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Pierre Janet's Treatment of Post-traumatic Stress¹

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Pierre Janet's therapeutic approach to traumatized patients was the first attempt to create a systematic, phase-oriented treatment of post-traumatic stress. Janet viewed the trauma response basically as a disorder of memory which interfered with effective action. Relying heavily on the use of hypnosis, he taught that the treatment of post-traumatic psychopathology consisted of forming a stable therapeutic relationship; retrieving and transforming traumatic memories into meaningful experiences; and taking effective action to overcome learned helplessness. Most of his observations and recommendations are as challenging today as when he first made them, starting a century ago.

KEY WORDS: post-traumatic stress (PTSD); dissociation; hypnosis; Janet; history of psychiatry.

INTRODUCTION

Pierre Janet was probably the first psychologist to formulate a systematic therapeutic approach to post-traumatic psychopathology and to recognize that treatment needs to be adapted to the different stages of the evolution of post-traumatic stress reactions. Starting in the early 1880s, Janet developed an eclectic treatment approach based on his clinical experience with many severely traumatized patients with either hysterical (dissociative) or psy-

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chasthenic (obsessive-compulsive) post-traumatic features. Our review of Janet's psychotherapy of post-traumatic syndromes covers publications written over a period of 50 years (Janet, 1886, 1889, 1898a, b, 1903, 1904, 1911, 1919/25, 1923/25, 1932, 1935). However, throughout this paper we shall refer mainly to his magnum opus on psychotherapy, *Psychological Healing* (PH) (Janet, 1919/25).

THE STAGES OF POST-TRAUMATIC ADAPTATION

Janet considered the inability to integrate traumatic memories as the core issue in post-traumatic syndromes: treatment of psychological trauma always entailed an attempt to recover and integrate the memories of the trauma into the totality of people's identities. He never developed a nosology for a Post-traumatic Stress Disorder as such, but he clearly recognized the fundamental biphasic nature of the trauma response, and he described all the contemporary DSM-III criteria for PTSD in great detail in both his case histories and in his theoretical works (see van der Kolk *et al.*, 1989).

He divided the trauma response into three stages: the first one consists of a mixture of dissociative (hysterical) reactions, obsessional ruminations, and generalized agitation precipitated by a traumatic event. The second stage of delayed post-traumatic symptomatology consists of a blend of hysterical, obsessional, and anxiety symptoms in which it often is difficult to recognize the traumatic etiology of the symptoms. The third and last stage is characterized by what modern authors call post-traumatic decline (Titchener, 1986) and includes somatization disorders, depersonalization and melancholia, ending in apathy and social withdrawal. Like modern writers, Janet recognized that in chronic cases complete recovery is rare, even when the patient is capable of recounting the trauma in detail.

Therapeutic Rapport and Moral Guidance

Janet was very much aware of the need to establish a special, safe patient-therapist relationship before attempting to deal with traumatic memories. He considered "rapport" between patient and therapist indispensable for resolution of the trauma, but recognized that severely traumatized patients are prone to idealization, which can develop into intense "somnambulistic passion" (Janet, 1897, 1935). "Rapport" was not only what we would today call a therapeutic alliance, but also a specific method for reducing symptoms and increasing mental energy. True to his times, Janet thought that moral guidance was an essential element of the doctor-patient relation-

ship at all stages of treatment (PH, p. 1112). This was based on the notion of the late 18th century hypnotists, the *magnetiseurs*, of *rapport magnétique*; the notion of "rapport" also was the ancestor of the psychoanalytic concept of *transference*. Like Freud, who later declared that "transference is a resistance" (Freud, 1911), Janet considered *rapport* both a symptom of illness in its own right and a vehicle for cure (Janet, 1897; Haule, 1986). In the hypnotic rapport, the traumatized patient was prone to develop a pathological fixation on the therapist which Janet called "the somnambulistic influence" (Janet, 1897). He thought that "this strange illusion" (PH, p. 1156) was related to post-traumatic dissociation, narrowing of consciousness, and feelings of helplessness. The intensity of this somnambulistic influence bore no apparent relationship to the therapist's competence. The pathological need for guidance built up between treatment sessions and reached a crescendo—the somnambulistic passion—early in the therapy. Janet claimed that it usually was a transient phenomenon which decreased when patients became ashamed about the intensity of their dependence. The real motivation for therapy came from the patients' despair and their hope for improvement. Janet called their settling down to talk seriously about what troubled them "the act of adoption" (PH, p. 1154; Janet, 1929).

Personality characteristics of the therapist also played an important role in the nature of the therapeutic relationship: he was not to position himself as a parent surrogate or as an omnipotent protector, but as a skilled agent of therapeutic change (PH, p. 1112). Janet advocated two apparently contradictory attitudes for the therapist: on the one hand the patient must accept his authority and guidance, on the other, the therapist needs to minimize his control over the patient (Janet, 1897; cf. Haule, 1986). Relying too much on the doctor's authority would lead to only temporary cures [Freud, (1914) was to warn later also about the danger of transference cures]; ignoring the need to keep the patient fundamentally in control over their own lives led to excessive "somnambulistic influence" (today we would call this transference psychosis) which made treatment impossible. Like many contemporary therapists, Janet learned the hard way that if one neglects the dimension of control, passion is likely get out of hand. In several case reports he tried to demonstrate how "rapport" could be used even with severely disturbed patients to foster independent action rather than excessive dependency and misdirected passion.

"Psychological Force" and "Psychological Tension"

While most of Janet's concepts are readily understandable in contemporary terms, his notion of *psychological force* and *psychological tension*

(van der Hart and Friedman, 1989) are not easily translated into contemporary concepts. *Psychological force* referred to the total amount of psychic energy available, *psychological tension* to the level of organization of this energy and the capacity for competent, creative, and reflective action. Janet thought that a person's psychological tension largely determined whether one could deal with potentially traumatizing experiences. Once traumatized, the degree of remaining psychological tension also influenced the severity of the patient's impairment and determined what treatment would work. The patient's mental resources must be carefully assessed: in acute and simple post-traumatic reactions there usually are enough mental energy reserves to do the work of integrating the traumatic memories successfully. However, chronic and complex traumatization decreases psychological tension, causing mental energy to be wasted on compulsive repetitions, psychosomatic symptoms, and wasteful agitations, crises, and impulsive and purposeless acts. The end result in mental exhaustion and disorganization: "the subject is unable to recite the events as they occurred and yet, he remains confronted with a painful situation in which he was unable to play a satisfactory role and make a successful adaptation. The struggle to repeat continually this situation leads to fatigue and exhaustion which have a considerable impact on his emotions" (PH, p. 663).

Janet organized the treatment of this mental exhaustion around three economic principles: increase psychological income by promoting sleep and diet; reduce expenses by curing coexisting medical conditions and relieving crises and agitation; and liquidate debts, by resolving traumatic memories. Janet advocated two strategies for treating mental disorganization: channeling energies which would otherwise be wasted on agitations constructively; and stimulating the mental energy level by such methods as performing progressively more difficult tasks (Ellenberger, 1950; Schwartz, 1951).

JANET'S STAGE MODEL FOR THE TREATMENT OF POST-TRAUMATIC STRESS

Janet's psychotherapeutic approach to post-traumatic stress consisted of the following stages:

1. Stabilization, symptom-oriented treatment and preparation for liquidation of traumatic memories.
2. Identification, exploration and modification of traumatic memories.
3. ~~Relapse prevention, relief of residual symptomatology, personality~~

In all phases retrieval, exploration, and modification of traumatic memories were indicated. Taking charge of one's life also needs to be fostered during all stages of post-traumatic stress, within the limits of the patient's capacity. Janet's stage model is very similar to modern models of treatment for post-traumatic stress disorder (PTSD) and dissociative disorders (Braun, 1986; Brende, 1984; Brown and Fromm, 1986; Parson, 1984; Kluff, 1987; Sachs *et al.*, 1988). Brown and Fromm (1986) identified five stages: (1) stabilization; (2) integration, with the substages of (a) controlled uncovering, (b) integrating introjects, and new personality states; (3) development of self; (4) drive integration; and (5) dealing with enduring biological sensitivity. Each of these stages requires different therapeutic techniques. Similarly, in multiple personality disorder (MPD), a condition with a well-established childhood traumatic etiology, Sachs *et al.* (1988) have identified five phases: (1) making and sharing the diagnosis, (2) identifying the various personality states and understanding their purpose and function, (3) sharing with the therapist and other personality states the specific traumata associated with each personality state, (4) integrating the various personality states into a single functioning whole, and (5) learning new coping mechanisms which will enable functioning of the unified personality and prevent future splitting of the personality.

Stage models such as these can only provide broad therapeutic guidelines: they must be modified to fit individual cases. Janet varied the sequence and methods according to the stage of the disorder and the status of the patient's mental economy. Certain issues, such as working through the traumatic memories, must be addressed over and over again during the course of treatment. Janet was well aware that systematized treatment approaches without solid scientific verification had serious limitations (PH, p. 1210). He therefore offered his stage model only as an heuristic approach.

STAGE 1: STABILIZATION AND SYMPTOM REDUCTION

People with acute post-traumatic reactions, or with exacerbations of chronic pathology, first of all needed stabilization of symptoms. This consisted mostly of rest (including hospitalization), simplification of life style, and forming a therapeutic relationship. In uncomplicated, generally acute, cases these procedures usually were sufficient to allow for retrieval and working through (liquidation) of the traumatic memories. Because of their low level of psychological tension, chronic and complex cases first required mental

stimulation and reeducation in preparation for liquidation of the traumatic memories.

Rest, Isolation, and Simplification of Life Style

Rest was meant to restore energy and build up reserves and was particularly suitable for patients who were too exhausted by repeated failures to overcome the vicissitudes of the trauma (PH, p. 466). Traumatized patients often had great difficulty achieving a modicum of calm: acute patients often were delirious, and chronic patients sometimes were so agitated that they could not even lie down. Janet did not have much faith in sedatives such as bromides (PH, p. 693). Hence, even in these agitated energy wasting conditions and in depletion states Janet advocated more active remedies.

In many cases, a simplification of life style was necessary to get treatment underway (PH, p. 473). Janet believed in protecting patients from their social obligations and family pressures. He regularly utilized hospitalization and called this "isolation" (PH, p. 485). Initially, little was expected of the patient beyond automatic (as opposed to complex) activity: the therapist made all the decisions, solved the problems and made the necessary changes in the environment. Hospitalization was used as an opportunity to effect changes in family organization (PH, p. 587). He thought that younger patients with recent trauma histories benefitted most from hospitalization, but if often was beneficial for more chronic cases as well. Janet recognized that institutionalization had serious drawbacks, but he felt that when there was too much disruption in the patient's life, short-term asylum allowed for a more specific focus on the treatment of the psychological trauma (PH, p. 581). For example, his patient Irène twice attempted suicide and became progressively worse until she was hospitalized at the Salpêtrière (Janet, 1904). Sometimes, readmission was necessary; for example, Irène returned 3 months after discharge, following the death of her father (Janet, 1904).

Stimulation and Reeducation

For patients suffering from low psychological energy Janet prescribed stimulation in order to get treatment going (PH, p. 942). This included education to enable patients with post-traumatic reactions to perform elementary daily functions such as eating and sleeping, and to make social contact, particularly in the doctor-patient relationship, where they could begin to face traumatic issues. These methods, to be described more fully under Stage 3, ranged from simple focused self-disclosure (PH, p. 969) to awareness exercises (PH, p. 972). The risks of these treatments, including agitation and

fatigue, could be balanced by varying the exercises (PH, p. 982 ff), or by stopping them altogether.

Hypnosis for the Stabilization Stage

Hypnosis for symptom relief was commonly used at the end of the 19th century. Janet used hypnosis in the stabilization phase to produce relaxation, to modify symptoms, and to alleviate life-threatening conditions (Janet, 1898a). In some post-traumatic psychasthenias, it could increase the patient's energy level and strengthen the therapeutic rapport. Sometimes Janet used extended hypnosis, for days or even weeks, without offering any specific suggestions. (Wetterstrand, 1892). Hypnosis could provide relief from insomnia, conversion reactions, and amnesic states; intractable motor paralyses or life-threatening anorexia could be approached directly; patients could exercise their limbs, eat, or drink, and thereby protect their physical well-being (PH, p. 457). Success at this stage improved the "rapport" and facilitated later hypnotic retrieval of traumatic memories (Barrucand, 1967).

Symptom-oriented suggestions during this stage might address such minor symptoms as headaches, or such debilitating conditions as epileptic pseudoseizures. Janet recognized the limitations of this approach. Sometimes, patients were able to accept suggestions unrelated to the trauma, while trauma-related material met with stiff resistance. In some cases, this produced an exacerbation of symptoms or the development of new complaints. Janet felt that these failures were the result of emotional states related to subconscious trauma-related fixed ideas that could only be resolved when the underlying traumatic memories were successfully liquidated (van der Hart and Horst, 1989; van der Kolk *et al.*, 1989).

STAGE 2: THE MODIFICATION OF TRAUMATIC MEMORIES

For Janet, liquidation of traumatic memories was the key to resolution of post-traumatic stress. Dissociated traumatic memories continued as subconscious fixed ideas and emerged periodically out of personal and conscious control as behaviors, feelings states, somatic sensations, and dreams without relevance to current experience, but appropriate to the original trauma (Janet, 1893). The lack of integration of the traumatic memories led to arrested personality development; "unable to integrate the traumatic memories, they seem to have lost their capacity to assimilate new experiences as well. It is . . . as if their personality which definitely stopped at a certain point cannot enlarge any more by the addition or assimilation of new elements: all [traumatized] patients seem to have had the evolution of their lives

checked; they are attached to an unsurmountable obstacle" (PH, p. 660). In uncomplicated cases, traumatic memories and the psychological charge associated with them were "near the surface" and often available to nontrance interventions. Simply discussing their experiences and sometimes sharing a diary with the therapist could lead to resolution. Usually, post-traumatic patients were more complicated, requiring technical modifications for trance induction, uncovering traumatic memories and transforming them. Controlled emotional expression of traumatic memories was later taken up by Breuer and Freud (1895) as the cathartic method.

Uncovering Traumatic Memories

Janet pioneered the use of hypnosis and automatic writing in the therapy of post-traumatic patients who suffered mainly from dissociative symptoms (Janet, 1886, 1889, 1898a, b, 1904). He believed that even in the most complicated and chronic cases, memories had to be traced back to the first significant traumatic event. Patients frequently expressed surprise and relief to discover that their symptoms were not physical, but due to psychological trauma. In many patients, trance induction itself was the first obstacle; some took weeks or months before they could successfully enter into a hypnotic state. Janet thought that these patients often were trying to hide traumatic secrets. Modern explanations of this resistance to trance induction would also include a fear of reexperiencing trauma-related emotions (Brown and Fromm, 1986).

Janet employed a variety of visual imaging techniques to uncover traumatic memories, ranging from direct hypnotic suggestions to automatic writing, and fantasy and dream production. In floridly symptomatic or highly resistant patients, suggestion by distraction eased uncovering techniques. Once traumatic memories had been uncovered, Janet drew upon three treatment approaches: (1) direct reduction, using a technique called neutralization; (2) the substitution method, in which traumatic memories were replaced by neutral or even positive images; and (3) therapeutic reframing. Janet frequently used only hypnotic suggestion to transform traumatic memories. An example of this was Zy, a woman who was admitted to the Salpêtrière suffering from depression, insomnia and night terrors (Janet, 1896). Trance induction revealed that her dreams dealt with her son's death 3 years earlier, and her father's and brother's before that. Through hypnotic suggestion, Janet first transformed the dream contents and then eliminated them completely. In a similar case, the hypnotic suggestion to "dream aloud" uncovered traumatic memories in his patient Co (Janet, 1895). This 33-year-old woman had become ill 4 years earlier. She had experienced a series of psychological shocks

which included witnessing her father's economic ruin, a man crushed by a street-carriage, and the death agony of a close friend. Co suffered from insomnia and she had no conscious recollection of the traumas. After her admission to the Salpêtrière, Janet produced hypnotic sleep and instructed Co to dream aloud. She was thereby able to recover the traumatic dreams of the funeral of her friend.

Janet uncovered Lucie's traumatic memories using automatic writing (Janet, 1886, 1889). Lucie was one of Janet's earliest patients who suffered from multiple personality disorder (MPD). She had hallucinatory episodes consisting of feelings that scary men were hiding nearby. Lucie was unable to recall an earlier experience related to this phenomenon either awake, or under hypnosis. After Janet encouraged her to use automatic writing under hypnosis her alter-personality, Adrienne, described how at age 7, two men had frightened her while playing at her grandmother's home. In this case, post-traumatic dissociation was responsible for the development of a hidden alter-personality based on the primary fixed idea. A modern author, Summit (1987), has called such states "the hidden child phenomenon."

Neutralization of Traumatic Memories

Hypnotic liquidation of traumatic memories was Janet's most direct and venturesome treatment approach (PH, p. 670). It consisted of a stepwise process of reexperiencing and verbalizing traumatic memories, starting with the least threatening, and working toward assimilation of the most traumatic events. For many traumatized patients, however, it was too painful and demanding to actually relive and verbalize the trauma. They simply could not manage to transform the traumatic event into a neutral narrative. Putting pressure on them to do so could lead to increased resistance, and produce more unbidden intrusions of traumatic memories: this procedure clearly was not without its risks. However, when cautiously applied in suitable prepared patients traumatic memories often could be successfully assimilated. Janet's most famous example of this approach was Irène (Janet, 1904).

Irène was a 20-year-old Parisienne with an intensely dependent relationship on her mother, who had fallen dead from her bed in front of the patient after a long illness which had exhausted them both. She entered a fugue state and was amnesic for the loss. Her post-traumatic symptoms included somnambulistic crises occurring several times per week. During these episodes Irène dramatically reenacted the sequences of her mother's death and funeral. Janet used hypnosis to uncover the traumatic memories and to liquidate them. At first, attempts to induce hypnosis met with resistance. Trance states frequently resulted in delirious crises, in which Irène would mimic her mother's death. Over several months, Irène's memories slowly came

into consciousness: "After much labor," Janet reported, "I was able to construct a verbal memory of her mother's death. From that moment . . . the assimilated event ceased to be traumatic" (PH, p. 681).

The Substitution Method

For many patients, symptom-oriented hypnotic approaches were too superficial, and neutralization too potentially traumatizing. Sometimes Janet substituted neutral or even positive imagery for the traumatic memories (Janet, 1889, 1894, 1894/5, 1898a, b). He either changed the cognitive interpretation of the traumatic events or the patients' emotional reactions. Changing the content of the imagery helped Janet's patient Cam to assimilate the memory of the death of her two children. Janet successfully replaced the hallucinated traumatic images with a picture of blossoming flowers (Raymon and Janet, 1898).

Another example of changing traumatic memories is Marie, one of Janet's early patients at the Salpêtrière (Janet, 1889). Marie had severe anxiety attacks, seizures, and spasms during her menses. Under hypnosis, she recovered the memory of her first menstrual period: she had been totally unprepared, and was deeply shocked. To stop the blood flow she jumped into a cold tub. After this she fell ill and didn't menstruate for 5 years. Subsequently she experienced her periods as episodes of reliving the original drama, for which she had total amnesia afterwards. Janet's initial attempts to influence Marie's traumatic memories were fruitless. Using hypnotic age regression to the time before her menarche, suggestion of normal periods led to cessation of the monthly crises. However, her anxiety attacks persisted until their relationships to another trauma were uncovered. At age 16 Marie had seen an old woman fall down the stairs and die. Since then, just hearing the word "blood" was enough to trigger the somatic sensations related to this traumatic event. The anxiety attacks disappeared when Janet suggested the woman had only tripped and not died. Marie had yet another hysterical symptom: she was blind in her left eye. Initially she was opposed to exploration of this blindness and said she was born with it. Hypnotic age regression to 5 years, however, revealed normal vision. At 6, Marie had been forced to share a bed with a child suffering from impetigo on the left side of her face. The hypnotic suggestion that this child had not had impetigo and was really a nice person relieved Marie's blindness. The improvements were maintained at 5 months' follow-up, and Janet thought that Marie had benefited in her physical appearance as well.

Reframing

While Janet's hypnotic substitution techniques worked fairly well for patients with predominantly hysterical, i.e., dissociative, post-traumatic symptomatology, technical modifications were required for patients with predominantly psychasthenic features. These patients dealt with their traumatic memories with excessive scrupulousity and obsessions (Janet, 1903). They were plagued by guilt, and preoccupied with how they should have behaved differently. Janet thought that these "mental manias of perfection" were attempts to restore their pretraumatic harmony (Janet, 1935).

Under these conditions, Janet focused purely on the verbal memories, rather than on traumatic imagery, and sought to reframe the narrative account in terms acceptable to the patient. Instead of hypnotic substitution of imagery, he used reassurance and restoration of morale. An example was Janet's treatment of Nicole, a 37-year-old married woman whose post-traumatic psychasthenic illness developed over a period of 12 years (Janet, 1935). Nicole was obsessed with the traumatic ending of a love affair several years prior to her marriage. Following this rejection, she became depressed whenever she thought about her former lover during which she experienced terrible feelings of anxiety, abandonment and guilt. Nicole's subsequent recovery barely concealed the continuing lack of resolution of her psychological trauma. She was silent about the affair, but she continued to suffer from agoraphobia and was beset with fears of dying or fears of throwing herself from a window. She married 6 years later and never wondered whether she should tell her husband about the affair. After her third delivery, which coincided with an anniversary reaction, a radical change occurred: there was a recurrence of the post-traumatic psychasthenic reaction along with all the memories of the affair and its termination. Nicole confessed to her husband, overwhelming him with interminable and insoluble questions, "How come I didn't offer any resistance? How come I didn't feel any shame after I had been thrown out, no regret? Am I thus not worthy to live? Is the past irreparable? Can I continue as if nothing has happened?"

Janet thought that Nicole functioned at a higher mental level during this second crisis than during the first. She was better able to put her unhappy story into words, but was still ill-equipped to deal with the moral issues over which she was brooding. He helped her to reinterpret her past conduct as pathological rather than immoral. Although still difficult to accept, it was easier to see herself as a patient than as a criminal. In modern terms, Janet substituted Nicole's "patient myth" for a "therapeutic myth" (Frank, 1973; van der Hart, 1988), which made the traumatic event acceptable, and promoted its assimilation.

STAGE 3: PERSONALITY REINTEGRATION AND REHABILITATION

Assimilation of traumatic fixed ideas was necessary, but insufficient for complete resolution of post-traumatic stress. Three further clinical issues had to be addressed: prevention of relapse, reintegration of the personality and management of the residual symptoms of the post-traumatic pan-neurosis. All three conditions were associated with psychological instability and a lowering of psychological tension. Janet described how continued reliance on dissociation in the face of threat made these patients vulnerable to repeated relapses. He tried to deal with this problem by trying to stabilize the patient and to consolidate the gains made in the first two treatment stages (Janet, 1893). Psychological trauma often had not only caused an arrest in the capacity to integrate new experiences (Janet, 1904), but sometimes led to a regression to earlier developmental stages as well (Janet, 1893).

Specific post-traumatic personality defects included: poor attention and concentration; suggestibility; inability to initiate, maintain, follow-through and complete acts; constricted affect and hypochondria. Each of these personality deficits could coexist with residual symptoms of the post-traumatic pan-neurosis. These might include functional somatic complaints, motor contractures, psychasthenic doubts, ruminations and scrupulosity. All patients were likely to experience residual apathy, boredom and depression. Janet addressed his therapy to these symptoms of the pan-neurosis. Treatment for each of these conditions—relapse prevention, symptom relief, and personality reintegration and rehabilitation—included education, stimulation and moral guidance. Janet tried to integrate these various therapeutic approaches in order to increase patients' mental energy, recover lost functions and acquire new skills.

Education

Janet's educational approach was based on a learning model, and was aimed at reducing symptoms and restoring personality functions (Janet, 1898a, 1903; PH, p. 710). Post-traumatic patients with residual psychasthenic (obsessional) symptoms, for example, were taught techniques similar to contemporary thought-stopping and response prevention (Janet, 1903). Education was used to restore attention and concentration, motor functions, and contact with reality. Aesthesiogeny was a specific technique for recovery of the awareness for physical sensations (Janet, 1893; 1898a; PH, p. 788). Janet also described behavioral methods for more complex and purposeful acts. The graduated treatment sequence started by performing simple actions; these were first modelled by the therapist and then carried out by the patient. Simple

tasks were repeated until they came naturally, and finally the patient was urged to get involved in spontaneous activities without supervision. Janet remarked that it was not always clear how this could be accomplished; often, he met with resistance regardless of whether he coaxed firmly or gently (PH, p. 741). Treatment failures might either develop recurrences of old symptoms, or symptom substitution (PH, p. 743, 745).

Excitation

Although educational activities, hypnosis and psychological treatment were meant to be psychologically stimulating, most post-traumatic patients required further therapeutic excitation to foster positive emotions, motivation, and a sense of mastery (PH, p. 858). Stimulating activities included awareness exercises (PH, p. 972) and graduated performances of familiar but neglected activities (PH, p. 967). Patients were encouraged to work on their social phobias, residual psychological and external conflicts, procrastination and unresolved problems. Janet thought that repeated courses of stimulating educational treatment had a cumulative beneficial effect (PH, p. 1022). There was an ever present risk of fatigue or exhaustion, and a need to channel agitation into creative pursuits. Janet encouraged patients to take pride in their own successes and urge them to overlook failures (PH, p. 986). However, he advocated being truthful when patients asked for feedback about the quality of their performance.

Drug Treatment

Janet saw sedatives such as bromides, and the stimulants as a necessary evil (PH, p. 1030). He made the astute observation that psychological symptoms were often less troublesome when the patient's general health was worse (PH, p. 1064). Nevertheless, he did employ pharmacological agents such as tea, coffee, alcohol, opium, and strichnine to increase psychological tension and used physiotherapy, hydrotherapy and electrical stimulation as well. He also experimented with newly discovered endocrine preparations such as adrenaline, pituitary extract and thyroxine (Janet, 1904).

Termination

Janet used the hypnotic rapport in the second treatment stage to liquidate the traumatic memories, and in the third stage to stimulate growth and assist in rehabilitation. Reduction of the therapeutic influence signalled the

beginnings of termination (PH, p. 1194). The patient developed a quieter attitude, was more open to positive influences and relapses were less severe and of shorter duration. Janet regarded ingratitude as the best sign of recovery: when the patient started to forget appointments he was on the road to recovery (PH, p. 1198/9). He lengthened the gap between sessions at this stage, and in severe and complicated cases infrequent appointments maintained the therapeutic influence over time: for example, Janet stayed in touch with Irene for 16 years (PH, p. 1202).

DISCUSSION

Janet's treatment model anticipated modern approaches to therapeutic integration. He was well aware that psychotherapy still was at a prescientific stage and that it was less specific than drug treatment in medicine (PH, p. 1208, 1210). However, his own data showed that his patients improved more by psychotherapy than was predicted by chance, or likely to be due to spontaneous remission (PH, p. 340 ff, p. 1211). He advocated the need to define specific treatment techniques for specified conditions (PH, p. 146), repeatedly warned against therapeutic panaceas (e.g., PH, p. 132, 464, 490). Janet's approach to psychotherapy was a theoretically informed eclecticism applied to both traditional nosological categories and his own unique model of mental economy. It was truly prescriptive in that characteristics of the disorder, its stages, and the vicissitudes of mental economy dictated treatment rather than vice-versa. Janet utilized both traditional methods and his own innovations, but always embedded treatment within the frame of the therapeutic alliance.

Janet was a flexible clinician who viewed the different stages of post-traumatic syndromes as constantly shifting and returning, requiring different treatment approaches at different times. Sometimes, restoration of personality functioning was required before all of the traumatic memories could be assimilated; at other times, retrieval of a traumatic memory could stabilize a patient's mental state (Janet, 1894/5). In patients with dissociative disorders Janet emphasized integration of traumatic memories more than integration of various personality states: he was impressed by how liquidation of traumatic memories could bring about personal integration and he frequently saw these two processes occurring simultaneously (Janet, 1893). Modern authors such as Braun (1986) and Sachs *et al.* (1988) are more outspoken about the need to distinguish a separate treatment phase for the integration of personality states.

Traumatic memories were often difficult to resolve completely, because they tended to contain multiple layers: just when the therapist felt that all of the memories had been explored, a new layer might emerge (Janet, 1894). Janet attributed his failure to help some of his patients with a pathological

dependence to his inability to reach inaccessible traumatic memories. He reported relatively few examples of liquidation of traumatic memories from before age 6. Contemporary studies of patients with MPD have revealed severe physical and sexual abuse in some patients during infancy (Coons and Milstein, 1986; Putnam *et al.*, 1986; Kluft, 1987).

The substitution technique is one of Janet's most original contributions to psychotherapy. The same technique later shows up in the work of Breukink (1923), Erickson (Erickson and Rossi, 1979) and during the 1980s (Eichelman, 1985; Lamb, 1982, 1985; Miller, 1986; Waxman, 1982). In Janet's and Erickson's approaches the therapist was the operator, but some modern clinicians encourage their patients to be self-directive and to construct and enact their own revisions of the original traumatic event. The question whether such approaches lead to further dissociation of traumatic memories—as Janet thought—or to their implicit assimilation remains unanswered. Contemporary authors (Kluft, personal communication) have warned that in patients with a history of incest where the child was denied validation of the trauma because of threats by the perpetrator, the substitution technique could easily be misunderstood by the patient as an extension of the process of negation of the trauma.

One of Janet's pioneering concepts which has fallen in disuse and has not been retrieved for contemporary psychiatry is his model of mental economy. This model proposed that trauma causes an instability in patients' psychological energy levels and always interferes with psychological tension, the capacity to organize energy into focussed and creative action. Recent research has again supported the validity of these concepts: van der Kolk and Ducey (1989), analyzing the Rorschachs of people with PTSD concluded that: "the lack of integration of the traumatic experience causes extreme reactivity to environmental stimuli: the initially overwhelming external event, through lack of assimilation, is perpetuated internally and continues to exert disorganizing effects on the psyche." This research concluded that "the effort to keep memories of the trauma at bay interferes with the capacity to sublimate and fantasize, preventing "thought as experimental action." This interferes with the ability to grieve, and to work through ordinary everyday conflict and to accumulate restitutive, gratifying experiences. Hence, they are deprived of precisely those psychological mechanisms which allow people to cope with the injuries of daily life." Janet's recognition of this unfocussed and ineffectual psychological energy provided the rationale for his system of psychotherapy which divided treatment into those methods which encouraged conservation of mental economy (psychological restitution), and methods to economic augmentation (aimed at psychological growth). Concluding a tribute to the broad scope of Janet's vision, Ellenberger (1950, p. 482) remarked that Janet's psychotherapy is not a partial and exclusive method: "Not only does it not exclude other methods, but it often enables us to understand them

better and to specify their domain of application. It is less a special therapy than a general economy of psychotherapy."

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