and are listed in another section of this final issue. Their important service is gratefully acknowledged. I would also like to acknowledge a person who served as Editorial Assistant to the *Journal* for both volumes of the *Journal*: Phoebe Herr. She served as an effective assistant and a critical link among reviewers, contributors, the Society, and myself. As I leave Purdue, alas, I must find another Assistant. We all shall miss her very much.

On behalf of the Board of Directors of the Society and the Editorial Advisory Board of the *Journal,* I wish you a very productive and happy new decade.

Charles R. Figley, Ph.D.
Editor

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Pierre Janet on Post-Traumatic Stress

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One hundred years ago, in 1889, Pierre Janet published L'Automatisme Psychologique, his first work to deal with how the mind processes traumatic experiences. Janet claimed that vehement emotions interfere with proper appraisal and appropriate action. Failure to confront the experience fully leads to dissociation of the traumatic memories and their return as fragmentary reliving experiences: feeling states, somatic sensations, visual images, and behavioral reenactments. A century later, Janet still provides an unsurpassed framework for integrating current knowledge about the psychodynamic, cognitive, and biological effects of human traumatization.

KEY WORDS: Janet; post-traumatic stress disorder (PTSD); dissociation; memory; history of psychiatry; cognitive psychology.

PIERRE JANET ON POST-TRAUMATIC STRESS

It is ironic that in the closing decades of the 20th century psychiatry is slowly rediscovering a knowledge base about the effects of traumatization on psychological processes that was central to European conceptions of psychopathology during the last decades of the previous century. While numerous French and British psychiatrists studied the relationships between trauma and "hysteria" during that time (Trimble, 1981), the teachings of Jean Marie Charcot at the Salpêtrière most clearly focused that generation's attention on the psychological effects of overwhelming experiences.

The idea that some mental disorders are caused by traumatic events, however, antedates the heyday of the Salpêtrière and has been around since

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the time of Homer. A variety of studies during the 19th century first brought scientific methods to bear on the question of how trauma effects the human psyche (Carlson, 1986; Ellenberger, 1970; van der Hart & Horst, 1989). By the end of the 19th century, psychiatrists in both Europe and the United States had become intensely interested in defining the relationships between psychological trauma and psychopathology (Nemiah, 1984; Perry and Laurence, 1984). In America, this issue occupied such people as William James and Morton Prince, while in Europe, Charcot's teachings stimulated both Janet and Freud to focus their early theories on the impact of traumatic experiences.

Early in this century, the study of psychological and biological processes in psychopathology took divergent paths. While Janet's integrative approach enjoyed a brief vogue, Freud's conceptions went on to dominate psychiatry for much of this century. The central psychoanalytic tenet that most psychopathology is the result of a childhood intrapsychic conflict between unacknowledged instinctual drives and external reality left little room for an integrated understanding of the emotional, cognitive, and biological effects of human traumatization. Abraham Kardiner (1941) attempted such an integration by augmenting the psychoanalytic model with his notion that the human trauma response is a "physioneurosis," i.e., a mental disorder with both psychological and biological components. Only recently have students of trauma started to reach back beyond Freud to Janet's work which may contain an as yet unsurpassed synthesis of the transformation of traumatic experiences into psychopathology.

In 1889, Janet published *L'Automatisme Psychologique* (Janet, 1889). His basic argument was that when a person experiences emotions which overwhelm his capacity to take appropriate action, the memory of this traumatic experience can not be properly digested: it is split off from consciousness and dissociated, to return later as fragmentary reliving of the trauma, as emotional conditions, somatic states, visual images, or behavioral reenactments. Janet was the first to identify dissociation as the crucial psychological mechanism involved in the genesis of a wide variety of post traumatic symptoms (Janet, 1889, 1894a, 1898, 1907, 1909a, 1911).

JANET'S CAREER

Janet started out as a philosophy teacher who, like several other noted contemporaries, such as the philosopher Henri Bergson, was very interested in the nature of hysteria. His detailed studies of several hysterical patients

where, as a medical student, he was put in charge of a laboratory for the study of hysteria. He rose to great prominence in international psychiatry during the turn of this century (Ellenberger, 1970; van der Hart and Friedman, 1989). William James summarized Janet's ideas in his 1896 Lowell Lectures with: "the mind seems to embrace a confederation of psychic entities" (Taylor, 1982, p. 35). Janet was invited to speak at numerous congresses, and he travelled repeatedly to both North and South America. However, his influence on French psychiatry was of short duration: within his own institution, Janet's studies of hysteria were received with little enthusiasm; his colleagues at the Salpêtrière had started to distrust the drama and suggestibility with which hysterical patients had been surrounded during Charcot's tenure. Babinski and Déjerine, the two most powerful physicians left at the institution, believed that hysteria was exclusively the result of suggestion, and rejected the use of hypnosis on moral grounds. The split between biological and dynamic psychiatry had started: the rapid expansion of knowledge in the natural sciences favored the sober and quantifiable study of organic functions over the further investigation of such less easily definable psychological phenomena as consciousness, emotions, and motivation.

After Charcot's death, French psychiatry little by little adopted predominant medical attitudes. When Déjerine became superintendent of the Salpêtrière, Janet lost his space at the hospital, but he continued as professor of psychology at the Collège de France and kept up an active private practice. Meanwhile, in Vienna, Freud also had started his career investigating the relationship of childhood trauma to psychiatric illness. He firmly believed in the sexual origins of mental illness even before he abandoned the seduction theory, but he changed his original opinion that "the ultimate cause of hysteria always is the sexual seduction of a child by an adult" (Freud, 1896) to the belief that psychopathology was caused not by sexual trauma itself, but by childhood sexual wishes.

In contrast with Freud, who thought that memories of conflictual issues were repressed, Janet thought that mental patients suffered from a loss of capacity to store and utilize conscious information. Thus, his psychology was a psychology of consciousness and hence he has been considered a founder of cognitive psychology (Ey, 1986). While Freud's teachings became the principal psychological theory of much of the 20th century, sweeping away most rival interpretations of human behavior, Janet became a mere historical curiosity. Well after having lost his central position in psychiatry in his native country, he received an honorary doctorate at Harvard's tricentenary celebration in 1936. He lived till 1947 and died in oblivion, at age 88, during a newspaper strike; his death went virtually unnoticed.

THE PSYCHOLOGICAL PROCESSING OF TRAUMATIC EXPERIENCES

The Interplay Between Memory and Action

Although Janet recognized that temperamental differences play an important role in people's vulnerability to environmental stress, he identified a traumatic precipitant of the mental illness in 257 of the 591 cases in his first four major works (Crocq and Verbizier, 1988). Careful reexamination of these cases has led contemporary scholars to rediagnose them in the DSM III-R diagnostic system as having histrionic, borderline, dissociative and post-traumatic stress disorders (van der Hart and Horst, 1988), which is consonant with the current understanding that, depending on age, the length and severity of the trauma, social support, and premorbid history, trauma can result in a variety of psychiatric disorders (van der Kolk, 1988; Herman *et al.*, 1989).

Janet believed that traumatization resulted from failure to take effective action against a potential threat. The resulting helplessness gave rise to "vehement emotions" which, in turn, interfered with proper memory storage. The interplay between action and memory was fundamental in his psychology; he went so far as to state that: "memory is an action: essentially it is the action of telling a story" (Janet, 1919, p. 661). He thought that successful integration of memories depends on successful action of the organism upon the environment: "the healthy response to stress is mobilization of adaptive action" (Janet, 1909b, p. 1557). In order to take appropriate action a person needs to attach a verbal representation to the experience: "It is not enough to just be aware of a memory: it is also necessary that the personal perception 'knows' this image and attaches it to other memories" (Janet, 1911, p. 538). He saw memory as a creative act, in which the individual organizes, categorizes, and transforms experiences into already existing cognitive schemes (van der Kolk and van der Hart, 1989).

The crucial factor determining successful integration of a particular experience into existing memory systems is the subjective interpretation of that event: frightening or novel experiences may not fit into already existing cognitive schemes and therefore may fail to be integrated. This causes memories of these experiences to be split off from conscious awareness and voluntary control, and for fragments of unintegrated events to later show up as pathological impulses (automatisms). Memories of traumatic events thus can be dissociated from conscious awareness, but return in a variety of maladaptive ways: as paralyses, amnesias, and reenactments. Conversion reactions are one example: the usual personality has lost the memory of sensory aware-

off part of consciousness is aware of its presence (Nemiah, 1984). Janet believed that dissociation is accompanied by the formation of new cores of consciousness which contain the memories of intensely arousing experiences. He called these "subconscious fixed ideas" and taught that they are usually accessible under hypnosis (Janet, 1894, 1897). The function of fixed ideas is to concurrently organize traumatic memories, and to keep them out of conscious awareness (Janet, 1909a). However, since they result from a failure in coping with past experience, this attempt at adaptation ultimately misfires: they continue to effect perceptions, mood, and behavior. Janet noted that many psychiatric patients dissociated in response to stress and behaved "automatically": with irrelevant images, ideas, emotions, and movements, which seemed to be dictated by past experience, rather than by a rational assessment of current exigencies (Janet, 1909a). "These patients have a disturbance of action as well as a disorder of memory, and that is hiding the most serious trouble: that of the will" (Janet, 1911, p. 532).

Memory Disturbances

Janet was the first to describe the memory disturbances that accompany traumatization. He explained post-traumatic amnesias and hyperamnesias as failures to transform traumatic experiences into less fightening "narratives" (Janet, 1904). The resulting "phobia of memory" (Janet, 1919, p. 661) promotes dissociation which becomes a customary way of dealing with stress. This results in a chronic narrowing of consciousness, i.e., a decreased capacity to flexibly integrate a variety of emotional states into the same ego state (Janet, 1898; cf. Horowitz, 1987). The best example of this is multiple personality disorder (MPD), where different emotions are assumed by entirely separate ego identities (Janet, 1935).

Janet believed that memories could be stored at various levels, as narratives as well as sensory perceptions, visual images (nightmares and hallucinations), and "visceral" sensations (anxiety reactions and psychosomatic symptoms). Freud (1920) later also noted that traumatic material that has no complete verbal representation causes anxiety against which the sufferer defends with suppression, avoidance, and flight. He also recognized that while conscious memories and feelings related to trauma are forgotten, they may return as intrusive recollections, feeling states (such as anxiety unwarranted by current experience), and as behavioral reenactments (Freud, 1939). Similarly, Krystal (1984) has noted that traumatized adults often regress to earlier stereotyped emotional and behavioral patterns, including infantile dependency, obsessive compulsive behavior, and difficulties in modulating

Contemporary cognitive psychologists have identified three modes of information processing: enactive, iconic, and symbolic/linguistic (Kihlstrom, 1984) which are analogous to the stages of sensorimotor, preoperational, and operational thinking described by Janet's student Piaget (Piaget, 1970). In the course of developmental maturation, memories are less likely to be encoded primarily on a sensorimotor level, and increasingly have linguistic representations. However, stress causes people to revert to earlier modes of memory processing: trauma leaves them in a state of "unspeakable terror" because the experience does not fit into existing conceptual schemata. This precludes accommodation and assimilation of the experience on a symbolic level and causes it to be organized on a sensorimotor or iconic level as horrific images, visceral sensations, or as fight/flight/freeze reactions (van der Kolk, 1987; van der Kolk and van der Hart, 1989). Modern research on Vietnam veterans with PTSD has shown that nightmares, flashbacks, and behavioral reenactments generally are preceded by physiological arousal (Blank, 1985; Rainey *et al.*, 1987; van der Kolk *et al.*, 1984).

Contemporary trauma researchers have repeatedly noted the occurrence of specific memory disturbances (Horowitz, 1986; Terr, 1988; van der Kolk, 1987; Pitman, 1989; Pynoos, 1989), but the vast recent expansion in knowledge of memory processes has not yet been systematically applied to the study of post-traumatic psychopathology.

Janet's Economic Model

While most of Janet's concepts are quite accessible to modern readers, his notions of *psychological force* and *psychological tension* need further explanation (van der Hart and Friedman, 1989). Psychological force referred to the total amount of psychological energy expressed, while psychological tension reflected the level of organization of this energy and the capacity for reflective, creative, and competent action (Janet, 1903, 1920). Thus psychological tension denotes the capacity to harness one's energy to adapt to reality with appropriate action. Janet called this "realization," which he viewed primarily as a "linguistic act": the capacity to combine one's interpretation of reality, one's personal narrative, with effective action. Effective "realization" requires a continuous adjustment of one's preconceived ideas to the reality of current experience. Traumatized people fail to adapt appropriately to contemporary reality. Because certain important memories were not assimilated into everyday personality functioning, perceptions about later emotionally charged events are controlled by prior reactions; pychological force is no longer tempered by psychological tension to be mobilized for adap-

While these concepts about psychic energy are out of fashion, Janet's basic observations find support in modern knowledge about PTSD. The psychoanalyst Krystal (1969, 1984) has also emphasized loss of affect as a signal. Contemporary research confirms that people with PTSD have an impaired capacity for affect modulation and respond to emotionally charged situations with rigid, primitive, and totalistic reactions appropriate to overwhelming and traumatizing situations—either with flight/fight responses or by freezing (van der Kolk and Ducey, 1989). Their capacity to symbolize, fantasize, or sublimate is impaired (they lack psychological tension) and they can not use symbolic imagination for planning and "thinking as experimental action" (Freud, 1911).

TRAUMATIC PRECIPITANTS

Emotional Reactions, Rather than External Events

In an attempt to identify the precipitants for this inability to integrate experience, Janet wrote: "I was forced to recognize in certain cases the role of one or several events in a person's past experience. These events, which had precipitated a violent emotion and a destruction of the psychological system, had left traces. The memory of these events and the mental energy involved in keeping them at bay absorbed a great deal of energy, leading to a continuing deterioration" (Janet, 1930, p. 128). Janet thought that the initial emotional reaction to the traumatic event (which he called "vehement emotion") determines the intensity of the post-traumatic reactions. He thought that when people become very upset they stop being able to make sense of an experience, and can no longer figure out what action to take to escape: "Making intellectual sense of an unexpected challenge leads to proper adaptation and a subjective sense of calm and control" (Janet, 1935, p. 409).

Janet emphasized the necessity of taming the excessive excitement that is part of the fear response before one can take effective action. He claimed that: "the individual, when overcome by vehement emotions, is not himself. . . I have shown on numerous occasions that the characteristics which have been acquired by education and moral development may suffer a complete change under the influence of emotion. . . Forgetting the event which precipitated the emotion. . .has frequently been found to accompany intense emotional experiences in the form of continuous and retrograde amnesia. . . They are an exaggerated form of a general disturbance of memory

the continuation of physiological emergency responses "somnambulistic crises" and claimed that most patients initially try to deal with excessive arousal by telling themselves that the situation was not as bad as they thought it was (Janet, 1904). However, this avoidance interferes with mastery: when they continue to be too upset to tell their story, they cannot transform their memories into a neutral narrative: they are "unable to make the recital which we call narrative memory, and yet remain confronted by (the) difficult situation" (Janet, 1919, p. 660). The resulting "a phobia of memory" (ibidem, p. 661) prevents integration ("synthesis") of traumatic events and further promotes dissociation (Janet, 1903, p. 145).

Modern studies support Janet's contention that post-traumatic reactions originate in "vehement emotions" that are biologically encoded; the notion that "traumas produce their disintegrating effects in proportion to their intensity, duration, and repetition" (Janet, 1909b, p. 1558) has been repeatedly rediscovered. Kardiner (1941) said that sufferers from war neuroses remain in a state of physiological preparedness for the return of the trauma that causes an enduring vigilance for and sensitivity to environmental threat. Contemporary research supports the notion that the initial level of physiological arousal predicts the severity of the post-traumatic response (e.g., Kilpatrick *et al.,* 1985). For example, in both a 1- and a 5-year follow up of survivors of an oilrig disaster in the North Sea, Holen (1987) found that the severity of the initial dissociative phenomenon predicted long-term outcome. We have rediscovered how, in PTSD, autonomic arousal is no longer a preparation for, but a precipitant of emergency responses which bear little relationship to the nature of the current stimulus (Strian and Klicpera, 1978). In situations reminiscent of combat stress, war veterans with PTSD react even biologically as if they are back in the traumatic event: with autonomic arousal (Kolb and Multipassi, 1982; Pitman *et al.,* 1987; Rainey *et al.,* 1987), as well as abnormalities of the catecholamine (Kosten *et al.,* 1985) and endogenous opioid systems (van der Kolk *et al.,* 1989).

THE BIPHASIC NATURE OF THE TRAUMA RESPONSE

Janet never defined a specific post-traumatic stress syndrome (see van der Hart *et al.,* 1989). Nevertheless, his descriptions of acute post-traumatic reactions recognize the same alternation between intrusive and avoidant symptoms following traumatization that is central in the contemporary DSM-III definition of PTSD. Janet thought that a range of visceral, perceptual, emotional, or motoric (reenactment) symptoms represented involuntary intrusive reliving of elements of the trauma. Fugues, amnesias, reduced interest

avoiding having to deal with traumatic memories. According to Janet, traumatized people respond to subsequent stress with inappropriate action: either with generalized hyperreactivity (somnambulistic crises) or with inattentiveness and lack of concentration that prevents effective action (abulia) (Janet, 1889, 1904, 1909a). Abulia resulted from failing to act effectively during the traumatic events. This biphasic nature of the human response to trauma has been repeatedly spelled out over the past century, first by Janet, and later by Kardiner (1941), Lindemann (1942), Krystal (1969, Horowitz (1986), and a host of other contemporary psychiatrists. By believing that intrusive reliving experiences could occur on a somatic (visceral and visual), emotional (affective), or motoric (reenactment) level, Janet collapsed the contemporary DSM-III-R criteria B, instrusive symptoms, and D, hyperarousal, into one category. Category C shows up in Janet's classification as fugues, amnesias, reduced interest and involvement, constricted affect, and the abulias (loss of will for action) (Brett and Ostroff, 1985; Brett *et al.,* 1988). Janet recognized that in many patients these conditions coexist. He noted that the particular shape of the individual's trauma response, whether predominantly intrusive or numbing, was less a function of the traumatic precipitant, than related to temperamental predisposition.

THE NATURAL HISTORY OF POST-TRAUMATIC STRESS

Janet 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 with poorly recognizable traumatic etiology. The third and last stage is characterized by what modern authors call post-traumatic decline (Titchener, 1986) which includes somatization disorder, 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.

Janet seems to have been the first to recognize that traumatized people become stuck on the trauma (cf. Freud, 1920; Horowitz, 1986; Kardiner, 1941; van der Kolk, 1989) and seem to be unable to go on with their lives. He said that traumatized people become "attached to the trauma": "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

Janet anticipated the DSM-III-R in noting that the expression of traumatic experiences may be delayed for days, weeks, or years: "Rarely do the principal disturbances of the emotion appear exactly at the moment of the provoking event" (Janet, 1909a, p. 155). The time required to perceive the inescapable reality of the trauma, the time necessary for the individual to expend useless efforts to fight the inescapable, and the occurrence of other stressful events that depleted the individual's last reserves all play a role in determining how long the latency period will be prior to the onset of post-traumatic symptoms.

Post-Traumatic Decline

Unable to accumulate new compensatory experiences and incapable of leaving the traumatic memories behind, the patient is caught in a descending spiral of increasing emotionality (somnambulistic crises), exhaustion (abulia), and psychosomatic symptoms. Decreased energy causes social and emotional withdrawal alternating with generalized agitation under stress. Decreased "psychological tension" means that the patient no longer is capable of adapting creatively to his environment and ends up in a state of chronic helplessness expressed in both psychological and somatic symptoms (Janet, 1903, 1, p. 559). Some patients end up with a chronic dissociative syndrome, others develop a predominantly psychasthenic picture with a variety of clinical expressions: anxiety, depression, brooding, and lack of motivation (Janet, 1903, 1909a, 1935). Eventually, the traumatic events become less intrusive and only a pervasive desire to get away from it all remains: "complete avoidance is characterized by complete absence of allusion to sensitive objects or the anxiety associated with them. It is as if the 'functions' never existed" (Janet, 1935, p. 352).

Thus, Janet's formulation anticipates both Titchener's concept of post-traumatic decline (Titchener and Knapp, 1976) and Seligman's notion of learned helplessness (Maier and Seligman, 1976): "(The hysteric) has lost the mental synthesis that constitutes reflective will and belief: he simply transforms into automatic wills and beliefs the impulses which are momentarily the strongest. (The will links the word and the action on the short run, belief links word and action in the long run.)" (Janet, 1919, p. 661).

VULNERABILITY

Janet was struck by the fact that even minor events could precipitate

emotional difficulties and he believed that both environment and heredity played a role (Janet, 1909a, 1909b). Both Janet, and contemporary researchers of the relationship between childhood trauma and psychopathology acknowledge the likelihood of temperamental vulnerabilities (Kagan *et al.*, 1987).

Janet thought that the victim's state of mental preparation determined the degree of "vehement emotion" (physiological arousal) in the face of threat (1909a, 1935). "Vehement emotion" is the result of a combination of the emotional state at the time of the event and the cognitive appraisal of the situation. Preparedness depends on the novelty of the situation, the speed of events, and physiological vulnerabilities such as intoxication, illness, fatigue, or depression. Under these circumstances, stressful events could precipitate either hyperarousal (vehement emotions) or unfamiliar states of mind which set the state for recurrent intrusive recollections (Janet, 1904; cf. Holen, 1987). Janet noted that the traumatizing event itself need not be a dramatic one: it is the intensity of the emotional *reaction* that determines whether an event precipitates post traumatic psychopathology. He noted that if people became too upset to tell their story, memories could not be transformed into a neutral narrative: a person is "unable to make the recital which we call narrative memory, and yet he remains confronted by (the) difficult situation" (Janet, 1919, p. 661).

CONCLUSIONS

The relationship between psychological trauma and psychopathology was a central issue at the inception of modern psychiatry. Throughout the 19th century many careful observations were recorded about this interrelationship, and it is not surprising that much of our contemporary knowledge about traumatization had started to be grasped during that era. It is unfortunate that a variety of new developments in the beginning of this century shifted the focus of psychiatry so thoroughly away from the role of terrifying experiences in the genesis of psychopathology; until recently, both psychoanalysis and biological psychiatry by and large ignored the impact of overwhelming experiences on people's development. In view of the prevalence of traumatic life histories in so many psychiatric patients, the rediscovery of the relationship between trauma and psychopathology was bound to occur sooner or later. Janet's particular contribution is that he not only saw these relationships, but combined them in a framework that has not been surpassed since his days.

ways from modern nosology: the DSM-III requires a severe, objective stressor as a necessary precondition for the development of PTSD. While this convention has value in diagnostic standardization, it clearly is at odds with the occurrence of fullblown stress syndromes after even minor stresses. Janet himself argued strongly against simple attributions, such as trauma, in the origin of psychoneuroses: "I was forced to recognize in certain cases the role of one or several events in a person's past experience. These events which precipitated a violent emotion and a destruction of the psychological system, had left traces. The memory of these events and the mental energy involved in their recall and resolution. . .absorbed a great deal of energy, leading to continuing deterioration. This notion has been fruitful and has given rise to a theory of neurosis and psychosis by the unconscious persistence of an emotional trauma. [However], I have never claimed that all the neuropathic weakness are exclusively the consequence of traumatic reminiscences" (Janet, 1930, p. 128).

Janet used no formal concept of defense, but he recognized the adaptive values of symptoms such as the narrowing of field of consciousness, amnesia, avoidance, and withdrawal. He considered post-traumatic stress reactions primarily as disorders of psychological insufficiency and only secondarily as anxiety reactions. His models of psychasthenia and dissociation deemphasized the very symptom, anxiety, that is the basis of the current DSM-III classification of PTSD. Instead, his principal focus was on the decreased capacity for mental synthesis: the unsuccessful assimilation of traumatic memories into neutral narrative.

Janet's formulation that when events overwhelm the psyche, they are dissociated from conscious awareness, and are stored on a variety of mental levels, ought to be reconsidered and inform our current debate about whether PTSD is "really" an anxiety disorder, or an affective disorder, or a dissociative disorder. We might spend our energies wisely by furthering our understanding of the variety of ways with which people cope with potentially traumatizing experiences and to once again investigate the role of memory in PTSD. Janet's challenge is as relevant today as it was a century ago, namely, how memories of traumatic experiences can be more successfully retrieved, neutralized, and put in perspective of the totality of our patients' lives.

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Pierre Janet's Treatment of Post-traumatic Stress[1]

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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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