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PARADOXICAL INTENTION AND DEREFLECTION

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Paradoxical intention and dereflection are two techniques developed in the framework of that psychotherapeutic approach and school which is called logotherapy (Fabry, 1968; Frankl, 1938, 1955, 1958, 1962, 1966, 1967, 1969; Kaczanowski, 1967; Weisskopf-Joelson, 1955). Logotherapy is usually subsumed either under the category of humanistic psychology (Buhler & Allen, 1972; Frankl, 1973; Misiak & Sexton, 1973) or regarded as belonging to phenomenological (Spiegelberg, 1972) and existential psychiatry (Allport, 1959; Frankl, 1967a, 1972; Patterson, 1966; Pervin, 1960). More specifically, some authors contend that logotherapy is the only existential-psychiatric school and system that has succeeded in developing psychotherapeutic techniques in the proper sense of the word (Leslie, 1965; Lyons, 1961; Tweedie, 1961, 1963; Ungersma, 1961). They obviously refer to the techniques that have been termed by this author, paradoxical intention (Frankl, 1947, 1960) and dereflection (Frankl, 1947, 1955).

Paradoxical intention has been practiced by this author since 1929 but its formal description has been couched only in a publication that dates back to 1939 (Frankl, 1939). Later on, its methodology was ever more refined and understood in the context of the whole system of logotherapy (Frankl, 1956). Ever since, the growing literature on paradoxical intention has shown this technique to be an effective therapy in cases of obsessive-compulsive and phobic conditions (Gerz, 1962; Kaczanowski, 1965; Kocourek, Niebauer & Polak, 1959; Lehembre, 1964; Medlicott, 1969; Muller-Hegemann, 1963; Victor & Krug, 1967; Weisskopf-Joelson, 1968) in which it often proves to be a short-term treatment (Gerz, 1966; Dilling et al., 1971; Jacobs, 1972; Marks, 1969, 1972; Henkel et al., 1972; Solyom et al., 1972).

If one wishes to understand how paradoxical intention works he should take as a starting point the mechanism called anticipatory anxiety: A given symptom evokes, on the part of the patient, a response in terms of the fearful expectation that it might recur; fear, however, always tends to make true precisely that which one is afraid of, and by the same token, anticipatory anxiety is liable to trigger off what the patient so fearfully expects to happen. Thus, a self-sustaining vicious circle is established: A symptom evokes a phobia; the phobia provokes the symptom; and the recurrence of the symptom reinforces the phobia. (See Fig. 1)

Now, one of the targets of fear is fear itself: Our patients themselves then speak of "anxiety about anxiety." Upon closer investigation, however, it soon turns out that this "fear of fear" is frequently caused by the patient's apprehensions about the potential effects of his anxiety attacks: He is either afraid that they may eventuate in his collapsing or fainting; or in a heart attack or stroke.

So much for the patient's motivation for his fear of fear; but now let us examine his reaction to it. The most typical reaction to fear of fear is "flight from fear" (Frankl, 1953): the patient begins to avoid whatever situation used to arouse his anxiety. The patient, as it were, runs away

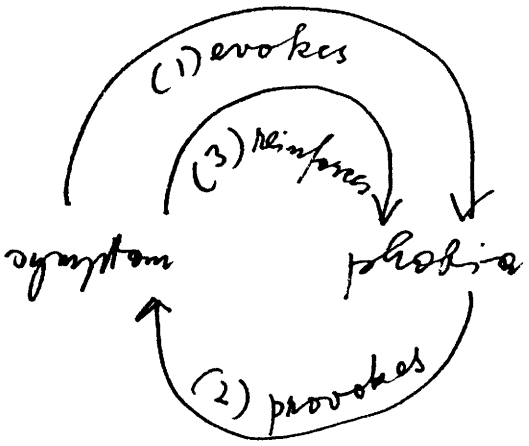

Figure 1

from his fear. And this is exactly the starting point of any anxiety neurosis: "Phobias are partially due to the endeavour to avoid the situation in which anxiety arises" (Frankl, 1960). This finding has later on been confirmed by learning theorists and behavior therapists. It is the contention of Marks (1970), e.g., that "the phobia is maintained by the anxiety reducing mechanism of avoidance." Contrariwise, "the development of a phobia can be obviated by confronting one with the situation he begins to fear" (Frankl, 1969).

The "flight from fear" reaction to "fear of fear" constitutes the first of three pathogenic patterns as they are distinguished in logotherapy (Frankl, 1953), i.e., the phobic pattern. The second is the obsessive-compulsive pattern: Whereas in phobic cases the patient displays "fear of fear," the obsessive-compulsive neurotic exhibits "fear of himself," and he does so inasmuch as he is either caught by the idea that he might commit suicide; or even homicide; or he is afraid that the strange thoughts that haunt him might be signs of imminent, if not present, psychosis. How should he know that particularly the obsessive-compulsive character structure is rather immunizing him against real psychosis (Frankl, 1955)?

While "flight from fear" is a characteristic of the phobic pattern, the obsessive-compulsive patient is characterized by his "fight against obsessions and compulsions." But alas, the more he fights them the stronger they become: Pressure induces counterpressure, and counterpressure, in turn, increases pressure.[1] Again, we are confronted with a vicious circle.

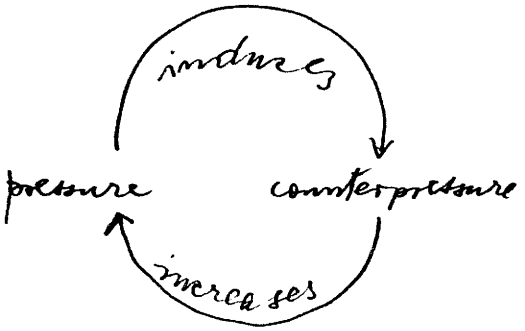

Figure 2

How then is it possible to break up such feedback mechanisms? In other words, how can we take the wind out of the individual fears of our patients? This is precisely the business of paradoxical intention which may be defined as a process by which *the patient is encouraged to do, or wish to happen, the very things he fears* (the former applying to the phobic patient, the latter to the obsessive-compulsive). In this way, we help the phobic patient stop fleeing from his fears, and the obsessive-compulsive patient stop fighting his obsessions and compulsions. In any way, the pathogenic fear now is replaced by a paradoxical wish. Now, "the bull is taken by the horns," as a patient of Briggs (1970) once put it. The vicious circle of anticipatory anxiety is now unhinged.

As to illustrative case material, the reader is referred to the pertinent literature (Frankl, 1955, 1962, 1967, 1969, 1974; Gerz, 1962, 1966; Jacobs, 1972; Kazcanowski, 1965; Medlicott, 1969; Solyom et al., 1972; Victor & Krug, 1967; Weisskopf-Joelson, 1968). In this paper, only unpublished material is quoted. The first quota-

[1] This is most conspicuous in cases of blasphemous obsessions. For a technique to treat them specifically, see Frankl (1955).

tion to serve as an example is taken from an unsolicited letter I once received from a reader of a book of mine:

> I had to take an examination yesterday and discovered ½ hour beforehand, that I was literally frozen with fear: I looked at my notes and my mind blanked out. The things I had studied so long looked completely unfamiliar to me and I panicked: "I don't remember *anything!* I will fail this test!" —Needless to say my fear increased as the minutes went by, my notes looked more and more unfamiliar, I was sweating and my fear was building each time I rechecked those notes! *Five minutes* before the examination, I knew that if I felt this way during the exam, I would surely fail, and then your paradoxical intention came to my mind; I said to myself, "Since I am going to fail anyway, I may as well *do my best at failing!* I'll show this professor a test *so* bad, that it will confuse him for days! I will write down total garbage, answers that have nothing to do with the questions at all! I'll show him how a student *really* fails a test! This will be the most ridiculous test he grades in his entire career! With this in mind, I was actually giggling when the exam came. Believe it or not, each question made perfect sense to me —I was relaxed, at ease, and, as strange as it may sound, actually in a terrific mood! I passed the test and received an A. P.S. Paradoxical intention also cures the hiccups. If one *tries* to keep hiccuping, one can't!

For another case report, I am indebted to Larry Ramirez:

> The technique which 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 nineteen 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.

In fact, humor forms an essential element in the practice of paradoxical intention. Lazarus (1971) also points out that "an integral element in Frankl's paradoxical intention procedure is 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."

However, we should not overlook and forget that the sense of humor represents an exclusively human property—after all, no other animal but man is capable of laughing. More specifically, humor is to be regarded as a manifestation of that specifically human quality which is called in logotherapy, the capacity of self-detachment (Frankl, 1966). Anyway, it is no longer tenable to deplore, as Lorenz (1967) once did, "that we do not as yet take humor seriously enough" (Lorenz, 1967). We logotherapists have been doing so, I dare say, since 1929. And it is most noteworthy, in this context, to remark that recently even the behavior therapists have come to recognize the importance of humor. To quote Hand et al. (1974) who "treated patients with chronic agoraphobia effectively by group exposure *in vivo,*" it was observed that "an impressive coping device used by the groups was humor (*vide* the paradoxical intention of Frankl, 1960). This was used spontaneously and often helped to overcome difficult situations. When the whole group was frightened, somebody would break the ice with a joke, which would be greeted with the laughter of relief."

But even prior to this observation some behavior therapists had demonstrated how the therapeutic effects obtained by behavior modification can be maximized by including logotherapeutic techniques such as paradoxical intention in the armamentarium. It is perfectly along the lines of such a sound eclecticism that Jacobs (1972) cites the following case:

> Mrs. K. suffered from a "severe claustrophobia of at least 15 years standing. The phobia extended to flying in aircraft, travelling in elevators, being in trains, buses, cinemas, restaurants, theaters, department stores and other closed, confined spaces. . . . The problem was particularly debilitating since Mrs. K., who lived in Britain, was an actress and was often required to fly abroad in order to act on stage and television. . . . The patient presented herself for treatment eight days before being due to leave South Africa, where she was holidaying, to return to Britain. . . . She feared she would choke or die. . . . She was then taught thought stopping and told to use this to block out any 'catastrophic thoughts.' Frankl's technique of paradoxical intention was then brought in to further attack her cognitions and behavioral responses to the phobias. She was told that whenever she began to feel anxious in any of the phobic situations, instead of trying to

fight and suppress the symptoms and thoughts which troubled her, she was to say to herself, 'I know there is nothing physically wrong with me, I'm only tense and hyperventilating, in fact I want to prove this to myself by letting these symptoms become as bad as possible.' She was told to try to suffocate or die 'right on the spot' and to try to exaggerate her physical symptoms. She was then taught a brief modified form of Jacobson's progressive relaxation. She was told to practice it and to apply it in the phobic situations to remain calm, but it was stressed that she should not try too hard to relax or fight the tension. While under relaxation, desensitization was begun. ... Before the patient left the consulting room, she was instructed to seek out all the previous phobic situations, such as elevators, crowded stores, cinemas, restaurants, initially with her husband, then alone; place herself in them and to do the following: to relax as taught, hold her breath if she hyperventilated, to tell herself to let it come, 'I don't care, I can handle it, let it do its damndest, I want to prove that nothing happens.' ... She was seen two days later and reported that she had carried out her instructions, that she had been in a cinema and restaurant, had travelled innumerable times in elevators alone, and had been in several buses and crowded stores .... The patient was seen four days later, just prior to her departure, by plane, for Britain. She had maintained her improvement and was feeling no anticipatory anxiety whatsoever regarding the flight she was about to undertake. She reported, and her husband confirmed, that she had been in elevators, buses, crowded stores, in a restaurant and cinema, etc. without any anxiety or fear. ... The patient wrote to me, the letter being received two weeks after she had left South Africa. She reported that she had had no difficulty at all during the flight home and she had been completely free of her phobias. She had also been travelling on London subway trains—which she had not done for many years. I saw Mrs. K. and her husband 15 months after the termination of her treatment. Both confirm that she has remained completely free of her previous symptoms."

Jacobs also describes the treatment of another case which was of compulsive rather than phobic nature:

Mr. T. had suffered from an extremely debilitating obsessive-compulsive neurosis, and "had undergone various treatments, such as psychoanalytically oriented therapy and E. C. T., both to no avail. His neurosis was of 12 years standing." He had "over the previous 7 years developed an obsession and fear about choking, so that he found it difficult to eat or drink as he became extremely anxious and in trying to force himself to swallow had produced a state of globus hystericus. He found it difficult to cross a road as he thought he might choke when halfway across it. ... He was then instructed to deliberately set about doing the very things he had so feared and which his obsessions were meant to obviate, until they no longer bothered him. ... The patient was also instructed to practice relaxation whenever eating, drinking or crossing roads. 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—which he was quite unable to do. He was instructed to try to choke at least 3 times a day. ... The next few sessions were devoted to further anxiety reduction techniques and the use of paradoxical intention. ... By the 12th session the patient was able to report the complete disappearance of his former obsessions."

The literature on paradoxical intention also includes cases in which this logotherapeutic technique was combined with suggestive treatment. Such a case was reported by Briggs (1970) at a meeting of the Royal Society of Medicine:

I was asked to see a young man from Liverpool, a stutterer. 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. He used to have a kind of mental rehearsal of everything he was going to say, and then try to say it. Then he would become frightfully embarrassed about it. It seemed logical that if this young man could be enabled to do something which previously he had been afraid to do it might work. I remembered a short time before having read an article by Viktor Frankl, who wrote about a reaction of paradox. I then gave the following suggestions—"You are going out into the world this week-end and you are going to show people what a jolly good stutterer you are. And you are going to fail in this just as you have failed in the previous years to speak properly." 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 successful. I don't claim any credit for this case, if it should go to anyone but the patient it should go to Viktor Frankl.

Briggs combined paradoxical intention with suggestion deliberately; but suggestion cannot be completely eliminated in therapy anyway. As to paradoxical intention, however, it would be a mistake to dismiss its therapeutic success as a merely suggestive effect. Benedikt (1968) subjected patients in whose cases paradoxical intention had been successful, to test batteries in order to evaluate their susceptibility to suggestion; it turned out that they were even less susceptible than the average. Moreover, many patients set out to use paradoxical intention with a strong conviction that it simply cannot work, but eventually succeed; they do so not because of, but rather in spite of, suggestion. Let us take up, as an example, the following verbatim report which might cast some light on the issue at hand; it was delivered by another reader of a book of mine:

Two days after reading *Man's Search for Meaning*, a situation arose which offered the opportunity to put logotherapy to the test. During the first meeting of a seminar class on Martin Buber, I spoke up saying I felt diametrically opposed to the views so far expressed. While ex-

pressing my views I began to perspire heavily. When I became aware of my excessive sweating I felt even more anxiety about the others seeing me perspire which caused me to sweat even more. Almost instantly I recalled a case study of a physician who consulted you, Dr. Frankl, because of his fear of perspiring, and thought, here I am in a similar situation. Being ever skeptical of methods, and specifically of logotherapy, in this instance, I determined the situation was ideal for a trial and put logotherapy to the actual test. I remembered your advice to the physician and resolved to deliberately show those people how much I could sweat, chanting in my thoughts as I continued to express my feelings on the subject: "More! More! More! Show these people how much you can sweat Spencer, really show them!" Within two or three seconds after applying paradoxical intention I laughed inwardly and could feel the sweat beginning to dry on my skin. I was amazed and surprised at the result. For I did not believe logotherapy would work, it did, and work so quickly. Again, inwardly, I said to myself: Damn, that Dr. Frankl really has something here! Irregardless of my skeptical feelings logotherapy actually worked in my case.

Paradoxical intention can also be successfully used in children (Lehembre, 1964), and this can be done even in a classroom setting. I owe a pertinent illustration to Pauline Furness, a counselor and elementary school teacher:

Libby (11 years old) constantly stared at certain other children. These children complained to Libby, threatened her and all to no avail. Miss H., Libby's teacher, insisted that Libby must stop staring at the other children. The teacher had tried behavior modification techniques, isolation punishment and one-to-one counseling. The situation became worse. Miss H. was most helpful and we formulated a plan of action. The next day before school she called Libby to the room and said, "Libby, today I want you to stare at Ann and Richard and Lois. First one and then the other for fifteen minutes each all day long. If you forget, I'll remind you. No classwork, only staring. Won't that be fun?" Libby eyed Miss H. quizzically, "B... b... but, Miss H., that sounds goofy." "Not at all, Libby, I am really serious," Miss H. replied. "It seems so silly," Libby replied smiling slightly. Now Miss H. broke out in a wide grin, "It does seem ridiculous, doesn't it? Want to give it a try?" Libby blushed. Miss H. then explained that sometimes if we force ourselves to do something we don't want to do it breaks the habit. The class filed in and when all were seated Miss H. gave Libby the secret signal to begin. Libby looked at Miss H. for a moment and then came up to her and pleaded. "I just can't do it!" "OK" said Miss H. "We'll try again later." By the end of the day Miss H. and Libby were both delighted at Libby's inability to stare. For eight successive days Miss H. started each morning with this question to Libby privately, "Want to try staring today?" The answer was always "No!" Libby never fell back into her behavior pattern of staring. She was proud of her achievement and later in the term asked Miss H. if she noticed that the staring had stopped. Miss H. said she had and congratulated Libby. In our final consultation about Libby, Miss H. reported to me that Libby had gained new stature with classmates and a much improved self-image. I enjoy working with paradoxical intention because it offers a theme of "Let's not take life so seriously. Let's make fun out of our problems. If we can stand aside and peek at them and laugh at them, they will go away, pooh!" I often say this to the children and they capture the spirit of the jest.

And we may say, she captured the spirit of our technique which rests on man's capacity of self-detachment.

Such cases are intended just to elucidate the principle of paradoxical intention rather than to elicit the impression that this technique is effective in each and every case, and that its effect is easy to obtain, at that. Neither paradoxical intention in particular, nor logotherapy in general is a panacea—panaceas simply do not exist in the field of psychotherapy. Paradoxical intention may, though, be effective even in severe and chronic cases, that is to say, in old age as well as in childhood. In this respect, ample material has been published by Kocourek, Niebauer & Polak (1959), Gerz (1962, 1966) and Victor & Krug (1967). One of the cases reported by Niebauer was a 65-year-old woman who had suffered from a hand-washing compulsion for 60 years; Gerz treated a woman who had a 24-year history of phobic neurosis; and the case treated by Victor & Krug was one of compulsive gambling that had lasted for 20 years. That in such chronic and severe cases success is available only at the expense of total personal involvement on the part of the therapist, is demonstrated in detail by a report on an obsessive-compulsive lawyer treated by Kocourek (Frankl, 1975).

Results obtained by paradoxical intention in obsessive-compulsive neurosis must be evaluated with a view to the fact that here "the prognosis is probably worse than that of any other neurotic disorder" (Solyom et al., 1972): "A recent summary of 12 follow-up studies on obsessive neurosis from seven different countries sets a nonimproved rate of 50% (Yates, 1970)." Eight studies on the behavioral treatment of obsessive neurosis reported that only "46% of the published cases were rated improved" (Solyom et al., 1972).

It has been pointed out right at the outset of this paper that paradoxical intention lends itself to short-term treatment. That this does by no means imply short-term result, is a well-established fact which has done away with much of the myth of "symptom substitution," and that this also holds for paradoxical intention, has been evidenced by Lehembre (1964) in cases of

stuttering, and by Solyom et al. (1972) in obsessive thoughts to which paradoxical intention had been successfully applied.

It should be noted that among the authors who have applied paradoxical intention with much success and afterwards published on their experience with this technique, many had never had any formal training in logotherapy, or a chance to watch a logotherapist in action, even if only in the setting of classroom demonstrations. They have solely been leaning on the literature in the field. That even lay people can benefit from a book on logotherapy by way of self-administered paradoxical intention may be seen from the following excerpt quoted from another unsolicited letter:

> For five months I have been searching for information, concerning paradoxical intention here in Chicago. I first learned of your method through your book "The Doctor and the Soul." Since then I have made many phone calls to different places. I ran an ad ("Would like to hear from anyone having knowledge of or treated by paradoxical intention for agoraphobia. Write ..., Tribune ...") in our Chicago Tribune for a week but received no replies. So why am I still trying to find out more about paradoxical intention? Because during this time, I have used paradoxical intention on my own, following as best I could from examples in the book. I have had agoraphobia for 14 years. I had a nervous breakdown at 24 while going to a Freudian psychiatrist for 3 years for a different problem. In the third year I broke down. I could no longer work, or even go outside. My sister had to support me as best as she could. After 4 years of trying to help myself, I put myself into a state hospital—my weight had dropped to 84 pounds. Six weeks later I was released "improved" from the hospital. Several months later I had a breakdown again. I could not leave the house at all. This time I went to a hypnotist for 2 years. It wasn't too much help. I had panics, tremors, felt faint. I feared getting the panics, and I always got the panics. I'm afraid of big stores, crowds, distances, etc. Nothing has really changed in 14 years. A few weeks ago, I started to feel nervous and frightened, when your method came to mind. I said to myself "I'll show everyone in the street how well I can panic and collapse." I seemed to quiet down. I continued to a small nearby store. While having my items checked out, I again felt nervous and started to feel panicky. I noticed my hands were sweating. Not wanting to run out just as the man was almost through, I used paradoxical intention, saying to myself "I'll show this man how much I can really sweat. He'll be so amazed." It wasn't until I got my groceries and was on my way home, that I realized I had stopped being nervous and frightened. Two weeks ago, our neighborhood carnival started. I was always so nervous and scared. This time before I left the house I thought to myself, "I would try to panic and collapse." For the first time I went right in the middle of the carnival where the crowd was. Yes, at times the fear thoughts would start and I started to feel the panic coming on, but each time I used paradoxical intention. Whenever I felt uncomfortable, I used your method. I stayed 3 hours and hadn't enjoyed myself so much in years. I felt pride for the first time in a long time. Since then I have done many things that I would not have done before. No, I am not cured, nor have I done many of the bigger things that I can't do. But I know something is different when I'm out. There are times I feel as though I had never been ill. Using paradoxical intention makes me feel stronger. For the first time I feel I have something to fight back with, against the panics. I don't feel so helpless against them. I have tried many methods, but none gave me the quick relief your method did, even if they aren't the most difficult things I do. I believe in your method, because I have tried it on my own with just a book. Sincerely ... P.S. I also used paradoxical intention for sleepless nites, and it puts me to sleep in a short time. A few of my friends also use it successfully.[2]

That insomnia yields to paradoxical intention, has been stated often times (Frankl, 1955). It should be kept in mind, however, that the patient would hesitate to apply it as long as he is not cognizant of a well-established fact, that is, that the body provides itself with the minimum amount of sleep it really needs, by itself. So, he need not worry and may as well start using paradoxical intention, in other words, wishing—for a change—for a sleepless night.

Another case of self-administered paradoxical intention is the following:

> On Thursday morning, I awoke out of my sleep, disturbed, thinking "I'll never get well, what am I going to do?" Well, I was getting more and more depressed as the day went on. I could feel the tears starting to come. I was feeling so hopeless. All of a sudden, I thought I'll try paradoxical intention on this depression. I said to myself "I'll see how depressed I can get." I thought to myself "I'll really get depressed and start crying, I'll cry all over the place." In my mind, I started to imagine great big tears rolling down my cheeks, and I continued to imagine that I was crying so much, that I flooded the house. At this thought and sight in my mind, I started laughing. I imagined my sister coming home and saying "Esther, what the hell have you been doing, did you have to cry so much, that you flooded the house?" Well, Dr. Frankl, at the thought of this whole scene, I began laughing and laughing, so much so, that I became frightened that I was laughing so much. I then said to myself "I'll laugh so much and so loud, that all the neighbors will run over to

[2] The patient also reported "an experiment" she had tried: "When I went to bed I was visualizing myself in situations that make me panic. What I wanted to do was practice paradoxical intention at home, so I'd be good at it when I'm out. Well, in the past (before using paradoxical intention) I would try to remain calm as I went through this visualization and would become upset seeing myself in these situations. Now (when I try to panic in my visualization so I can use paradoxical intention) I'm not afraid, I don't panic. I guess because I want to panic I can't."

see who's laughing so much." This seemed to tone me down a bit. That was Thursday morning, today is Saturday and the depression is still gone. I guess using paradoxical intention that day, was like trying to watch yourself in a mirror when you're crying, for some reason it makes you stop. I cannot cry while looking into a mirror. P.S. I did not write this letter for help, because I helped myself.

That people can "help themselves" by using paradoxical intention on themselves is conceivable only if this technique is understood as a device that utilizes, or mobilizes, a coping mechanism wired into each and every human being. That is why paradoxical intention is often applied unwittingly. Ruven A. K. reported the following:

I was looking forward to serving in the Israeli 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.

The very counterpart is another instance in which the principle underlying paradoxical intention was not only used unwittingly but also unwillingly; it concerns a client of my former student Uriel Meshoulam of Harvard University who reported the story to me as follows:

The patient was called to the Australian army, and was sure he would avoid the draft because of his stuttering. To make a long story short, he tried three times to demonstrate his speech difficulty to the doctor, but could not. Ironically, he was released on grounds of high blood pressure. The Australian army probably does not believe him until today, that he is a stutterer.

What is true of single individuals—that they have used paradoxical intention inadvertently—also holds for whole groups. Thus, Ochs (1968) found out that ethnopsychiatries such as that developed by the Ifaluk use psychotherapeutic principles which are "logotherapeutic" in that they "later on have been systematized by logotherapy." Other authors have claimed the same with respect to Zen psychiatry and Morita psychotherapy (Yamamoto, 1968). It would be strange, indeed, if logotherapy had not been anticipated, although not systematically, by people and peoples all along.

On the other hand, logotherapy was anticipating much of what later on was rediscovered, more or less methodically, by behavior therapists. In short, logotherapy has been anticipated by the past, and itself has "anticipated the future, which has in the last decade caught up with it" (Steinzor, 1969). Marks (1969) recognized that the flooding technique "has certain similarities" to the paradoxical intention technique (Frankl, 1939, 1947). After all, "paradoxical intention," as Agras (1972) sees it, "effectively exposes the patient to his feared situation by asking him deliberately to try to bring on the feared consequences of his behavior instead of avoiding situations. Thus, the agoraphobic with a fear that she will faint if she walks alone is told to try and faint. She finds she cannot and is enabled to confront her phobic situation." Similarly, during flooding the patient is "encouraged and persuaded to enter the most disturbing situation" (Rachman, Hodgson & Marks, 1971). And in the setting of another behavioristically oriented treatment called "prolonged exposure" (Watson, Gaind & Marks, 1971) the patient is equally "encouraged to approach the feared object as closely and as quickly as he can, and avoidance is discouraged." Marks (1974) also noticed that the paradoxical intention technique "closely resembled that now termed modeling" (Bandura, 1968). Likewise, such similarities to the paradoxical intention technique can be discovered in the techniques called "anxiety provoking," "exposure *in vivo*," "implosion," "induced anxiety," "modification of expectations" and "prolonged exposure," i.e., techniques on which the first publications have been turned out in 1967-1971.

Paradoxical intention is not only practiced by behavior therapists, but the results obtained by this logotherapeutic technique are also interpreted by them in behavior therapeutic terms: Lazarus (1971) points out "that 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." And Dilling, Rosefeldt, Kockott & Heyse (1971) think that "the good, and sometimes very fast, results obtained by paradoxical intention, can be explained along the lines of learning theory."

Lapinsohn (1971) tried to interpret the results obtained by paradoxical intentión on neurophysiological grounds. Such an explanation is as legitimate as that attempted by

Muller-Hegemann (1963) whose orientation is basically reflexological. This is in accordance with an interpretation of neurosis that was offered by Frankl:

> All psychoanalytically oriented psychotherapies are mainly concerned with uncovering the primary conditions of the "conditioned reflex" as which neurosis may well be understood, namely, the situation - outer and inner - in which a given neurotic symptom had emerged the first time. It is this author's contention, however, that the fullfledged neurosis is not only caused by the primary conditions but also by secondary conditioning. This reinforcement, in turn, is caused by the feedback mechanism called anticipatory anxiety. Therefore, if we wish to recondition a conditioned reflex, we must unhinge the vicious cycle formed by anticipatory anxiety, and this is the very job done by our paradoxical intention technique. (1947)

However, behavior therapists have not only come up with interpretations how paradoxical intention works, but also set out on experimentation in order to prove that it really works: Solyom et al. (1972) successfully treated chronically ill patients who had suffered from obsessive neurosis for 4-25 years. One had had a 4½ year lasting psychoanalysis, four had had electroshock treatment at one time or another during their sickness. The authors now chose two symptoms that were approximately equal in importance to the patient and in frequency of occurrence, and applied paradoxical intention to one of the obsessive thoughts; the "control thought" was left untreated. Well, it turned out that, although the treatment period was short (6 weeks), there was an improvement rate of 50% in the target thoughts. "Some subjects later reported that after the experimental period they had successfully applied paradoxical intention to other obsessive thoughts." On the other hand, "no new obsessive thought replaced the successfully eliminated obsession." The authors conclude that "paradoxical intention alone or in combination with other treatments, may be a relatively fast method for some obsessive patients."

So far, two of the "three pathogenic patterns" that are distinguished by logotherapy, have been discussed: the phobic pattern, characterized by "flight from fear," and the obsessive-compulsive pattern whose characteristic is "fight against obsessions and compulsions." What then is the third pattern? It is the sexual neurotic pattern which again is characterized by the patient's fight. Here, however, the patient is not fighting against anything as the obsessive-compulsive neurotic does, but rather fighting for something, namely, sexual pleasure. But it is a tenet of logotherapy (Frankl, 1955) that, the more one aims at pleasure the more he misses the aim. It is the very "pursuit" of happiness which dooms it to failure. Happiness must ensue, and that is why it cannot be pursued. This also holds for sexual pleasure. Sexual performance (male potency) and sexual experience (female orgasm) are obviated by being made a target. The more a male patient cares for demonstrating his potency the more he is liable to wind up with impotence. And the more a female patient is concerned with her orgasm the more she is likely to wind up with frigidity.

However, whenever potency and orgasm are made a target of intention they are also made a target of attention (Frankl, 1952). In logotherapy, this is referred to in terms of "hyper-intention" and "hyper-reflection" (Frankl, 1962), respectively. Both are reinforced by one another. A feedback mechanism is established.

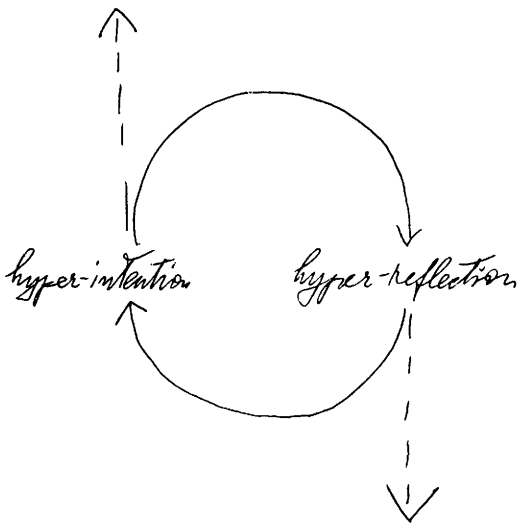

Figure 3

In order to secure potency and orgasm, the patient pays attention to himself, to his own performance and experience. To the same extent, however, attention is withdrawn from the partner and whatever the partner has to offer in terms of stimuli specifically arousing the patient sexually. By the same token, potency and orgasm are diminished. This, in turn, enhances the patient's hyper-intention. The vicious circle is completed.

If this circle formation is to be broken up, centrifugal forces have to be brought into play as it were. Instead of striving for potency and orgasm, the patient should be himself, give himself. And instead of observing and watching himself, he should forget himself. In order to implement this process, in other words, in order to counteract the patient's hyper-reflection, another logotherapeutic technique, along with paradoxical intention (Frankl, 1939, 1947, 1955, 1960), has been developed: "de-reflection" (Frankl, 1955).

Kaczanowski (1965, 1967) has contributed illustrative case reports regarding de-reflection. Here let me just quote a case of impotence in which Kaczanowski's patient is said to have "been the lucky one to get the most glamorous girl of his acquaintance as his wife" and understandably "wanted to give her the greatest possible sexual pleasure which she deserved and certainly expected." As Kaczanowski is reasoning, "his desperate striving for sexual perfection and his hyper-intention of virility could be the reason for his impotence." He succeeded in helping "him to see that real love had many aspects worthy of cultivation. The patient learned that if he loved his wife he could *give* her *himself,* instead of trying to give her a sexual climax. Then her pleasure would be the consequence of his attitude, not an aim in itself" (Kaczanowski, 1967).

What is even more important, Kaczanowski, in addition to counteracting the patient's self-defeating "fight for pleasure," enacted de-reflection perfectly along the lines of a technique that had first been described by Frankl in 1946 in German and in 1952 in English: Kaczanowski "told the patient and his wife that no attempt at intercourse should be made for an undetermined period of time. This instruction relieved the patient's anticipatory anxiety. A few weeks later, the patient broke the order; the wife tried to remind him but, fortunately, she disregarded it too. Since that time, their sexual relations have been normal" (Kaczanowski, 1967).

In the respective publications (Frankl, 1946, 1952, 1974) describing this technique it was also pointed out that in the formation of hyper-intention, a decisive role is played by a "demand quality" that the patient attaches to sexual intercourse. More specifically, this demand quality is due to (1) the situation "which appears to be one of *Hic Rhodus, hic salta*" (Frankl, 1952); (2) the patient (fight for pleasure); or (3) the partner. In cases falling under the third category, the patient is potent only as long as he can take the initiative. Incidentally, there is an analogue on the subhuman level: There is a fish species whose females are used "coquettishly" to swim away from the males that seek cohabitation. However, Konrad Lorenz succeeded in training a female to do the very contrary, i.e., forcefully to approach the male. The latter's reaction was complete impotence.

Recently, two more pathogenic factors have entered the etiology of impotence: (4) peer pressures and (5) pressure groups. The demand quality mentioned above irradiates and emanates from a society that is imbued by achievement orientation, and sexual performance is not exempted from such an overemphasis on achievement. Ginsberg, Frosch & Shapiro (1972) have pointed out that the "increased sexual freedom of women" resulted in the fact that "these newly free women *demanded* sexual performance." Likewise, Stewart (1972), reporting in the medical magazine *Pulse* on impotence at Oxford, states that "females run around *demanding* sexual rights." Small wonder that "young men now appear more frequently with complaints of impotence," as Ginsberg, Frosch & Shapiro (1972) contend.

So much for peer pressures—as to group pressures, however, just consider pornography and sex education both of which have become big industry. "The hidden persuaders" are at their service, and so are the mass media. "In an age such as ours in which hypocrisy in sexual matters is so much frowned upon, it is strange to see that the hypocrisy of those who propagate a certain *freedom from censorship* remains unnoticed"—after all, it should not be "so hard to recognize that their real concern is unlimited freedom *to make money*" (Frankl, 1974).

Before illustrating the logotherapeutic approach to sexual neurosis let us quote from the first pertinent publication in English the description of a "trick" devised to remove the demand placed on the patient by his partner: "We advise the patient to inform his partner that he consulted a doctor about his difficulty who said that his case was not serious, and the prognosis favorable. Most important, however, is that he tells his partner that the doctor also has absolutely forbidden coitus. His partner now expects no sexual activity and the patient is "released." Through

this release from the demands of his partner it is possible for his sexuality to be expressed again, undisturbed and unblocked by the feeling that something is demanded or expected from him. Often, in fact, his partner is not only surprised when the potency of the man becomes apparent, but she goes so far as to reject him because of the doctor's orders. When the patient has no other goal before him than a purely fragmentary, mutual sexual play of tenderness, then, and then only, in the process of such play is the vicious circle broken'' (Frankl, 1952).[3]

This trick is illustrated by a case report that I owe to my former student at U.S. International University, Myron J. Horn:

> A young couple came in complaining of incompatibility. The wife had told the husband often that he was a lousy lover, and that she was going to start having affairs to satisfy herself. I asked them to spend at least one hour every evening, during the next week, in bed together, nude. I said it was okay to neck a little but under no circumstances were they to have intercourse. When they returned the following week they said they tried not to have sex but had had intercourse three times. Acting irate, I demanded they try again next week to follow my instructions. Midweek, they called and said they were unable to comply and were having relations several times a day. They did not return. A year later I met the mother of the girl, who relayed that the couple had not had a recurrence of the impotence problem.

The art of improvisation plays a decisive role in the logotherapeutic treatment of impotence. I am indebted to Joseph B. Fabry for a case history from which, both the possibility and the necessity of improvisation can be seen:

> After I had been lecturing about dereflection, one of the participants asked if she could apply the technique to her boy friend. He found himself impotent, first with a girl with whom he had had a brief affair, and now with Susan. Using a Frankl technique, we decided that Susan should tell her friend that she was under 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. Next week Susan reported that it had worked. Her friend was a psychologist and had taken Masters and Johnson instruction about curing sex failures, and was advising his own patients in such matters. Four weeks later Susan reported that he had had a relapse but that she had ''cured'' him on her own initiative. 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. Again it worked. By her inventiveness Susan has shown that she indeed understood well the workings of dereflection by asking her friend to *forget* about watching out for his own pleasure by trying to help her in her problem. Since then no more problem with impotence had occurred.

The ''centrifugal forces,'' as I put it at the outset, were brought into play by Susan ingeniously. In order to assist her boy friend in overcoming hyper-intention as well as hyper-reflection, in order to help him in giving himself and forgetting himself, she took over the role of a patient. By the same token, he was allotted the role of a therapist.

The report from which I am going to quote now, concerns a case of frigidity rather than impotence. It has been published by Frankl (1962), even if only sketchily:

> The patient, a young woman, came to me complaining of being frigid. The case history showed that in her childhood she had been sexually abused by her father. However, it was not this traumatic experience in itself that had eventuated in her sexual neurosis. It turned out that, through reading popular psychoanalytic literature, the patient had lived all the time in the fearful expectation of the toll that her traumatic experience would some day take. This anticipatory anxiety resulted in both excessive intention to confirm her femininity and excessive attention centered upon herself rather than upon her partner. This was enough to incapacitate the patient for the peak experience of sexual pleasure, since the orgasm was made an object of intention and an object of attention as well. Although I knew that short-term logotherapy would do, I deliberately told her that she had to be put on a waiting list for a couple of months. For the time being, however, she should no longer be concerned with the question whether or not she was capable of orgasm, but rather concentrate on her partner, better to say whatever made him loveable in her eyes. ''Just promise me that you won't give a damn for orgasm,'' I asked her. ''This we'll take up discussing only after a couple of months when I start treating you.'' What I had anticipated happened after a couple of days, not to say nights. She returned to report that, for the first time not caring for orgasm, she had experienced it the first time.

Now, I would like to quote from an unpublished paper the report on a case in which premature ejaculation was treated by Gustave Ehrentraut who had studied logotherapy at U.S. International University. He did not apply de-reflection but rather the other logotherapeutic technique mentioned above, namely, paradoxical intention:

> In the past 16 years the time of Fred's ability to prolong the sexual union had continually decreased. I attempted to deal with the problem through a combination of Behavior Modification, Bio-energetics, and sexual education. He

[3] The reader may notice how justified Sahakian & Sahakian (1972) are in remarking that the technique outlined above and first published by Frankl in 1947 has been corroborated in 1970 by Masters & Johnson in their research on human sexual inadequacy.

had been in sessions for a period of two months and no significant change had been accomplished. I decided to attempt Frankl's Paradoxical Intention. I informed Fred that he was not to worry about his premature ejaculation, that he wasn't going to be able to change it anyway, and that he should, therefore, only attempt to satisfy himself. He should cut the duration of intercourse to one minute. The next session, seven days later, Fred related that he had intercourse twice that week, and he could not reach a climax in less than five minutes. I told him that he must reduce the time. The next week, he was up to seven minutes the first time, and eleven minutes the second time. Denise stated that she had been satisfied both times. Since that visit, they have not felt it necessary to return.

Claude Farris is a Californian counselor who once treated a case that represented another type of sexual neurosis, and like Gustave Ehrentraut used paradoxical intention rather than de-reflection:

Mr. & Mrs. Y. were referred to me by Mrs. Y's gynecologist. Mrs. Y. was experiencing pain during intercourse. Mr. & Mrs. Y. had been married for three years and indicated that this had been a problem from the beginning of their marriage. Mrs. Y. had been raised in a Catholic convent by sisters, and sex was a taboo subject. I then instructed her in Paradoxical Intention. She was instructed not to try to relax her genital area but to actually tighten it as tight as possible and to try to make it impossible for her husband to penetrate her and he was instructed to try as hard as he could to get in. They returned after one week and reported that they had followed instructions and had enjoyed painless intercourse on her behalf for the very first time. Three more weekly sessions indicated no return of the symptoms. Paradoxical Intention has proved effective in many cases in my experience, and at times almost works me out of business.

I hope it does not totally. Anyway, what I regard to be most remarkable about Harris' inventive way of tackling the case is the idea to bring about relaxation through paradoxical intention. What comes to mind, in this context, is an experiment that David L. Norris, a California researcher, once conducted. In this setting, the subject, "Steve S. was actively trying to relax. The electromyograph meter which I use in my research read constantly at a high level (50 micro-amperes) until I told him that he probably would never be able to learn to relax and should resign himself to the fact that he would always be tense. A few minutes later Steve S. stated, 'Oh hell, I give up,' at which time the meter reading immediately dropped to a low level (10 micro-amperes) with such speed that I thought the unit had become disconnected. For the succeeding sessions Steve S. was successful because he was *not* trying to relax."

That this might also apply to some trends that are in at present, has been indicated by Frankl (1973). More recently, however, Edith Weiss-kopf-Joelson has confirmed this suspicion when she reported: "I was recently trained in doing Transcendental Meditation but I gave it up after a few weeks because I feel I meditate spontaneously on my own, but when I start meditating formally I actually stop meditating" (personal communication).

Videant consules and counselors.

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