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MEMORIES OF SEXUAL ABUSE: JANET'S CRITIQUE OF FREUD, A BALANCED APPROACH

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Summary.--Since the late nineteenth century explanations of sexual trauma have invoked unconscious mental mechanisms of forgetting. Memories have been seen as submerged only to be therapeutically recovered. Explanations and related therapies have tended to be either hotly advocated or decried, not the least were those of Janet and Freud. Once again there is a vigorous debate surrounding the status of recovered memories. This paper was undertaken to contribute to reasoned and balanced dialogue by exploring an historical dimension. There is a renaissance of interest in the oeuvre of Janet. In this article Janetian sources are examined in which he criticised Freud's views on sexual trauma and elaborated his own position, a position which is yet significant today.

The question of the validity of recovered memories of childhood sexual abuse is embedded in questions of the prevalence of early sexual abuse, the validity of psychological models of suppression of traumatic memory, and the reliability of the methodology of their therapeutic detection and recovery. Debate of these questions has twice peaked over the past century, first at the end of the nineteenth century with the work of Janet (1859-1947) and Freud (1856-1939) and currently towards the end of the twentieth century with the debate of recovered memory. A continuum of positions currently obtains with regard to the validity of recovered memories (Brown, Schefflin, & Hammond, 1998), but increasing rapprochement is occurring (Lindsay & Briere, 1997).

Considerable attention has been given in recent years to Freud's changed perspective of sexual trauma in neurosis (e.g., Masson, 1984; Israels & Schatzman, 1993; Powell & Boer, 1994, 1995). Much less well known is the stance on traumatic memory and its recovery adopted by his contemporary Janet who did not advocate primarily uncovering the traumatic memories regarded as underlying posttraumatic hysterical disorders. Instead, Janet developed a systematic approach to treatment aimed at therapeutic integration (Van der Hart, Brown, & Van der Kolk, 1989) which can be regarded as the basis of modern phase-oriented treatments of posttraumatic stress (Herman, 1992; Brown, 1995). This paper examined the diagnostic and therapeutic views of Janet and aimed to promote a balanced approach to recovered memory.

Janet's oeuvre is currently undergoing a renaissance of interest (Brown, 1991). This was stimulated by Ellenberger's chapter on Janet in *The Discovery of the Unconscious* (1970) and gained momentum with the development of the neodissociation theory (Hilgard, 1977) and Janetian studies of posttraumatic dissociation (Van der Kolk, Brown, & Van der Hart, 1989; Van der Kolk & Van der Hart, 1989). Janet's views on trauma, posttraumatic dissociation, and the recovery of memories are embedded in a series of publications extending over 50 years, from 1886 to 1935. His most comprehensive account, a critique of Freud and a resumé of his own views, is to be found in his *opus Psychological Healing* (1919/1925). A summary of this account forms the core of this paper. It is first contextualized by outlining the current debate on recovered memory.

PRESENT STATUS OF RECOVERED MEMORY

In the decades following Freud's change of mind, interest in actual sexual abuse and sexual trauma left center stage, although it unobtrusively preoccupied those involved with children. As late as 1975 the principal textbook of psychiatry in the USA (Kaplan & Sadock, 1975) did not consider the influence of sexual abuse on children and paid minimal attention to the contribution of incest to adult psychopathology.

Several contemporary developments reversed this trend. Interest in posttraumatic stress extended from the military-industrial to the domestic arena and to the influence of sexual trauma on adults and children. Increasing evidence accrued for childhood sexual abuse, e.g., father-daughter incest (Herman, 1981) and for submerged memories thereof with either partial or complete amnesia. Concurrent evidence also accrued for related posttraumatic syndromes in adulthood, ranging from borderline personality disorder (Stone, 1990; Zanarini, 1996) to dissociative disorder (Goodwin & Sachs, 1996).

By way of contrast, Kihlstrom (1995) asserted that there is an epidemic of spurious sexual abuse claims, that memories of abuse are suggested, and that those thus induced suffer from an iatrogenic personality disorder, the false memory syndrome. Schacter (1996) analyzed the dangers of suggestive therapeutic techniques, and Pope (1996) examined in detail the claims of those proposing a false memory syndrome. He found them wanting on a number of grounds, most important of all that they lacked empirical support.

A continuum of positions with regard to the authenticity or inauthenticity of recovered memories of childhood sexual abuse evolved (Allen, 1995), ranging from those arguing their frequent falsehood to those accepting them at face value and regarding them as extremely accurate. The British Psychological Society and the American Psychiatric Association have taken a neutral position. In the face of accumulating research on the process of remembering, Loftus (1993) appears to have moderated her earlier position on memory (Loftus, 1979), stating (Loftus & Yapko, 1995, p. 187): "If one asks neutral questions (nonleading questions), and a client comes up with a previously unrecalled memory of abuse, then the therapist should consider treating it as authentic, but still be open to the possibility of other sources of influence. Although formal epidemiological studies have yet to be conducted, Brown (1995) felt that the "epidemic of false memory creation through professional therapy by experts rather than paraprofessionals does not stand up to scientific scrutiny," and Brewin (1996) recently cited increasing scientific evidence against the null position on false memories. Kluft (1995) felt that the solutions are philosophical and empirical, and in the same vein, Pennebaker and Memon (1996) advocated combined clinical and empirical validation. Van der Hart and Nijenhuis (1995) stated that statements of childhood sexual abuse and other abuse can only be validated with certainty externally.

FREUD ON POSTTRAUMATIC STRESS

Janet's and Freud's studies on sexual trauma towards the close of the nineteenth century arose in an adversarial ambiance of assertion and counterassertion. As noted by Healy (1993, p. 14), Tardieu made a medicolegal study of "assaults on decency" in 1857, drawing attention to the frequency of child sexual abuse. Healy (1993, p. 14) further noted an orthodox medical response of denial: "Fournier in 1880 and Brouardel in 1883 argued for 'the simulation of sexual attacks on young children' and speculated on 'the causes of error in expert opinions with respect to sexual assaults.'" Healy felt that these reports would have been available to both Janet and Freud.

Freud's seduction theory was based on interpretation of data initially obtained by hypnotic uncovering and subsequently by the pressure technique in 18 clinical cases of hysteria (Freud, 1896). Israels and Schatzman (1993) reported that Freud (1896) initially defended the seduction theory providing seven answers alone to the objection that sexual abuse occurred in fantasy rather than reality. These objections comprised: the subject's reluctance to recall traumatic scenes, their resilience to suggestion; the uniformity of details, consistency with the rest of the case history, therapeutic success linked with uncovering, and independent corroboration. Only one year later, in September 1897, Freud switched to four "groups of motives" for changing his mind. The latter was subsequently published in the first selection from the Freud-Fliess letters (Freud, 1897a/1954), and later by Masson in the complete letters (1897b/1985). These motives included lack of therapeutic success, improbability of causatively perverse fathers in such widespread disorders, inability to ascertain truth from reality in the unconscious, and the possibility that sexual abuse might never have really occurred.

Freud subsequently recanted his sexual abuse theory (Freud, 1906), using instead his well known conflict model (Freud, 1905). Although Freud still gave some credence to the etiologic significance of sexual abuse, Powell and Boer (1995) contended "that he may have been significantly biased toward interpreting certain types of incest allegations as fantasies" (p. 563). As Bowers and Farvolden noted (1996), Freud referred to his earlier inability to discriminate between true cases and "the deceptive memories of hysterics concerning their childhood and the memory-traces of actual happenings" (Freud, 1906, p. 276). Instead, Freud mostly substituted disturbances of infantile sexuality for sexual trauma and substituted sexual fantasy and psychic reality for objective reality. He was thus able to retain his psychosexual model of personality development, basing it on failure to master key psychosexual developmental stages due to the threat of autoerotic activity and incestuous desires (Freud, 1905), and to the vicissitudes of the Oedipus complex (Freud, 1924). Actual memory gave way to repressed memory and to symbolic elaboration of disturbing sexual fantasy. However, the role of actual trauma was not entirely abandoned by the psychoanalysts. War trauma, for example, was seen as activating latent psychosexual processes. Simmel (1919) spoke of the contribution of combat trauma to symptom content rather than to the underlying psychosexual constellation or form. Just a decade later in his 1933 article, *Confusion of tongues between adults and the child*, Ferenczi bemoaned "the traumatic factors which had been unjustly neglected in recent years" (1933, p. 156).

JANET ON POSTTRAUMATIC STRESS

Janet acknowledged sexual trauma and its psychological concomitants, regarding these as a subset of all posttraumatic disorders (Janet, 1919/1925). He described two principal nosological categories: posttraumatic hysteria, characterized by dissociation and persistence of memories as subconscious fixed ideas, and posttraumatic psychasthenia, in which memory is more actively retained in consciousness and obsessively recalled (Van der Kolk *et al.*, 1989). In both disorders,

memories are episodically active, and, when unchecked, this process results in posttraumatic decline with corresponding lack of mental integration or synthesis.

Janet considered posttraumatic hysteria to be essentially a disorder of the biographical function or memory processing. He summarized his theories in 1928 (Janet, 1928) and revised them in 1932 and 1935 (Janet, 1932, 1935). In the initial theory, Janet (1928) contrasted narrative memory comparable to normal reconstructive memories with experiential traumatic memory comprising more or less rigid repetitions of the same events (Janet, 1889, 1904, 1919, 1928). These conceptualizations have been taken up again by a number of contemporary authors: narrative or reconstructive memory, for example, by Loftus (1993) and Van der Kolk and Van der Hart (1991), and experiential traumatic memory by Van der Kolk and Van der Hart (1991), Van der Kolk and Fisler (1995), Van der Hart and Nijenhuis (1995), and Whitfield (1995).

Experiential traumatic memories are automatically reactivated and reenacted, often under state-specific trigger conditions. Janet wrote (1904) that traces of the traumatic memory linger as subconscious fixed ideas that cannot be 'liquidated' until they have been translated into a personal narrative. Janet (1894) further distinguished between primary fixed ideas, which are more faithful representations of the actual traumatic event, and secondary fixed ideas, which present after the disappearance of the former through treatment. Janet distinguished three forms of secondary fixed ideas: Derivative fixed ideas associated with the principal fixed idea, e.g., those of cemeteries, when associated with a principal fixed idea of death; stratified fixed ideas, associated with traumatic fixed ideas antedating the current trauma, and accidental fixed ideas, associated with subsequent stressful life events. Both primary and secondary fixed ideas continue to intrude into consciousness as terrifying perceptions, obsessional ruminations, and somatic disturbances such as those that accompany anxiety states.

In the 1932 revision of this theory, Janet recognized that traumatic memory should rather be considered as vulnerable to postevent modifications. Of his famous case of posttraumatic grief, Irène, he wrote (Janet, 1932/1993): "I am now obliged to return to this point and to conclude that in the reproduction there is a certain organization in relation to the character and feelings of the patient, that this organization partially transforms the reproduction of the conduct by giving her something theatrical" (p. 97). He regarded such reproductions as abbreviated from the outset and further wrote: "There are suppressed details: when some months later I could help the patient to recall the complete memories of this night, I observed that many details had been absent during the delirium" (p. 97). The patient reproduced events which had not occurred, e.g., fantasies of suicide by lying on a railroad, and these were integrated into the enactment. Thus, even though traumatic memories are reproductive, they are not exact reflections of the original traumatic events. There is lack of concision, they are unadapted to the present, and there is a drive to *restitutio ad integrum*: If one element is activated, all of other elements automatically follow. Subjective modifications also include dreamlike distortions of reality and condensation of by joining different traumatic memories and fantasy elements. Van der Hart, Nijenhuis, and Van der Kolk (1997) further classified these transformations of historical facts into nonsocially adapted curtailments, in which key elements of traumatic experience may be omitted, and distortions, when for example another person's trauma is "experienced" as if it were the subject's own.

There are important differences between experiential traumatic memories (as manifestations of primary and secondary fixed ideas) and ordinary reconstructive memories (narrative-autobiographical memories). Traumatic memories are highly resistant to deliberate modification, for example, by autosuggestion or therapist-induced suggestion, for example, by the substitution technique (Van der Hart *et al.*, 1989). In regard to the latter, Janet frequently found symptom-oriented therapeutic approaches too superficial on the one hand, and the direct approach or "neutralization" too potentially retraumatizing on the other. He therefore advocated preliminary substitution of neutral or even positive imagery for the traumatic memories (Janet, 1898a, 1889,

1894). Following this indirect approach he was subsequently able to help patients access and attempt to assimilate their actual psychological trauma. This was a very arduous task with potential for further dissociation, retention of pathogenic fragments, and residual psychological "scarring" (Janet, 1919/1925, p. 678).

JANET'S CRITIQUE OF FREUD

At the Seventeenth International Congress of Medicine, London, 1913, Janet presented a major critique of psychoanalysis (Janet, 1913). This report was translated and republished in the *Journal of Abnormal Psychology* (Janet, 1914/15a), and a follow-up paper specifically focused on sexual trauma (Janet, 1914/15b). These articles drew a critical response from Ernest Jones in a later issue of the same *Journal* (Jones, 1915). Janet subsequently expanded and summarized these themes. They form the basis for Chapter 11 of *Psychological Healing* (Janet, 1919/1925; cf. 1925, pp. 589-698) and were presented in precise form in his *Principles of Psychotherapy* (Janet, 1923/1924, pp. 42-46). The following is a resume of the main points related to memories of sexual abuse taken from *Psychological Healing* (1925). The page references are to that work.

Janet's critique of Freud's sexual theories is embedded in his critique of psychoanalysis. He first examined Freud's methods of data collection. Addressing the unreliability of free association he wrote: "... the patient still feels himself to be under observation and will be more inclined than we are to suppose to rearrange his words so as to produce a definite effect" (p. 603). Janet continued by noting the limits of interpretation in which Freud linked trauma to repressed sexual wishes even to the point of subordination of obvious current trauma to putative fantasized early sexual abuse. A patient's current grief trauma had thus been interpreted by Freud in terms of frustrated unconscious sexuality (p. 607).

Nevertheless, Janet saw uncovering subconscious phenomena such as deliria, dreams, automatic writing, and somnambulism, as important approaches to accessing trauma (p. 605). He advocated dream induction, recording, and description, preferring to attribute conscious and incidental dream distortion rather than unconscious ideation according to Freud's psychosexual theories.

Janet next proceeded from methodological criticism of the interpretation of unconscious processes to examination of their etiologic "causes" (p. 608). He criticized Freud's substitution of repression for dissociation: "as an explanation of the subconscious character of certain traumatic memories" (p. 609). Rather, Janet regarded repression as an independent process resulting in dissociation. "Freud calls 'repression' what I called a 'narrowing of the field of consciousness'" (Janet, 1913, quoted by Ellenberger, 1970, p. 539). As such, repression was seen by Janet as actively caused rather than as a passive effect: "A memory or an idea which has been persistently repressed, disappears from consciousness, and no longer tries to manifest itself there; it becomes subconscious and lives apart; dissociation has resulted from repression" (p. 608). In separate existence, posttraumatic phenomena are then vulnerable to elaboration by association of ideas and can lead to dissociation not only of mental but also of physical phenomena.

Janet next criticized Freud's rubrication of trauma under the pansexual doctrine of the neuroses: "Whereas previous observers have held that traumatic memories are to be found in *some* neuropaths, the psychoanalysts declare that, and this is their innovation, that such memories are to be found in *all* neuropaths" (p. 613). In line with arguments expressed in the current debate on recovered memories, Janet claimed that, when present, sexual trauma is usually obvious or readily inferred without resort to psychological interpretation: "the patient volunteers the information of rape, abandonment, adultery, etc." (pp. 613-614). In other cases the trauma must be uncovered, but in some, "With the best will in the world, the patient cannot recall anything of the kind" (p. 614).

Janet noted, however, that Freud later recanted: "It is proper to add that at a later date (1905) Freud admitted that he had been led astray in certain respects by the fallacious reminiscences of some of his patients. He was, therefore, no longer inclined to be quite so definite in his views as to the etiology of the various neuroses. But he still maintains as a fundamental principle that "in a normal sexual life a neurosis is impossible." He continues to believe that the neuroses, and even some of the psychoses, such as dementia praecox, have unique and specific causes. He still believes them to be due to a sexual disturbance consequent upon a mishap whose influence persists in the form of a traumatic memory" (p. 620).

In the next section, Janet made plain the ubiquity of sexual issues and themes and provided linguistic and logical objections to Freud's "unrestricted generalization," his pansexualism (p. 622). Regarding the specificity of these sexual occurrences for psychopathology, Janet wrote: "We must, then, be concerned with a sexual adventure or mishap serious enough to have disturbed the subject to such a degree that it has left a distressing memory, one still able, at the time when the patient comes to consult us, to arouse emotion, fatigue, and psychological disturbances. If the term be understood in this sense, then psychological analysts, i.e., Janetians, as contrasted with psychoanalysts, declare that in their experience such sexual adventures have not happened to every neuropath. They declare that only in a restricted number of their neuropathic patients can they find evidence of the existence of traumatic memories of this kind" (p. 623).

Janet differentiated nonsexual from sexual emotions and memories in "neuropaths." He felt that hysterical symptoms frequently follow nonsexual incidents, and that traumatic hysteria is often associated with nonsexual emotions, memories, and fixed ideas, so that "... every memory, every thought, competent to arouse strong and lasting emotions can play the part of a fixed idea, and may originate hysterical, i.e., dissociative, symptoms" (p. 625). Janet proceeded with a philosophical critique: "To me it seems that the psychoanalytic method is, before all, a method of symbolical and arbitrary construction; it shows how the facts 'might be' explained if the sexual causation of the neuroses had been definitely accepted, but its application cannot be insisted upon so long as that theory is still unproved" (pp. 627-628).

Janet then presented his views on the probable contribution of sexual trauma to the neuroses. He agreed that there are a proportion in whom sexual trauma causes emotion, exhaustion, and reduction in psychological tension (Freud's ego strength). These findings are consistent with those of Freud's initial seduction theory. In other neuroses, sexual disturbances are secondary: "In many cases we can prove that sexual disturbances, e.g., frigidity, are not the cause of the nervous disorder but are its consequence and its expression" (Janet, 1903, Vol. I, p. 623) (p. 630). In this regard, he cited the transient need of depressed patients to escape their suffering through the compulsive need to love and be loved (p. 631). This he regarded as part of a general disturbance, e.g., aboulia (a disturbance of volition), often ante-dating the sexual disorder (pp. 632-663).

Janet finally summarized his critique of Freud's sexual theories. He felt that one cannot assume the presence of repression or the symptomatic consequences of it if there is no evidence (p. 650). According to Janet, "transformed, i.e., repressed, memories" are not always present (p. 651): "Must we hunt for transformed memories as explanations for the authoritarian manias or love manias which are so natural an outcome of a desire for self-defense or of self-elevation?" Espousing clinical skepticism, Janet wrote "It is far more likely that a symptom is caused by the laws of the disease than by accidental memories. We must not interpret symptoms historically unless clinical observation makes such an interpretation indispensable, and we should never indulge in risky hypotheses" (p. 651). There may be no particular traumatic event and no traumatic memory.

Returning to etiology, Janet emphasized multifactorial causation. Thus, in addition to antecedent trauma and chronic factors, he drew attention to the contribution of ongoing life-stresses, bodily disorders, intoxications, and fatigue against a backdrop of heredity and constitution (p. 652). Referring to his hierarchical “economic” model (Janet, 1903), which described levels of integrity of personality functioning (themselves the counterparts of Freud’s ego strength or weakness), he suggested that following trauma (and in mental illness in general) there is a lowering of psychological tension or organizational capacity, so that the subject may have difficulty regaining the previous level.

JANET'S APPROACH TO PSYCHOLOGICAL TRAUMA

In contrast to Freud, Janet did not regard trauma as the basis of all neurosis. Instead, he believed that it contributed to an important subset, with sexual trauma forming a further subset. Thus, he found “In some, seduction and a concealed childbirth. In some patients there was paraplegia, with contracture of the adductor muscles (“the guardians of virginity”) brought about by the memory of rape or by that of sexual relationships with a husband who had become odious.” In this connection, he quoted the case of Ky., whose posttraumatic hysteria could be linked with paternal incest (Janet, 1898b, Vol. II, p. 519): “I ascertained that there was an intimated relationship between the symptoms and the memory of the incestuous intimacy with the dread of its consequences. By modifying the patient’s ideas, I was able to relieve her of all her symptoms and thus to confirm my theory [hypothesis] as to their origin” (p. 593).

Janet recognized that therapists would require rules for the diagnosis of traumatic memories: “Whereas some doctors never trouble their heads about traumatic memories and do not even know that these exist and whereas others fancy them everywhere, there is a place for persons who take a middle course and who believe that they are able to detect the existence of traumatic memories in specific cases. The doctors comprising the last group need diagnostic rules. Unfortunately the psychological phenomena in question are still imperfectly known, and it is far from easy to give precise indications” (p. 670).

Janet suggested the following grounds for endorsing a link between memories and symptoms: onset of symptoms concurrent with a tendency to dwell on the memory, development of symptoms parallel with the evolution of the memory, and symptoms modified by the modification of the memory. He concluded that “Not until I had made a great many verifications of this kind, did I feel justified in believing that in certain cases, a traumatic memory had been a factor of disease” (p. 594; also quoted by Powell & Boer, 1994). For Janet, the cause of any given psychological illness is determined by elimination. Thus one must exclude cases of exhaustion due to routine social pressures, e.g., what is now known as psychological “burn-out.” “When we can find no explanation in the subject’s extant life, we are certainly entitled to delve into his past” (p. 670). This also included interviewing other family members. Janet felt that one must not be too circumspect in exploring trauma. On the other hand, one must reduce the risk of reactivation of traumatic memories and the possibility of doing harm: “If the doctor is careful not to make up his mind beforehand that he will find a memory responsible for the whole illness ... he will be able to make his examination tactfully and without unduly troubling the patient’s mind” (pp. 670-671). Janet’s general guidelines for the detection of traumatic memories were thus to avoid suggestive influence and to proceed with tact and without prejudgment of memory, not the least sexual memory.

Janet preferred the thorough approach to history-taking of the German school (p. 671). Indications of trauma, whether the trauma is sexual or non-sexual, are often indirect, including amnesias, phobias, emotional reactions to issues raised, and reactive (“accidental”) depressions, i.e., unrelated to personal development or to alterations in general health status. These reactions have the power to

reactivate traumatic memory, and when thus elicited, one must ask what part it plays and whether it is still traumatic: “We are only entitled to regard as traumatic memories, those memories which recur again and again at the present time and which lead the patient to make efforts which are frequent, obvious, and competent to induce exhaustion” (pp. 671- 672).

DISCUSSION

Janet’s critique of Freud’s sexual trauma theory finds striking parallels in present day criticisms including those of Macmillan (1989, 1990, 1997). Israels and Schatzman (1993) showed that Freud’s evidence for his seduction theory was flawed and that the supposed stories of seduction were most probably fantasies and the consequence of Freud’s highly suggestive therapeutic procedures. Powell and Boer (1994) examined Freudian antecedents (Freud, 1896) of the present day debate on recovered memory. They too found Freud’s therapeutic procedures highly suggestive, and his reasons for validating recovered memories strongly subject to confirmatory bias, a process defined by Brehm and Kassir (1993). They found support for these contentions in the work of Janet, who had repeatedly alluded to Freud’s tendency to select his evidence to support his theories, e.g., “The psychoanalysts set to work in order to discover a traumatic memory, with the *a priori* conviction that it is there to be discovered ... owing to the nature of their methods, they can invariably find what they seek” (1919/1925, p. 653).

Janet, however, did not sufficiently distinguish between Freud’s sexual trauma theory and subsequent pansexual model of neurosis. In his critique of Freud’s pansexualism, by conflating sexual trauma with general sexual themes, Janet inadvertently down played sexual trauma. Freud’s first model of the neuroses, although based on the seduction hypothesis, was not specific with regard to the part played by childhood sexual abuse and traumatic memory. By way of contrast, “Janet argued that these disorders are multifactorial and are underpinned by traumatic experiences in only a portion of cases. When trauma does obtain, Janet discouraged an exclusive focus on sexual events at the expense of other nonsexual and later incidental trauma, although he may have underplayed sexual trauma, in particular incest, since he did not mention many cases” (Hacking, 1995).

While there is increasing evidence for linking childhood sexual abuse with adult mental illness (e.g., Mullen, Martin, Anderson, Romans, & Herbison, 1993), particularly personality and dissociative disorders, the extent of the link has yet to be established. A number of empirical studies indicate that many patients with dissociative identity disorder report childhood sexual abuse. These studies have been recently subject of a comprehensive overview by the Dutch researchers, Boon and Draijer (1993). Their own study supported the view that dissociative identity disorder can be considered to be a specific and complicated posttraumatic stress disorder which develops in early childhood in response to severe and chronic abuse. They went on to propose a continuum of trauma-related disorders ranging from posttraumatic stress disorder (incidental trauma), through borderline personality and somatization disorder (moderate to severe early trauma) to dissociative identity disorder (very severe early trauma). Boon and Draijer’s study was based on unconfirmed reports. Kluff (1997) analyzed the scientific literature vis-a-vis the rate of independent validation of reports of abuse in dissociative identity disorder. He noted that Coons and Milstein (1986) gave an 85% validation rate, which was subsequently confirmed by Coons (1994). These studies, however, did not examine the rate of confirmation of recovered memories. In Kluff’s own study of dissociative identity disorder (1995, 1997), 56% had instances of confirmed abuse. Of this 56%, over half had either always retained a conscious awareness of their experience of abuse or were able to obtain confirmatory documentation during the course of treatment.

In a warning similar to Janet's, Dowson and Grounds felt that "The evidence does not suggest that certain childhood experiences are necessary for the development of a particular personality disorder or that the effects of sexual abuse are readily predictable in an individual" (1995, p. 188). Janet's rejection of the generalization of childhood sexual abuse as the exclusive etiologic factor in hysteria and the neuroses is an appropriate caution and a guide in diagnosis of patients presenting with severe dissociative and personality disorders. When such disorder has been identified, it is therefore important to evaluate dispassionately a history of incest or other forms of childhood sexual abuse. Denial of the occurrence of amnesia for trauma occurring in both the professional and lay communities mostly lacks empirical support (Pope, 1996). Total amnesia has been reported for combat trauma (Thom & Fenton, 1920; Myers, 1940; Sargant & Slater, 1941; Torrie, 1944; Fisher, 1945; Grinker & Spiegel, 1945; Hendin, Haas, Singer, Houghton, Schwartz, & Wallen, 1985; Sonneneberg, Blank, & Talbot, 1985), extreme experiences in concentration camps (Jaffe, 1968; Nederland, 1968), torture (Goldfeld, Mollica, Pesanvento, & Faraone, 1988), traumatic loss (Van der Hart, Brown, & Turco, 1990; Coons & Milstein, 1992), and robbery (Senguta, Jena, & Saxena, 1993). Coons and Milstein (1992) reported dissociative amnesia induced by physical abuse, marital discord, committed crime, and suicide attempts. These studies tend to confirm the existence of acute or chronic total amnesia for actual traumatic experiences. Furthermore, a number of studies have pointed to the temporary existence of (total) amnesia for sexual abuse in childhood (e.g., Albach, 1993; Briere & Conte, 1993; Feldman-Summers & Pope, 1994; Williams, 1995; Elliott, 1997). Whitfield (1996) summarized the findings of 31 such studies. The percentage of those reporting amnesia varies widely, but some research supports the clinical observation that subjects can forget about sexual abuse in childhood for considerable periods of time. Even were the validity of the links between sexual abuse in childhood, traumatic memory, amnesia, and dissociative and other psychopathology accepted, the reliability of the process of clinical exploration remains a central issue. This is particularly so in the current context of widespread dissemination in media of the link between sexual abuse in childhood and adult psychiatric disorder. Thus, the reliability of therapists' elucidation and patients' reporting of traumatic stress must be considered. All agree that identification of traumatic memories, particularly of sexual abuse in childhood, should proceed with caution. These memories should neither be exaggerated, nor should they be downplayed. Thus, Van der Hart and Van der Velden (1995) advised practitioners to "Treat the disorder(s) you have determined after careful study, not the disorders that you perhaps suspect" (p. 436), and Schooler, Bendiksen, and Arnbadar (1997) advocated a balanced approach when seeking to distinguish between fabricated and recovered memories of sexual abuse. In this regard, there are currently a number of sound, clinical guidelines (Brown, 1995; Van der Hart & Nijenhuis, 1995; Kluff, 1996; Pope & Brown, 1996).

Spiegel and Schefflin (1994) stated that accuracy of memory cannot be guaranteed by its detail, vividness, degree of emotional involvement, consistency over time, self-confidence, honesty, and attestation to good memory. Sources of diagnostic inaccuracy may include credulousness of patients' "stories," confounding different traumatic memories, mixing real experiences with fantasy or symbolic elements, and confabulating by filling in the holes of traumatic memories. Amongst others, Spiegel and Schefflin (1994) cite the following criteria for plausibility of traumatic memories: the nature of the symptoms and signs, trigger phenomena, flashbacks and reexperiences, transference of trauma, role of external motives, responsivity to treatment, and external evidence. Kluff (1996) offered the following preliminary clinical recommendations: make a thorough psychiatric diagnostic evaluation; when sexual abuse in childhood is suspected, check the patient's suggestibility, and if this obtains, refrain from hypnotic uncovering; when there is no evidence for sexual abuse in childhood, don't reinforce patient's expressions either for or against it; avoid leading questions or suggestions; draw conclusions cautiously; chart objective, narrative evidence; use other sources of information; discourage communication with perpetrators; acknowledge fallibility of one's own and patient's memory; stabilize the patient's mental state before treating the traumatic memories. Clearly this field is in flux, and more recent guidelines for example eschew the

use of hypnosis altogether when assessing patients for a history of sexual abuse. Contraindications for treating the latter include no awareness of history of trauma, ongoing abuse or enmeshment with perpetrators, and general contraindications such as extreme regression, ego-weakness, and severe psychopathology such as psychosis.

Ellenberger wrote (1970, p. 406) that “The influence of Janet on Freud is a controversial problem,” that has never been objectively studied. The following is a partial listing of Janetian and equivalent Freudian concepts: unconscious, repressed complexes or subconscious, dissociated, fixed ideas; transference or rapport, somnambulistic influence, and the need for direction; free association or automatic talking; psychoanalysis or psychological analysis; working through or dissociation as a therapeutic process; the reality principle or function of reality; ego strength or weakness or levels of psychological tension and degrees of psychological synthesis and complementary series or constitutional stigmata with incidental or “accidental” traumatic stress factors.

Clearly Janet influenced Freud’s first sexual trauma model. In this regard, Ellenberger (1970) quoted Regis and Hesnard (1922, p. 352): “The methods and concepts of Freud were modeled after those of Janet, of whom he seems to have inspire himself constantly”—until the paths of the two diverged” (Ellenberger, 1970, pp. 539-540). Adopting a broader based, empirical clinical approach, post-Freudian psychoanalysts have since tried to widen their concepts, e.g., that of repression, so as to include both conscious (suppression) and unconscious dimensions (Erdelyi, 1994, 1996). We suggest that Janet’s approach to dissociation and traumatic memory would therefore richly repay further study.

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