you feel when you go crazy." After this fear overtook him, he called an ambulance while still at his office—the patient is a police district inspector—by reporting that someone had had a nervous breakdown and needed to be taken away. The doctor gave him baldrian drops and brought him home. "From this day on I have been waiting to go crazy. That is, I keep waiting to do something that a crazy person does: I might break a windowpane, or smash a window display. If I'm alone with my child, then I expect to kill him—who would hold you back, I ask myself, if you were to go crazy and kill the child? I am afraid of bridges and open windows, for I am afraid of jumping. I am afraid that I may throw myself in front of an oncoming car or an approaching trolley car. Finally, I am afraid of shooting myself. On the street, I'm afraid that I could have a heart attack, a stroke, or who knows what. That is, I am afraid that I could get myself so agitated that I have a stroke. I've waited 17 years for all of this. I watch myself, I can't forget myself." In addition to this there is scrupulosity, brooding, counting compulsion and a complicated reading ceremony. "Everything is fine, work is going well with no difficulty or stress, my marriage is very good, and the children cause me no worry or disgrace." The patient has already twice undergone inpatient treatment at neurological clinics. For the last year and a half he has received psychological treatment from a specialist in individual psychology, meeting for sessions 3 times a week. "An inferiority complex in connection with my red hair and a need for recognition were discovered." Therapeutically the patient was led to look his anxiety in the face, indeed to laugh in its face. With the help of paradoxical intention the patient was enabled to take the wind out of the sails of his fear.

It can be shown[10] that such a typical neurotic repetition compulsion can be traced back to an insufficient feeling of evidence,[11] and the control

[10] Viktor E. Frankl, *Ärztliche Seelsorge*, 1st ed. (Vienna 1946), p. 158.

[11] Consider the case of Franziska (Vienna Neurological Clinic), a patient on whom we had performed a prefrontal lobotomy: ". . . I have always believed that it is not I lying in the bed. I had to get into the bed over and over, until I was really I. I have always believed that it is not I who gets into bed, but rather someone from the next room or someone else, and therefore I get out over and over again, often for hours. . . . Previously, I could only stop washing when I succeeded in firmly imagining that it is I who was washed. . . ."

compulsion to an insufficient confidence in instinct. E. Straus has pointed out with justification that obsessive-compulsive disorder is characterized by an aversion to anything temporary. No less characteristic, in our opinion, is an intolerance of all uncertainty. Nothing having to do with knowledge is allowed to remain uncertain; likewise nothing having to do with a decision is allowed to be viewed as temporary. Rather, everything must be defined and remain definite. The obsessive person would prefer to prove everything—even that which rationally cannot be proven, for instance one's own existence or even the reality of the external world. The external world is as indemonstrable as it is indubitable.

People with obsessive-compulsive neuroses try to compensate for a lack of knowledge with over-deliberateness or for decisional insufficiency with over-conscientiousness. In the cognitive sphere this amounts to a hyperreflection, to a compulsion to observe, and in the realm of decision to a hyperacuteness of conscience. As soon as the conscience even whispers, the patient experiences a threat.

People with obsessive-compulsive disorder are animated by a Faustian compulsion, a will for 100 percent certitude, the struggle for 100% certain knowledge and correct decision. Like Faust, compulsive people fall apart in finding "that for humans, nothing is perfect."

But he does not give up the fight for 100 percent certitude in knowing and in deciding. So, just as for someone with an anxiety neurosis the anxiety concretizes and condenses around the content and the object, the absolutism of people with obsessive-compulsive disorders is a reduction of *pars pro toto* (R. Bilz), that is, a substitution of the part for the whole. It limits itself to a pseudo-absoluteness. The good school child satisfies him or her self with absolutely spotless hands, the efficient housewife contents herself with an absolutely clean home, and the intellectual satisfies himself with absolute order[12] on his desk.

Therapeutically, it all comes down to building a golden bridge, which ultimately leads to the self-destruction of rationalism. As they begin to tread this path, we put the solution into the patients' hands: the most rational thing is not wanting to be too rational.

Prevention comes down to a recommendation, a recommendation to overcome the will to hundred-percentness, to renounce the demand for 100 percent astute knowledge or correct decision. This recommendation was already anticipated long ago: "Be not overly righteous, and do not make yourself overly wise. Why should you make yourself crazy?"

[12] One of our patients expressed himself as follows: "My 'sanctuary' is the room that I clean and that no one enters but myself. Everything revolves around the order and cleanliness of all the things belonging to me, things which do not serve me, but which are served by me."

(Ecclesiastes 7:16). The patient is not exactly crazy or mentally ill; but who would hold it against the Bible that it has not posited the differential diagnosis between neurosis and psychosis?

Sexual-Neurotic Reaction Patterns

We stated earlier that as the wish is the proverbial father of thinking, so is fear the mother of occurrence—of the occurrence of illness. This holds at least for anticipatory anxiety: a symptom that is in itself harmless and fleeting produces a corresponding phobia, the phobia in question intensifies the symptom, and the symptom, intensified in this way, confirms the patient still more in the phobia. The vicious circle is closed. But anticipatory anxiety exists not only in this general sense, but also in a particular sense. In the particular sense we distinguish between (1) fear of anxiety, as we encountered it primarily in anxiety neuroses, and (2) fear of the self, as manifested in compulsive neuroses.

We encounter anticipatory anxiety also in the case of sexual neuroses, in both general and specific forms. As regards the former, we see repeatedly how our male patients become unconfident due to a single, not to mention accidental, sexual failure. Once they become unconfident their anticipatory anxiety is empowered for a repetition of the impotence. Not infrequently is it only then that their actual sexual neurosis is born, in that it is actually the anticipatory anxiety that establishes the impotence. In other words, the anticipatory anxiety makes the one-time failure a first-time failure.

If we ask ourselves how it is that the general anticipatory anxiety that makes the impotence permanent is provoked, the answer would be through the particular anticipatory anxiety of the impotent one, which consists in the anticipation that something is expected or demanded of him. Namely, what is feared is that some achievement is demanded, namely, coitus. And it is precisely this demand character that exercises such a pathogenic effect.

The demand that is attached to coitus for people with sexual neuroses can stem from the following three sources:

1. The partner with whom the patient is to have intercourse
2. The situation in which the coitus is to take place
3. The patient himself who is intending to have intercourse—largely because he is all too intently focused on the sexual act

In the first case, the person with a sexual neurosis is afraid of not measuring up to the demands of a sexually demanding, "temperamental" partner. This fear is no less typical in cases where the patient is much

older than the partner—then he feels overwhelmed in his sexual ability; when she is older than him, he may feel inferior, for then he assumes that she is more experienced sexually, and is afraid of having his sexual ability compared with that of one of his predecessors.

In the second case, the person with a sexual neurosis cannot bear entering into a situation that involves a sexual demand, a "*hic Rhodus hic salta*."[13] For this reason, the neurotic person typically fails whenever he looks for a get away, an hourly rate motel, or responds to an invitation that involves a sexual challenge—while the same patient, as soon as he has an opportunity to improvise a sexual encounter, is not in the least impaired in his function.

In the third case, it is not only the *hic—hic et nunc* (that is, the here—the here and now) that plays a role, it is characteristic of our impotent patients that they direct their consciousness toward coitus itself. In other words, they put themselves on the spot. Let us consider for example the situation in an hourly rate motel. There we have a "*carpe*—not *diem*, but *horam*" (that is, seize the hour, not seize the day). For the neurotic type that we are considering, time is money; this money however is pleasure. What this neurotic type invests—for instance in renting the room—what he has put into it, he wants to get out of it. Only he forgets that this is essentially not possible. There is something he has not reckoned with, for the more he seeks his own pleasure, the more it escapes him, and finally the pleasure is completely lost.

The above is clinically substantiated and explained in the following.

To illustrate the first case, consider the story of Mr. W., who is returning from being a prisoner of war and must come to grips with the realization that his wife has been unfaithful to him. He reacts to this experience by an onset of impotence, which leads to his wife's leaving him, whereupon the impotence progresses. He marries a second time, but his second wife is also unfaithful, also because of his severe impotence. At the same time she demands that the patient have sex with her, threatens that if he fails again she will continue to be unfaithful, and makes good on this threat repeatedly. We are dealing, if you please, with a gynogenic (i.e., caused by women) impotence that can be contrasted with the female androgenic (i.e., caused by men) sexual disorders that we have elsewhere noted and described (just think of the frequent cases of frigidity linked to premature ejaculation). To a large extent, a gynogenic impotence is also present in the following instance.

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[13] *Apparently this Latin phrase refers to a braggart who claimed to have jumped remarkably high at the last athletic games in Rhodes, to which the reply was "Here is Rhodes, now jump!" An apt English phrase might be "put your money where your mouth is."—JMD*

To illustrate the second kind of case, let us consider the story of Joseph (Vienna Neurological Policlinic). Joseph is 44 years old and has already consulted 10 specialists with no success. In providing a psychiatric history, he relates that after 3 weeks of vacation he returns home, and his wife calls him—contrary to her normal custom—into their bedroom. This sufficed to trigger a (first-time) incidence of impotence, which later became fixed precisely through the ineptitude of his wife: having once failed in allowing the patient the spontaneity and initiative in sexuality—a failure that provoked the impotence—she began all the more to reproach him with his impotence. This mistake on the part of the wife must have then fixed the impotence. His gynogenic impotence was inevitable.

George (Vienna Neurological Policlinic) illustrates the third kind of case. George was a 43-year-old patient, who had heard that there is such a thing as male climacterium (i.e., male change of life with attending decrease in libido and ejaculation). His wife is pregnant, hence sexual intercourse is irregular, and after the delivery is reduced to nothing more than coitus interruptus. In the Viennese dialect there is an apt expression for this type of intercourse: "being careful." Now, those who are careful, who must "pay attention" to themselves, cannot really give themselves, they are incapable of self-donation. Thus, it is not surprising that this concrete case resulted in erectile dysfunction, which on the part of the wife leads to dyspareunia (i.e., pain accompanying intercourse). Once the wife made the mistake of telling her husband about her own lack of pleasure, the "vicious circle for two" closed in on itself. The reduction of the male potency led to a decrease of female orgasm, and this decrease led to an increasing reduction of the male potency (see Figure 13).

In all the above cases of impotence we are dealing with a reactive sexual neurosis, with a particular kind of psychogenic impotence. What does the therapy look like?

First we must see to it that patients in sexual neurotic reactions learn to see the situation as something humanly[14] understandable. Moreover, it is necessary to strip the demand character from the sexual act. It is necessary to enable an unstated retreat. With regard to the demand that arises from the patients themselves, it is necessary to convince the patients that they should not proceed programmatically with coitus, but rather content themselves with fragmentary intimacies, somewhat in the sense of a mutual sexual foreplay. Then coitus arises of itself; then the patients find themselves before *a fait accompli*. With regard to the partner and any

[14] As noted in the introduction, Konrad Lorenz was able to make a female *betta splendens* fish swim energetically at the male fish, rather than coquettishly swimming away from him, upon which the male, so to speak, reacted humanly: his mating apparatus was shut down reflexively.



A Vicious Circle for Two

Figure 13

demand coming from the partner, the following trick helps. We tell the patient to explain to the partner that we have strictly forbidden sexual intercourse—in reality there is no talk of a strict forbidding of this kind, and the patient should not act according to this, either in the long run or the short, rather—now freed of the sexual pressure that the partner had laid upon the patient up until the issuing of an apparent prohibition of sex—the patient advances closer and closer to the instinctual goal at the risk of being rejected by the partner—because of the alleged prohibition of sex. As soon as this happens, the patient has a done deal. The more the patient is refused, the more the patient is successful.[15]

Premature ejaculation stands as a chapter in itself. The psychological tendency to premature ejaculation is well known, how after irregular intercourse it crops up, even in normal men. It normally starts giving them problems only when reactive anticipatory anxiety arises. Therapeutically, it is recommended in cases such as this to encourage *coitus repetitus* (repeated coitus) even at the price of administering the appropriate medical drugs. (From this we see how mistaken it would be, in such cases, to prescribe sedatives.) As soon as the coitus repetitus produces at least a relatively retarded ejaculation, the accelerated reflexive occurrence is derailed and the anticipatory anxiety is deprived of its object.

What the patient with premature ejaculation ultimately needs is to discharge sperm and to release tension. In other words, he is looking for freedom from his lack of pleasure—for the negative pleasure of such liberation. With this, however, we mean that he is looking for the restoration of a mental state, that is, the prematurely ejaculating patient is oriented toward a state—and not toward an object. The object of something

[15] Only once did we hit upon a difficulty: the partner of the patient had insisted on intercourse, since she saw in it the only evidence of love. At that, we knew exactly what to do, and directed the patient to inform his partner that there are Madonna types and harlot types (S. Freud), and that men affected by the Madonna type react to her with impotence, precisely because they do not desire him, but rather love him. From then on, the wife of the patient saw impotence as a sign of love. Meanwhile, the patient's function was immediately restored.

such as love for example cannot be seen. And what is the object of love? The person of the partner; for to love means to be able to say "thou" to him or her (indeed, to "catch sight of" the person) and, beyond this, to be able to say "yes." In this regard, the sexuality of the prematurely ejaculating patient is in fact a sexuality "without a vision of the person" of the partner.

While premature ejaculation prescinds from the person, from the object of the drive (to express it psychoanalytically) masturbation also prescinds from the object of the drive. Masturbation means, to make use of the expression of A. Moll, a rejection of the amorous touch—the masturbator is concerned only with the sexual release. From then on all intentionality departs from sexuality (meaning, it is no longer directed toward something beyond of itself). For love is after all purely and simply intentional. Now comes a loss of every connection of person to person, of the *I* to the *thou*. Hence, the depression that follows masturbation is anthropologically understandable.

We mentioned above that the prematurely ejaculating patient is searching for freedom from a lack of pleasure, for a negative pleasure. In contrast to this, the impotent patient is searching for positive pleasure. We have mentioned that precisely because he is looking so anxiously for pleasure this pleasure escapes him. In other words, the principle of the impotent patient is rightly called a pleasure principle. It is self-defeating—it stands in its own way. Pleasure numbers among those things that must remain an effect, and that cannot be intended; sleep is also one of these things, of which DuBois writes that it is a dove that flies away as soon as you make a grab for it. Pleasure is also an effect that does not allow itself to be "grabbed at." Kierkegaard speaks analogously when he notes that the door to happiness opens outwards; it closes itself all the more tightly as we try to push our way into happiness. We could say that the hunt for happiness scares it away—the fight for pleasure chases it away. In particular, people with sexual neuroses hunt for happiness and chase pleasure. The fight for pleasure is characteristic of the sexual-neurotic reaction pattern. We are dealing here with a forced intent for sexual pleasure and orgasm.

In the case of sexual neuroses, a forced reflection is linked to the forced intention. Both are pathological, an excess of attention and intent. The patient observes himself, he does not consider the partner, he gives her no consideration, he does not give her himself, and all of this inhibits potency and orgasm. It results in a hyperreflection, as we have called it.

Consider a concrete instance. Miss S. (Vienna Neurological Policlinic) comes to us on account of her frigidity. In her childhood, the patient was sexually abused by her father. Heuristically, however, we act as if there was no such thing as a psycho-sexual trauma; rather, we ask the patient

whether she had expected to be injured by the incest, and the patient confirms our supposition. She was influenced by popular literature that has a vulgar version of psychoanalysis at its core: the patient was convinced that "that must be paid for." In other words, a book-induced anticipatory anxiety had developed. The patient was captive to this anticipatory anxiety whenever she found herself in an intimate situation with her partner, "lying in wait." As a consequence, her attention was divided between her partner and herself. All this however necessarily frustrates having an orgasm, for to the extent that one focuses on the sexual act one is unable to surrender the self; that is, in place of the object of love comes the sex act as the focal point of attention. In the case of our patient, not only a forced reflection on the sex act was brought about by the effect of the book-induced anticipatory anxiety, but also a forced intention of sexual pleasure, the forced intention of an orgasm. The patient wished once and for all to preserve and confirm her own femininity. One speaks of a bibliotherapeutic treatment; in our case the attempt at an auto-bibliotherapy had only led to a bibliogenic neurosis. The therapy in contrast took aim at the forced intention and the forced reflection. In this sense, we made it clear to the patient, starting with DuBois's analogy cited above, that what holds for falling asleep also holds for sleeping with someone. "The happiness in love that you so forcefully and tensely pursue," we proposed to her, "is no different than sleep—it is like a bird that flies away as your hand stretches out toward it. Don't think about the orgasm. The less you care about it, the more and the sooner it will come of itself." *Abstinendo obtinere*—thus runs the motto of a monastic order, and, if it did not come across as blasphemous, one would be tempted to counsel our patient to follow these words of wisdom when the modest happiness of her earthly love is in question. I then convinced my patient that I had at the moment no time to take on her treatment, and told her to come back in two months. Until then, she was not to worry about her ability or inability to have an orgasm—this would be amply discussed during the treatment—but only to be sure to turn her attention to her partner whenever they have intercourse. What happened next corroborated my approach. What I expected indeed took place. The patient returned not in two months, but already in 2 days—healed. She merely freed her attention from herself, from her ability or inability to experience orgasm—in short, she underwent a dereflection—and the now unfettered devotion to her partner had sufficed to bring about an orgasm for the first time.

I offer two counterparts to the above case involving men. One of our patients, who came to us because of impotence, recalled a detail while telling his history. He was in Paris and had visited a nightclub with some

of his friends. While they stared spellbound at the stage—where nude dancers were performing—he was troubled to find that he was not experiencing an erection. As we expected, it became clear that the patient had not looked at the stage, but had rather paid attention only to whether an erection was coming on.

Hermann, a 24-year-old physician was married for only 3 weeks when he began to experience impotence. He had no sexual intercourse with his wife prior to marrying. Only improvised sexual acts had ever succeeded. The very first attempt at intercourse had not succeeded at all. "I watch myself then like a hawk to see how the erection is—will it be decent or not? Then every arousal subsides, because I am watching myself."

The pathogenesis of reactive sexual neuroses consists not least in that sexuality is reduced to a mere means to an end. This throws a light not only on therapeutic necessities, but also on preventive possibilities. Because it means there may be trouble when the sexual life is turned into sexual technique. People with sexual neuroses pervert and degrade sexuality to a mere means to pleasure, while in reality it is a means of expression, namely, the expression of a striving for love; to the extent to which the sexual life is taken out of the totality of the love life, to the extent to which the sexual life is disintegrated and isolated, to that same extent do people with sexual neuroses lose the immediateness (the "not-being-a-means"-ness) and uninhibitedness, which is a condition and presupposition of normal sexual functioning.

Human sexuality is always more than mere sexuality, namely, insofar as it is the expression of a striving for love. When it is not this, then there will be no complete sexual pleasure. Maslow noted once, "The people who can't love don't get the same kind of thrill out of sex as the people who can love." So, in the interest of the greatest possible pleacsure even if there were no other reasons for it, we should stand up for the view that the human potential that lives within sexuality should be used to the fullest, namely, the ability to incarnate love, the most intimate, most personal relationship between persons.

Just how right Maslow was becomes apparent from the summary of 20,000 answers to 101 questions posed by the American magazine *Psychology Today.* It became evident that of the factors that contributed to a maximizing of potency and orgasm, "romanticism" (which may mean anything between amorousness and real love) was the most important.

Sexuality obviously cannot be through and through human. For it is something that humans share with other living creatures. It is better said that human sexuality becomes respectively more or less human, that it is

respectively more or less humanized. In fact, sexual development and maturity follow a series of levels, which crystallize into three stages.

It is known that Freud introduced the distinction between the end and the object of a drive. On the immature level of human sexuality, a drive is directed only to its end (*Triebziel*), and this is the release of arousal and tension, regardless of the manner in which this is achieved. Masturbation can also achieve this. When sexual intercourse becomes the end of the drive, thereby including an object of the drive, then maturity has been reached. In opposition to this, we maintain that the person who in actuality uses other persons as a means of discharging arousal and tension has in reality turned sexual intercourse into an act of masturbation. Our patients speak here of "masturbating on a woman." In our opinion, the mature stage is only achieved when the one relates to the other no longer as a means to an end, no longer as an object, but rather as a subject. At the level of maturity the relationship is taken to a human plane, the relation becomes an encounter, in the context of which one partner is comprehended by the other in his or her humanity. If he or she is experienced not only in his or her humanity, but also in his or her uniqueness, then the encounter is transformed into love.

Whoever does not arrive at the mature stage of human sexuality, but remains rather on the immature level, is incapable of seeing his or her partner as a unique and unrepeatable subject, that is, as a person. But as a prophylaxis for sexual neurosis, the maximal "personalization" of sexuality is desirable not only in terms of the person of the partner, it is desirable also in terms of one's own person. The normal sexual development and maturity of persons leads to a growing integration of sexuality into the totality of the individual person. From this it becomes clear that antithetically, every isolation of sexuality runs contrary to every integrating tendency, and thereby promotes neuroticizing tendencies. The disintegration of sexuality—tearing it out of the personal and the interpersonal transsexual context—constitutes a regression.

Preview

Chapter 6. Iatrogenic Neuroses: On Neuroses Arising from a Medical Intervention

This chapter is dedicated to the discussion of iatrogenic neuroses, or those neuroses that arise in reaction to the intervention of the physician or therapist. While this chapter contains sundry warnings and admonitions, it has two main themes:

- In iatrogenic neuroses, anticipatory anxiety typically fixates the symptom in question, which has been highlighted during treatment. For example, psychoanalysis may lead to a forced scrutinizing of neurotic symptoms, increasing anticipatory anxiety of the symptoms and fear that the symptoms are precursors of a psychotic illness. This can contribute to an anxiety neurotic or obsessive-compulsive reaction pattern of the sort described in chapter 5.
- To avoid triggering iatrogenic neuroses, therapists should:
    - Allow patients to speak and objectify their symptoms
    - Validate the reality of their symptoms and avoid trivializing their symptoms—even when there is no organic cause
    - Avoid premature diagnoses and stigmatizing patients
    - Be forthright and offer reassurances as appropriate. For example, when they appear concerned, patients with obsessive-compulsive disorders should be reassured that their symptoms are not precursors to psychotic disorders

Chapter 6
Iatrogenic Neuroses: On Neuroses Arising from a Medical Intervention

We may say that the iatrogenic constitute a subgroup of reactive neuroses. As iatrogenic neuroses we designate those (predominantly neurotic) states of illness in which it becomes retrospectively apparent that the physician-*iatros* has induced the pathogenic moment. This doctor-induced pathogenesis rests in essence on anticipatory anxiety; at least it does so insofar as it is anticipatory anxiety that first fixes the symptom in question. Above we have used the expression coined by F. D. Roosevelt, albeit in a completely different context, and which is equally valid in this context: nothing is to be feared as much as fear itself. Going beyond this, there is almost nothing to be feared as much as those doctors who have become so masterful in breeding iatrogenic neuroses through unintentional or thoughtless words to their patients, that one could quite justifiably speak of them as iatrogeniuses.

Turning now to the question of a possible prophylaxis for iatrogenic neuroses, it can be said that it must begin with patients describing their problem. Here above all we must let the patients speak, and in this manner allow the benefit that self-expression brings to slowly take shape: it allows patients to objectify and simultaneously distance themselves from the symptom.

The situation must be constructed just as thoroughly as the anamnesis, or self-expression, is carried out. The examination must be ostensibly thorough—its precision should be made apparent to the patients. Under no circumstance may we trivialize their difficulties, characterizing them as merely nervous or even imagined or suggested. One cannot help thinking that such comments can be made out of frustration when negative results

are obtained following laborious examination: the doctor unloads frustration on patients, dismissing them and where possible branding them as hysterical. Being called hysterical, however, will be identified by that patient as an accusation of feigning illness, and will be experienced as insulting. In the case of complaints for which there is no organically demonstrable cause, we attempt to make this clear to the patients by saying things like: "You are not imagining anything—what you feel, you really feel—I do not want to talk you out of anything. Nevertheless, there is fortunately no organic illness here, the condition is unpleasant, but not dangerous, and this is always better than the opposite." While any kind of trivializing only elicits protest from patients, it is possible with this approach to remove their attention from the subjective symptom. How often is it the case that potential healing lies less in the dissolving of the symptoms themselves than in the shifting of attention, which—insofar as a physician focused attention on the symptom—was the pathogen to begin with.

It is not only always necessary to let patients speak, but it is also necessary to speak and let speak. And here again we must remember to speak in plain language and translate technical terms. For instance, I know of a patient who insisted she knew just how sick she was. She suffered from a *cor pulmonale* (i.e., severe cardio-pulmonary disorder)—or so she read in a medical record. But in doing so she overlooked the notation "o.B."—*ohne Befund* (i.e., "not found").

Finally, it is necessary not only to speak, but under certain conditions to be silent as well. Certainly, the psychotherapeutic profession has in jest been called a work of the mouth, but psychotherapists and general practitioners must also be able to keep their mouths shut. It is never justified to say, "What one cannot diagnose is to be considered a neurosis." In addition to the precept "no diagnosis of a neurosis *per exclusionem*" (i.e., by process of elimination) there is a second, "no diagnosis *ex iuvantibus*" (i.e., deduced retrospectively from a prescription that proved helpful). I know of a case, one among many similar cases, of a young girl complaining of pains, whose complaints bore a markedly hysterical character; an injection of physiological saline solution—I would rather call it in this case a "psychological saline injection"—even bore prompt results. Despite this, an X-ray was ordered and showed the presence of a cancer metastasis.

One should never make a diagnosis at all costs, since precisely these sorts of makeshift diagnoses often end up causing neuroses. One only need think of Karl Kraus's apt observation: diagnosis is among the most widespread of illnesses.

Under certain circumstances, not speaking can be just as harmful as speaking too much. This happens when the doctor acts too mysteriously and, even if well intentioned, remains silent about the negative results of a test. The patient then does not understand his ailment and generally has the tendency to project the worst. Therefore it is recommended to be forthright with the patient even about the negative results of an examination.

This pertains not only to the psychiatrist, it pertains above all to the psychiatrist. It should be noted that psychotophobia numbers among the iatrogenic phobias, and that it is more prevalent than many will admit. In such cases, it is precisely the compulsive neurotic type that reacts to neurotic experience with psychotophobia. Attending physicians should not feed this phobia. On the contrary, they should confront it with the appropriate measures, and these measures include making it known to the patient that compulsive neuroses confer a certain kind of immunity to psychotic illness.

Gertrude (Vienna Neurological Policlinic) was 25 years old. She was a physician and the wife of a physician. She suffered from a pseudoneurosis overlaid by an iatrogenic neurosis, with characteristics of agoraphobia and later of psychoto- and criminophobias. She had extreme agoraphobia and trembling. She lost 15 kilograms in the past half year. Her basic metabolic rate was + 31 percent. She relates that since she visited a psychiatrist, all her other phobias were triggered. "The sword of Damocles, the oncoming of insanity, hung over my life. I tried to come to terms with this, namely, with the schizophrenia. I asked my husband in a general way: What actually happens to people with schizophrenia, do they have to live permanently in an asylum? Only if they become a threat to society at large, was his answer. At this a hellish fear of myself awoke within, the fear that I could become dangerous to society at large. I began to fear the sight of any knife and any hammer, purely for thinking that I could suddenly, at the outbreak of the insanity, become a murderer. I saw myself sitting lifelong in a cell, separated from my little boys, who perhaps also carry the seeds of this dreadful fate within them."

Since Haug we know that a forced self-scrutiny in and of itself tends to lead to abnormal phenomena, such as depersonalization symptoms, which in turn give rise to psychotophobia. The tendency toward exaggerated self-scrutiny, however, need not be pathological; rather, it can arise, for example, during puberty for physiological reasons, but can also have professional causes, so to speak, namely, in the case of psychology and psychiatry students. The misleading talk about split consciousness,

schizophrenia,[1] split personality, etc., soon makes these all appear as "ghosts," in the sense of Ibsen's play by the same name. For example, a psychology student once asked me whether it's possible that her brother, who suffered from schizophrenia, may not have laid the foundation for the illness with a childhood head injury. During a fight one of his schoolmates hit him on the head with a drawing tablet. Perhaps this had split his personality.

This also holds true of therapy. There should never be therapy at any cost. No therapy *ut aliquid fieri videatur* (i.e., simply in order to appear to be doing something). Many physical or local treatments that are unnecessary in this sense only contribute toward fixating symptoms that for a long time were merely neurotic. So for instance, I know of a Swiss patient, psychologically fully normal, who sought treatment from a psychologist for years because this psychologist had told her that otherwise the id, the unconscious, would revenge itself on her in some other way, would one day ambush her consciousness, would take her by surprise and overcome her. Why had she begun the psychoanalysis to begin with? Because her (very rich) friend had once told her that she herself was going to an analyst, that it was doing her tremendous good, and that she should absolutely start doing the same.

Hans H. is 35-years-old. Two years ago, following a feverish illness, he experienced a problem walking. Twice he visited a neurological clinic, where on the first visit the possibility of multiple sclerosis was raised. However, on the second visit, after experiencing positive therapeutic results from high frequency radiation, he was assumed to be functional. A neurological specialist, who was also treating the patient, prescribed hormone injections. All to no effect. At the same time, the patient underwent treatment by a quack. The patient exhibited a walking disability reminiscent of a severe case of inherited muscular dystrophy; he was only able to get around with the help of two crutches. The objective neurological diagnosis, meanwhile, was conclusively negative. The patient then comes to one of my classroom demonstrations, where he is told that he will receive "a serum" injection that, as the students can attest, has had excellent results in other cases. Whereupon the patient is slowly injected with 5 ccm sodium pentothal (a weaker dosage), and immediately asked to report on his subjective sensations. He reports that he feels an emptiness in his head. We immediately make use of this by telling him that the emptiness in the

[1] The word "*Spaltungsirresein*" owes its coinage to the old association psychology, under whose influence Eugen Bleuler conceived of schizophrenia as a becoming independent (that is, a separation) of association complexes. That this mental illness is an actual splitting of the personality, or has anything to do with such a splitting, is in no way the case.

head is a result of all the "nerve energy" moving from the head to the legs. Soon he will feel how the "power of life" will "concentrate" in his legs—does he not feel this already? "Yes, but at present only in the thighs." After a few minutes (which I fill with suitable, albeit completely indirect, masked verbal suggestions) the patient finally reports that the "nerve energy" has reached the outer portions of his lower extremities. He is then sat up, told to stand up and to walk around the classroom, he is assured that the attempt will be successful, and it was successful. Without the crutches, and with a certain amount of hesitation—and suggestive encouragement—he begins to walk completely normally with no support at all, and runs overjoyed into the arms of his wife, who had accompanied him. He bids us farewell, thanking the colleague who gave him the injection for the "miracle healing."

A final word on the therapy of iatrogenic neuroses: it should take as its starting point the task of making clear to the patient what was emphasized above, namely, the role that anticipatory anxiety plays in the emergence of illness and the significance of forced self-scrutiny, which is capable of disrupting all automatically regulated functions. The mere directing of attention, in other words, forced self-scrutiny, is sufficient to bring unconscious sensations to consciousness.

Every explanation of this kind will have a complete therapeutic effect if one thing is not omitted: making patients understand that no matter how real the mechanism of anticipatory anxiety that underlies their neurotic complaints is—and indeed it is a pathogenic mechanism—we can completely understand it as something human, and indeed need not declare it an illness. For then patients will not continue to feel stigmatized, and from here on out the foundation is removed from iatrogenic fears.

Preview

Chapter 7. Psychogenic Neuroses: On Neuroses with Psychological Causes

This chapter is devoted to clarifying the sense in which neuroses are psychogenic.

- The role of psychological traumas and conflicts in producing neuroses is grossly exaggerated. In fact, traumas and conflicts are common and rarely produce neuroses.
- Whether or not a trauma or conflict produces a neurosis depends on the character structure and reactions of the individual person. Hereditary factors may predispose some people toward neurotic reactions; hence the psychogenesis of neuroses typically indicates only a primary causality—other factors may have a causal influence.
- Freedom and responsibility give rise to the possibility of being anxious and guilty, each of which are primary clinical phenomena in neurotic individuals.
- A significant task of psychotherapists in treating neuroses is to use traditional techniques like dream analysis or relaxation therapy in order to bring to light "unconscious rationality." That is, some motives may be unconscious (thus not in the sphere of freedom and responsibility), yet also noninstinctual (hence, rational). Such motives should be made conscious so that they can be brought into the sphere of freedom and responsibility.

Chapter 7
Psychogenic Neuroses: On Neuroses with Psychological Causes

The psychogenesis of true neuroses does not imply, as is so often held, that the neurosis in question is determined by a psychological trauma or through a psychological conflict. These are in fact rarely the ultimate and actual cause of the illness under consideration. That a mental trauma, that is, a sufficiently difficult experience, has an injurious, a permanently damaging effect on a person, depends in each case on that person, on the complete character structure, and not on the actual experience that the person had to undergo.

The founder of individual psychology, Alfred Adler, was in the habit of saying, "The person makes the experience"—meaning by this that it depends upon persons whether and how they are influenced by their environment.

Not every conflict will lead to psychological illness; rather, it is necessary to show that the perceived conflict is pathogenic—for only then is the illness in question psychogenic.

For example, our department was sent a case that had been investigated and treated elsewhere with narcoanalysis with the conclusion that this was a psychogenic illness based on a marital conflict and that it was, moreover, incurable. In reality, it soon became clear that the case was not a psychogenic, but rather a functional illness; that is, it was what we characterize as a pseudo-neurosis. In fact, the patient was completely free of any complaints after a few injections of dihydroergotamine—so much so that after her physical health was restored, she was fully up to the task of confronting the marital conflict. That this conflict existed was indisputable, but it was not pathogenic, and therefore our patient's illness was not

psychogenic. Were marital conflict per se pathogenic, then perhaps 90 percent of all married people would be neurotic.

Already the ubiquity of most conflicts speaks against their pathogenesis. Regarding psychological traumas, Kloos believes that "with a modicum of ingenuity and interpretive skill, they can be found in the life of every person." I find that it's not even necessary to be ingenious. In order to prove my own assertion to myself I undertook a sampling with this in mind, and had my colleague Lotte Bodendorfer review 10 cases from our psychotherapeutic outpatient department with an eye to those conflicts, problems, and psychological traumas that could be identified in the medical history. She found 20. These 20 conflicts and other problems were then sorted into categories, whereupon an equally random series of 10 cases from our neurological station, wholly unremarkable from the psychological point of view, were examined or explored with an eye for the same thing, that is, these somatic illnesses were scrutinized for the same kind of problems. They found 51 conflicts among the 10 cases. These neurological patients had in fact suffered and, to make use of an expression from Speer, managed to "process," even more psychological traumas and conflicts. Small wonder, when we take into consideration that each of their somatic illnesses necessarily entailed an abundance of problems. Similar and similarly difficult experiences therefore had mentally traumatized the one group and not the other. Thus, what individual persons experience cannot be attributed to the environment, but to persons individually and their attitudes toward their experiences.

It would not make sense, then, to try to prevent neuroses by attempting to spare people all conflicts or remove all difficulties from their paths. On the contrary, difficulties should rather be prescribed to mentally toughen people, so to speak. It would in particular be mistaken to overestimate the mental strain of problems in their pathogenic significance; for it is an old fact of experience that situations of the most extreme danger, and crisis in general, are accompanied by a decrease in neurotic illness. In the life of individuals it is repeatedly the case that strain in the sense of mental demand rather has the effect of promoting health. I always compare this to the fact that a dilapidated building can be secured and supported by putting a weight upon it. Conversely, situations of relief, for instance of release from a long and oppressive mental burden, are dangerous from a mental health perspective. We need only think of instances such as the release from captivity. Not a few people go through a true mental crisis only once they have been released, while during their captivity precisely the external and internal pressure forced them and enabled them to give their best and to achieve great heights, both physically and morally. As soon as the

pressure fades, particularly if this happens suddenly, the sudden release becomes a threat to the person, and this situation is reminiscent in a certain sense of the so-called Caisson-illness, in which a diver who surfaces too quickly from the depths can become life-threateningly ill because of the sudden reduction of atmospheric pressure that results.

We[1] and afterwards Walter Schulte,[2] Manfred Pflanz and Thure V. Uexkuell[3] were able to show that at least the sudden relief of stress can be at least as pathogenic as the stress itself.[4]

Even more significant than a mental strain, as far as the etiology of neurotic illness is concerned, is a hereditary burden, and the Kretschmer school is justified in sparing no efforts to point out that all complexes unfold their pathogenicity only where they have a suitable constitutional ground. Ernst Kretschmer rightly points out that constitution decides whether a complex becomes pathogenic or not, indeed, that the constitution not infrequently "itself creates its conflicts"—not least of all, as Wolfgang Kretschmer was able to demonstrate, through the "potentiating influence of constitutional interaction within the family." According to Kurt Schneider, neuroses only develop in people with personality disorders. That is, it is clear that not even the authentic, psychogenic neuroses are completely psychogenic.

All this might give us pause in taking psychogenesis all too literally—even with regard to neurotic illnesses in the narrow sense, that is, illnesses that are neither psychosomatic, nor functional, nor reactive. But this etiological reservation should not bother us or be a source of frustration, since we are in no way ready to draw any fatalistic consequences from it. Rather, we consider a kind of mental orthopedics to be completely possible. For where we have the tendency with respect to "psychogenic"

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[1] See *Ärztliche Seelsorge*, 1st ed., (Vienna 1946), p. 81: "The release from spiritual pressure is dangerous."

[2] See *Der Nervenarzt, 22,* 140, 1951, and *Acta Neuroveg, 4,* 503, 1952: "The time of release after a previous strain appears to be a period that should be observed for the development and manifestation of vegetative disorder as well as other things, a period that under certain circumstances is more eventful than the time of the strain itself."

[3] See *Klinische Wochenschrift, 30,* 414, 1952: "Not only so-called pressures, but also precisely their opposite, namely the sudden cessation of mentally and physically stressful situations, can lead to disorders that also manifest themselves somatically. Sometimes the disappearance of problems can be as significant as excessively burdensome problems. The presence of a goal, which holds the strengths and the desires of persons in suspense, works as an anti-pathogen. Being challenged by a goal, receiving a task, works as an anti-pathogen. An energetic perspective does not suffice. The concept of meaninglessness is more suitably applied to the circumstances."

[4] Recall the case related above of a colleague who, exhausted and overworked, was asked to join an Alpine rescue expedition that lasted several hours. As soon as he had fulfilled his medical duty, he collapsed and had great difficulty in safely bringing himself off the cliff (see note 108). See Hermann Buhl (a famous Austrian mountaineer): "Rescued mountain climbers often die while being transported on the stretcher, simply because the tension of the defense mechanism is released too quickly."

illnesses (neuroses in particular) to posit a constitutional foundation rooted in personality disorders, we are still far from saying that there is no leeway for our psychotherapeutic investigation.

Indeed, more than this: Precisely when we also present to the patient and confirm the fateful core of a constitutional personality disorder (for instance an obsessive-compulsive personality disorder) as fateful, precisely then will we correct that mistaken attitude toward this fate, and be able to focus on optimal therapeutic success while at the same time reducing the suffering to an unavoidable minimum. We do know something, after all, about compulsive-neurotic symptoms, the extent to which the fruitless struggles of patients only increase the trauma of the symptom, or even establish it to begin with.

The constitutional, personality-based foundation of neuroses can, therefore, be completely offset (pedagogically and therapeutically). In which case neurosis may be nothing other than a "decompensating symptom"—the decompensating for an "insufficient constitution" (Ernst Kretchmer). Under certain circumstances, then, it could be a matter of imparting to the patients that particularly strong spiritual grasp that normal persons need to a lesser extent, but which the mentally instable desperately need, in order to compensate for their instability. Once in their life every person with a personality disorder stands at the crossroads of this decision between, on the one hand, a bare disposition, and on the other hand, his or her own disposition to a real personality disorder. Prior to this decision, we should not yet describe them as personality disorders at all. That from which the personality disorder first arises (from which it can arise, but does not necessarily arise) we could call a personality instability, in contrast to a personality disorder.

After this etiological reservation, this *reservatio mentalis* with regard to the psychogenesis of psychogenic neuroses, we turn to case analysis.

Maria suffers from a tic that is situation related. Whenever she—a movie actress—is to be photographed, she compulsively throws her head into her neck. She moves in spite of herself—she defies by moving. Her tic in fact represents—in the sense of "symbolic representation" (E. Straus)—a gesture of defiance. What is she fighting against? A narcoanalysis has no effect. But on the next day's consultation, the patient remembers—without narcoanalysis—that the tic first appeared when a colleague, with whom she had been unfaithful to her husband the night before, was present during a photo shoot. Finally it occurs to her that the very first time the tic appeared was when her mother stood across from her at a photo shoot. The patient's history yielded the following: "My father had said, 'Maria, come sit on my lap.' My mother said 'You stay there.' The

father said, 'Get up and give me a kiss!' The mother said, 'No, she stays there.' Stay there, come here, from one side and the other, my whole life has been this way. Already as a child I've done this, or stamped my foot, in school and at home." One could assume that were the patient not a movie actress, but a fashion model, and were required to pose in nylons, then she would have developed a tic in the form of stomping her foot. The analysis can be summarized as follows: the photographer next to whom the mother stood represents the mother in the sense of the mother-image, while the actor, who stood next to the patient during the photo session was, in juxtaposition to the mother-image, a representation of the father or a father-image. Indeed, the patient asserted spontaneously that her colleague reminded her of her father. That the photographer represents the mother, or at least that aspect which forbids sitting on the lap of the father or future father-images, makes it equally understandable that the tic was a reaction precisely to his (the photographer's) function, just as the first incidence of the tic occurred when such a father-image stood next to the patient. In other words, when the polar field between the mother- and father-images was constituted. This constellation is pathogenic because the actual situation coincided with an infantile conflict situation. To a question about her husband, the patient responded that he tyrannizes her to no end. The yoke, which the tic appears to be shaking off, is therefore the marriage. But anticipatory anxiety is involved in this case as well, for the patient admits that after this first case of the tic, she not only continued to expect, but dreaded any future occurrences. The therapy attempted to substitute relaxation for the tic as a means of releasing rancor, resentment, and so forth, a therapeutic combination not unlike that of catatymic imagery (*Bildstreifendenken*) and logotherapy, which Betz proposed and named "logotherapy in symbols." According to this model, the patient was directed, in the context of relaxation exercises, to substitute her unconscious protest with a conscious decision, arrived at on the basis of her responsibility for the child and to the child that "was everything to her." Naturally, the relaxation exercises were also employed according to the model that is outlined, largely as part of a therapy for tics, outlined in the book, *Die Psychotherapie in der Praxis*.[5]

We also make use of classic dream interpretation based on the method of free association that Freud introduced to science. However, we do it in order to raise not only unconscious drives, but also unconscious rationality to consciousness and to responsibility. Dreams, those true productions of the unconscious, contain not only elements of the instinctual unconscious, but also those of the rational unconscious. If, however, in order to

[5] See V. E. Frankl, *Die Psychotherapie in der Praxis. Eine kasuistische Einführung für Ärzte*, p. 144, 1st Ed., (Vienna, 1947).

reach them, we make use of the same methods Freud used to track the merely instinctual unconscious, then we, who in this manner aim at a different target—namely, the uncovering of the rational unconscious—could say of psychoanalysis: we march together, but we strike independently. Also with regard to the empirical facts of the rational unconscious, we must allow ourselves to be guided by the great virtue of psychoanalysis: objectivity. But, we demand such objectivity not only on the part of the analyzed, but also on the part of the analyzer. We demand, not only from the investigated objects (e.g., produced ideas), but also from the investigating subjects, that unconditional impartiality that prevents them from closing their eyes even to the facts of unconscious rationality.

Psychoanalysis has rightly seen that there can be a conflict between individual strivings in a person. How often these conflicts appear within Freud's so-called psychopathology of everyday life, has been clearly demonstrated by the psychoanalytically inaugurated theory of the interpretability of the so-called Freudian slip.

Case 1 A colleague, speaking about mental asylums that at one time were ignominiously linked with euthanasia, says, "there the patients were done in (*umgebracht*)—I mean, taken in (*untergebracht*)—in a more humane manner than in the asylum. . . ."

Case 2 A colleague argues for preventing conception (*Empfängnisverhütung*) and repeatedly mistakenly speaks of preventing disaster (*Verhängnisverhütung*).

Case 3 A colleague defends a petition for a popular vote (*Volksbegehren*) that opposes abortion by setting limits on when it can be performed, and misspeaks by saying, "Should this not lead the deputies of the National Council to a change of opinion, then we will initiate a popular birthing (*Volksgebären*)." (Personal communication of Dr. Konrad Schima, professor of criminology.)[6]

The case of Maria was psychoanalytically interpreted insofar as it was judged to involve psychogenic causes. The following case can be approached both causally and teleologically, that is, one can evaluate them along the lines of individual psychology.

Leo (Vienna Neurological Policlinic) claims to be homosexual, but is in reality bisexual. Causality: At the age of 7, he was seduced by a homosexual

[6] *Naturally, these slips lose something in translation. A glimpse at the original German words in each example will help the reader to see the similarity of the words that were substituted.—JMD*

youth; at the age of 17 he falls in love with a girl, and is sexually aroused, behaves sexually normal, even though he experiences premature ejaculation. Later he has homosexual reactions and fantasies, for instance, with occasional wet dreams. Teleology: As soon as the patient is directly asked whether he is afraid of marriage or will be forced into it, he answers, "Yes I am supposed to marry the one that suits both by my mother and my situation as a farmer, and I won't be allowed to marry the one that suits me."

Let us consider the case of Rosa (Vienna Neurological Policlinic). Three years earlier the patient collapsed (at the time her blood pressure, measured using a Riva-Rocci style sphygmanometer, was 110) and she experienced heart palpitations. She complained of headaches, paresthesia, and a sensation as if her heart had stopped. Up to this point the picture is cardiovascular and angioneurotic or vasovegetative, with an endocrine component linked to the vegetative components. Two years ago she entered menopause. Both components reveal the functional side of the anxiety neurosis from which the patient suffers and whose reactive side is given in the patient's anticipatory anxiety that she "would collapse again." In response to the phobia, the patient's husband, with whom she had been in conflict up to this point, changed his habits and "became the best husband." Herein lies the third, psychogenic, side of the case, completely in the sense of a "secondary motive of illness" (Freud), which is secondary insofar as it only fixates a primary occurrence of illness, while an "arrangement" (Adler) would be pathogenic in a primary sense.[7]

If one were to imagine the realm of the phenomenology of psychogenic neuroses elliptically demarcated, then both anxiety and compulsion stand as the focal points of this ellipsis. For they are, so to speak, two clinical primary phenomena. And this is not accidental; for to anxiety and compulsion correspond the two fundamental possibilities of being human: "fear" and "guilt" (indeed, the feeling of guilt plays an important role in the psychology of compulsive neurosis). But the ontological conditions for these two possibilities, that is, that from which fear and guilt arise, are human freedom and responsibility. Only a being that is free can be afraid, and only a being that is responsible can be guilty. (Kierkegaard wrote, "Fear is the vertigo of freedom.") From this it follows that a being that is blessed with

[7] As a digression, we find evidence for the possible "arrangement" character of a fear of the street in the Bible, in Proverbs (22:13): "The sluggard says, 'There is a lion outside! I shall be slain in the streets!'" (RSV translation). In biblical living conditions, the sluggard, who pleads claustrophobia as an excuse, obviously does not fear collapse, heart attack or insult, but rather lions, tigers, and hyenas.

freedom and responsibility is condemned to being fearful and being guilty.[8]

Naturally, anxiety and guilt also play a role in psychoses. Now, for example in cases of endogenous depression, if in the present day and age, in contrast to earlier times, feelings of anxiety predominate over guilt feelings it can be said that guilt had a generation, which did not do what it should have done; whereas anxiety has a generation that does not *know* what it should do.[9]

[8] "Being responsible" is "the essence of human existence" (Viktor E. Frankl, "Philosophie und Psychotherapie. Zur Grundlegung einer Existenzanalyse," *Schweiz. Med. Wschr, 69,* 707, 1939). Now, logotherapy is repeatedly reproached for and accused of claiming and stressing the same thing that individual psychology points out, namely, the responsibility of the person. But this confuses two things: (1) The responsibility of neurotic patients for their symptoms (in the sense of the arrangement concept of Alfred Adler), and (2) the responsibility of persons as such, that is, not of the sick, and not for their symptoms, but for their existence as a whole. Granted, the latter implies also the responsibility of sick persons, but precisely not for their illness, although all the more for their stances toward their illness.

[9] See the section in chapter 2 on "Personal Pathoplasty."

Preview

Chapter 8. Noogenic Neuroses: On Neuroses with Spiritual Causes

Whereas previous chapters have focused on psychological and somatic contributions to mental disorders, this chapter explores neuroses arising from the spiritual dimension of the human person.

- Not all existential or spiritual crises are pathological or neurotic. Some crises are part of normal maturational processes. Yet, increasingly people turn to psychiatrists and therapists with problems that previously would have been referred to the minister.
- Noogenic neuroses are those neuroses that arise when existential frustration is dealt with in a maladaptive fashion, e.g., when the existential or spiritual character of the crisis is ignored or repressed. Symptoms may include depression, anxiety, aggression, addiction, and other neurotic traits.

Chapter 8
Noogenic Neuroses: On Neuroses with Spiritual Causes

We have repeatedly spoken of a simultaneous somatotherapy and psychotherapy, and accordingly, if you will, of a two-dimensional therapy on the basis of a somatogenic and psychogenic two-dimensional etiology. In conclusion we would like to show how we must follow personal being, and therefore also the sick person, beyond the two dimensions of the somatic and the psychological into a third dimension, that of the spiritual. For, in addition to the somatic and the psychological dimensions, the spiritual is its own dimension. But not only this, it is in fact the authentic dimension of being human, something that psychologism does not wish to acknowledge (while spiritualism commits the error of treating the spiritual dimension as the only dimension of being human). Neuroses can take root in this dimension as well—in such cases we speak of noogenic (arising from the spiritual) neuroses; for the person standing under the tension of a conflicted conscience, or under the pressure of a spiritual problem, or in the midst of an existential crisis, can also become neurotically ill.

There are existential maturation crises that proceed according to the clinical pattern of a neurosis without being neuroses in the narrow sense of the word, namely, in the sense of a psychogenic illness. It is also easy to see that a person under the stress of a spiritual problem or undergoing the tension of a conflict of conscience will fall as ill with a superficial vegetative syndrome as would anyone with a neurosis in the ordinary sense of the word. It is important to be aware of and point out such incidences and the danger of their mistaken interpretation, particularly in a time in which an increasing number of patients turn to the psychiatrist, patients who come not with psychological symptoms but for help with human problems.

Although, contrary to widely held opinion, the frequency of neurotic illness has not increased, at least in the last decades (Johannes Hirschmann), an increase in the "need for psychologically enlightened, sympathetic treatment" (W. G. Eliasberg) must be noted. However, we are certainly not mistaken if we suggest that behind this "psychotherapeutic need" there stands a metaphysical need, that is, the human need to satisfy ourselves about the meaningfulness of our lives. Indeed, Charlotte Bühler confirms that in the context of psychotherapy, "the problem of the meaning and value of life can be of the greatest consequence."

In earlier days, such people had gone to the priest. We live in a secularized age, and should not be surprised if the care of the soul has also been secularized. But already in the previous century, Kierkegaard had ventured the assertion that "the priests are no longer the caregivers for the soul; the doctors have become this."

It is not that we share the opinion of Freud that this "rejection of religion takes place with the fateful inexorability of the aging process," but, the "migration of western humanity from the minister to the neurologist," as it was termed by V. E. von Gebsattel, is a fact from which the minister may not hide, and a duty that the neurologist may not refuse, for it is a predicament that requires him to provide medical ministry for the soul.

The religious doctor least of all can withdraw from such a requirement. Precisely the religious doctor refrains from a pharisaical gloating when the patient does not seek out a priest. It would be pharisaical if the doctor, in the face of the suffering of an unbelieving patient, were to take delight and think: if he were religious, then he would find refuge in a priest. When a non-swimmer is in danger of drowning, we do not likewise say to ourselves: he or she should have learned to swim. Rather, we give help—even if we are not swimming instructors. Doctors who provide medical ministry find themselves in a predicament. For "whether he likes it or not—today it often falls to the doctor rather than the minister to advise in non-medical life crises," and "one cannot change the fact that human beings in life crises today look not for a minister, but look for a counselor with life experience in the medical doctor" (H. J. Weitbrecht). "It is the patient who places before us the task of assuming into psychotherapy the task of caring for the soul" (Gustav Bally), and it was "our era" that "compelled the doctor to carry out, in ever greater scope, the tasks that were in an earlier time matters for priests and philosophers" (Karl Jaspers). According to Alphons Maeder, "this shift was propelled by the situation itself," and "all too often is psychotherapy required to strike out into the realm of spiritual care" (W. Schulte).

Faced with the "migration of western humanity from the minister to the neurologist," the neurologist now runs the risk of misdiagnosing the difference between what is illness, such as a neurosis, and what is purely human, such as an existential crisis. The doctor could well arrive at the misdiagnosis of a mental illness where there is something essentially different, namely, a spiritual crisis; here the noogenic has taken the place of the psychogenic.

It is also not excluded that a psychotherapy that actually bypasses the specifically human problem, and projects it out of the realm of the human onto the subhuman level, is not only helpless in the face of existential frustration, but that it contributes to the repression of the existential crisis, and thereby to the development of a noogenic neurosis. Zev W. Wanderer from the Center for Behavior Therapy (Beverly Hills, California) appears not to have been bothered by such considerations when he applied the behavioral therapeutic technique of "thought-stopping" in a case of existential depression.[1]

That not only a behavioral therapy, but also a psychoanalytic treatment can bypass a specifically human problem, and that this can happen not only to a patient but to a therapist as well, is shown by the following protocol.

> Since the summer of 1973 I have been employed as an assistant psychologist by two psychiatrists in San Diego. During my supervision sessions I often disagreed with the psychoanalytic theory that my employers sought to teach me. Yet, as their manner was very authoritarian I was fearful of expressing my contrary opinions. I feared that I might lose my job. I therefore suppressed my own opinions to a large degree. After several months of this self-suppression, I began to feel anxiety during my supervision sessions. I began to accept the therapeutic aid of some of my friends. However, we succeeded only in making the anxiety problem worse; for what did we do but approach the problem in a somewhat psychoanalytic manner. We sought to uncover the early traumas in me that were causing my transference anxiety with my supervisors. We studied my early relationship to my father, etc., to no avail. Thus, I increasingly found myself in a state of hyper-reflection, and my condition grew worse. My anxiety rose to such a level at my supervision sessions that I had to mention it to the psychiatrists in order to explain my behavior. They recommended that I see a psychoanalytically oriented psychotherapist for personal therapy in order to get to the hidden meaning

[1] See Wanderer, *J. Behav. Ther. & Exp. Psychiat., 3,* III, 1972.

> of this anxiety. Not being able to afford such professional help, my friends and I increased our efforts to uncover the deep hidden meaning of my anxiety and I became worse. I often had extreme anxiety attacks. My recovery began with Dr. Frankl's class *Man's Search for Meaning* on January 8th, 1974. I heard Dr. Frankl speak of the difficulties encountered when one tries psychoanalytically to unmask an authentic response. During that 4-hour class I began to see how the therapy I had undergone had increased my problem—an iatrogenic neurosis almost. I began to see that it was my own self-suppression in the supervision sessions that had caused my anxiety. My disagreement with the psychiatrists and my fear of expressing this disagreement had caused my reaction. I quickly ended the therapy and felt better upon doing so. Yet, the real change came during my next supervision session. During this session I began to express my opinions and disagreements with the psychiatrists when I actually felt such disagreements. I felt no fear of losing my job, for my peace of mind had become far more important than my job. As I began to express myself in this session, I immediately felt my anxiety beginning to decrease. In the past two weeks, my anxiety has decreased by 90 percent.

When faced with noogenic neuroses, with neuroses that arise from the spiritual dimension, it is important that they elicit a psychotherapy that takes its starting point in the spiritual dimension. Now, this is precisely how logotherapy understands itself.

Preview

Chapter 9. Collective Neuroses: On Societal Neuroses

This chapter discusses the idea that society may have "neuroses" or dysfunctional traits that typify the era, as well as the idea that society influences the form individual neuroses take. Some of what Frankl writes reflects observations from the time when the book was first published in 1956 and some of the observations pertain particularly to the European continent of the time. Nevertheless, the general theses regard the human condition: human beings influence and are influenced by the society and era in which they live.

- The present era is marked by a failure to fulfill the will to meaning, which can lead to an exaggerated will to pleasure. The existential vacuum that results from failing to fulfill the will to meaning is most powerfully felt during leisure time in the form of boredom.
- Four symptoms characterize the collective neurosis of the present era:
    - Provisional existential attitude: immersing oneself wholly in the present day without concern for the future
    - Fatalistic attitude toward life: believing that one's life is fated or controlled by outside factors such as those posited in astrology
    - Collectivist thinking: wishing to be absorbed by the crowd, and abandoning the view of self as free and responsible
    - Fanaticism: ignoring the personhood of others and the validity of meanings espoused by others
- Freedom and responsibility are the two marks of human spirituality. All four of the symptoms of the collective neurosis of the current time period can be traced back to a flight from responsibility and a fear of freedom. The symptoms indicate a spiritual weariness or nihilism.
- An otherwise healthy person may suffer from one or several of these collective neurotic symptoms.

Chapter 9
Collective Neuroses: On Societal Neuroses

In a 1932 letter to H. Blüher, Sigmund Freud speaks of "this disjointed age." Today as well, we often still speak of an illness of the age, of an illness of the Zeitgeist. Could it be that this illness of the age is identical to that with which all psychotherapy is concerned, that is, with neurosis? Could it be that the age has fallen neurotically ill? There is in fact a book—the author is F. C. Weinke—that carries the title: *Der nervöse Zustand, das Siechthum unserer Zeit (The Nervous Condition, the Infirmity of our Time)*. The book appeared in Vienna, published by J. G. Heubner in '53—not 1953, but 1853. Infirmity, "*Siechtum*" in the original German, was still written with an "h." We see that the modernity of the neurosis is not so new.

That neuroses have not increased, but rather, as far as their frequency is concerned, have remained constant for decades, and that among neuroses anxiety neuroses have in fact decreased, was demonstrated by Johannes Hirschmann. Only the clinical picture of a neurosis has changed, only the symptomatology has become different, and insofar as this is the case, anxiety has in fact been reduced.

Not only neurotic anxiety, however, but also anxiety as such has not increased. Freyhan has pointed out that in earlier times, for example in the ages of slavery, of religious wars, of witch burning, of mass migration, or of the great epidemics—that all these "good old days" were in fact not any more free of anxiety than our times. Indeed, it can be supposed that earlier centuries had even more anxiety and even more ground for anxiety than our century. This shows us that it is not entirely appropriate to designate ours as "the age of anxiety."

We cannot therefore claim that the frequency of neurotic illnesses has increased in our day. What alone has increased is rather something different, namely, the psychotherapeutic need, that is, the need of the masses to turn to the psychiatrist in their times of spiritual need.

That the percentage of endogenous psychoses remains amazingly constant is well known. However, this has a good explanation. That, for example, the Vienna Steinhof Institute reached a record number of 5,000 admissions (a more than 40-year high) in 1931, whereas in 1942 it reached its lowest number with approximately 2,000, can be easily explained. In the thirties, at the time of the worldwide economic crisis, patients were left by their families in institutions for as long as possible, indeed the patients themselves were often happy to have a roof over their heads and something warm in their stomachs. It was different in the forties. Because of the equally comprehensible, justifiable fear of being euthanized, the sick were taken home or released as soon as possible—or when possible not committed to the institution at all.

It is not just that the clinical picture of neuroses has been transformed, nor that its symptomatology has changed. We see something similar with regard to psychoses (Heinrich Kranz). It has become apparent that endogenously depressed persons today seldom suffer from feelings of guilt; instead fear of losing their employment, or their employability, stands in the foreground. These are the themes of contemporary endogenous depression (A. V. Orelli)—but presumably only because they are the concerns of the average person of today.

Concerning the etiology of the illness of our time, it has been claimed that it is the tempo of our days that makes persons so ill. In this vein, the sociologist Hendrik de Man explains, "The tempo does not allow for acceleration beyond a certain limit without penalty." Now, the idea that persons cannot endure an acceleration equal, for example, to their mechanical locomotion, that they in this way have not kept up with technical progress, is not a new prophecy, but it is a false one. As the railroad was unveiled in the last century, medical authorities believed it impossible that people would be able to endure the speeds associated with rail travel without falling ill. And just a few years ago one still entertained doubts about whether it was healthy to fly in a supersonic jet. Thus, we see how right Dostoevsky was in defining the human person as the creature who can get used to anything. The contemporary tempo of life does not come into consideration at all as a cause of the illness of our time, as a cause of illness at all. I would go so far as to assert that the accelerated tempo of life today is actually an attempt at self-healing—even if an unsuccessful attempt. Indeed, the breakneck speed of life can be easily understood if we conceive of it as an

attempt at self-anesthetization: people are in flight from an inner desolation and emptiness, and in the course of this flight plunge into the thick of the commotion. Janet described what he called , that is, a feeling of emptiness among neurotic patients that he characterized as psycho-asthenic. Now, this feeling of emptiness is also present in a transferred sense, that is, in that feeling of existential emptiness, that feeling that there is no goal and meaning in our existence. The person of today experiences many times over what is perhaps most pithily characterized by a variation on a few words from Goethe's *Egmont*: He hardly knew from whence he came—not to mention where he was going. And one could add that the less he knew about the end of his path, the more he accelerated the tempo at which he ran along the path.

We have characterized the feeling of existential emptiness, the feeling of being without a goal and a meaning to our existence, as an existential frustration, as a failure to fulfill the will to meaning. We have juxtaposed this will to meaning with the will to power, as it appears for instance in Adler's individual psychology—not without good reason—in the form of the striving for recognition. And we have also juxtaposed the will to meaning with a second phenomenon, namely the will to pleasure, which Freud's psychoanalysis so thoroughly believes is dominant, in the form of the pleasure principle. And we see how precisely where the will to meaning remains unfulfilled, that the will to pleasure serves to anesthetize the existential unfulfilment of persons, at least as far as their own consciousness is concerned. In other words, the will to pleasure first appears when a person's will to meaning is unfulfilled. Sexual libido only runs wild in an existential vacuum. The existential disappointment of the person in the struggle for existential meaning will be vicariously compensated through a sexual anesthetization.

The existential vacuum can equally be made manifest or remain latent. We live in a time of increasing automation, and this also brings with it a resulting increase in free time. But this yields not only a time free from something, but also a time free for something. The existentially frustrated person, however, knows of nothing with which to fill this time, nothing with which the existential vacuum can be filled.[1] Schopenhauer was of the opinion that humans vacillate between crisis and boredom. But we today, including we neurologists, have more to do with boredom than with crisis. Boredom has become a spiritual illness of the first order.

[1] Consider the finding of a Hamburg social institute that 58 percent of the youth surveyed "do not know what to do with themselves" in their free time, a number which does not even include the sports enthusiasts, who certainly constitute a further 30 percent. The rest also prefers collective events. Another survey claims to have shown that 43.6 percent of all moviegoers in the world go to the movies only because they "don't know what to do with their time."

If we ask ourselves about the main clinical forms in which the existential vacuum confronts us, then we would have to name among others the so-called Sunday neurosis, that is, the depression that breaks out as soon as the weekday activity comes to an end, and we become acutely aware that we don't know of any concrete meaning in our personal existence, we become aware of the supposed meaninglessness of our lives.

But not only the end of the workday, but also the end of our days puts before humanity the question of how it should fill out its time. The aging of the populace also confronts persons, often torn out of their professional work, with their existential vacuum. Finally, it is not only in advanced age, but also in youth that we often see the extent to which the will to meaning is frustrated, for "in countries with a high standard of living, many young people commit their offences above all out of boredom, which is becoming an increasingly significant problem of our time" (Wolf Middendorf).

But the existential vacuum need not be manifest, it can also lie latent—cocooned or masked—and we know of many masks behind which the existential vacuum can hide. Let us think only of the illness of the managers, who, thrust into their activity by a fit of work-mania, suppress the will to meaning through the will to power, particularly in its most primitive and banal form, "the will to money."

H. Pluegge was able to show that existential frustration in general, and the so-called Sunday neurosis in particular, can end in suicide, by demonstrating on the basis of 50 suicide attempts that they were all ultimately and actually to be traced back neither to illness nor to economic trouble, neither to professional nor to other conflicts, but amazingly to one thing only: to boredom.

And so Karl Bednarik may also be right when he once wrote, "The problem of the material suffering of the masses has turned into the problem of prosperity, the problem of leisure." Paul Polak had pointed out already in 1946 that one cannot give oneself over to the illusion that the resolution of social problems will of itself lead to the disappearance of neurotic illness. The opposite is actually right: only once the social problems are resolved will existential issues break out with a fury in the consciousness of the person. "The answer to the social question will give free reign to the spiritual question, it will mobilize the spiritual problem. Only then will persons become truly free, truly take the offensive against themselves, and finally recognize the issue as it is in itself, will recognize their own existential issues."

We have defined neurosis in the strict sense as a psychogenic illness. In addition to neurosis in the narrower sense of the word, we understand neuroses in a wider sense, for example somatogenic, noogenic, and sociogenic

neuroses. In the case of each of these, we are dealing with neuroses in the clinical sense. But there are also neuroses in a metaclinical and neuroses in a para-clinical sense. To the latter belong the collective neuroses. They are quasi-neuroses, neuroses in a transferred sense. For we have after all seen that we cannot speak of an increase in neuroses in the clinical sense. That is, the clinical neuroses have not increased to that extent that they have become collective. Insofar as we are justified in speaking of collective neuroses in a para-clinical sense, four symptoms characterize our experience with the collective neurosis of the present:

1. Provisional existential attitude: people of today are used to completely immersing themselves in the present day.
2. Fatalistic attitude toward life: if people with a provisional attitude tell themselves that it is not necessary to act and to take their fate into their own hands, then those with a fatalistic attitude tell themselves that this is not even possible. The person of today is obsessed with a superstition about the various powers of fate. At any rate, a Gallup poll showed that only 45 percent of Austrian women do not "believe in an astrological connection between their lives and the position of the stars."
3. Collectivist thinking: if the previous two existential attitudes, the provisional and the fatalistic, indicate that people fail to grasp the situation, then the next two symptoms of a pathology of the Zeitgeist indicate that they are hardly capable of understanding the person, that is, themselves and others qua persons. People today wish to be absorbed into the crowd; in reality they get lost in it, give themselves up as free and responsible beings.
4. Fanaticism: if people with the collectivist attitude ignore their own personhood, then the fanatic ignores that of the other, of anyone who thinks differently. Fanatics do not allow the other any validity, for them only their own opinion counts.

Let us now ask ourselves how widespread these collective-neurotic symptoms actually are. To this end, I asked my colleagues to take a poll of people who are not neurotic in the strict clinical sense, a poll that presented the following test questions. It asked a question about symptom 1, the provisional existential attitude, "Are you of the opinion that there is in fact no reason to act and take fate into your own hands, since ultimately the atomic bomb will fall, and everything is meaningless?" The question regarding symptom 2, the fatalistic attitude, ran as follows: "Do you believe that persons are ultimately nothing more than a plaything of external and internal forces and powers?" The question regarding collectivist thinking asked, "Do you believe that the most important thing is simply

not to be noticed?" And finally the trick question about fanaticism: "Are you of the opinion that the person who desires the best is also justified in using any means that appears useful in reaching that end?" I am firmly of the opinion that nothing is as characteristic of fanatics as the fact that for them everything is reduced to a mere means to an end. It is their point of view that the end justifies the means. The opposite is in reality the case, that to the contrary, there are also means that are capable of desecrating the holiest of ends.[2]

On the basis of this test my colleagues were able to determine that of all those studied, only one was truly free of all four symptoms of the collective neurosis, while not fewer than half of those studied manifested at least three of the four symptoms. This result of our survey shows that individuals who are not clinically neurotic can be collectively neurotic. Carrying out a crosscheck, the results of the psychiatric examinations undergone by those accused by the war crimes tribunal show that they were all diagnosed as clinical healthy.

We now know that not only the mental, but also the spiritual—a conflict of conscience, for instance—can lead to a neurosis. We characterize these as noogenic neuroses. It is conceivable that so long as persons are at all capable of experiencing a conflict of conscience, they will be immune to fanaticism, indeed to collective neurosis. On the other hand, those who suffer from collective neurosis, for instance political fanatics, will be capable of overcoming their collective neurosis to the degree that they are able to hear again the voice of their conscience, to suffer from it.

Years ago I spoke on this topic at a medical conference to professional colleagues, some of whom lived under a totalitarian regime. After the presentation they came up to me and said, "We know very well the phenomenon of which you spoke. Among us, you should know, it is called functionary's disease. Many party functionaries eventually suffer a nervous breakdown under the increasing burden of their conscience. But then they are healed of their political fanaticism." That is, while the coexistence of collective neurosis and clinical health is possible, the relation between collective neurosis and noogenic neurosis is inversely proportionate.

All four symptoms of the collective neurosis—the provisional existential attitude, the fatalistic attitudes toward life, collectivist thinking, and fanaticism—can be traced back to a flight from responsibility and a fear of freedom. Freedom and responsibility, however, constitute the spirituality

[2] If these means were to become an end in themselves, then we would be dealing not with fanaticism, but with terrorism.

(*Geistigkeit*) of human persons. People today are spiritually weary; and this spiritual weariness is precisely the nature of contemporary nihilism.

Preview

Part II. Logotherapy and Existential Analysis

Part II is dedicated to explaining how logotherapy and existential analysis can be used in the treatment of a wide variety of mental disorders. Chapter 10 discusses the application of logotherapy to noogenic neuroses, which logotherapy is uniquely able to address given its focus on the spiritual—or the free and responsible—dimension of the human person. Chapter 11 considers how logotherapy may be brought into the treatment of psychogenic and somatogenic disorders. Chapter 12 then presents two tools that were developed by Viktor Frankl and have very broad applications in the treatment of neuroses: paradoxical intention and dereflection. Chapter 13 goes on to discuss logotherapy's role as a supportive therapy for suffering persons who cannot be cured but must learn to live with their disorders. Chapter 14, the last substantive chapter, offers reflections on how existential analysis can provide a view of the human person, which may serve as a corrective to certain reductionistic tendencies in biological and psychoanalytic psychology. Frankl concludes the book with his own summary. He reviews the five spheres in which logotherapy is indicated. But above all he reminds readers that logotherapy, which has been called the Third Viennese School of Psychotherapy, is indebted to Freud and Adler, the founders of the first two Viennese schools. Although Frankl has criticized both schools for various reductionistic tendencies, the last line of the book reads: "I believe that it is the same with Freud: no one will ever be able to measure up to him." This line reveals a common thread that runs throughout the whole of the book: Frankl is one of few founders of a psychotherapeutic school who was always at pains to be eclectic, learning from others and integrating their insights and techniques into an overarching theory of the human person and the etiology and treatment of mental disorders.

Part II
Logotherapy and Existential Analysis

Preview

Chapter 10. Logotherapy as a Specific Therapy of Noogenic Neuroses

This chapter examines how logotherapy may be used to treat noogenic neuroses—those neuroses that arise from spiritual issues. Here as throughout the book, it is important to bear in mind that the term "spirit" (*Geist*) lacks religious overtones in Frankl's original German usage. It simply refers to that dimension of the human person that is free, responsible, and directed toward finding meaning. His choice of the term "noological" reinforces this: the Greek term *nous* is often translated simply as "mind."

- Logotherapy insists that it is wrong to treat neuroses that arise from spiritual issues as though they arose from somatic causes (e.g., by using tranquilizers) or from psychological causes (e.g., by using analysis of childhood conflicts). Conversely, logotherapy does not aim to replace traditional medical and psychological treatments, only to supplement them.
- Examples of spiritual causes of neurotic reactions include crises of conscience, value conflicts, existential frustration, and a sense of meaninglessness or despair. In and of themselves, these events (e.g., a crisis of conscience) are not pathological, but reactions to such conflicts can be.
- Logotherapy has the task of bringing persons to awareness of their responsibility, but it must not seek to transmit to them concrete values. It must merely assist patients in their task of discovering the values that they are meant to actualize, and to see the meaningfulness of doing so.
- Logotherapists must always ask why a given existential crisis has produced neurotic symptoms. Even while addressing the existential crisis, logotherapists must also consider whether somatogenic causes or psychological causes are at work.

Chapter 10
Logotherapy as a Specific Therapy of Noogenic Neuroses

Noogenic neuroses require a therapy that addresses the dimension from which they stem. They require either a therapy from a spiritual perspective (which I call logotherapy), or one that targets personal spiritual existence (which I call existential analysis).

A concrete case should illustrate all this. A patient comes to us with nervousness, weepiness, stuttering, sweating, trembling, twitches in her eyelids, and a weight loss of 7 kilograms in 4 months. At the root of all this lies a conflict of conscience between marriage and faith: should she sacrifice one for the sake of the other? She lays great value on the religious upbringing of her children, while her husband, an outspoken atheist, is decidedly against it. In itself, this conflict is human and not at all pathological; only the effect of the conflict, the neurosis, is an illness. But it was not possible to treat the illness without raising a question about meaning and value. The patient herself asserts that she could have the most wonderful life, have her quiet and her peace (peace of mind!), if she would only adapt to her husband—to her social environment in general. But the problem is as follows: should one—may one—adapt oneself at any price, moreover adapt oneself to this man, this society? But this—adapting herself to the worldview of her husband—this she cannot do, she declares, for this means sacrificing her "self." Now, had the patient not made this observation, then the psychotherapeutic—in the concrete instance, the logo-therapeutic—treatment of the patient's neurosis (obviously noogenic, arising from the spiritual and hence requiring treatment starting with the spiritual) may under no circumstance reinforce the one or the other leaning, be it toward adaptation to the husband or toward self-affirmation of her own

worldview. For logotherapy has the task of bringing persons to consciousness of their responsibility; but beyond this it may not transmit to them concrete values of any sort. Rather, it must limit itself to allowing patients, acting on their own, to find the values awaiting realization through them and to find the meaningfulness of having these values realized through their activity. What cannot come into consideration is an imposition of the value hierarchy and the worldview of the therapist upon the patient. Now, the patient had explicitly given us to understand that to give up her religious conviction, or its translation into practice, is to sacrifice herself—and this gives us therapeutically the right to make it clear to her that her neurotic illness is nothing other than the result of the threatened, or already realized, spiritual rape of her own self. It was initially possible, through a suppression of the affective resonance of the organism through medication, to deflect for a while the psychophysical effects of the spiritual conflict, so that we could initiate a causal therapy. The causal therapy involved advising the patient, on principle and with reference to the standards of her own worldview, against conforming to her husband; but from a tactical point of view we advised all the more that she avoid every provocation of her husband and to prepare and facilitate for him access to a better understanding of her own conviction—precisely on the basis of her religious conviction.

The doctor will have to be on his guard against every imposition of a worldview—of his or her worldview. But logotherapists will also take great care not to allow patients to transfer responsibility to their therapist if only because logotherapy is essentially an education to responsibility. Acting out of this responsibility patients must push forward on their own to the concrete meaning of their personal existence. I therefore use the term existential analysis for that psychotherapuetic method of treatment which helps patients to discover moments of meaning in their own existence, to uncover possibilities of value. Admittedly, such existential analysis presupposes a conception of the person, in the context of which things such as meaning and value and spirit have a place, the place to which they are in reality entitled. In other words, a conception of the person as spiritual, free, and responsible—responsible precisely for the realization of values and for the fulfillment of meaning—is always presupposed. That is, we presuppose the conception of a person ordained toward meaning.

Logotherapy obviously does not intend to replace psychotherapy in the narrower and usual sense of the term, but rather to fulfill it—fulfill its conception of the person to that of a "full" person (to the fullness of which belongs the spiritual as an essential component, as we have heard). Richard Kraemer once stated very nicely with regard to logotherapy: until now the

spirit (*Geist*) stood as the opponent of the psyche (*Seele*); but now the spirit has become our comrade-in-arms in the fight for the health of the psyche, and henceforth we confront illness with three armored divisions: with somatotherapy, with psychotherapy, and with logotherapy.[1]

When one characterizes logotherapy as a psychotherapy that not only does not ignore the spiritual, but precisely takes its starting point in it, then logos signifies the spiritual, and meaning above and beyond this, but this is not meant in a religious sense.

Psychoanalysis introduced us to the will to pleasure, which we can conceptualize as the pleasure principle, and individual psychology familiarized us with the will to power in the form of the striving for prestige (*Geltungsstrebens*); but rooted still more deeply in the human person is what we call the will to meaning:[2] the struggle for the most meaningful fulfillment of personal existence.

Individual psychology takes its starting point in the feeling of inferiority. Now, the people of today suffer not so much from the feeling that they are worth less than any other, but rather from the feeling that their existence has no meaning. This feeling of meaninglessness today leaves the feeling of inferiority far behind, as far as the etiology of neurotic illness is concerned. We claim that the failure to fulfill a person's need for the maximally meaningful realization of his or her being can be no less pathological than sexual frustration. At the same time, we repeatedly have occasion to see that also in cases in which sexual frustration stands in the foreground, an existential frustration looms in the background: the futile human call for a maximally meaningful life, which is precisely that which makes that life worth living in the first place. Sexual libido runs wild where there is an existential vacuum.

Agoraphobia need not be, or need not only be, an expression of hyperthyroid and sympatheticotonia, nor need a "fear of collapse" be simply an expression of hypercorticalism with arterial hypotonia, as in the cases discussed in chapter 4. I have in mind a case in which it became evident that the anxiety of the patient was an existential anxiety. "Infinity," she told us, "has oppressed me. I lose myself in it. There is such a lack of foundation—as if my very self were dissolving." Who here does not think of what Pascal said about his experience of endless space, or of a statement by

[1] See Richard Kraemer, *Zschr. Psychotherapie, 2,* 125, 1952: "with his (Frankl's) approach a new phase of psychotherapy begins to emerge. Klages found the magic formula for the first, older epoch: 'The spirit as opponent of the soul.' The new phase will have to have as its task and its responsibility the transformation of it, the spirit, into a faithful comrade-in-arms."

[2] See Viktor E. Frankl, *Der unbedingte Mensch: Metaklinische Vorlesungen* (Vienna 1949), p. 117. Reinhard Lauth also speaks, independently of myself, of a "will to meaning" (*Die Frage nach dem Sinn des Daseins* [Munich 1953], p. 250).

Scheler: "The endless emptiness of space and time is the emptiness of the human heart." Insofar as anxiety is ultimately afraid of the nothingness, the "unending emptiness of space" here takes the place of nothingness; but this emptiness of the macrocosm appears to be merely a projection of an inner emptiness, of an existential emptiness—the emptiness of the microcosm, a reflection of the emptiness of one's own existence. If this existence has no content, or the subject of such an existence "no object," has no object that can fulfill it existentially, then this subject becomes its own object—the object of a self-reflection. Since Haug we know that a forced self-observation suffices to produce an appearance of depersonalization, and what could be more obvious than that the original anxiety grabs onto this depersonalization as its apparent ground, and this brings about that which our patient suffers from the most: fear of psychotic illness (of which she sees depersonalization as an alarming symptom), that is, psychotophobia. In addition to this, in this particular case, the patient must repeatedly endure iatrogenic noxa, which spin her ever more deeply into a psychotophobic anticipatory anxiety as in a cocoon. She finally came to fear only one thing: of one day "ending up on a cot" (i.e., a hospital bed). Corresponding to the multidimensional structure of this case it was necessary to proceed with a multidimensional therapy.

First, we needed to address the functional aspect: the anxiety—or rather, the openness to anxiety—is caused by a vegetative or endocrine disorder. Accordingly, the patient received dihydroergotamine injections. The vegetative components of anxiety do not have a reason, but a cause; it is the patient who creates the reasons—the apparent reasons. Second, we needed to address the reactive, iatrogenic aspect: unconsidered statements from doctors she had consulted gave the patient the apparent reasons in question—statements from which she concluded that her psychotophia is well founded, and that the anxiety is a precursor of a psychosis. On these "grounds," the patient develops a "fear of anxiety." This secondary, potentiated, and potentiating anxiety will be therapeutically confronted by showing that the reasons that make the patient afraid of anxiety are precisely apparent reasons, that the psychotophobia is in reality without a foundation, and that the patient has the right to ignore her anxiety and to act without regard to it. Third, the existential aspect: only those who are acting for something specific can ignore symptoms of an illness in their action—can act "past" these symptoms. It is therefore therapeutically necessary, in the sense of an existential analysis, to lead the patient to the concrete possibilities for meaning in her own personal existence.

So it is understandable that logotherapy makes an appeal to the will to meaning. To this extent it earns the characterization of an appellative

psychotherapy. But it does not only make an appeal to the will to meaning: where this will is unconscious, is suppressed, it must first of all evoke this meaning. However, on the side of the object, insofar as a frustration of precisely this will to meaning—an existential frustration—lies at the root of a noogenic neurosis, logotherapy must repeatedly attempt to posit concrete possibilities of a personal fulfillment of meaning—possibilities whose realization are demanded of and entrusted to the patient alone, whose realization can fulfill the frustrated will to meaning and thereby satisfy the claim for meaning that every human places on his or her existence. At this point, every logotherapy flows into an existential analysis—just as in fact every existential analysis culminates in a logotherapy. If Darwin identified the struggle for existence and Kropotkin recognized mutual assistance over and above this, then existential analysis sees the struggle for a meaningful existence and understands itself as an ally in the discovery of meaning.

Not infrequently it becomes clear that physicians, confronted with the task of medical ministry, jump ship. It could be that they take shelter in the somatic, it could be that they take shelter in the psychological. The first occurs whenever they attempt literally to satiate the patient with a tranquilizer. In any case, they do their best to attain a "benevolent amputation of all so-called mental anguish and pangs of conscience" (Friedrich Nietzsche).

While somatologism ignores the spiritual, psychologism projects the noetic into the merely psychological. But the will to meaning belongs to the noetic. Physicians escape into the psychological whenever they fail to confront patients' despair about the meaningfulness of their existence with rational counterarguments against suicide, but rather only pursue the emotional background of the despair they are trying to "expose." As if the truth of a worldview depended upon the health of the one "viewing the world."[3] In reality, there is truth despite illness, and moreover not only despite neurotic, but also despite psychotic illness. Two times two equal four even if a paranoid schizophrenic person says it. At the same time, problems and conflicts per se are by no means something pathological. Even unresolved conflicts are as such, as unresolved, also not necessarily pathological. We are not "of the sincere opinion that the healthy person has no unresolved conflicts" (H. J. Weitbrecht). Just as there is

[3] See Viktor E. Frankl, "Psychotherapie und Weltanschauung," *Internationale Zeitschrift für Individualpsychologie*, September 1925: "For from the very beginning it is naturally not given that that which is not 'normal' is also false. It can be just as well asserted that Schopenhauer observed the world through gray glasses as that he saw it correctly, while all other, normal, people had rose-colored glasses. In other words, it is not Schopenhauer's melancholy which deceives, but rather the will to live of normal persons holds them captive to the delusion of an absolute value of life."

truth despite illness, there is suffering despite health. Psychologism forgets the former, pathologism overlooks the latter.

Pathologism does not differentiate between the simply human and the truly pathological. And despair need not be pathological. One of my patients, a university professor, who suffered from periodic endogenous depressive states, was not concerned and troubled about the meaningfulness of his existence during the depressive phases, but rather during the normal intervals.

So for instance the despair of a person with regard to the apparent meaninglessness of an existence, this questioning of meaning—which ultimately underlies all despair—is in itself far from being pathological. Such despair is human, but not pathological. To claim that persons questioning the meaningfulness of their existence must for that reason already be ill would be pathologism. In response to it we are called to distinguish between the human and the morbid.

Not even every suicide is pathological. And by no means must suicide always be "the conclusion of a pathological psychological development," to cite a book title. This is not to say that suicide is able to solve a problem or a conflict. It can be shown that one committing suicide in one instance lacks courage, and one committing it in another instance lacks humility; but even if the one is no hero, and the other no saint, neither are thereby insane. They do not suffer from a psychological illness, but rather from a spiritual crisis, a crisis of conscience. And even if the conscience of one who commits suicide is in error, this error is nonetheless still human.

Most questionable is the pathologism that not only confuses the pathological with the human, but with that which is the most human there can be, namely, anxiety about the most meaningful fulfillment of human existence possible, where this most human of all concerns is taken for something all-too-human, for a weakness, for a complex. Indeed, this demand for meaning that humans levy against existence (i.e., this will to meaning) is so far from being a symptom of illness that we mobilize it as a remedy—in the sense of the proposed psychotherapy starting from the spiritual.

However, we may not forget that not only does the will to meaning embody the most human of phenomena that there could possibly be, but also that its frustration is nonetheless not always pathological. One need not be ill when thinking that one's existence is meaningless, indeed one need not even become ill from this. Existential frustration is neither something pathological, nor is it in every case something leading to pathology. That is, it is in and of itself nothing pathological, indeed not even necessarily pathogenic; for insofar as it is pathogenic, it is only optionally pathogenic. Whenever it is

in fact pathogenic, that is, whenever it in fact leads to neurotic illness, then we call such neuroses noogenic.

Let us ask ourselves, when is existential frustration pathogenic? Now, this requires the cooperation of a somato-psychological stimulus (*Affektion*), which must first link itself to the existential frustration. For a noogenic neurosis to arise, a somatopsychological stimulus must become linked to the existential frustration. In fact, it is not even conceivable otherwise, for precisely according to logotherapy, an incidence of illness can occur only in the sphere of the psychophysical organism, and not in the spiritual person: the spiritual person cannot become ill. But the human person can certainly become ill. Whenever this is the case, the psychophysical organism must be involved. A psychophysical stimulus must be present, if we are to be able to speak of neurosis at all. In this sense, we consciously speak only of noogenic neuroses—but not of noetic neuroses: noogenic neuroses are illness "from the spirit"—but they are not illness "in the spirit": there are no "nooses." Something noetic cannot in itself and as such be pathological, and therefore cannot be neurotic. The neurosis is not a noetic, not a spiritual illness, is not an illness of the human person merely in the person's spiritual dimension; rather, it is always the illness of a human person in that person's unity and totality. Nonetheless, it becomes clear from all of the above that the characterization of noogenic neurosis is preferable to existential neurosis: only a frustration can properly be existential—but this is precisely not a neurosis, is indeed nothing pathological.

At this point in our considerations there arises—in addition to the already discussed danger of pathologism—still another danger: the danger of a noologism. To fall into the mistake of noologism involves wanting to assert that every neurosis is noogenic. The opposite mistake, pathologism, involves asserting that every existential frustration is pathogenic. It is as little the case that every existential frustration is in itself something neurotic as that every neurosis is rooted in an existential frustration. H. J. Prill reports, from the University Women's Clinic of Würzburg, that he was able to establish an existential pathogenesis in 21 percent of the cases of organ neurosis. And my coworker Eva Niebauer, the director of the psychotherapy outpatient unit of the Neurological Policlinic in Vienna, could ultimately only qualify 14 percent of the cases that occurred as noogenic neuroses. R. Volhard and D. Langen were able to demonstrate an analogous percentile: 12 percent, no more and no less. That is, not every neurosis is noogenic—not every neurosis arises from a conflict of conscience or a value problem.

While psychologism incorrectly diagnoses every neurosis, and thereby also the noogenic, as psychogenic, noologism views every neurosis, hence also the psychogenic (as well as the somatogenic pseudo-neuroses), as noogenic. Paradigmatic for such a flagrant noologism are assertions such as the following: "Neurosis is always an exaggeration of relative values."[4] Further, "The problem of God is in every analysis the central conflict problem."[5] When the one author claims that neurosis is "always" an exaggeration of relative values, then he himself not only absolutizes something relative, but exemplifies above all a case of flagrant noologism; for it is neither the case that neurosis can always be traced back to an absolutization of relative values, nor that such absolutization of values always leads to a neurosis. We don't want to be more Catholic than the Pope. Even the Franciscan priest J. H. Vander Veldt of the Catholic University of America in Washington confirms our own view, insofar as he explicitly explains that not every neurosis has an underlying conflict, not to mention a moral or even a religious conflict. And when the other author, contrary to the warning of J. H. Vander Veldt, places not the moral, but rather the religious conflict as not only one of the conflicts, but rather as the only conflict underlying the etiology of neurosis, thereby "idolizing" it (to use his favorite expression) by claiming that the problem of God is the central conflict problem in "every" analysis, then he throws H. J. Weitbrecht's warning to the wind: "It is not our task, as if posing as priests, to judge guilt, and even less to have the audacity of viewing every illness as a form of rebellion against the divine order. The hubris of wanting to see through everything and penetrate it to the core is to be rejected as unbefitting to a doctor."

Next to the Scylla of psychologism, the Charybdis of noologism lies in wait for us. While the psychologist projects the spiritual right out of the realm of the human—which is precisely constituted as such through the dimension of the spiritual—into the realm of the merely psychological, the noologist interprets the body onesidedly and exclusively as an expression of the spiritual. It is indeed the case that physical illnesses do not generally have that status in a life history and that expressive value for the mind/spirit (*Geistseele*) that psychosomatic medicine so generously ascribes to it. Psychosomatic medicine teaches that only those who allow things to "make them sick" become sick—while in contrast it can be shown that under certain conditions also those who are happy become ill. And if the words of Juvenal—*mens sana in corpore sano* (a healthy mind in a healthy body)—are so misunderstood as to mean that a healthy mind

[4] J. A. Caruso, *Die Wiener personalistische Tiefenpsychologie als symbolistische Teilerkenntnis der menschlichen Person*, (1954) p. 3.
[5] Wilfred Daim, *Umwertung der Psychoanalyse*, (Vienna 1951), p. 311.

is dependent upon a healthy body, then I am able, as a psychiatrist, to testify that there are cases of *mens insana in corpore sano* (an insane mind in a healthy body), while as a neurologist I can vouch for the fact that there are cases of *mens sana in corpore insano* (a sane mind in an unhealthy body)—for instance, in a crippled body. Certainly, every illness has its "meaning"; but the real meaning of an illness lies not in the "that" of the being ill, but rather in the "how" of the suffering, and therefore this meaning must first be conferred upon every illness, and this happens whenever the suffering person, the *homo patiens,* fulfills the meaning that lies latent in a suffering that fate necessitates precisely through the proper, upright suffering of a fate that is truly his or hers. Illuminating such possibilities of meaning, the search for meaning in this sense is the task of medical ministry (*ärztlicher Seelsorge*).

Illness triggered by the mental, but precisely not caused by the mental—in other words, a nonpsychogenic illness—we characterize as psychosomatic. However, in contrast to psychosomatic medicine, we do not maintain that we are always dealing with specific complexes, conflicts, problems and traumas, which then become pathogenic. Rather, it is easily shown that the complexes, conflicts, and traumas in which a specific pathogenesis is supposedly repeatedly incriminated must be considered as virtually ubiquitous. And they have not caused a given illness every time they are mentioned in a medical case history. To draw such a conclusion would be the same as concluding that a reef that first emerges and becomes visible during low tide is the cause of the low tide. In reality the low tide merely uncovers the reef: likewise, the various complexes, conflicts, problems, and traumas are not the causes of the respective illness, but they emerge in such number and variety during a medical history because in the case of the patients concerned, we are dealing with people surrounded by anxiety and care, whose anxiety is already the effect of neurotic illness.

Something analogous can be applied in the sphere of noogenesis (though not of pathogenesis in general). It is also true of noogenic neuroses that the existential frustration that may lie at its foundation is so ubiquitous, that it cannot in itself and as such be pathogenic. Therefore, here too a somatopsychological stimulus must first arise, and the psychophysical organism be involved.

Thus, the etiology of neurotic illness involves two things: a personal reaction and a psychophysical correlate. The personal reaction involves either a wrong passivity in the form of a flight from anxiety (which is the anxiety neurotic reaction pattern) or a wrong activity in either in the form of a struggle against the compulsion (which is the obsessive-compulsive

neurotic reaction pattern) or a struggle for pleasure (which is the sexual neurotic reaction pattern). The therapeutic corrective fosters a proper passivity (an ignoring of the neurosis, which can only be expected, indeed can only be demanded, to the extent to which there is an acting-toward-something on the side of the patient) and proper activity.

The psychophysical correlate involves *sit venia verbo*, a resonance of the psychophysical organism to the reaction of the spiritual person. It is constituted by a corresponding disposition and a corresponding constitution.

With regard to disposition, we have come to know the role that not only extreme strain, but also extreme relief, can play. Manfred Pflanz and Thure von Uexkuell were able to show that also according to internal medicine persons become ill only when they have either too much or too little pressure, that is, when they do not have a task corresponding to their abilities. When they have such a task, it is manifestly "antipathogenic," it sustains health. What matters is the therapeutic corrective of an appropriate demand—which serves precisely as "something" that motivates action (see above).

With regard to constitution, we have ultimately come to know the role that is played on the part of:

(a) Personality disorders, particularly in the obsessive-compulsive form;
(b) Neuropathy, particularly sympatheticotonia or vagotonia;
(c) Endocrinopathy, particularly Type I-III functional disorders:
    –Type I (Basedowian—hyperthyroidic),
    –Type II (Addisonian—hypocortial), and
    –Type III (Tetanoid).

We may not overlook a single one of the aspects that converge in the etiology of neurotic illness, nor may we overestimate any of them, if we are to avoid falling into a somatologism, psychologism, or noologism (see Figure 14).

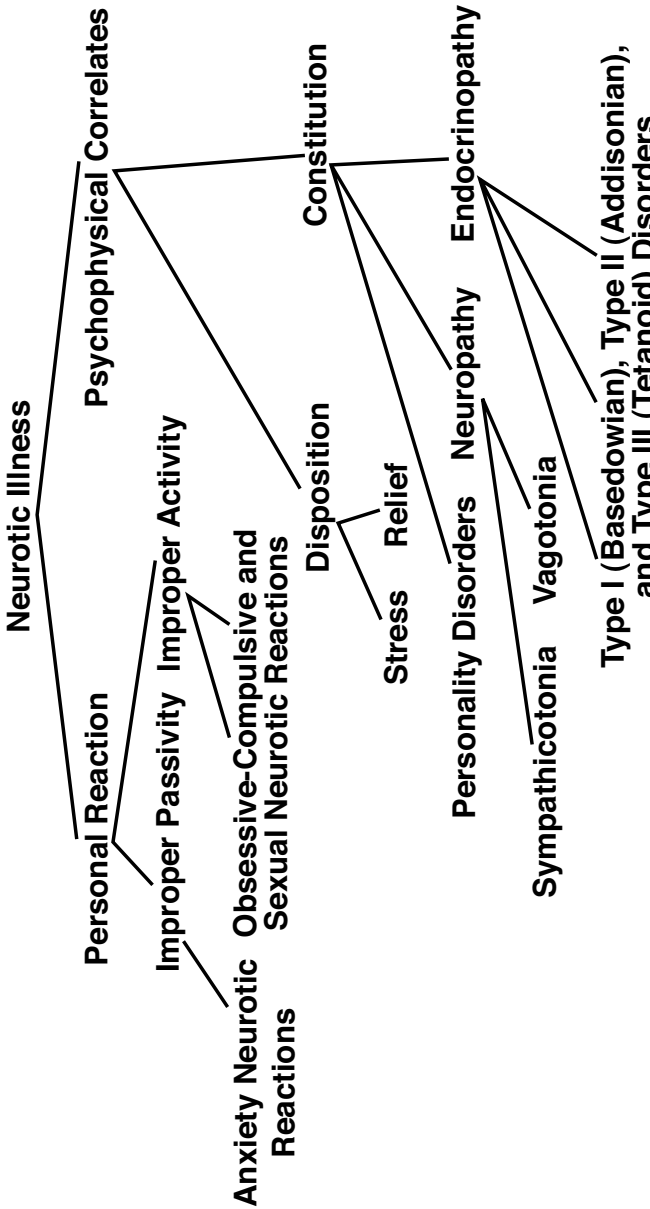

Neurotic Illness
Personal Reaction
Improper Passivity
Improper Activity
Anxiety Neurotic Reactions
Obsessive-Compulsive and Sexual Neurotic Reactions
Psychophysical Correlates
Disposition
Stress
Relief
Constitution
Personality Disorders
Neuropathy
Sympathicotonia
Vagotonia
Endocrinopathy
Type I (Basedowian), Type II (Addisonian), and Type III (Tetanoid) Disorders

Figure 14

Preview

Chapter 11. Logotherapy as a Nonspecific Therapy

This chapter examines how logotherapy can be used to supplement therapies that address mental disorders arising from somatic and psychological causes. In such contexts, logotherapy can serve multiple purposes.

- It is not always necessary to get at the root of a psychological problem (that is, to identify its cause) in order to treat it. For example, a patient may develop effective defenses against anxiety without identifying the root cause of anxiety.
- Filling an existential vacuum is antipathogenic. That is, finding a meaningful task to complete may help to ward off neurotic reactions to symptoms or crises.

Chapter 11
Logotherapy as a Nonspecific Therapy

From what was said above it follows that in the case of noogenic neuroses, logotherapy is a specific therapy: noogenic neuroses, as neuroses originating in the spiritual dimension of the person, demand logotherapy as a therapy that adopts a spiritual perspective. In the case of noogenic neuroses, logotherapy is indicated insofar as these neuroses present logotherapy's narrower scope of indication. Within the boundaries of this sphere, logotherapy is indeed a replacement for psychotherapy. But there is also a wider sphere of indication for logotherapy, and this is represented by neuroses in the narrow sense, that is, not the noogenic, but the psychogenic neuroses. And within this sphere logotherapy is not a replacement for psychotherapy, but merely a supplement to it.

Logotherapy is not, however, simply a supplement to psychotherapy; it is also a supplement to somatotherapy—or better said, it is a somato-psychological simultaneous therapy, placing a lever under both the somatic as well as the psychological, so as to lift the neurosis from both of these angles. After all, we see time and again how between a vegetative and endocrine functional disturbance, on the one hand, and a pathogenic reaction to this disturbance on the other, a vicious circle is established, in which a reactive anticipatory anxiety is combined with a vegetative readiness for anxiety, in the course of which the patient first falls into an anxiety neurosis. A neurotic circle arising in this manner should have corresponding therapeutic forceps, whose arms address both the somatic as well as the psychological. This approach will be managed so that, for instance, in cases in which hyperthyroidism lies at the root, psychotherapy will be provided for the reactive anticipatory anxiety, and the vegetative anxiety readiness will be addressed with a targeted therapy using

dihydroergotamine injections. Now it becomes evident in precisely such cases that therapy oriented in this manner is only able to be completed, that is, the neurosis is fully conquerable only when patients have an orientation and an alignment toward a concrete meaning in their personal existence, a meaning that must be illuminated through existential analytical means.

The neurotic circle can only thrive in an existential vacuum, and therapy can only be completed if it succeeds in filling this existential vacuum through logotherapy. Logotherapy then is a noetic supplement to somatopsychological therapy.

It is therefore certainly not the case that logotherapy overlooks the biological or the physiological. It seeks only one thing, namely, that after the physiological and the psychological have received attention, the noological is not forgotten. When a house is built and the roofer finally begins to work, no one would reproach him for not giving thought to the basement.

In the cases we discussed earlier, it can hardly be said that the existential vacuum, in which alone it was possible for a neurosis to take root, was pathogenic. Nevertheless, filling this vacuum was anti-pathogenic (to make use of the expression of Manfred Pflanz and Thure von Uexkuell). Likewise, in authentically somatogenic or psychogenic cases, which in no respect have arisen from the spiritual, a therapy that addresses the spiritual is appropriate. And in such cases the words of Paracelsus hold true: the illness arises from nature, but its cure only from the spirit. The neuroses were not noogenic, yet nevertheless logotherapy combined with a somatopsychological simultaneous therapy was indicated. In such cases we can speak of logotherapy as a nonspecific therapy.

I consider the writings of Edith Weisskopf-Joelson on this topic to be exceptionally accurate: "Although traditional psychotherapy has insisted that therapeutic practices be based on findings of etiology, it is quite possible that certain factors might cause neuroses during early childhood and that entirely different factors might relieve neuroses during adulthood. . . . Helping the patient develop effective and socially acceptable defenses against anxiety—such as a supportive system of ethical values—seems a more realistic, even though perhaps a less ambitious, goal of therapy than 'getting to the roots' of the disorder."

The following case serves to substantiate this. Mrs. W. (Vienna Neurological Policlinic) is 30 years old. She comes with the most extreme psychotophobia and criminophobia, including fear of homicide and suicide. The psychotophobia is related to hypnagogic hallucinations (i.e., hallucinations experienced when falling asleep); the patient is apparently eidetic (i.e., prone to very vivid and detailed visual sensation). She is also

extremely obsessive-compulsive and this constitutes the constitutional, personality-related foundation of her neurosis, while the neuropathic side emerges in the form of a sympatheticotonia (in whose legitimacy there is no reason, together with F. Hoff and Curtius, to doubt), that is, of a sympatheticotonia overlapping with a hyperthyroid. She has an enlarged thyroid, exothalamus, tremors, tachycardia (a pulse rate of 140 per minute), weight loss of 5 kilograms, and a Basic Metabolic Rate of + 72 percent. A dispositional aspect is now joined to this constitutional foundation: the vegetative derangement due to a 2-year-old strumectomy (i.e., removal of a goitrous tumor). And finally, a conditional factor: a vegetative disequilibration; one day the patient drank a strong espresso, contrary to her usual habit, upon which she experienced a vegetative anxiety attack, to which she responded with reactive anticipatory anxiety. (She stated, "after the first attack, the mere thought of it immediately caused to me become anxious again.") Later the anticipatory anxiety condensed, as we have heard, around her obsessive-compulsive ideas. Thus far we have the constitutional, dispositional, and conditional moments, or the somato- and psychogenesis. However, beyond this it became evident that there was also a noogenesis insofar as the patient lived in an existential vacuum: she said things like, "There is a spiritual void. I'm hanging in midair. Everything appears meaningless to me. It has always helped me the most to have someone to care for, but now I am alone. I want to have a reason for living again!" The patient's motive for coming to us did not lie in her existential frustration. However, the therapy only took effect when she was shown the way to fill her existential vacuum and to dismantle her neurotic structures.

In light of the wide spectrum of possible indications and combinations of existential analytic logotherapy, it is understandable that M. B. Arnold strictly declares, "Every therapy must in some way, no matter how restricted, also be logotherapy."

Preview

Chapter 12. Paradoxical Intention and Dereflection

This chapter presents two therapeutic techniques developed by Viktor Frankl to treat various neuroses: paradoxical intention and dereflection. The chapter illustrates these techniques in 14 different patient cases.

- Paradoxical intention can be understood in the light of the theory of "Reactive Neuroses" developed in chapter 5. In cases of anxious neurotic fear and of obsessive-compulsive fear, something abnormal is feared rather than accepted. The patient seeks to flee from or fight against the symptom or compulsion, and this gives rise to anticipatory anxiety, which in turn increases the likelihood of the feared symptom or compulsive behavior. In the case of sexual neuroses, we are dealing with a forced desire (hyperintention) of something normal (potency or orgasm) which results in anticipatory anxiety of failure, which in turn increases the likelihood of failure.
- Logotherapy asks: What would happen if we prompted phobic patients to attempt to desire that which they fear? Or prompted obsessive-compulsive patients not to fight their compulsion, but to act on it? Or prompted the sexual neurotic to seek impotence or frigidity? In each instance such a "paradoxical intention" takes the wind out of the sails of anticipatory anxiety and effects "self-distancing." The fact that there is often humor involved only aids in this self-distancing process.
- Dereflection can be understood in the following manner. Human beings are meant to know and love things beyond themselves. Neuroses often lead to a misuse of our faculties insofar as individuals suffering from anxiety, obsessive-compulsive, and sexual neuroses tend toward compulsive self-observation. For example, a person who suffers from neurotic insomnia may both fear sleeplessness and hyperintend sleep (a natural function)—in either case the individual is focused inward on the self, its fears, and symptoms.
- Thus, logotherapy posits that anticipatory anxiety and hyperintention can be diminished by directing attention outside of oneself (dereflecting). The patient is led to ignore fears, symptoms, and hyperintentions. This is best accomplished indirectly insofar as the patient discovers a concrete meaning or purpose. Here psychotherapy becomes logotherapy. The therapist may also use cognitive or pharmacological therapies to help restore the patient's trust in natural processes (e.g., ability to sleep or attain an erection).

- Both of these techniques often work very quickly and without identifying the underlying initial causes of the neurotic behavior. While some patients experience complete and lasting success using these techniques, other patients (e.g., some patients with obsessive-compulsive disorders) may require continuous psychotherapeutic care and occasional inpatient treatments if only to provide a helpful change in environment. Even in such cases the techniques of paradoxical intention and dereflection may help patients to manage symptoms.

Chapter 12
Paradoxical Intention and Dereflection

Paradoxical Intention

The Therapeutic Technique

In his foreword to a book on logotherapy, Allport calls logotherapy one of the trends subsumed in the United States under the characterization "existential psychiatry." However, Robert C. Leslie asserts that logotherapy, precisely in this respect, holds a "highly exceptional position" such that in contrast to the other existential psychiatric orientations it is possible to draw a proper technique out of it. Analogous references are found in the relevant writings of Donald F. Tweedie, Aaron J. Ungersma, Godfryd Kaczanowski, and Crumbaugh. We are speaking here of paradoxical intention, as it is has already been described in my 1939 publication, "On Pharmaceutically Supporting the Psychotherapy of Neuroses."[1]

In the following we wish to introduce paradoxical intention not by way of induction, that is, on the basis of the therapy of neuroses, but by the way of deduction, by deriving it from the theory of neuroses.

For this purpose let us return to anxiety neuroses. Over and again it can be observed that the anxiety of patients with anxiety disorders is potentiated to a fear of the anxiety. This fear of anxiety is motivated by a fear of collapse, a fear of coronary infarct, or a fear of stroke (see chapter 5 on reactive neuroses), depending on whether the patients are afraid of having a breakdown out in the open, collapsing from a heart attack, or having a stroke. Now, this fear of anxiety leads patients to flee from the anxiety.

[1] Viktor E. Frankl, "Zur medikamentosen Unterstüzung der Psychotherapie bei Neurosen," *Schweizer Archiv für Neurologie und Psychiatrie, 43,* 26, 1939.

In other words, they run away from the anxiety—paradoxically, by staying at home. For, what we are dealing with here is the first of the reaction patterns discussed, namely, the agoraphobic reaction pattern.

It is different with obsessive-compulsive disorders. The patients are afraid of the compulsion. Indeed, as noted already, this anxiety is motivated by their fear that what they suffer from could degenerate into, be a precursor or even the symptom of, a psychotic illness (psychoto-phobia), that they could do something criminal (crimino-phobia), that is, harm themselves (suicide phobia) or someone else (homicide phobia). While people with anxiety disorders take flight from the anxiety, people with obsessive-compulsive disorders fight against the compulsion. The reaction of compulsive patients consists in fighting the compulsions, in attacking them, in confronting them—in contrast to people with anxiety neuroses who run from the anxiety attacks. We have here a reaction whereby the obssessive-compulsive neurotic reaction pattern elevates the obsessive-compulsive personality disorder (*anankastische Psychopathie*) to a reactive obsessive-compulsive disorder (*reaktive Zwangsneurose*).

It is again different with sexual neuroses. The struggle for pleasure is the characteristic mark of the sexual neurotic reaction pattern. People with sexual neuroses pursue pleasure, and precisely for this reason does it evade them. They hunt pleasure; but pleasure is an effect that does not allow itself to be "caught"; it must rather remain an effect, and cannot be intended. The hunt for happiness scares it away, the fight for pleasure drives it away. To the forced intention of sexual pleasure is added then a forced reflection on the sexual act; but exaggerated attention has no less a pathogenic effect than exaggerated intention.

The example of anticipatory anxiety illuminates how fear brings about that which it fears. But just as fear makes real that which it fears, a forced desire makes impossible that which it intends. Logotherapy makes use of this insofar as it attempts to lead patients into paradoxically desiring, or intending precisely that which they so greatly fear.

Both in the case of the anxious neurotic fear of fear as well as in the case of the obsessive-compulsive fear of compulsion, we are dealing with a fear of something abnormal, while the forced intending of male potency and female orgasm, which we encounter in cases of sexual neurosis, is not a fear of something abnormal, but a forced desire for something normal. Now, what would happen if we linked the desire with something abnormal, thereby putting a stop to the neurosis (see Figure 15)? What would happen if we were to prompt and instruct phobic patients to make an attempt to desire precisely that which they fear (even if this were to happen only for a moment)? For if I, as someone impotent, emphasize my "will"

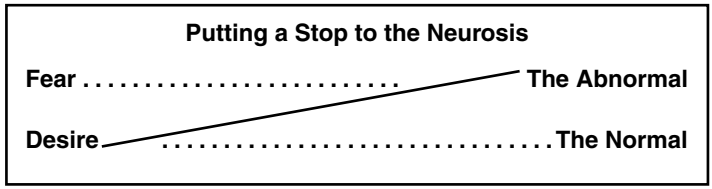


Figure 15

for coitus, namely forcibly intend it, and thereby make it impossible, what would happen if I, as agoraphobic, also "emphatically" willed a collapse? When they succeed in paradoxically intending that which they fear, this psychotherapeutic measure has an amazingly beneficial effect on phobic patients. As soon as patients learn to allow a paradoxical intention to take the place of anxiety, the wind is taken out of the sails of their fear.

A concrete instance could explain all this, so we will return to the case of the young colleague who suffered from severe hidrophobia. By nature he is vegetatively unstable. One day he extended a handshake to his supervisor and noticed as he did so that he began to sweat conspicuously. The next time, in a similar situation, he was from the outset expecting to break out into a sweat, and the anticipatory anxiety itself drove the sweat of anxiety into his pores. Our hidrophobic colleague was now instructed by us precisely to intend that he "sweat up a storm" for the person that he is meeting. "To this point I have only managed to sweat 1 liter," he would say to himself (as he later reported); "but now I'm going to sweat 10 liters!" And the result? After suffering for four years from this phobia, he was able finally and fully to free himself of it in a week on the basis of the method we showed him—during a single session.

Such results from therapeutic treatment demonstrate not least that so-called short-term therapy (*Kurztherapie*) can be both short and good, namely, when it does not pretend to be depth psychology. But it need hardly thereby be a superficial psychology. And by the way, the opposite of depth psychology is not superficial psychology, but height psychology (*Höhenpsychologie*).[2] Regarding the allegation that all of this amounts to symptomatic therapy, we refer to J. H. Schultz: "The variously expressed concern that the formation of substitute symptoms or some other wrong

[2] See Viktor E. Frankl, *Zentralblatt für Psychotherapie, 10,* 33, 1938: "Where is that therapeutically oriented psychology that includes these 'higher' levels of human existence in its scope, and in this sense, and in contrast to 'depth psychology,' earns the name 'height psychology'?"

attitude must necessarily follow the elimination of symptoms in such cases is wholly unfounded at that level of generality."

Patients should objectify the neurosis and distance themselves from it. Patients should learn to look anxiety in the face, indeed to laugh in its face. This requires the courage to be ridiculous. The physician may not shy away from telling patients, indeed demonstrating to patients, what they should tell themselves. Nothing frees patients to achieve this self-distance as does humor. Humor deserves to be called an "existential trait," on the same level as "concern" (*Sorge*) (M. Heidegger) and love (L. Binswanger).

Clinical Case Study

Now, what does the implementation of paradoxical intention look like in practice?

One day a young surgeon came to us. Every time the director of his clinic entered the operation theater the surgeon began to be afraid of trembling while he operated. Later, this fear sufficed to actually make him tremble. Finally, he was able to overcome this tremor phobia, or the tremors that it set loose, only by getting drunk before every operation. Now this case set up a therapeutic chain reaction. For after I related his case history and my method of treatment in one of my clinical lectures, I received a letter from one of my pupils, a medical student, who reported the following fact. She had also suffered from tremor-phobia, which became acute whenever the anatomy professor entered the dissecting room; then the young woman would in fact begin to tremble. After she heard about the case of the young surgeon in my lecture, she attempted on her own to apply the therapy to herself. From then on, whenever the professor came to observe the dissecting, she told herself, "Now I am really going to tremble for him—I'll show him how well I can tremble!" Upon which—as she wrote to me—both the tremor-phobia as well as the trembling itself promptly vanished.

Let us consider another case. Marie (Vienna Neurological Policlinic) was treated and an abridged version of her case history was written up by Dr. Kocourek.[3] In the foreground of the clinical picture stood spasmodic heart palpitations. With them were associated anxiety and "a collapselike feeling." After the first palpitations and anxiety attacks the fear arose that it could all come back again, whereupon the patient again experienced palpitations. In particular, she was afraid of collapsing out on the street or of having a stroke. The patient was directed by Dr. Kocourek to tell herself, "My heart should no longer beat. I will attempt to collapse upon the

[3] See the section "Anxiety Neurotic Reaction Pattern" in chapter 5.

street." The patient was directed to programmatically seek out any situations unpleasant to her, rather than avoiding them. Two weeks after initiating treatment the patient reported, "I feel very well, and experience hardly any palpitations. The anxiety attacks have fully disappeared." After the patient was discharged, she reported 17 days later, "I occasionally have palpitations, and tell myself, 'My heart should beat even more.' The palpitations then disappear."

The following case should serve to illustrate the applicability of paradoxical intention in cases of obsessive-compulsive disorder. Mrs. R. is 52 years old. Her mother before her had suffered from severe obsessive-compulsive disorder. Fourteen years ago, the first symptoms of obsessive compulsion became apparent in the patient herself. She had been merely pedantic to that point. She began to suffer from a counting compulsion. When reading, she often started over 10 times, or got stuck on a word. She had to keep her chest of drawers in the most perfect order, checking everything, at the same time experiencing great fear that they could be disturbed. In order to be sure that she had really closed her drawers, she had to slam them shut in a specific rhythm. She repeatedly knocked her knuckles sore, broke keys, and ruined doorknobs—by the constant checking on whether the doors were really closed. Even her husband was not always allowed near her chest of drawers, and once she had to buy a shirt for herself after she could not bring herself to allow her husband near her dresser. The patient was admitted as an inpatient, turned over to Dr. Niebauer for psychotherapy, and treated by the head of the department only insofar as he illustrated paradoxical intention to her. That same afternoon the patient brought two of the drawers in her closet into disarray, and was even a little proud of the fact. It is notable that only after this therapeutic effect, a discussion with Dr. Niebauer revealed that when the patient was 5 years old, her brother ruined her favorite doll, whereupon the patient began putting away her toys. When she was 16 years old, her sister took one of her dresses without asking, and after this she began locking up her dresses. Dr. Niebauer trained the patient in the meaning of paradoxical intention: imperfection must be intended—everything must be as disorderly as it can possibly be. The patient should open her closet with the desire of messing everything up. Two days after the initiation of the treatment, the patient came so far that she no longer needed to count or inspect. On the 4th day of the treatment, she forgot to lock the closet. On the 6th day of treatment she no longer needed to repeat everything she does. Two weeks after the initiation of treatment the patient was able, as she spontaneously reported, to use her fountain pen normally again, something she had not been able to do for years, since this had to happen

according to a specific system. She told the doctor, "I am very proud." On the 2nd day after this, the patient was discharged, upon which she told the department head, "I am no longer afraid. Everything is quite normal. I am going home a new person." The patient had suffered from obsessive-compulsive disorder for 14 years, and the recovery had occurred over the course of 16 days. The recovery is still in effect.

Let us consider another case. Mr. P. (Vienna Neurological Policlinic) was a 44-year-old musician. The patient was treated and his case history written up by Dr. Niebauer. Since childhood, the patient was very pedantic. At the age of 16 he had scarlet fever, and was treated in a hospital for infectious diseases. At that time, other patients sharing the patient's room had procured food and smuggled money out in secret. Since then the patient suffered from the obsession that every banknote could be a source of infection. He is afraid of bacteria, infectious diseases, skin diseases, and sexually transmitted diseases. He has his own specific ritual. When he arrives home after work, he cleans the doorknob many times over and washes his hands. Any of his friends who come to visit him know about this and do the same, since he would otherwise have no peace. He cannot enter into any kind of bargain that would require him to accept a banknote. He always receives his salary in brand new banknotes, and only in 10-shilling notes—the smallest banknote denomination. This way, when he pays for something, it is impossible for him to get a banknote as change. Any coins that he receives go into their own bag, and are washed repeatedly, or boiled, at home. He constantly carries a little bottle of water and soap with himself. After a visit the whole apartment is washed. When his son comes home, he is completely brushed off, his schoolbooks and briefcase washed off. His car is also similarly washed. Only then is he calmed down. He has several different coats that shield him from bacteria. When he has one of these coats on, he is "immune" and can even receive dirty banknotes. While at work he always wears such a white protective coat; but for a concert he has to perform in a dark suit. At such times he is anxious and uncertain. He never goes to bed before 2:00–3:30 in the morning, since he always has so much planning, so much organizing to do before he can rest; meanwhile he's always falling asleep at work. As a child, he was never clean enough for his mother, and was always made to wash. During puberty, he heard of a pub where someone contracted leprosy through a banana. Since then he avoids bananas, believing that these are always picked by lepers and are a certain source of infection. In 1953 he came for treatment as an outpatient, but the psychotherapist at that time lost patience after the 5th visit and told him that no one could help him. Dr. Niebauer recommended to the patient (as a paradoxical intention)

that he wish for that which he fears, and say to himself, "I am looking to find as many infectious diseases as possible." In this vein, he should hide banknotes everywhere, leave them lying all over the house, just grab doorknobs repeatedly, and "dig himself into the mire of bacteria." Already at the 3rd session the patient explained to the attending doctor, "It's like a miracle. For 28 years I've suffered from a fear of bacteria; I am completely changed. As I left you on Saturday, I immediately began with your suggestion. I simply sat down in my car, wiped nothing off, immediately threw away two little bags that I kept in the car for keys and spare change, and simply stuck my wallet into my jacket. I also didn't wipe off the garage or the garage door handle, as I usually do. At home I did not wash my hands, I no longer brush my son off or wash his briefcase, but rather let him do what he wants. Moreover, I brought home a banana for my wife and child and ate one myself, whereas earlier I never even entered a store where they sell bananas." During the 4th session the patient reports that he has continued with what he was doing, that merely days ago he would have sooner expected to die suddenly than ever be able to leave behind certain obsessive-compulsive habits. During the 6th session he states, "I'm going around in one and the same suit. I don't even own two coats any more. I don't need them any more. You don't even know how many things I can already do. And the wonderful thing about it is that my family doesn't have to do anything any more either. If I'm allowed to enter the apartment in my suit without brushing off, then naturally my wife and son are allowed to do that too." During the 7th session a further discussion reveals that the patient has had a fear of illness since earliest childhood. A neighbor who had taken care of him had had the habit of telling him hundreds of horrible stories about hospitals whenever he was sick. During the 8th session the doctor sees continued marked improvement. The patient even drives acquaintances in his car, he no longer washes the car, and he helps in the counting out of his wages. Nevertheless, he sometimes falls into compulsive activity fully mechanically, without being aware of it. When his wife makes him aware of such activity, he is able to stop it easily enough. Three months after the initiation of treatment, during the 10th session, the doctor observed continued improvement, and wrote, "He is leading a fully normal life." Three weeks later, during the 11th session, the patient states that he still has some obsessive thoughts, as earlier, but he is always successful in suppressing the obsessions. Eight months later he states, "I am still not 100 percent satisfied: it crops up every once and a while. But contrary to how it used to be I am doing *very* well—80 percent of it is gone!"

Mrs. Anna H. (Vienna Neurological Policlinic) was very pedantic from youth. At the age of 5, she insisted on having her own handkerchief. Nothing was clean enough for her. She would stay awake till five in the morning to get her homework in order. *Delire de toucher* of the highest order. The malady became ever graver. In 1950 and 1951 the patient found herself in a nerve clinic twice. When she was directed to the outpatient clinic by her doctor, she had to get up at four in the morning, so as to make it to us by noon—such was the extent to which her repetition and control compulsions handicapped her. In our ward, a daily discussion with Dr. Niebauer was arranged in which the patient was directed to desire that everything should be as dirty as possible. The patient was instructed "to spring head over heels directly into the dirt," and on the 8th day the patient, who had been suffering from a severe obsessive-compulsive disorder for 60 years, was washing herself no more than a total of 30 minutes a day. On the 10th day she washed in the common patients' sink of the large infirmary, needing no more time than the average patient. On the 15th day she went home for 2 hours and washed only once. On the 21st day she went out a second time, again washing only once. On the 25th day, during the third outing, "the patient made her own snack at home, for the first time in years; before leaving the ward she declared 'Absolutely not—out of the question' when asked if she wanted to wash first. On the 30th day she was discharged practically healed, but not before having cleaned up the infirmary of her own accord. Half a year later she had a follow up visit and reported that she stays at work all day, and does not need more than an hour a day for washing up and dressing.

Consider another case of washing compulsion. Mrs. H. (Vienna Neurological Policlinic) suffers from severe obsessive-compulsive disorder rooted in an obsessive-compulsive personality disorder. The first symptoms of compulsion appeared early in childhood. She suffers from a continuous feeling of being dirty, and touches only that which she absolutely must. She is afraid of getting dirty, of having to wash, and of not being able to stop washing. Everything must be put down and organized as neatly as possible. She never goes out of the house, and her mother and sister actually suffer from the illness no less than the patient herself. "Nothing makes me happy any more," says the patient. Her life is meaningless and empty. She is instructed by the attending physician, Dr. Kocourek, to ignore the feeling of being dirty—indeed, more than this: to satirize it such that she sets herself the goal of becoming as dirty as possible. More and more, she is encouraged to be disorderly. When she was admitted, it had taken her 6 hours to wash and dress, while on the 3rd day of the treatment it only took her 10 minutes in the morning and 10 in the evening. On the 5th day she

succeeded in reducing the time to 5 minutes. Soon the patient is completely normal, goes to the theater, is at home for 4 hours and only washes herself once. At her discharge she feels fine, and after the discharge does better than ever before. In contrast to how it used to be, for example, she rides the streetcar without putting on gloves.

Naturally, an obsessive-compulsive personality disorder requires continuous psychotherapeutic care, if not repeated inpatient treatment, for the mere change of milieu pulls the patients out of an environment that interferes with liberation from the well-established compulsive neurotic ritual ceremonies.

Consider still another case of washing compulsion. Mrs. Emily B. (Vienna Neurological Policlinic) is 65 years old. She has suffered from a severe washing compulsion since she was 4 years old. When she was not able to wash her hands, she licked them clean. Later, she was afraid of sick people, in particular those with rashes. Twenty-five years ago she encountered someone suffering from lupus and became anxious that she might have been infected. Since then she has never stopped cleaning her clothes. She threw her umbrella and gloves out right away. She avoids people and never sits down. Someone with lupus could have been sitting there. She never touches a doorknob. Her husband must also conform to a ritual whenever he enters the room. First he has to brush off his jacket, then his hair, clean his shoes, wash his hands, open and close the door, then wash his hands once more, and so on. "When he gets the shopping bag that hangs in a specific place in the kitchen, he has to walk out of the kitchen backwards to be sure that he really doesn't touch anything, et cetera." For a long time the patient has been unable to work, and spends all her time in bed: "That is my island of refuge." But there she also must constantly be wiping things off with towels, towels that her husband can never wash out thoroughly enough. "For hours she wipes off her clothes and her body. She wipes the bed up to 300 times, and the cloths used for this are constantly being washed." (The following case excerpts were provided by Dr. Niebauer.) "For example, her husband brings her breakfast in the morning on a specially disinfected tray. Whereupon she has to clean off a place on her bed for the breakfast, which takes an hour, since she wipes off one and the same spot innumerable times." The sheet cannot have the slightest wrinkle. The patient despairs and says, "My life has become a hell." With an analogous case in mind, in which we had performed a prefrontal lobotomy and were able to heal the patient, we admitted this patient to determine whether this was indicated. At the time, it took her 6 hours each time she dressed or undressed. She was treated by Dr. Niebauer with paradoxical intention. After 9 days in the

clinic, she was darning the socks of other patients. After 11 days she was cleaning the instrument table, washing nightstands, cleaning syringes, carrying out dirty wastebaskets full of bloody and festering bandages. After 13 days she receives her first permission to go out, and at home does not wash herself a single time. Triumphantly she reports that she had eaten a roll with dirty hands. Two months later she is free of complaints. At home, she only needs half an hour to dress or undress, "goes shopping, runs errands, and sews clothes on the sewing machine which earlier she had not touched. She makes coffee, dusts, all things that she had never done. She comes home and doesn't immediately take off her clothes, sits down in the living room without brushing or wiping herself off. She jokes about her obsessive-compulsive disorder." She is admitted into another hospital for a case of chronic eczema and put into the wing for patients with erysipelas (an acute, inflammatory skin disease), which doesn't bother her in the least. But she does have repeated regressions. She repeatedly needs medical counseling and supportive psychotherapy. But each time it is possible to relieve her malady without having to perform a lobotomy.

Paradoxical intention is no less indicated in cases of criminophobia. Let us consider an example. The patient (Vienna Neurological Policlinic) is 23 years old and has suffered since the age of 17 from compulsive ideas that she could in passing, without knowing it, have killed someone. She then has to retrace her steps to be certain that there is no dead woman lying along her path. She is treated by Dr. Niebauer. The patient is counseled to tell herself: Yesterday I killed 30 people, today 10, and I have to hurry on if I'm to reach today's quota on time. Six days later the following conversation is tape recorded.

> Patient: "I have to say that with paradoxical intention close to hand, I don't have to look around at all. I'm completely finished with those compulsive thoughts that I might have killed somebody!"
>
> Dr. Niebauer: "How do you deal with things now?"
>
> Patient: "Very simply, I just tell myself, whenever one of those compulsive thoughts crops up, that I just have to keep on going, since I still have so many more that I have to kill. With that, however, the compulsion goes away."

Let us turn to an analogous case. Mr. Karl G. (Vienna Neurological Policlinic) is afraid that he could have a stroke, get cancer, throw himself

in front of a train, throw his child out of the window, or so forth.[4] Motivated by this criminophobic thinking, he had all of the windows in his apartment barred. The patient is treated with paradoxical intention by Dr. Niebauer. He states, "Yesterday I killed one person, the day before two — now, today I'm going to kill three, and that person there will be the first." Three months later, he tells the doctor, "Things are excellent. I don't have any more compulsive thoughts. I can't even imagine that I ever had such thoughts."

A subgroup of criminophobic fears requires particular attention: obsessive blaspheming thoughts. We treat these phobias most effectively by trying to address the patients' disorder so that we make them aware that with this fear of blaspheming they actually blaspheme: to consider God so poor at diagnosis that we deny him the ability of diagnostically differentiating between blasphemy and obsessive thoughts amounts to blasphemy. In reality, so must we assure the patients, God certainly does not ascribe an obsessive blasphemous thought to the personal dimension of the patient. Obsessive-compulsive personality disorder—the substrate of their compulsive neurosis—is indeed not ascribable to their spiritual person, it is rather attached to their mental character. In this respect, the patients are neither free nor responsible; even though they are responsible for the attitude toward the obsessive thoughts: they constantly fight against the blasphemous thought, thereby only intensifying its "power" and their own torture. To shut off this struggle against the symptom—by turning off the motive of this struggle—is the goal of this technique.

Dr. Hans O. Gerz, the clinical director of the Connecticut State Hospital in the United States, draws upon extensive clinical experience. He sees in paradoxical intention a technique specifically effective in phobic and in anxiety and compulsive neurotic cases. With this method it is possible, even in severe cases of compulsive neurosis, to achieve at least significant relief for the patients. In acute cases, it is an excellent short-term therapy.[5] At the symposium on logotherapy that was held as part of the 6th International Congress for Psychotherapy, Gerz related the following two case histories.

A. V., 45 years old, married mother of a 16-year-old son, has a case history 24-years long, during the span of which she suffered from a most severe phobic syndrome, consisting of claustrophobia, agoraphobia, fear of heights, fear of elevators, fear of crossing bridges, and the like. Because of these complaints, she had been treated by psychiatrists for the full 24

[4] See the section on "Obsessive-Compulsive Neurotic Reaction Patterns" in chapter 4.
[5] See H. O. Gerz, "On the treatment of phobic and compulsive neurotic syndromes with 'paradoxical intention' according to Frankl," *Z. Psychother. med. Psychol., 12,* 145, 1962.

years, including repeated treatments with long-term analysis. In addition to this, she was repeatedly confined to hospitals, at which times she received numerous electroshocks. Finally a prefrontal lobotomy was proposed. She had been compelled to spend the last 4 years in an institution. But both the electroshocks as well as intensive treatment with barbituates, phenothiazines, MAO inhibitors, and amphetamine compounds had had no effect. She was not capable of being anywhere outside of a particular area around her bed. In spite of all the tranquilizers that she received, she was always in a state of high excitement. Likewise, an intensive, year-and-a-half-long psychoanalytic treatment by an experienced analyst was to no avail. On March 1, 1959, Gerz took over the treatment using paradoxical intention. Every medication was immediately suspended, and nevertheless it was possible to eliminate one symptom after another, one phobia after another, using the aforementioned method.

First the patient was directed to want to collapse, and to intend to be as anxious as possible. After only a few weeks the patient succeeded in doing all that she earlier could not possibly do: leave the ward, ride the elevator and things like that—all this with the firm resolution of fainting and losing consciousness. In the elevator, for example, she says, "Look, doctor, I'm trying so hard to collapse and to be afraid—all in vain. I simply can't do it any more." And she began, for the first time in many years, to take walks outside of the asylum, with the intention of being afraid, but was incapable of doing so. Five months later, according to all reports, the patient was for the first time in 24 years free of every fear as she went home for a weekend. Or nearly every fear: only the crossing of a bridge had gotten the better of her. But the very evening that she returned to the asylum, she was put into Gerz's car so that she could ride to a bridge and cross it. "Now try to be afraid, as afraid as you can possibly be." Gerz conveys to us her words: "It's just not working—I'm just not afraid—I just can't be, doctor." Shortly after this she was discharged. Four and a half years have passed since then, and she now leads a normal and happy life in the circle of her family. A few times a year she looks up Dr. Gerz, but only to express her gratitude.

And now let us consider the case of an obsessive-compulsive patient. Mr. M. P. is a 56-year-old attorney, married, father of an 18-year-old college student. Seventeen years ago he was "quite suddenly" overcome, as by a lightning strike from the heavens, with the terrible compulsive thought that he may have underestimated his income tax by $300, thereby defrauding the state—even though he had worked out his income tax return according to his best knowledge and conscience. "After this, I couldn't be rid of the idea—try as hard as I might," he told Gerz. He saw

himself, because of this deception, pursued by the public prosecutor and jailed, he saw the newspaper full of articles about him, and saw himself losing his job. He then committed himself to a sanatorium, where he was treated first with psychotherapy and then with 25 electroshocks—with no success. In the meantime his condition worsened to such an extent that he had to close his law offices. During sleepless nights he fought against obsessive-compulsive thoughts that multiplied from day to day. "I was barely free of one, when another one sprang up," he told Gerz. In particular, he was plagued by the obsession that his various insurance policies could have expired without his noticing it. He was constantly having to double check them—and then lock them up again in a special steel safe, each individual policy tied up with *x* number of strings. Finally, he took out a special insurance policy with Lloyds of London, worked out specially for him, intended to protect him from the consequences of any unconscious and unintended mistakes that he could have made in the course of carrying out his law practice. But then soon it was all over with this practice; for the repetition compulsion became so severe, that the patient had to be admitted to the Middletown psychiatric clinic. Here his treatment with paradoxical intention with Dr. Gerz began. For 4 months the patient came to him for logotherapy, three times a week. Over and over he was directed to use the following paradoxical intention formulation: "I don't give a darn about anything. To hell with perfectionism. Everything's fine with me—as far as I'm concerned let them lock me up. The sooner, the better! What, be afraid of the consequences of a mistake that I may have made? Let them go ahead and arrest me—three times a day, while they're at it! At least this way I'll get my money's worth, that beautiful money that I gave up to keep those insurance men in London happy." And now he began, through paradoxical intention, to want to make as many mistakes as possible, and began to intend to make still more mistakes, to bring all his work into disarray and show his secretaries that he is the "biggest maker of mistakes in the world." And Gerz did not doubt that the patient was now capable not only of formulating paradoxical intentions, but of formulating these intentions as humorously as possible, something to which Gerz naturally had to contribute, for example, by greeting the patient as he came into his office with something like the following, "What on earth! Are you still walking around free? I thought that you'd have been a long time behind bars—I've looked in the papers to see whether they would report the terrible scandals that you've caused." Whereupon the patient would break into a loud laugh and adopt an ironic attitude, he would laugh at himself and his own neurosis by saying, for example, "I don't care—let them lock me up; at the worst the insurance industry will

go bankrupt." It's been over a year since the completion of his treatment. "This paradoxical intention really struck a chord with me. It worked like a miracle, let me tell you! In 4 months you have succeeded in making a new man of me. Admittedly, now and again one of my old fears enters my head; but now I can get rid of it immediately—now I know exactly how to handle myself!" And laughing he adds, "And above all, there's nothing nicer than finally being locked up really good and tight."

That logotherapy can be carried out in a relatively short amount of time is readily seen from a report by Eva Niebauer-Kozdera on the statistical results of the outpatient clinic she runs according to logotherapeutic principles: she points to a 75.7 percent rate of healing and improvement—improvement to the extent that no further treatment is necessary—in an average of eight sessions.[6] Gerz explains, "The number of sessions needed depends to a large extent on how long the patient has been ill. Acute cases that only go back several weeks or months allow themselves to be cleared up, in my experience, in four to twelve sessions."[7]

Gustav Lebzeltern[8] quite decidedly contradicts the assertion of Hans Hoff, H. Strotzka, A. M. Becker, and E. Wiesenhuetter that paradoxical intention "to a large extent technically" builds on an older model; in other words, DuBois's suggestion therapy "is experiencing a recent resurrection in the form of logotherapy." Gerz[9] (writing about 7 years of clinical experience with the logotherapeutic technique of paradoxical intention) and Donald F. Tweedie were able to show that paradoxical intention in particular cannot be reduced to the mere effects of suggestion. Benedikt was able to observe that "most patients initially are in fact explicitly skeptical of the method and do not even believe that it will be successful. A patient once even said to me, "Such nonsense, one should get better from this?" And often the patients go away with great anxiety when they are directed to paradoxically intend and to carry out the exercises. "But this can't help," they feel. Then the patients come to the physician and say, "I can hardly believe it, it really has worked." As Benedikt presents in his dissertation on

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[6] *Wiener klinische Wochenschrift, 67,* 152, 1955.

[7] Op. cit. See also Peter R. Hofstaetter: "Der gegenwärtige Stand und die gesellschaftlichen Voraussetzungen von Neurosenlehre und Psychotherapie in Nordamerika," in Viktor E. Frankl, V. E. von Gebsattel, & J. H. Schultz (Eds.) *Handbuch der Neurosenlehre und Psychotherapie*: "Eysenck bases himself on five [studies] covering 760 cases of neuroses that were treated psychoanalytically and on nineteen statistics with a total of 7,293 cases treated with eclectic methods. Among the psychoanalytic studies, an average of 44 percent were characterized as healed, substantially healed, and improved; in the eclectic studies 64 percent. Appel and his colleagues base themselves on 12 reports of over 4,131 cases of neuroses treated with a variety of methods for at least three months. The average success rate was around 67 percent."

[8] Gustav Lebzeltern, *Angstzustände und deren Überwindung* (Graz, 1967).

[9] Gerz, *Zeitschrift fuer Psychotherapie und medizinische Psychologie, 16,* 25, 1966.

paradoxical intention, patients on whom this logotherapeutic technique was applied with outstanding success have actually shown themselves in suggestibility tests to be below average in their openness to suggestion. "In spite of this it is all too easy to understand that those psychiatrists who have spent years educating themselves in psychoanalysis very rarely get over their bias against Frankl's technique in order to convince themselves of the effectiveness of the logotherapeutic method by trying it themselves. But the academic spirit invites us to test without prejudice whatever therapeutic possibilities offer themselves to us."[10]

Treatment with paradoxical intention is, however, also possible where the attending physician is nothing more than logotherapeutically oriented in his theoretical convictions. In the context of the Viennese Neurological Policlinic, a purely psychoanalytically oriented colleague employed there made use of the logotherapeutic technique as the only possible short-term therapy in a given context. A member of the Viennese psychoanalytic society attempted to explain the results he achieved with this method of treatment in psychodynamic terms. The American psychoanalyst Edith Weisskopf-Joelson expresses herself in one of her works on logotherapy as follows: "Psychoanalytically oriented therapists may claim that no real improvement can be achieved with methods such as logotherapy, that indeed the pathology lying on the 'deeper' levels has not been touched, and the therapist has rather made the mistake of setting up defense mechanisms. However, such conclusions are not without their danger. That is, they may divert us from real possibilities of psychotherapy solely on the grounds that these possibilities just happen not to fit into our personal theory of neuroses. Above all we should not forget that in cases of defense mechanisms, 'deeper levels' and 'continuation of neurosis' on these deeper levels, we are dealing with purely theoretical constructions and by no means with empirical observations." "In any case we can say," declares Gerz, "that phobias that can be interpreted as products of suppressed aggression can also be cleared up in the same way, if the patients—precisely through paradoxical intention—are led to do precisely that which their anxiety so strongly keeps them from doing, that is, to at least symbolically live out their aggression."[11]

Glenn G. Golloway of the Psychiatric Clinic in Ypsilanti, Michigan, United States, had once said, "Paradoxical intention is aimed at manipulating the defenses and not at resolving the underlying conflict. This is a

[10] Friedrich M. Benedikt, "Zur Therapie angst-und zwangsneurotischer Symptome mit Hilfe der 'Paradoxen Intention' und 'Dereflexion' nach V. E. Frankl," Doctoral Dissertation. Munich 1968.
[11] Hans O. Gerz, "Zur Behandlung phobischer und zwangsneurotischer Syndrome mit der 'paradoxen Intention' nach Frankl," *Z. Psychother. Med. Psycho., 12,* 145, 1962.

perfectly honorable strategy and excellent psychotherapy. It is no insult to surgery that it does not cure the diseased gall bladder it removes. The patient is better off. Similarly, the various explanations of why paradoxical intention works do not detract from paradoxical intention as a successful technique."

Progressive psychoanalysts, particularly in the United States but also in Europe, are not shy of using logotherapeutic treatment techniques. And they are having a lot of success with such application. It can naturally not be objected when they then interpret this success differently than would a logotherapist, that is, purely psychodynamically. So, for instance, J. L. Haarington writes, "Frankl's paradoxical intention is an attempt to consciously put into action the attitude described by Fenichel, which is anti-phobic and establishes automatic defense mechanisms. In the context of the psychoanalytic model, paradoxical intention is readily understood as a symptomatic treatment that mobilizes a defense mechanism that demands a smaller expenditure of psychological energy than the phobic or compulsive neurotic symptom itself. Whenever paradoxical intention is successfully employed, the Id is satisfied, the super-ego binds itself to the ego, and the ego itself gains strength and becomes freer. The outcome is a reduction of anxiety and symptoms."

Dereflection

Anticipatory Anxiety and Compulsive Self-Observation

Schelling once wrote: "Simple reflection is the most dangerous mental illness." In anxiety neuroses, we are repeatedly able to observe a compulsive self-observation attaching itself to the anticipatory anxiety that we so often find linked to anxiety neurosis. Indeed, this is the most vicious thing in this vicious circle. Whoever is caught in the nervous anticipation of a sleepless night understandably wants to fall asleep. But precisely this wanting does not allow them to rest and precisely prevents them from falling asleep, since falling asleep has relaxation above all as a prerequisite. But this does not happen. On the contrary, insomniacs watch themselves with high-strung attention, looking for much-desired sleep. Not only is the sleeplessness anxiously anticipated, but the act of falling asleep is scrutinized to such an extent that it cannot help but be rendered impossible. Precisely the vigorous desire to sleep drives away sleep.

It is different in the case of obsessive-compulsive disorders, as we have written: while here, in the sphere of decision-making and judgment, we find a hyperacuteness of conscience, in the sphere of knowledge and cognition we find a hyperreflection, a compulsive self-observation, to be

precise. For the characteristic marks of people with obsessive-compulsive disorders are scrupulosity and pedantry—being overly conscientious and overly conscious. What they seek is the absolutely perfect decision and absolutely certain knowledge. But they run aground in their cramped and violent will for absolute certainty, in the judgmental and cognitive absolutism from which they suffer. They experience what Faust says: "that nothing perfect is granted to humans."

As we saw, in the case of sexual neuroses it is again different: to the forced intention of sexual pleasure joins itself a forced reflection on the sexual act. Both are pathogenic—an excess of both intention and attention. For in a manner that is completely analogous to sleeping, sleeping with (i.e., the sexual act) is disrupted by too much intention as well as by too much attention. Underlying both as their root, however, is precisely that anticipatory anxiety, that anxious anticipation of a disruption that on the one hand gives rise to the forced desire for undisturbed function, and on the other produces the equally forced self-scrutiny of the dreaded disturbance. Thus, we see how all intending as well as all observation is apt to disrupt a function in its normal course, and accordingly it is understandable that psychotherapy not infrequently relies more on removing attention from some symptom or other, upon which the attention was focused, than on dissipating the symptom itself. In such cases, one can readily remind the patient of the well-known story about the millipede that collapsed as soon it self-consciously made the futile attempt to consciously set all his "thousand feet" in motion: it no longer knew with which foot he should begin the whole chain of steps, nor in which succession he should be lifting his feet.[12] For reflection disrupts the completion of every act that is normally carried out unconsciously and automatically.

It is clear that just as we should choose the therapeutic method of paradoxical intention with regard to anticipatory anxiety, compulsive self-observation analogously calls for dereflection as a corrective. While paradoxical intention enables patients to mock the neurosis, the help of dereflection enables them to ignore the symptoms.

In the final analysis, dereflection means ignoring one's self. In Bernanos's *Diary of a Country Priest* we find the beautiful sentence, "It is easier than one believes to hate oneself; grace consists in forgetting the self." Now, we can modify this and say what some neurotic people don't keep in mind often enough, namely, more important than hating yourself

[12] This above all holds of psychological activity, that is, not only of those cases in which one "thinks about something," that is, consciously wants to do something, but also of thinking itself. Did not Goethe once say in jest: "How did you get so far? . . . I never thought about the thinking" (*Zahme Xenien* 7).

(overconscientiousness) or noticing yourself (overconsciousness) is fully forgetting yourself. Not that our patients should then do as Kant did, who was once forced to dismiss a dishonest servant, but was not able to get over his pain at this dismissal. In order to force himself to get over it, he hung a sign on one of his walls with the direction "I have to forget my servant." He was like the man who was promised that he could make gold out of copper, but only on the condition that for 10 whole minutes, while carrying out the alchemistic recipe, he did not think about chameleons; whereupon he was not able to think of anything other than this strange animal, to which he had never given a thought his whole life long.

It doesn't work that way. Rather, ignoring something—accomplishing the required dereflection—is only possible by "acting past" this something, by existing for something else. And here psychotherapy turns into logotherapy, into existential analysis, whose essence in a certain sense consists in directing persons to the concrete meaning of their personal existence, which is analytically illuminated in each case.

Persons do not exist for the sake of observing themselves and contemplating their own egos; rather, they exist in order to give themselves up, to give themselves away, to knowingly and lovingly devote themselves. But ultimately and in its essence, all knowing and loving is directed to something outward, and the extent to which this is true is reflected in the fact that the old Hebrew language uses one word for both.

It is not the task of the spirit to observe itself and to contemplate itself. To the essence of the person belongs a being-directed-toward and an outward directedness, whether toward something or someone, toward a work or an individual, or toward an idea or a person. Only to the extent that we are intentional in this manner are we existential. Only to the extent that persons are spiritually with something or someone are persons with themselves.

We must now make this fact, this fundamental law of human existence, therapeutically fruitful. And here it is precisely people with anxiety neuroses who are drawn out of the vicious circle of their own self-encircling thoughts only when and to the extent that they learn to turn their attention away from symptoms and turn themselves toward some thing. The more victims of illness place some thing in the foreground of their consciousness, some thing that is able to make their life meaningful and worth living, the more they and their personal problems are pushed into the background of their experience. Thus, it is often much more important to focus first on removing attention from the symptoms, that is, to turn oneself to a concrete task that is personally important and can only be done by oneself, than to look for complexes and conflicts as a possible way of

alleviating the symptoms. For it is not through self-contemplation or through contemplation of the ego, not through allowing the thoughts to circle around our anxiety that we can be free of this anxiety, but rather through a self-giving, through a giving-up-of-oneself and a devoting oneself to a worthy object. That is the secret of all self-formation (*Selbstgestaltung)*, and no one has expressed it more aptly than Karl Jaspers when he said of persons that they "always become persons by giving themselves to the other," and when he concludes by writing, "Persons are what they are through the things that they commit themselves to."[13]

We thus recognize four essential types of attitudes or responses:

1. Improper passivity: Running away from anxiety attacks;
2. Improper activity:
   (a) Struggling against obsessions or compulsions, or
   (b) Forced intending of sexual pleasure with a forced reflection on the sexual act (the one is no less pathological than the other);
3. Proper passivity: Ignoring (dereflection) or even mocking (paradoxical intention) symptoms; and
4. Proper activity: Acting-past-the-symptoms or existing-toward-something—for the symptomatology of many neuroses ultimately shows itself to be a sort of mental debris that fills a spiritual vacuum.

Case Studies on Hyperreflection and the Technique of Dereflection

Miss B. (Vienna Neurological Policlinic) compulsively contemplates herself whenever she swallows. Becoming uncertain, the patient anxiously expects to swallow wrong, to choke. Compulsive self-observation and anticipatory anxiety disrupt her eating so much that with time she wastes away. The patient is therapeutically dereflected. The formula is given to her in this fashion: "I do not need to watch my swallowing because I don't need to swallow. For I'm never the one who swallows, rather—it swallows."

Consider an analogous case. Irmgard B. is 21 years old. Years ago the patient choked on a string bean. On another occasion she was invited by friends to lunch, got excited about something, and noticed herself gagging as a result. When it came time to eat she became nauseous. The next day she was overcome with fear of gagging and nausea. Because of the anticipatory anxiety she began to scrutinize the reflexive act of swallowing, and tried to force herself to reflect on "consciously swallowing," as she expressed it. We used therapeutic dereflection with the incorporation and

[13] See Max Scheler, *Philosophische Weltanschauung* (Bern, 1954), p. 33: ". . . only those who want to lose themselves in some . . . thing . . . will find their authentic self. . . ."

utilization of autogenic training (J. H. Schultz). She regained trust in the unconsciously guaranteed swallowing function. At the next meal she reported that she was again able to eat without any difficulties.

August B. is 21-years-old. The patient was treated and his case history written up by Dr. Niebauer. He was always an exemplary student, first in his class—maximally ambitious. He wanted to be as perfect as possible. After his graduation he became an accountant, but soon noticed that his handwriting was very illegible, and was often put on notice by his boss for not writing clearly enough. He then attempted to improve his writing. He dedicated all his free time to "learning how to write beautifully." He attempted to imitate how his friend formed his letters. He ultimately no longer knew how to write the letters, how he should really be writing. Over and over again he'd get stuck while writing: "should I form the letter this way or that way?" With time he could no longer write if someone was watching him. He feared being observed. He feared the anxiety. He then completely gave up his profession, since he could no longer write if anyone watched him, and he concentrated only on his handwriting. We gave him the following paradoxical intention: "Now I'm going to scrawl something. I'll write only in order to show how I can scrawl, and I'll get stuck thirty times over." The paradoxical intention was intensified through a stereotyped intention-building with the help of autogenic training. After a 3-week stay at the clinic the patient was completely healed, and was even able during his treatment session to "perform" his writing in front of numerous nurses and physicians.

We see that people with obsessive-compulsive disorders want to "do" everything with knowledge and deliberation, and as a result see everything precisely as "done" and "deliberate," and not as motion, as flux. But since Schelling we know that "the most noble activity of the human person is that activity which is not aware of itself," or as we might say, a doing that does not know itself, that has no consciousness of itself, and since Nietzsche we know that "all perfect doing is precisely unconscious, and is no longer willed."

We know and we acknowledge not only an instinctual unconscious, but also a spiritual unconscious, and this is the level on which disposition is grounded. Feeling can be much more refined than understanding can ever be acute.

All of this illuminates how much, in cases of obsessive-compulsive disorder, being taught to trust the unconscious requires a trust in unconscious spirituality, in the cognitive and decisive superiority of everything having to do with character and feeling in persons over those having to do with intellect and understanding; that is, what we have to teach people

with obsessive-compulsive disorders, what we have to give back to them, what we have to allow them to find again, is their trust in unreflected spirituality.

We know of a case in which the patient had a habit of watching himself in all he said and thought to such an extent that he began to be afraid that this compulsive self-observation could lead him to lose his train of thought when speaking. He developed a growing anticipatory anxiety, which became a real handicap to his career. In just a few sessions the patient was so far healed that he was able, for instance, to speak freely with a foreign diplomat. At the root of his compulsive self-observation was the fear of losing control over himself, of not having control and letting himself fall, of turning himself over to his unconscious.

There is a wisdom in language, and in it we can indeed see the stored up, enriched spirit of humanity. Language, in her wisdom, says that a person "falls" asleep; the unconsciousness that goes along with sleep is something into which we must allow ourselves to fall.[14]

Sleeping Disorders. What are physicians, or actually their patients, to do when faced with the sleep-repelling anxious anticipation that they are going to spend the coming night without sleep? It is an anxiety that can grow into a so-called fear of bed. People with insomnia are tired the whole day long; but it is hardly time to go to bed when fear of the next sleepless night strikes them. They become restless and excited, and this excitement no longer allows them to fall asleep. Now they commit the greatest mistake conceivable: they wait impatiently for sleep. With concentrated attention they tensely observe what is happening to them; the more they focus their attention, the less are they capable of relaxing enough to be able to fall asleep. For sleep is after all nothing other than full relaxation. And they are consciously striving to achieve sleep. But sleep is nothing other than sinking into unconsciousness. And all thinking about and all desiring to sleep are suited only for preventing one from falling asleep.

As DuBois once said, sleep is like a dove that sits on the hand if one holds the hand still, but flutters away as soon as one reaches out to grab it. Sleep is scared away if one strives for it, and the more tense this striving, the more this is the case. Whoever impatiently waits to fall asleep, and anxiously watches oneself for signs of falling asleep, chases sleep away.

[14] In this picture that we are drawing of the relationships between spirituality (*Geistigkeit*), the unconscious and wisdom, Charles Peguy's presentation of sleeplessness as a human distrust of God fits right in: "Now one tells me that there are persons who . . . do not sleep. What a lack of trust in me." (The speaker is God himself.) "I pity them. . . . I am aggrieved at them. . . . A little. They do not put any trust in me." God ultimately says of the sleepless that they "do not wish to entrust him with the direction of their life. While they sleep. The fools."

We can take the wind out of the sails of the anticipatory anxiety of a sleepless night only when we convince the patient that the body always gets the minimum amount of sleep that it absolutely needs. One has to know this, and out of this knowledge draw trust in one's own body.

Certainly, this minimum amount of sleep is specific for every person, and different for every individual. But this does not come down to the length of sleep, but rather to the so-called amount of sleep, and this amount of sleep is the product of the length of sleep and the depth of sleep, that is, there are people who do not have to sleep long at all, and the reason they do not is because although they sleep briefly, they sleep deeply. It is also true that with one and the same person sleep depth varies throughout the course of a night, and there are various types, differentiated according to their sleep curve. One type sleeps most deeply prior to midnight, and the other reaches maximum sleep depth only as morning approaches. If such types are robbed of a few hours of their morning sleep, then they are naturally robbed of a larger amount of sleep than the types who sleep deeply at midnight, and whose sleep curve is already ebbing in the morning.

If it is really the case, as I asserted above, that tensely striving and trying to fall asleep drives away sleep, then what would happen if one were to lie down and not strive to fall asleep, but rather strive for nothing at all or even strive not to sleep? The effect would be that such a person would fall asleep. In other words, in place of a fear of sleeplessness must come precisely the intention to pass a sleepless night, in other words, the conscious renunciation of sleep. One must merely form the intention: tonight I don't want to sleep at all, tonight I am merely going to relax and think about this or that; about my last vacation, or about my coming vacation, and so forth. If, then, as we have seen, wanting to sleep makes falling asleep impossible, then wanting not to sleep paradoxically brings on sleep. For at least then one does not fear sleeplessness any more, and is thereby in a better position to fall asleep.

Within the spiritual unconscious there is—in addition to the ethical unconscious and the moral conscience—so to speak, an aesthetic unconscious: the artistic conscience. With regard to both artistic production and reproduction, the artistic is dependent on an unconscious spirituality in this sense of the term. The in itself irrational and therefore not completely rationalizable intuition of conscience finds its artistic correlate in intuition, and this too is rooted in a dimension of unconscious spirituality. Out of it artists create, and the wells from which they draw therefore remain in a darkness that can never be completely illuminated by consciousness. Time and again, in fact, it becomes evident that at least excessive deliberateness is

capable of interfering with such production "out of the unconscious"; not infrequently forced self-contemplation, the will to a conscious "making" of that which must of itself happen in unconscious depths, becomes a handicap to the creative artist. All unnecessary reflection can only harm.

We are aware of a case, for instance, in which a violinist always attempted to play as consciously as possible, from setting the violin in place at the beginning to the smallest detail of technique, he wanted to "do" everything consciously, to undertake everything with self-reflection. This could only lead to a complete artistic failure. The therapy first had to extinguish this tendency to exaggerated reflection and self-observation: it had to be directed toward dereflection. The psychotherapeutic treatment had to give this patient back his confidence in the unconscious—by directing him to keep always in mind how much more "musical" his unconscious was than was his consciousness. Indeed, therapy oriented in this direction leads in a certain respect to a disinhibition of the artistic "creative powers" ocf the unconscious by freeing the essentially unconscious (re-)production process from the inhibiting influence of unnecessary deliberateness.

Compulsive self-observation can also be iatrogenic. We know of the case of a young actor whose boyish charm made him famous, and who was in danger of falling prey to hyperreflection. It became clear that the patient had been driven into a sweat whenever a psychoanalyst had attempted to analyze away his youthfulness as an infantilism, whereupon he began to switch over to serious roles. In the serious roles, he was taken seriously neither by the critics nor by the public, and his career stood in danger.

In precisely the cases just discussed, a very essential aspect of all psychotherapeutic goals makes itself evident. Today, we may in no way insist on the view that psychotherapy consists of a consciousness-raising at any price; for psychotherapists are only temporarily concerned with bringing something to consciousness. They are called to make the unconscious—and so also the spiritual unconscious—conscious only so that in the final analysis they can allow it to become unconscious again. They are to transfer an unconscious potentia into a conscious actus, but only in order to reestablish an unconscious habitus. Psychotherapists must ultimately restore the naturalness of unconscious execution. The mistake of not heeding this was characterized by Hans Urs von Balthasar as "one of the unforgivable shortcomings of psychoanalysis." He says, "Only when the roots of the plants are hidden in the earth, can the bloom unfold in health. It belongs to the truth of free and intellectual essences that a part of their selves must be entrusted to forgetfulness."

So, it is often the case that psychoanalysis must allow something to remain, or to become again, unconscious. But we also understand that the

becoming-again-unconscious, the forgetting, represents a significant defense-mechanism, and we grasp the deep wisdom contained in a legend of the Talmud, according to which every newborn child, as soon as it comes into the world, receives a blow upon the mouth from an angel, whereupon it immediately forgets what it had learned and seen before birth. Considering that we must view this Platonic "amnesia" as a defense mechanism, we could call this Talmudic angel a guardian angel.

PREVIEW

Chapter 13. Medical Ministry

This chapter is devoted to examining logotherapy's broadest sphere of application: the care of patients who cannot be cured, but rather must learn to find meaning in their suffering. As with the term "spirit," the term "ministry" is used without religious connotations. It refers to the care of patients not merely as bodily and psychological beings, but as free and responsible persons with a will to find meaning.

- There are three kinds of values human beings can actualize in life:
  - Creative values—by creating things through work, hobbies and activities
  - Experiential values—by encountering and loving other persons or things of value
  - Attitudinal values—by freely adopting a noble attitude toward one's situation
- Those confronted with suffering may not be free to change their situation, but they are free to adopt a noble attitude toward it and in so doing to actualize value. "For in the true and upright suffering of an authentic destiny is unfurled for us a final, indeed the greatest, chance for meaning and self-fulfillment."
- "*Homo patiens* draws out the *medicus humanus*—that is, the suffering human draws out the human in the physician. The doctor who is not also human, but is only scientific, is able to amputate a leg with the help of science; but science alone does not enable him to prevent the amputee from committing suicide. It is not enough to point out to the patient that such a suicide has no justification; for what would this mean to a person whose meaning in life stands or falls with the possibility of standing and walking on two legs?" The physician must go beyond science to accompany the patient in suffering and to help the patient discover his or her unique reason to live. This is the nature of medical ministry.

Chapter 13
Medical Ministry

In conclusion, we must mention logotherapy's broadest sphere of indication. While logotherapy in its narrow sphere of indication was specific, and in its wider sphere of indication it was nonspecific but nevertheless still therapy, in its widest sphere of indication it is no longer an actual therapy, but is transformed into what we characterize as medical ministry (*ärztliche Seelsorge*). As such, it is in no way a specialized medical ministry: the surgeon needs it as much as the neurologist and the psychiatrist—the surgeon who has to confront inoperable cases, or cases that are not only operable, but must be operated, such as amputations. Likewise, the orthopedist is also confronted with problems of medical ministry, not in working with people maimed through operations, but with those crippled from birth, with the physically and sensory impaired. The same can be said of the dermatologist working with disfigured patients, or the gynecologist working with infertile women, or the internist treating the incurably ill, or the gerontologist treating infirm persons. In other words, not only specialists, but all doctors must provide medical ministry, whenever they have before them a patient whose destiny confronts them with inescapable suffering. The neurologist, relatively speaking, will be least confronted with this task; we point out as an example that the illness of the central nervous system which makes up the greater part of severe neurological cases, multiple sclerosis, leaves 63.8 percent of the patients suffering from it in euphoria.

The necessity and the possibility of medical ministry will now be illustrated with a surgical case. A nurse in my clinic was operated on, and it became clear from the exploratory laparotomy that the tumor was inoperable. In her despair, the nurse asked me to come and see her. During our

conversation it became clear that she was not so much in despair because of her illness, but because of her inability to work. She loved her profession above all else, but was now no longer able to practice it. What was I to say in response to such despair? The situation of this nurse was truly without prospect. (A week later she died.) Nevertheless, I attempted to show her that to work 8, or God knows how many, hours in a day is no special achievement—just about anybody could imitate her in that. But to be so anxious to work while at the same time so incapable—and in spite of this not to despair—this would be an achievement, I told her, that not just anybody could duplicate. And, I further asked her, are you not actually being unfair toward all the thousands of patients to whom you, as nurse, have dedicated your life: are you not being unfair to them when you now act as if the lives of the ill or the infirm, that is, of those unable to work, were meaningless? As soon as you start to despair over your situation, I told her, it is as if the meaning of human life stands or falls with whether a person is able to work so and so many hours; but with this you deny all the ill and the infirm every right to life and every justification for their existence. In reality, you have right now a unique possibility: whereas until now you were never able to do more for all those people entrusted to you than provide them your professional assistance, now you have the chance to be more, namely, to be a human example.

These few suggestive words must suffice to show that even in cases of completely understandable—indeed seemingly justified—despair, it is possible to turn a depression around. One only has to know that all despair is ultimately one thing: idolatry—the absolutization of a single value (in the above case, idolization of the value of being able to work).[1] Even in such cases—we hope to have shown at least this—psychotherapy is neither hopeless nor pointless. One could at most ask whether we are still dealing here with medical activity. However, we are of the opinion that we are dealing with medical activity in the best sense of the word. It was the distinguished Professor Klaesi who, in his presidential lecture said about physicians who are confronted with the incurable: "Their highest activity and ability begins where the possibility of curing the ill leaves off."[2]

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[1] See Viktor E. Frankl, *Homo patiens* (Vienna 1950), pp. 87–88 and 90: "We would venture the assertion that persons who have despaired betray thereby that they have made an idol out of something. That they thereby betray that they have absolutized some thing that is only conditionally valuable, only has a relative value. . . . So we see then that every idolatry not only betrays itself, but also avenges itself, through despair." Asserting this is by no means yet asserting that every absolutization of a relative value leads to a neurosis, or that every neurosis is reducible to an absolutization of a relative value, and is "a departure from the value hierarchy." Not every despair is pathogenic, and not every neurosis is "noogenic."

[2] *Klaesi was a well-known Swiss psychiatrist, who became rector of the University of Bern in 1953. (I thank Franz Vesely for this historical fact.)—JMD*

We see that medical ministry is concerned with making people capable of enduring suffering that is necessitated by fate. It is not concerned with restoring the ability to work or to enjoy (both of which in the case in question were irreversibly lost), but with restoring the ability to suffer.

The ability to suffer, however, is ultimately nothing other than the ability to realize what we characterize as attitudinal values. Meaning can be given to existence not only through creative values (e.g., by creativity working), nor only through experiential values (e.g., by having an experience of love or enjoyment), but also through suffering. Indeed we are not dealing here with just any kind of possibility, but rather with the possibility of realizing the highest value, with the opportunity for the deepest fulfillment of meaning. We can give our lives meaning by doing a deed or completing a work. But we can also give our lives meaning by appreciating the beautiful, the good, and the true, by experiencing only a single person in his or her essence as a unique "thou," that is, by loving him or her. But also persons finding themselves in a predicament in which they are unable either to realize values through their own activity or to give their life meaning through experiences—these persons too can still give their lives meaning precisely in the way that they confront their destiny or their predicament, in the way they take on the suffering necessitated by fate. Precisely in this they are given a final possibility for value. For in the true, upright suffering of an authentic destiny is unfurled for us a final, indeed the greatest, chance for meaning and self-fulfillment.

And so life has meaning up to the very last breath. It retains its meaning up to the very last breath for the possibility of realizing values always remains—precisely through the way that we face a suffering necessitated by fate. And now we understand the wisdom of the words of Goethe who once said that there is no situation that cannot be ennobled, either through effort or through patience. We must only add that correct patience, namely upright suffering of authentic destiny, is in itself an achievement, is indeed the highest achievement that can ever be vouchsafed to a person. Even when a person must abandon the realization of creative and experiential values, even then they can "achieve" something; it is not for nothing that the German language speaks of "achieving" renunciation.

As noted above, the realization of attitudinal values, that is, the endowment of life with meaning through suffering only comes into question when the suffering is necessitated by destiny. In other words, no one can reject the operation of an operable tumor by explaining, "I must accept my suffering bravely and humbly"—taking on such suffering is meaningless because such suffering is not fated, it is not necessary. Only

those persons who see themselves confronted with an inoperable tumor can realize attitudinal values through the manner in which they accept their destiny, and thereby give meaning to their suffering as well.

Let us try to answer the question of why the meaning that is offered to persons in suffering is the highest meaning possible. Attitudinal values show themselves as exceptional in relation to creative and experiential values to the extent that the meaning of suffering is dimensionally superior to the meaning of work and of love. Why is it superior? Let us presuppose that *homo sapiens* allow themselves to be divided into *homo faber*, who creatively fulfill the meaning of their existence, into *homo amans*, who enrich their lives with meaning through experiencing, encountering, and loving, and into *homo patiens*, who, called to a readiness to suffer, can still extract meaning from suffering.

Now, *homo faber* is properly speaking what we call successful persons. They only know two categories, and only think in terms of these two categories: success and failure. Their lives move between these two extremes in line with an ethics of success. It is different with *homo patiens*: their categories have long since ceased to be success and failure, they are rather fulfillment and despair. This pair of categories, however, runs perpendicular to the line of an ethics of success. Fulfillment and despair belong to another dimension; for *homo patiens* can find fulfillment even in the most extreme failure, in defeat (see Figure 16).

Thus it has shown itself that fulfillment is compatible with failure just as success is compatible with despair. Still, this can only be understood with reference to the dimensional difference between the two pairs of categories. Admittedly, were we to project the triumph of *homo patiens*, his or her fulfillment of meaning and of self in suffering, along the line of an ethics of success, then, because of the dimensional difference, it would have to portray itself point by point, that is, look like a nothing, appear as an

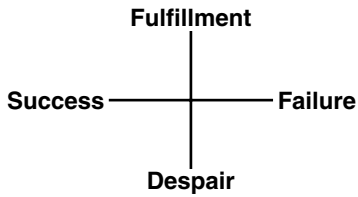


Figure 16

absurdity. In other words, in the eyes of *homo faber* the triumph of *homo patiens* must of necessity be foolishness and an irritation.

Now, what does it look like when somebody presents a living testimony of how fate demanded of him or her to first retreat from any possibility of realizing creative values, and then from any possibility of finding meaning through experiencing, encountering, or loving, such that the only possibility remaining is to surrender to this fate, to adapt to it? A concrete case serves to illustrate how the transformation a patient must undergo occurs. It involves turning from the possibility of giving life meaning through creativity, which stands in the foreground of the everyday consciousness of your average existence, to the necessity of giving meaning to existence through suffering.

A patient suffering from a tumor of the spinal cord can no longer continue in his profession. By trade he drew advertisements. All creative value possibilities, therefore, disappeared. In the hospital he reads avidly, more avidly than he had ever had opportunity before. He realizes, therefore, experiential values, he now gives his life value through absorbing cultural values. But in the end, his paralysis becomes so advanced that he is no longer able to hold a book in his hands, and is also no longer able to bear wearing headphones; so, he is no longer able to realize experiential values, and he also knows that his end is drawing near. But how does he approach this fate? He asks the doctor on nightshift not to disturb his rest on his (the patient's) account: this is his one concern; and just by this, by caring in his last hours more about others than himself—by this quiet heroism—he realized an achievement that is certainly far greater than the drawing of any advertisement that he had ever completed in the days when he was still able to work. Now he had become an advertisement for what persons, even in such a situation, are still capable of achieving.

Another case shows how not only the renunciation of work, and of the possibilities of meaning that derive from work, but also the renunciation of love can bring persons to recognize the possibility of meaningful fulfillment that lie within the suffering of even this fateful loss.

An old general practitioner once came to us. A year ago, the wife whom he loved above all things died, and he cannot get over this loss. We asked the severely depressed patient whether he had considered what would have happened had it been him who died before his wife. "What an unbearable thought," he answered, "my wife would have despaired." Upon which we simply replied, "Just look, your wife has been spared this, and you have spared her this, admittedly at the price of now having to mourn her passing." In this moment his suffering took on meaning: the meaning of a sacrifice.

What Paul Dubois reportedly said is certainly true: a doctor can quite conceivably do without all of that—but then he should be aware that there is only one thing that makes him different from a veterinarian: his clientele.

Homo patiens draws out the *medicus humanus*, that is, the suffering human draws out the human in the physician. The doctor who is not also human, but is only scientific, is able to amputate a leg with the help of science; but the help of science alone does not allow him or her to prevent the amputee, or intended amputee, from committing suicide either before or after the amputation. It is no use to point out that such a suicide has no justification; for what would this mean to a person whose meaning in life stands or falls with the possibility of standing and walking on two legs? The attending surgeon who wants to avoid any kind of doctoring of the soul should not be surprised if he or she does not find a patient on the operating table ready for the operation, but on a postmortem table following suicide.

It was not by accident that the founder of the General Hospital in Vienna, Kaiser Joseph II, directed that a tablet be hung over the door, with the inscription: *Saluti et solatio aegrorum*—that is, dedicated not only to the healing, but also to the consolation of the ill. That the latter also falls into the sphere of a doctor's duties is also attested to in the recommendations of the American Medical Association: "The doctor must also console the soul. That is by no means solely the task of the psychiatrist. It is simply the task of every practicing doctor."

Doctors remain doctors also in the exercise of medical ministry, but their relationship to their patients becomes an encounter of human person with human person. From being merely scientific doctors, they become human doctors. Medical ministry is nothing other than the attempt at a technology of this humanity of the doctor. And perhaps it is also the technology of the humanity that protects us from the inhumanity of technology, which has also made itself felt in the sphere of technical medicine, and has led to experiments on captives and prisoners of war.

If logotherapy in all spheres of indication is not a legitimate replacement of psychotherapy, but rather only its completion, even less is medical ministry a replacement of priestly ministry. Now, what is the relationship between medical and priestly ministry? Let us begin with their goals. The goal of medical ministry, indeed the goal of psychotherapy as a whole, is to heal the mind or soul. In contrast, the goal of priestly ministry, indeed the goal of religion as a whole, is to save the soul. Now, religion certainly has no psychotherapeutic motive, but it does have a psychohygienic effect. For it is the case that it provides human persons with an incomparable security

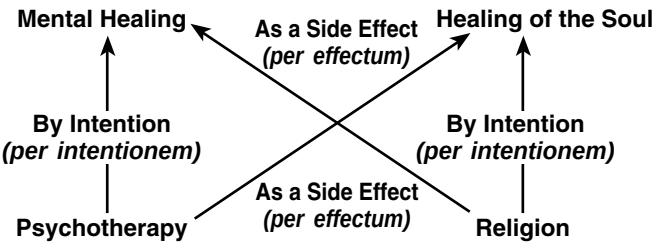


Figure 17

and spiritual anchoring, and this contributes tremendously to the maintenance of their mental equilibrium. On the other hand we see how psychotherapy—without so desiring—in individual cases has helped patients find their way back to the buried springs of their original faith, not *per intentionem*, but *per effectum* (see Figure 17).

It becomes evident that the restoration of the patients' ability to believe is not a fourth task of the doctor, in addition to the three tasks of restoring their ability to work, enjoy and suffer, but is only the possible effect of psychotherapy. We claim neither that "the analyst must be a healer and a savior,"[3] nor that "the psychoanalytical process is a process of redemption,"[4] nor even that "depth psychology attempts to contribute to the awakening of an understanding of the process of world redemption, an understanding lacking in general among intellectuals."[5] Psychotherapy stands in the service of religion just as little as religion is a means to the end of psychotherapy. Quite rightly did J. H. Schultz once observe that "as little as there can be a Christian or a Buddhist obsessive-compulsive disorder can there be a religion-specific scientific psychotherapy."

[3] I. A. Caruso, *Psychoanalyse und Synthese der Existenz* (Vienna, 1952), p. 187.
[4] Wilfred Daim, *Tiefenpsychologie und Erlösung* (Vienna-Munich, 1954), p. 219.
[5] Ibid., p. 301.

Preview

Chapter 14. Existential Analysis as Psychotherapeutic Anthropology

This chapter examines the role that existential analysis can play in psychotherapy and daily life.

- All forms of existential frustration, all doubts about the meaning of life—that is, whether pathological or not—require existential analysis in the broadest sense, though not necessarily the help of a professional. Thus, existential analysis cannot be reserved only for the physician, even though the physician is best able to deal with cases in which existential frustration gives rise to, or complicates, mental disorders.
- Existential analysis must focus on the whole person, not merely the psychological and physical dimensions, but also the spiritual dimension. It must be prepared to follow the spiritual to its unconscious or unreflected depths. It must be willing to seek the meaning that is reserved for the individual person at this moment in this situation.
- Every form of psychotherapy rests upon an anthropology or philosophy of the human person. It is the task of existential analysis to bring the tacit or unconscious philosophy of the person with which psychotherapy operates to a new level of consciousness so that it may be scrutinized and developed.
- Existential analysis enables a criticism of the philosophies that underlie certain dominant psychological models. It shows them to be reductionistic insofar as they reduce human persons to less than they are (e.g., to beings that are essentially narcissistic, or essentially seeking homeostasis, or essentially naked apes). Such views risk compounding the problems of persons with mental disorders, and deprive psychotherapies of important tools for treating mental disorders.

Chapter 14
Existential Analysis as Psychotherapeutic Anthropology

Charlotte Buehler has pointed out that most patients had turned to her with issues of value and meaning; in particular, "the problem of the meaning and value of life can be of greatest significance." Whenever a solution to these problems is deferred there arises what we have earlier discussed and termed existential frustration. Although this existential frustration is capable of making a person ill, it need not do so. Insofar as it is pathogenic, it is only optionally so. However, as soon as it actually becomes pathogenic, it results in a noogenic neurosis.

Just as existential frustration is not necessarily pathogenic, so too it is not necessarily pathological. But existential frustration that does not become pathogenic nevertheless requires existential analysis no less than does noogenic neurosis. Only in this case the existential analysis is not a therapy for neurosis, and is therefore not the proprietary domain of the doctor. Rather, it equally concerns philosophers and theologians, educators and psychologists; for they must take on the doubt about the meaning of life as much as must the doctor. So it becomes clear that while logotherapy is both specific as well as nonspecific therapy, and while medical ministry is nevertheless still medical, existential analysis goes beyond these indications insofar as its concerns are actually not only medical concerns. Thus understood, it is, in our opinion, legitimate that the Argentinian Association of Existential Logotherapy includes a chapter for nonphysicians. As always, psychotherapy in the sense of a therapy for neuroses remains a task of physicians; but psychohygiene, the prevention of

neurotic illnesses,[1] including noogenic neuroses, need hardly be something reserved only for doctors.

Now, to say that the frustration of the will to meaning—existential frustration in itself and as such—is not an illness is by no means to say that it cannot become life threatening. Indeed it can lead to suicide, to an admittedly nonneurotic suicide. From this it is clear that existential analysis, far from being, in such instances, a medical treatment of illness in the true sense of the word, can nonetheless be seen as a lifesaving measure. This becomes clear whenever—in serious cases of so-called extreme situations (prisoner of war camps, concentration camps, and the like)—an appeal is made to the will to live, to continue living, to survive this situation. It succeeds, as evidenced by experience, whenever this appeal can also be addressed to the will to meaning, in other words, when the desire to survive represents an obligation to survive, and is conceived and experienced as such—that is, when continuing to live has a meaning. In this regard, there are experiences that have been collected in prisoner of war camps. They confirm how correct and how significant are the words of Friedrich Nietzsche: "Only those who have a 'why' for living endure almost any 'how.'" In these words I see a motto for psychotherapy.

In this sense existential analysis is a search for meaning. The meaning, however, after which it seeks, is concrete, and this concreteness pertains to both the uniqueness of every person as well as to the individuality of every situation. The respective meaning is *ad personam et ad situationem* (that is, specific to this person and to this situation). In each case, the meaning sought after is required of and reserved for the individual.

Existential analysis extends its analysis to the totality of human persons, which is not only the totality of a psycho-physical organism, but of a spiritual person. Existential analysis follows the spiritual person into its unconscious depths.[2] To this extent it earns itself the characterization of depth psychology. Unless, of course, we were to conceive of the spiritual in persons, in contrast to the psycho-physical, as the "highest" dimension. Then, we would admit, existential analysis is the opposite of the self-styled, and so-called, depth psychology. Only in this case, depth psychology must not forget that the opposite of depth psychology is not a superficial psychology, and that a "height" psychology[3] is in fact authentic depth

[1] In view of the fact that noogenic neuroses do not have somatic causes, but under certain circumstances have somatic effects, their treatment is reserved for doctors.

[2] By unconscious in this context is meant the unreflected. Unconscious spirituality lacks a reflexive self-consciousness, while implicit self-understanding remains.

[3] See Viktor E. Frankl, *Zentralblatt für Psychotherapie, 10,* 33, 1938: "Where is that therapeutically interested psychology, that includes these higher layers of human existence in its scope, and in this sense and in contrast to the 'depth psychology' earns itself the name of 'height psychology'?"

psychology: "Only the peak of the human person is the human person" (Paracelsus).

In all of this, existential analysis is not actually an analysis of existence; for an analysis of existence is as little possible as a synthesis of existence. Rather, existential analysis is an explication of existence. Only we should not overlook that existence, persons, also explain themselves: they explain themselves, unfold themselves, reveal themselves in their ongoing lives. As a rolled up carpet reveals its unchanging pattern, so do we read in the course of a life, in the becoming, the essence of the person.

Consider a case. Mr. Stefan V., 58 years old, comes from abroad solely for the sake of his friends, to whom he had given his word that he would not take his life without first traveling to Vienna to speak with me. His wife died of cancer 8 months earlier. Because of this, he tried to take his own life, was confined to a hospital for weeks, and when asked why he had not attempted to kill himself again he responded, "only because I still had something to finish." Namely, he had to take care of his wife's grave. I asked, "And in addition to this, you have no tasks to fulfill?" To which he answered, "Everything seems meaningless, trivial." I said, "Does everything depend on how it appears to you: either trivial or not trivial? Is it impossible to believe that your sense of meaninglessness deceives you? You are right to have the feeling that nothing and no one can replace your wife; but you have the obligation of giving yourself the chance of some day feeling differently, and of surviving to the time when this might happen." He said, "I no longer have a taste for life." I made him aware that to require this of him would be requiring too much, and the question was rather whether he had the obligation to continue living, in spite of everything. To which he responded, "Obligation—that's just a word. Everything is useless." I replied, "Aren't things like friendship and promises, like putting up a gravestone for the dead, that is, for a person who no longer really exists—aren't these things that have a purpose beyond any kind of immediate usefulness or expediency? If you feel obligated to set up a gravestone, out of love for the departed, do you not therefore feel all the more obligated to continue living, out of love for her?" Indeed, he had unconsciously and implicitly recognized that being obligated stands above utilitarian considerations. It had not sufficed to take the patient at his word, as his friends had done; it was necessary to take him at his actions, and doing this belongs to the essence of existential analysis. In fact, he had handled himself as one who believes in being obligated, and more than this, as one who believes in a higher meaning of existence, in *s*omething that gives it meaning at all times, and therefore also after the last breath of the one that he loves, indeed, even to the last moment of his existence.

But existential analysis is also not only the explication of ontic existence, but also the ontological explication of what existence is. In this sense, existential analysis is the attempt at a psychotherapeutic anthropology, an anthropology that precedes all psychotherapy, not only logotherapy. Indeed, every psychotherapy plays itself out against an *a priori* horizon. There is always an anthropological conception at its foundation, no matter how little aware of this the psychotherapy may be. I do not hesitate to assert that a psychoanalyst betrays the anthropological conception that he or she espouses, for example, in the moment that he or she invites patients to lie down on the couch (rather than encountering them eye to eye).

There is no psychotherapy without an anthropology and a worldview. Paul Schilder himself concedes, "Psychoanalysis is a philosophy as well as a psychology. We always have a Weltanschauung, only some times we do not know it or do not want to know it." Analogous explanations are published by the American psychoanalysts G. W. Ginsburg and J. L. Herma, Joseph Wilder, Hugh Mullan, Jan Ehrenwald, L. W. Wolberg, M. W. Friedemann, Werner Wolff, Kurt Goldstein, G. N. Raines and J. H. Rohrer, Erich Fromm, H. Johnson, Ulrich Sonnemann and John R. Reid.

Just as there was once psychology without a soul, there is now psychology without a spirit. But precisely psychotherapy must guard itself from this blind spot for otherwise it forgoes one of its most important weapons in the fight for the mental health or recovery of its patients. For the one who ignores the spirit, and therefore also ignores the will to meaning, forgoes one of the most valuable tools in the hands of the therapist.

People today have grown spiritually weary, and this weariness of spirit is the essence of contemporary nihilism. A collective psychotherapy must confront this weariness of spirit. It is true that Freud once said that humanity is aware that it has spirit, and that it is his task to show that it has drives. But I think the fact that humanity has drives has been well enough demonstrated in the last century. Today it seems rather to have become necessary to show people that they have spirit. And psychotherapy, at least in the light of collective neuroses, must remember this.

And so, it is the task of existential analysis to render conscious the unconscious and implicit anthropological conception of psychotherapy, to explicate, unfold, and develop it no differently than a photograph is developed and thereby drawn out of latency. For the anthropological conception of the psychotherapist may in some instances be such that it precisely enhances the neuroses of patients. That is, it can itself be completely nihilistic.

The nihilism of today is reductionism. While the nihilism of yesterday identified itself by its talk of nothingness, the nihilism of today betrays

itself through the expression "nothing but." The human person is depicted as nothing but a "naked ape," to use the title of the bestseller, or a computer. In *The Modes and Morals of Psychotherapy,* the following definition is offered to us: "The human being is nothing but a complicated biochemical mechanism, whose energy is delivered by an internal combustion system which provides the computer with energy which is enormously rich in memory for the storing of encoded information." Now, as a neurologist I hold that it is perfectly legitimate to consider the computer as a model for certain activities of the central nervous system. The human person is a computer, but is at the same time infinitely more, dimensionally more than a computer. A cube that is constructed over a square is likewise somehow this square that serves as its basis and foundation. The square is indeed surpassed, but does remain included in the cube. In this case the mistake only arises when we attempt to claim that the cube is nothing but a square. For then we have "reduced" the cube to a square, by projecting it out of a higher dimension, the third, the dimension of space, down into a lower dimension, the second, the dimension of the plane, in which we have constructed the outline of the cube. And so reductionism shows itself as a projectionism. The human dimension, the "space" of the human, is *a priori* excluded, and human phenomena are projected down into a subhuman plane.

The moment this happens science is transformed into ideology. With the human sciences, we see that biology becomes biologism, psychology psychologism, and sociology sociologism. As we see it, there is no danger in researchers specializing; danger arises only when specialists generalize. We all know the so-called *terribles simplificateurs.* We can now place at their side the *terribles generalisateurs*, as I like to call them. The *terribles simplificateurs* simplify everything; they fit everything into one mold. The *terrible generalisateurs* however do not even remain with their mold, but generalize the results of their research.

A reductionist definition of values holds that there is nothing other than reaction patterns and defense mechanisms. I myself have once "reacted" to this interpretation by saying that I would never be ready to live for my reaction patterns, or die for my defense mechanisms. Let us consider, nevertheless, the extent to which such hypotheses are capable of undermining the enthusiasm for meaning and values. I know of the case of a young American couple just returned from Africa, where both had served in the Peace Corps. On their return, they were disenchanted and embittered. It became clear that for months they had to take part in the meetings of a group arranged by a psychologist. At the outset, apparently, something along the lines of an Inquisition had taken place.

> The psychologist: "Why did you join the Peace Corps?"
>
> The couple: "We wanted to help people less fortunate than us."
>
> He: "That means that you must be superior to them."
>
> They: "Somehow."
>
> He: "And that means that you have a need to demonstrate your superiority. Your real motive is therefore the unconscious need to prove to yourselves and to others how superior you are to them."
>
> They: "We've never looked at it that way, but still you are a psychologist, and so you must know better."

And the group meetings took their starting point from this. The members of the group learned to understand their enthusiasm for the Peace Corps, their readiness to sacrifice, their dedication to a task at the price of sacrifice and denial, as a mere complex, as a mere "hang up." But the worst was, as our sources assured us, that the young people, delivered up to and at the mercy of such indoctrination, learned to reproach each other with their "real" motives, not to mention hit each other over the heads with them. A mutual play at psychoanalysis was established. I would like to say that here we have a typical case of "hyperinterpretation." From the outset, motives are not taken seriously, nothing is considered genuine, everything is interpreted as the result and expression of an unconscious psychodynamic. So-called depth psychology likes to be characterized as a psychology of exposure. And exposing is completely legitimate. But it must pause where the "exposing psychologists" come upon something genuine, upon the human in the human person, which does not allow for further unveiling. If they do not pause there, then they expose only one thing, namely, their own unconscious motive, their own unconscious needs to depose and devalue the human in human persons.

One of the most prominent psychoanalysts of the day is the author of a 2-volume work on Goethe, and I'd like to cite the following, taken from a book review of this work:

> On page 1,538, the author portrays a genius as having the characteristics of manic-depressive, paranoid and epileptic disturbance, of homosexuality, incest, voyeurism, exhibitionism, fetishism, impotence, narcissism, obsessive compulsion, hysteria, megalomania, etc. The author seems to limit himself almost exclusively to the

> instinctual dynamisms underlying the work of art. He wishes to make us believe that Goethe's work is nothing other than the result of pre-genital fixations. He was not fighting, for instance, for an ideal of beauty or some other value, but in reality only to overcome premature ejaculation.[4]

Now let us expand our discussion of reductionism. One of the theories of motivation long outdated by the facts depicts human persons as beings who have needs and are directed toward satisfying these needs specifically for the purpose of avoiding tension, that is, for maintaining or reestablishing inner equilibrium. In other words, this outdated theory of motivation still clings to the concept of the so-called homeostasis, borrowed from biology, but which is no longer valid even in biology. Ludwig von Bertalanffy was long ago able to demonstrate that such important biological phenomena as growth and procreation can in no way be explained through homeostasis. Kurt Goldstein, the prominent brain pathologist, was even able to show that it is precisely the injured brain that is so keen to spare itself stress at any price. At the foundation of this mechanistic model lies the model of a closed system. But in fact human persons are beings who are open to the world, who are not actually concerned with one state or another within themselves (e.g., with the release of tensions or with inner equilibrium); but rather, human persons—at least those who are not neurotic—are concerned with things and partners in the world outside, and not, moreover, as more or less useful means to the end of satisfying needs, but rather for their own sakes. In other words, human existence is deeply characterized by its "self-transcendence." By this I mean the most fundamental anthropological state of affairs, namely, that human persons always direct themselves beyond themselves toward something that is not simply their own self—toward something or someone, toward a meaning that persons realize, or toward another human being whom they encounter out there. And only to the degree that persons transcend themselves in this manner do they also fulfill themselves, in the service of a thing, or in the love of another person! In other words, human persons are wholly human only when they are absorbed in some thing or are completely devoted to another person. And only those who forget themselves are completely themselves. How lovely, for example, is a child precisely when it is photographed and does not know that it is photographed, but is rather completely devoted to play!

How much the self-transcendence of human existence extends into its biological depths and foundations can be demonstrated on the basis of the

[4] J. Heuscher, *Journal of Existentialism, 5,* 229, 1964.

paradox that even the human eye is self-transcendent: its capacity to perceive the environment is unconditionally dependent upon its incapacity to perceive itself. When—except in a mirror—does the eye see itself or a part of itself? When it has cataracts. Then it sees a fog, that is, the clouding of its own lens. Or when it has glaucoma. Then it sees, circling around the source of light, a rainbow-colored corona. Analogously, human persons realize themselves when they overlook themselves, be it by devoting themselves to a partner or by becoming "absorbed" in a thing.

In reality, this reductionism is actually a subhumanism. But the deduction of human phenomena from subhuman phenomena also transforms them, that is, it dehumanizes them. Let us only think of the conscience: a typical reductionistic theory views this specifically human phenomenon as the mere result of conditioning processes. A dog that, upon urinating in the house, crawls under the bed with his tail between his legs acts in a manner that can, without any other consideration, be considered as the result of conditioning processes. It is dictated by a kind of anticipatory anxiety, namely, the anxious anticipation of punishment. Conscience has nothing to do with such anxieties. As long as fear of punishment, hope for reward, or the wish to please the superego, determine human behavior, we have not yet begun to speak of actual conscience.

Konrad Lorenz was careful enough to speak of "morally analogous behavior in animals." The reductionists are different. For them, there is no difference between animal and human behavior. For them, specifically human phenomena do not exist at all. They are denied, however, not on the basis of empirical findings, but completely on the basis of an *a priori* conviction. For reductionists it is from the outset excluded that there be something that is predicated of human persons but does not allow itself to be predicated of animals. The reductionists could modify the well-known credo of the sensualists and say that *nihil est in homine, quod non prius fuerit in animalibus* (there is nothing in humans not first found in animals).

It simply is not the case that nature makes no leaps. It makes quantum leaps, and it makes qualitative leaps, or—as the Marxists say—quantity transforms itself into quality. And so there is also a qualitative difference between humans and animals. What actually concerns us is less the difference between humans and animals and more the recognition of the specifically human as an irreducible phenomenon. We would have therefore nothing against it if it became evident that the human person is in reality an ape. There would be equally little objection if human characteristics were discovered in an ape, and I would not object, at least as long as it were truly the case, to call an ape a human person.

The question of whether the human person is an ape is an emotionally loaded one, because it gives the impression of disavowing the biblical creation narrative. This reminds me of an old joke. One Talmudist asks another, "Why should one write Moses with an 'l'?" Whereupon the other asked in return, "Does one write Moses with an 'l'?" To which the first asked, "Why shouldn't one write Moses with an 'l'?" To which the second replied scornfully and impatiently, "But why should one write Moses with an 'l'?" "But that's what I'm asking you," said the first. To the question, "Are human persons apes?", it is possible to ask in return: Why should they not be apes? And the answer to this question runs precisely: because this would contradict the biblical creation narrative. This is the only reason why the question is emotionally loaded.

To repeat: the single and only thing that interests us is the question of whether there is a qualitative difference between the human and the subhuman, that is, whether the specifically human exists at all. Now, this Konrad Lorenz never denied—after all, he speaks of a "flash-transition" (*Fulguration*). According to him, there is indeed the specifically human, whereby the response to the question about the qualitative difference between the human and the subhuman becomes in part an empirical one.

But I prefer to speak not of a qualitative, but rather of a dimensional difference. The advantage is that the various data raised to various dimensions and mutually contradicting each other do not stand in a mutually exclusive relationship despite such contradictions. Rather, in these various dimensions each higher dimension includes each lower dimension. In contrast to Nicolai Hartmann's model of ontological layers, according to which each higher layer of being "surpasses" each lower layer of being, our dimensional-ontological view has the advantage of recognizing that despite the specificity of each higher dimensional phenomenon the continuity of the one phenomenon with the other phenomenon is preserved. Despite the specifically human in the human person, the human person remains an animal. Being human and being an animal no longer stand in contradiction with one another. There is no relationship of exclusivity between the two, but rather one of inclusivity.

Finally, where there are dimensions, there are projections as well. I can project a phenomenon out of its proper dimension into a lower dimension. I can, for instance, project a human phenomenon into a subhuman level. Such a process is also completely legitimate, and it belongs even to the essence of science that it heuristically prescinds from the full dimensionality of a phenomenon, and takes its starting point in the fiction of a unidimensional reality. This process becomes questionable only as soon as it is ideologized. Then is it not only asserted that we are able to observe

inborn triggering mechanisms in human persons, but also that human persons are therefore nothing more than "naked apes." The reductionism projects human phenomena onto the subhuman level not only heuristically, but completely denies the existence of a human dimension, and—significantly—it does this *a priori*.

The above holds true not only of the relationship between human persons and animals, but also of that which stands above human persons. When it is said that we cannot demonstrate any kind of teleology in the realm of nature, this empty formula should be more carefully formulated: within the projected plane of biology and/or ethology we are not able to demonstrate anything like teleology. To conclude from this, however, that there is no teleology at all would not be an empirical result, but philosophy, and *a priori* philosophy at that. To speak legitimately, I can only say that within the projected plane of Konrad Lorenz we simply do not find an image of teleology—in his cross-sectional plane we simply do not find teleology. One could speak of a negative teleology—analogous to the so-called negative theology, which prescinds from pronouncing on what God is, and limits itself rather to saying what God is not. And if Konrad Lorenz were to refrain from disputing the possibility of teleology from the outset, and admit—bring himself to admit—its fundamental possibility, even if in a dimension lying beyond science, then he would have not only earned the Nobel Prize for his science, but would also be a candidate for a Nobel Prize which for the time being does not even exist, namely, the Nobel Prize for wisdom. For wisdom can be defined as knowing—and the simultaneous consciousness of the limits of such knowing.

Summary

In summary it can be said that logotherapy has five spheres of indication. As a therapy that is rooted in *logos*, in meaning, it is first of all indicated in cases of noogenic neurosis, which as such, as noogenic, arise not least from a loss of meaning. In this its first sphere of indication, we can consider logotherapy to be a specific therapy.

It is different in its second sphere of indication: in cases of psychogenic neurosis, in which it is introduced in the form of dereflection and paradoxical intention, it works as a nonspecific therapy insofar as the diverse pathogenic reaction patterns, whose dissolution are its concern, have nothing to do with the problem of meaning. This is by far not to say that such a nonspecific therapy is only a symptomatic therapy. For dereflection and paradoxical intention attack, in those cases in which they are truly indicated, the neurosis at its root, namely, where the triggering circular mechanisms became pathogenic. And so, even where logotherapy *qua* logotherapy is no longer a specific therapy, qua psychotherapy it is still a causal therapy that attacks root causes.

It is again different in its third sphere of indication: there it ceases to be a therapy at all for the simple reason that in this sphere of indication it is concerned not only with somatogenic suffering in general, but in particular with somatogenic illnesses that are incurable, in which from the outset the only concern can be to enable patients to find meaning to the very end, even in their suffering, through the realization of attitudinal values. As mentioned, here we are not dealing with, indeed we can no longer be dealing with therapy, but no one can deny that such medical ministry (*ärztliche Seelsorge*)[1] belongs precisely to the tasks of medical treatment and action.

[1] "What we are doing," said Freud, "is ministry in the best sense of the word."

This contrasts with logotherapy's fourth sphere of indication, in which it is no longer a medical treatment (even if of incurable suffering and illness, as it is in its third sphere of indication), but is rather confronted with sociogenic phenomena, such as the feeling of meaninglessness, the feeling of emptiness and the existential vacuum, that is, with phenomena to which the medical model can no longer be applied, since they are in themselves not pathological, even though they may be extremely pathogenic, e.g., in cases in which they lead to a noogenic neurosis.

Finally, the fifth sphere of indication for logotherapy is as follows: confronted with the sociogenic doubt and despair about meaning in life, it is entrusted not with the medical treatment of the ill, but with the human care for the suffering. In its fifth sphere of indication it is concerned with neither the specific or nonspecific therapy of noogenic or psychogenic neuroses, nor with the treatment or the care of somatogenic or sociogenic cases, but rather with prevention, namely, the prevention of iatrogenic neuroses. In actuality, however, we should speak of psychiatrogenic neuroses. What we refer to are cases in which doctors (*iatros*) or psychiatrists are complicit in the guilt of intensifying existential frustration insofar as they approach patients with completely subhumanistic models, so that the psychotherapy *nolens volens* leads to an indoctrination, and to a reductionistic one at that.

After this systematic overview we would like, in conclusion, to venture a historical overview. W. Soucek called logotherapy the "third Viennese school of psychotherapy" and as such placed it in succession to psychoanalysis and individual psychology.[2] If this is the case, then it cannot be overlooked or forgotten that the fundamental biogenetic law of Ernst Haeckel also holds of logotherapy. Just as, according to Haeckel, ontogenetic development recapitulates the phylogenetic, so in life, in the personal life history of the founder of logotherapy, there were at first phases in which publications came out whose manuscripts were personally directed by Freud and Adler to the editors of the international journals for psychoanalysis and individual psychology, where they then appeared in 1924 and 1925 respectively.[3]

In any case, Sigmund Freud once wrote, "All our presentations wait to be completed, overhauled, and thereby corrected." It is true that T. P. Millar believes that the contemporary situation argues against any theoretical revision worth naming coming out of the ranks of psychoanalysts.[4] Rather, he

[2] W. Soucek, "Die Existenzanalyse Frankls, die Dritte Richtung der Wiener psychotherapeutischen Schule," *Deutsche Medizinische Wochenschrift, 73,* 594, 1948.
[3] Ludwig J. Pongratz, *Psychotherapie in Selbstdarstellungen* (Bern: Hans Huber, 1973).
[4] T. P. Millar, *British Journal of Psychiatry, 115,* 421, 1969.

agrees with Ernest Hilgard, according to whom the actual reformulation of psychoanalytic theory most likely to reach the public is that which does not owe anything to any psychoanalytical organization and institution. Just how timely such a "reformulation" would be can be seen from the following statements. J. Marmor, president of the American Academy of Psychoanalysis writes, "In the last ten years it seems that the prestige of psychoanalysis has significantly fallen within the academic and scientific circles in our country."[5] And the editor of the *American Journal of Psychoanalysis*, Harold Kelman, confronted the American Psychiatric Association with the following facts: in 1945 practically every prospective psychiatrist wanted to undergo analysis as part of their training (*Lehranalyse*). In 1960 it was one out of seven, and in 1969 it was one out of twenty.[6] In general, "24 of 31 North American psychoanalysts speak of a reduction of interest in psychoanalysis in their sphere of observation reports."[7]

And still, what I have said in one of the books I wrote in English,[8] which is not yet translated into German, remains the case, namely, that psychoanalysis will also be the foundation for the psychotherapy of the future,[9] no matter how much it disappears from view (as is the case with every foundation). And so Freud's contribution to the foundation of psychotherapy abides, and his achievement is thereby incomparable. When we visit the oldest synagogue in the world, the *Alt-Neu-Schule* in Prague, the guide shows us two seats—on one sat the famous, legendary Rabbi Loew (of whom it is said that he created Golem out of a lump of clay), and on the other sat all other rabbis since; for none dared to set himself equal to Rabbi Loew and take his seat. And so it is that through the centuries the seat of Rabbi Loew remains unclaimed. I believe that it is the same with Freud: no one will ever be able to measure up to him.

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[5] J. Marmor, "The Current Status of Psychoanalysis in American Psychiatry," *American Journal of Psychiatry, 125,* 131, 1968.
[6] Harold Kelman, "How Does Psychoanalysis Fit into the Total Concept of Care?" *Psychiatric Spectator, 3,* 8.
[7] E. D. Wittkower & J. Naiman, "Psychoanalyse in internationaler Sicht," *Zeitschrift für Psychosomatische Medizin und Psychoanalyse, 19,* 220, 1973.
[8] *The Will to Meaning* (New York: New American Library, 1969).
[9] Edith Weisskopf-Joelson, "Logotherapy: The Psychotherapy of the Future," Symposium on Logotherapy, Annual Meeting of the American Psychological Association, Montreal, 1973.

Glossary of Medical Terms

Addisonian—An adjective Frankl used to describe Type II "pseudo-neuroses," which are due to Addison's disease (named after Thomas A. Addison, 1799–1854). Addison's disease is characterized by "asthenia, low blood pressure, and a brownish coloration of the skin, due to decreased secretion of cortisol from the adrenal cortex, resulting in hypoadrenalism." (*Webster's Encyclopedic Unabridged Dictionary of the English Language*, Random House, 1996)

Agglutination—The clumping of bacteria, red blood cells or other cells due to the introduction of an antibody. (*Webster's Encyclopedic Unabridged Dictionary of the English Language*, Random House, 1996)

Basedowian—An adjective Frankl used to describe Type I "pseudo-neuroses," which are due to an affliction of the thyroid named after the physician Karl von Basedow, 1799–1854. It is also known as Graves' disease and most frequently manifests itself as hyperthyroidism.

Dystrophy—Progressive changes that may result from defective nutrition of a tissue or organ. (*Stedman's Concise Medical Dictionary*, Baltimore, MD: Williams & Wilkins, 1997)

Endogenous depression—"A severe form of depression usually characterized by insomnia, weight loss, and inability to experience pleasure, thought to be of internal origin and not influenced by external events. Also called melancholia." (*Webster's Encyclopedic*

Unabridged Dictionary of the English Language, Random House, 1996)

Globus hystericus—Difficulty in swallowing; a sensation as of a ball in the throat or as if the throat were compressed; a symptom of conversion disorder. (Syn: globus syndrome.) (*Stedman's Concise Medical Dictionary*, Baltimore, MD: Williams & Wilkins, 1997.)

Iatrogenic—Resulting from a medical diagnosis or treatment.

Narcoanalysis—Psychotherapeutic treatment under light anesthesia (syn. Narcosynthesis).

Paresthesia—An abnormal sensation, such as burning, pricking, tickling or tingling. (*Stedman's Concise Medical Dictionary*, Baltimore, MD: Williams & Wilkins, 1997.)

Pathoplasty—The shaping of disease. The term is constructed from the terms "pathy," which means disease, and "plasty," which means molding or shaping. Frankl's discussion of pathoplasty focuses on the extent to which different dimensions of the human being—body, psyche, and noos—shape neuroses and psychoses.

Pseudo-neuroses—Any disorder characterized by psychological traits typical of a neurosis, yet with an underlying somatic cause. They are called "pseudo" neuroses because Frankl defines neuroses as psychogenic. Today, we would speak of "mental disorders due to a general medical condition." Yet Frankl's observations remain valid as each of the somatic causes he cites appear in the DSM as medical conditions that cause mental disorders.

Saprophytic—Growing on dead organic matter.

Sympatheticotonia—A condition in which there is increased tonus of the sympathetic system and a marked tendency to vascular spasm and high blood pressure; opposed to vagotonia. (*Stedman's Concise Medical Dictionary*, Baltimore, MD: Williams & Wilkins, 1997)

Tetanoid—An adjective Frankl used to describe Type III "pseudo-neuroses," which are due to any somatic condition giving rise to tetany—a neurological syndrome characterized by muscle twitches or cramps, usually resulting from low serum levels of ionized calcium or more rarely magnesium.

Vaginismus—Painful spasm of the vagina preventing intercourse.

Vagotonia—A condition in which there is increased activity of the parasympathetic system. Opposed to sympatheticotonia.

Vegetative syndrome—A term Frankl used to describe the pseudo-neuroses that are due to either sympatheticotonia or vagotonia. Frankl states that the dominant symptomatology is vegetative ailments and reactive hypochondriac complaints.

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PSYCHIATRY / PERSONALITY DISORDERS / PHILOSOPHY

"… a seminal work by one of the 20th century's leading intellectuals. Mental health professionals who were fascinated by reading *Man's Search for Meaning* in the 60s will welcome this new opportunity to once again read and learn from Viktor Frankl."

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Viktor E. Frankl, M.D., Ph.D., a world-renowned neurologist and psychiatrist, is remembered as the founder of Logotherapy and Existential Analysis. Dr. Frankl was Professor of Neurology and Psychiatry at the University of Vienna Medical School until his death in 1997. He is the author of 32 books, including the bestselling *Man's Search for Meaning*, which has sold over 9 million copies in over 20 different languages. His work has been hailed as "perhaps the most significant thinking since Freud and Adler" by the *American Journal of Psychiatry*.

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