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The value of hypnosis in the resolution of dissociation: Clinical lessons from World War I on the integration of traumatic memories

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ABSTRACT

Some World War I clinicians related the symptoms of traumatized servicemen to an underlying dissociation of their personality, consisting of two prototypical conditions: one involving functioning in daily life (inspired by Myers, whose work is also discussed in this article, and which will be labeled apparently normal part of the personality [ANP]) and one involving fixation in the traumatic experience and related attempts at defense (emotional part of the personality [EP]). These authors described two dissociative patterns. As illustrated in this article, one pattern consisted in the presentation of a dominant ANP suffering from constant or frequent intrusions from EP. The other pattern consisted in repeated complete alternations between ANP and EP. Instead of the use of purely symptom-oriented approaches, for the dissociative symptoms to be really resolved, an integration of traumatic memory in the personality, that is, between EP and ANP had to take place. These clinicians used hypnosis to access the traumatic memory and EP and to foster such integration; they agreed on the importance of the quality of the therapeutic relationship in this regard. However, they differed in opinion and practice as to the need to assists patients in their expression of traumatic emotions during this process. When the trauma was related merely to war experiences, such therapeutic processes took place within a simple phase-oriented treatment model, while in the presence of a history of previous trauma and related dissociation of the personality, this model had more complex applications. This is similar to modern treatment approaches of the sequelae—such as a complex dissociative disorder—of chronic (childhood) traumatization.

The Value of Hypnosis in the Resolution of Dissociation: Clinical Lessons from World War I on the Integration of Traumatic Memories[1]

> "[W]e must interpret the minor phenomena in the light of the major cases, the extreme cases in which the phenomena lend themselves better to investigation. In all such major cases, we find the dissociated activity to be not something than can be adequately described as an idea or a group or train of ideas, but rather the self-conscious purposive thinking of a [part of the] personality; and, when we study the minor cases in the light of the major cases, we see that the same is true of them."
> William McDougall (1926), p. 544)

1. Introduction

Mainly based on his observations of soldiers traumatized during World War I, which ended a century ago, the American psychiatrist and psychoanalyst Abram Kardiner (1891–1981) stated that "[t]he immediate reactions to shock or fright deserve our attention, particularly because of the sequelae we see in the chronic cases" (Kardiner, 1941, p. 38). He distinguished between non-pathological reactions, that is, those that do not lead to permanent fixation, and pathological reactions that take place in those who tend to fixate upon the trauma. Kardiner and other military clinicians during World War I (WWI) have made numerous clinical observations of acute war-related traumatization and its immediate and, sometimes, long-term aftermath. As some of his WWI colleagues stated, and as we may confirm (Van der Hart, Van Dijke, Van Son, & Steele, 2000), these observations made most sense when understood in terms of trauma-generated dissociation of the personality—as described earlier by Janet (1889, 1907, 1909)—in which this permanent fixation in trauma manifests. The question arises whether the observations of these mostly WWI "simple cases" (McDougall, 1926) may also be of value for our

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understanding of more complex cases, such as those of patients with histories of chronic childhood traumatization involving severe child abuse and neglect.

It should be noted that there were various other terms in use to denote traumatic experiences, in particular emotional shock and shell shock—a term coined by Charles Myers (1915), which eventually was considered (also by himself) as inadequate because soldiers could also be traumatized without being in the vicinity of exploding shells. Based on his clinical experiences during WWI at the Western Front, the American psychiatrist Thomas Ross described traumatic experiences as *breaking-points* (Ross, 1941), which is perhaps a better label than the metaphor of "trauma" as a wound: Something breaks in the individual's psyche while he is being traumatized and experiences an emotional shock. In other words, a dissociation of his personality develops. Trauma-generated dissociation of the personality as a dynamic psychobiological system involves, then, the existence of two or more subsystems, which have received different labels in the clinical literature and which we denote as *dissociative parts of the personality* (Moskowitz & Van der Hart, 2020; Nijenhuis & Van der Hart, 2011; Van der Hart & Moskowitz, 2018; Van der Hart, Nijenhuis, & Steele, 2006). Following Charles Myers (1940), one of the most important WWI clinicians who clearly recognized trauma-generated dissociation of the personality, we distinguish two major types of dissociative parts: (1) an *apparently normal part of the personality* (ANP), mainly dedicated to functioning in daily life and phobic of traumatic memories (Janet, 1911), and (2) an *emotional part of the personality* (EP), fixated in the trauma and in related attempts at defense. Thus, Kardiner's (1941) statement that trauma survivors are characterized by a "fixation on the traumati [zing] event" (p. 82) more specifically characterizes the EP.

These two major types of dissociative parts of the personality will be used in the analysis of the trauma-related symptomatology of traumatized WWI soldiers. Furthermore, for our analysis, it is also helpful to identify dissociative symptoms (whether or not labelled as such in the original sources), that is, symptoms stemming from this dissociation of the personality into ANP and EP. These dissociative symptoms may be phenomenologically categorized as negative (functional losses, such as amnesia and paralysis) or positive (intrusions, such as flashbacks or voices), and as psychoform (cognitive-affective) symptoms, such as amnesia, hearing voices) or somatoform (sensorimotor symptoms, such as anesthesia or tics) (Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2000, 2006).

The aims of this paper are: (1) to present some essential WWI observations of two observed dissociative patterns in survivors of war trauma—one, a chronic condition of re-experiencing trauma and the other, a pattern of alternation between re-experiencing and avoiding traumatic experiences—which might help modern clinicians working with more or less complexly traumatized patients, whether military or civilian, to become more sensitive and develop a deeper understanding of their trauma-induced dissociation of the personality; and (2) to address therapeutic principles, regarded as essential by leading WWI clinicians, for the (re)integration of the survivor's personality. Although formulated a century ago, these observations and principles remain most valuable, notwithstanding the great strides the clinical field has since made in the understanding and treatment of trauma. One of the treatment principles emphasized in this paper is the use of hypnosis for the exploration and integration of traumatic memories. Perhaps a few remarks about hypnosis should be presented in advance. First, there exists much controversy about its nature: Some authors believe it merely involves role-playing (Barber, 1972), while others view it as an altered state of consciousness characterized by a degree of absorption in some experience or imaginative involvement, the fading of awareness of one's surroundings, and alterations in perception and consciousness (including "a heightened and focused concentration that is achieved in order to actualize a particular goal or latent potential;" Kahen & Olness, 1993, p. 359). Therapy, then, consists in "the skillful use of attention to affect the phenomena characteristic of hypnotic experience and behavior" (Brown & Fromm, 1986), and one of its essential characteristics is that therapists help patients to remain in contact with them during these experiences. Second, many authors state that one such hypnotic phenomenon is heightened suggestibility (Barber, 1972). However, other writers (in particular, Pierre Janet and William Brown) whose work is discussed in this paper have found that suggestibility is a separate dimension, which may or may not accompany hypnosis. Third, these authors also regarded hypnosis in a more restricted way than the current understanding with its tenet that anybody can be hypnotized and manifest some heightened suggestibility. They equated hypnosis as induced by a therapist as "artificial somnambulism," complete with amnesia following the experiences in this condition, which, in other words, is dissociated from the remainder of the individual's experiences and personality. They regarded this condition as an exclusive characteristic of patients suffering from hysteria, which we now regard as including trauma-generated dissociative disorders; it could be used to access "natural somnambulistic states," such as the reexperiences of trauma. These authors found that once a patient is "cured," that is, (re)integration of the personality has occurred, this "artificial somnambulism" could not be evoked anymore.

2. Two trauma-generated dissociative patterns

Many WWI clinicians have described trauma-induced dissociation among traumatized soldiers in terms of two basic types of presentation of their dissociative symptoms, which are not per se mutually exclusive. The first presentation is the dominance, to varying degrees, of one mental condition, that is, *the chronic presence of an ANP, in which manifestations of an EP's fixation in the trauma intrude*. The second presentation consists of a more or less frequent alternation between two conditions, that is, *alternations between ANP and EP*: When EP dominates, the patient re-experiences the trauma (as described in various case examples below). In the old French nomenclature, some WWI authors used the expression of "hysterical attacks" (e.g., Kardiner, 1941; McDougall, 1926; Mott, 1919; cf. Van der Hart et al., 2000). Several examples of this alternation among dissociative parts will be presented below.

3. Kardiner's World War I observations

Kardiner (1941) gathered most of the clinical material for his book, *The traumatic neuroses of war*, while he was Attending Specialist in the Outpatient Department of a U.S. Veterans Hospital from 1922 to 1925. Thus, unlike most of the other clinicians whose work is presented in this paper, he worked with chronic patients. However, he also referred to acute cases presented in the existing literature. While he presented a few observations of a chronic presence of ANP with manifestations from EP, his study emphasized the alternations between ANP and EP.

3.1. Chronic presence of ANP with manifestations from EP

Kardiner (1941) provided an example involving a tic of the head:

> A sailor was on board a battleship, when, without his being warned, a turret situated above and to the right of him discharged a volley [which threw him to the ground], and since that time he has had a persistent tic of the head to the left.

> Consciously, the patient has no knowledge of the purpose of this tic, and he has long since forgotten the connection between the action and the purpose it served. (p. 15)

3.2. Alternations between ANP and EP

Kardiner mentioned a whole range of such alternations, in which the temporary dominance of the EP is called "attack," or "paroxysmal, recurrent symptomatology." Such attacks were usually followed by amnesia. He described states of apparent unconsciousness, lasting from minutes to hours, during which patients were impervious to external stimuli and insensitive to pain. This condition was very frequent during active warfare. Another form involved gradually ceasing one's activities and falling to the floor in a deep, narcoleptic sleep. (One might wonder if this is the re-enactment of the complete shut-down of functioning in the face of overwhelming threat, discussed in more recent literature; cf., Bracha, 2004; Nijenhuis, Vanderlinden, & Spinhoven, 1998; Schauer & Elbert, 2010; Van der Hart et al., 2006.) In Kardiner's terminology, the more common twilight states in which the paroxysmal changes in consciousness took place involved:

> abrupt changes from the state of sleep to a somnambulistic trance. They were, to all intents, fully enacted dreams. The patients [as *EPs*] would live through their war scenes very vividly while in these trances. Every detail of warfare was reexperienced, accompanied by the appropriate mimicry and at times intermingled with reminiscences of their former lives. (p. 37)

The same type of attack, with active hallucinatory experiences and mimicry, could abruptly take place during the waking state [ANP]. Then the relationship with the external world was completely severed.

> In a few cases, some contact with the external environment appeared to exist, except that the patients mistook situations and called individuals by wrong names. The sick chamber was often represented in hallucinations by a burning castle or a chateau surrounded by soldiers.. . . The amnesia for these episodes was, as a rule, complete, though they could sometimes be recalled as dreams. These patients were amnestic for their war experiences, sometimes for only individual episodes, sometimes for an entire war period, and occasionally even for long periods prior to entrance into service. This amnesia was usually persistent. (pp. 37–28)

Kardiner mentioned that a wide range of "periodic disturbances of consciousness" (p. 41) were a most frequent complaint among veterans six or seven years after return from the war.

> The variations in quality seem to depend chiefly on the degree of disorganization and are in part determined by the reaction to the original traumati[zing] event. (p. 42)

Thus, although Kardiner did not include the concept of dissociation in his discourse (nor the name of Pierre Janet), it seems reasonable to assume that his observations of these periodic disturbances of consciousness pertained to a trauma-generated dissociation of the personality involving alternations between dissociative parts (ANP and EP).

4. Roussy and Lhermette's World War I Observations

In their book, *Les névroses de guerre* (1917), subsequently translated into English as *Psychoneuroses of war* (1918), French neurologist Gustave Roussy (1874–1981) and neurologist and neuropsychiatrist Jean Lhermette (1877–1959) present a rich palette of signs and symptoms that characterized traumatized soldiers at the front during WWI, in particular somatoform (sensorimotor) dissociative symptoms that were abundantly described in the military psychiatric literature during and after this war (cf., Van der Hart et al., 2000). Although the notion of trauma-generated dissociation of the personality is missing in their book, the various clinical descriptions these authors presented indicate the existence of the two basic presentations.

4.1. Chronic presence of ANP with manifestations from EP

Roussy and Lhermitte (1917/1918) described a wide spectrum of negative and positive dissociative symptoms, which seemed to be presented by ANP, but came from EP. Although a psychoform (cognitive-affective) dissociative symptom, such as amnesia, is mentioned, the great majority of the symptoms are somatoform (sensorimotor) symptoms. According to Roussy and Lhermitte, they were the most common and therefore the most important of the neuroses of war. Thus, they provide detailed descriptions of: (1) elementary psychomotor complaints, such as paralyses and contractures of one or several limbs; disturbances of the gait; tremors, tics and choreiform movements; (2) psychical symptoms of sensation, such as algias; anesthesia, analgesia, hyperesthesia, etc.; psychical disorders of the senses (hearing and speech, visual disorders; disorders of sphincter control; visceral disorders such as respiratory and circulatory disorders). The treatment they used was most often "psycho-electric" in nature.

A typical clinical example presented by Roussy and Lheremitte pertains to monoplegia of the right leg, pseudo-coxalgic type:

> Wounded on the 9th of September 1914. Wound of the right thigh. All active movements were made equally well on the right and left sides. Power of the right limb slightly diminished, especially that of extending the knee. Reflexes normal. Slight lameness: toes turned outwards. On admission, the patient [probably as ANP] exhibited absolute and complete anaesthesia of the whole limb, extending up to the umbilicus; this anaesthesia disappeared on the day of admission after treatment with a powerful faradic current applied to the skin. Claudication completely cured in a month by re-education and electrical treatment. (1917/18, p. 4)

4.2. Alternations between ANP and EP

Under the heading of nervous attacks (*les crises nerveuses*), Roussy and Lhermitte describe two types: (1) the fit (attack) of terror (*la crise d'anxiété*) and (2) the fit (attack) of motor agitation (*la crise hystérique*). Both types of crises occur when EP has executive control and dominates consciousness, after longer or shorter intervals. What causes them is often, but not always, the recollection of previous emotions (that is, traumatic experiences)—for instance when the clinician asks the patient about the bombings he has experienced or the attacks he helped to repell.

4.2.1. Nervous attacks or crises

When, in such circumstances, the attack or crisis is a "fit of terror," the patient's expression soon bears witness to his deep emotion. He [as *EP*] rises excitedly and becomes agitated, his respiration is accelerated and his pulse quickens. Sometimes the very fear expressed by his eyes seems to beg for respite from the discussion of such an alarming subject. In such a patient the expression of terror is profound; his whole body shakes, his legs give way, his voice is broken and speech is disturbed. He tries to escape, cowers in a corner of the room or appears to repulse an imaginary enemy.. .

> In the intervals between the attacks, the patient [as *ANP*] is quiet and peaceful, though somewhat melancholy and preoc-

cupied. Sleep is irregular, interrupted by nightmares or dreams of war which, by bringing such recollections into consciousness, may engender a crisis of terror (1917/19, p. 114).

4.2.2. Fits of motor agitation (hysterical crises)

The authors mention that such attacks have already been minutely described by Charcot and P. Richer, at the Salpêtrière in Paris, in terms of "hystéro-épilepsie". Apart from the recollection of a vehement emotion, other causes, according to them, may be imitation and suggestion. The onset of the attack is striking:

> [T]he patient [as *EP*] makes various contortions, rolls on the bed or throws himself onto the ground. The body stiffens, the head is thrown back, the eyes are prominent and rolled upwards under the quivering lids. The face is cyanosed, the veins of the neck are distended and respiration is suspended for a short time. The limbs are thrown wildly about, striking the wall or the floor; the hand clutch at the garments or bed-clothes, tear or snatch at anything within reach; or the patient may fall to the floor making the most alarming movements, shouting, struggling, throwing himself at the nurses or breaking the windows.. . .
>
> When the active, struggling movements have ceased, the patient [as *ANP*] comes to himself, rather hazy and fatigued, but usually knowing what has occurred. (1917/18, pp. 115–16)

Over time, these alternating patterns have also been noticed in patients suffering from civilian trauma. Especially when the former type of crisis (fits of terror) occurred, this pattern eventually ended up as a major criterium of the diagnostic category, posttraumatic stress disorder (PTSD; APA, 1980), with its emphasis on intrusion (EP) and avoidance symptoms (ANP)—however, with great loss regarding the wide variety of manifestations of the underlying trauma-induced dissociation of the personality. The DSM-5 (APA, 2013) has explicitly included the possibility of the presence of negative "dissociative symptoms" of depersonalization and derealization, but this addition is far from adequate as it ignores the presence of positive dissociative symptoms, also included in previous editions of DSM, such as "dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumat [izing] events(s) were recurring" (APA, 2013, p. 271). PTSD and complex PTSD should be understood as dissociative disorders (for further arguments, see Dorahy & Van der Hart, 2015; Nijenhuis, 2014).

4.3. Hystero-emotional psychoses

It should be mentioned that Roussy and Lhermitte also describe so-called psychical disorders: those due to inhibition or diminution of mental activity, such as confusion and obtusion, and those due to "inordinate excitation of mental activity." Among the latter, they discuss the so-called hystero-emotional psychoses, which since the 19th century are also known as hysterical psychoses (e.g., Moreau de Tours, 1865; Spiegel & Fink, 1979) or dissociative psychoses (Van der Hart & Witztum, 2008). It seems that these psychoses have much in common with the alternations, described above, between ANP and EP, in particular in the fits of terror. The authors state that here, again, emotion is the basis of these mental disorders:

> [A]n intense emotion [*traumatic experience*], sometimes accompanied by a feeling of imminent death and maintained by the tragic and terrible scenes of the battle. (1917/18, p. 128)

According to Roussy and Lhermitte, the specific feature of these patients' mental condition is that between "the bouts of excitements" [*EP* activity], no real mental confusion is detected:

> The patient [as *ANP*] can speak and reply to questions with great ease. But if one reminds him of some episode in the fight or brings back some recollection or idea associated with it, he is at once overcome by emotion; he [*EP*] again pictures the scene he has lived through, sees "Boches," throws himself under the bed to shelter from shells, or runs ahead towards imaginary trenches. The thud of a distant cannon or some metallic noise [*triggers*] will often be sufficient to provoke an emotional attack with all the phenomena of oneiric delirium. (1917/18, p. 128)

The authors seem to imply that the patient [as *ANP*], in between these episodes of hysterical (dissociative) psychosis [*EP*], has amnesia for them. The same was observed with regard to the "nervous attacks".

5. Simmel's World War I observations

Unlike Kardiner and Roussy and Lhermitte, Ernst Simmel (1882–1947) did resort to the notion of trauma-generated dissociation—which he called splitting (*Spaltung*)—of the personality (1919, Simmel, 1918). Simmel was a German-Jewish neurologist and psychoanalyst who, during the War, was the chief doctor [*Oberarzt und Leitender Arzt*] of a specialized military hospital for war neurotics. In his book, *Kriegs-Neurosen und "psychisches Trauma"* (1918), he described examples of one dissociative part [*ANP*; which Simmel, following Jung (1906, 1909), called *personality or ego complex*] manifesting dissociative symptoms, as well those indicating the alternating pattern of re-experiencing [*EP*; which Simmel called *feeling-tone complex*] and avoiding trauma [*ANP*] (cf. Moskowitz & Van der Hart, 2020; Van der Hart & Moskowitz, 2018). The feeling-tone complex [*EP*], cut off from the ego complex [*ANP*], was in the service of *defense* at the time of the traumatizing event. For Simmel, the various manifestations of war trauma—labeled as, for instance, hysteria, neurohysteria, neurosis, neuropsychosis—are all disorders based on a profound change of the personality, that is, "a split or schism of the personality" (p. 8). He went even so far as to regard the "dissociation of the personality as the pathogenic power in all so-called nervous illnesses" (p. 11).

In his book, Simmel expressed his indebtedness to Breuer and Freud's (1893/95) early studies on hysteria and the etiological role of psychological trauma and trauma-generated dissociation. Breuer and Freud, in turn, were inspired by the pioneering studies of Pierre Janet (1889) and other French contemporaries. (Unfortunately, Freud soon disavowed this key understanding [cf., for instance, Zemach, 1986]). Simmel also acknowledged the influence of Jung's work on trauma and dissociation. (Jung continued to emphasize the essential role of trauma-induced dissociation in the maintenance of trauma-related symptoms; cf. Jung, 1921–1922).

5.1. Chronic presence of ANP with manifestations from EP

Like all of his colleagues, Simmel observed many patients in whom one mental condition was dominant and who manifested dissociative symptoms, for example:

> A soldier always suffered, upon attempting to eat, a spasm of the muscles of the jaw and of those concerned in swallowing, a spasm which produced a facial appearance of rage [*positive dissociative symptom stemming from EP*]. He [as *ANP*] had no understanding of the origin of the *tic*. In hypnosis—to which Simmel often resorted—the patient relived a forgotten scene: he oversaw, while lying in the enemy's territory, several enemy soldiers maltreating one of his comrades; he was overcome with rage and at that moment he received a bullet wound and lost consciousness [*initial reduction in level of consciousness resulting in window of vulnerability for dissociation*]. As in many

other such cases, the tic ceased as soon as the memory of the incident was restored to the patient in the waking state; that is, as soon as the dissociation was overcome [*integration of the personality*]. (Simmel, 1919, p. 50; this case is quoted and shortened by McDougall, 1926, pp. 300–301; see also Van der Hart et al., 2000, pp. 46–47).

Even though Simmel was not so explicit on this point, it is clear that such dissociative symptoms stemmed from another part of the personality, that is, an EP fixated in the traumatizing event, intruding in ANP's executive functioning.

5.2. Alternations between ANP and EP

Simmel also observed the basic pattern of avoiding (ANP) and re-experiencing trauma (EP), that is, the alternation between EP and ANP. However, in this regard he focused more on the "transitions forms" of somnambulism and sleep-walking (p. 15).

6. Myers' World War I observations

It was the English consulting psychologist to the British Armies in WWI, Charles Samuel Myers (1873–1946), who most clearly described and conceptualized the trauma-induced dissociation of the personality in acutely traumatized soldiers. (He may have been influenced by Janet's pioneering studies; in any case, he was familiar with Janet's work [Myers,1939]). Myers was initially uncertain about which concepts would best describe the basic dissociative conditions. Thus, after differentiating "normal personality" (Myers, 1916a) and, echoing Jung, "dissociated complex" (Myers, 1915) or "disordered personality" (Myers, 1916b), he settled on the distinction between a so-called Apparently Normal Personality (ANP) and an Emotional Personality (EP). The distinction between ANP and EP has been recognized in, and adopted by, modern psychotraumatology (e.g., Moskowitz, Dorahy, & Van der Hart, 2019; Nijenhuis, 2015; Van der Hart et al., 2006; Van der Kolk, Van der Hart, & Marmar, 1996), albeit often with the amendment, also applied in this paper, "apparently normal part of the personality" and "emotional part of the personality"—based on the assumption that each individual has but one personality, however divided it may be (Van der Hart et al., 2006).

6.1. Chronic presence of ANP with manifestations from EP

Myers did not particularly describe patients with this condition. One reason may have been that he mostly worked with acutely traumatized soldiers in advanced treatment centers and began treatment rather quickly; another, that patients remaining in this condition were soon referred to hospitals further away from the front lines or to Britain.

6.2. Alternation between ANP and EP

In his various publications, Myers emphasized such alternations. He observed that many patients initially stayed in states of light stupor, excitement, automatism, or depression:

[T]he attention of the patient often would appear to be concentrated on some narrow field, doubtless generally on the scene which produced his condition.. . . The recent emotional experiences of the individual have the upper hand and determine his conduct: the normal has been replaced by what we may call the 'emotional' personality [*EP*]. (Myers, 1940, pp. 66–67)

Then a dissociative alternation would take place:

Gradually or suddenly an 'apparently normal' personality usually returns—normal save for the lack of all memory of events directly connected with the shock, normal save for the manifestation of other ('somatic') hysteric disorders indicative of mental dissociation. Now and again there occur alternations of the 'emotional' and the 'apparently normal' personalities, the return of the former being often heralded by severe headache, dizziness or by a hysterical convulsion. On its return, the 'apparently normal' personality [*ANP*] may recall, as in a dream, the distressing experiences revived during the temporary intrusion of the 'emotional' personality. The 'emotional' personality [*EP*] may also return during sleep, the 'functional' disorders of mutism, paralysis, contracture, etc., being then usually in abeyance. On waking, however, the 'apparently normal' personality [*ANP*] may have no recollection of the dream state and will at once resume his mutism, paralysis, etc. (p. 67)

In current parlance, the "hysteric disorders" Myers refers to include the DSM-5 dissociative disorders, including the ICD-10 (WHO, 1992) dissociative disorders of movement and sensation (that is, DSM-5's conversion disorder) and posttraumatic stress disorder (PTSD).

7. Léri's World War I observations

In his book, *Commotions et émotions de guerre* (1918), subsequently translated in English as *Shell shock: Commotional and emotional aspects* (1919), the French neurologist André Léri (1875–1980) carefully distinguishes between commotional, contusional, and emotional patients—the latter suffering from purely psychological trauma (*l'émotion choc*). Perhaps he over-emphasized the differences of these three groups, overlooking that in certain cases there may have been a co-morbidity between, at least, the "contusional" and the "emotional" types (e.g., Dide, 1918). However, he did observe that contusional patients may become emotional ones.

In his descriptions of the "emotional patients," Léri, a student of Babinski, did not refer to the concept of (trauma-generated) dissociation of the personality, but he noticed the binary pattern of avoidance and re-experiencing of trauma. And he noted, in 1915, that the war neuroses almost always are manifestations of hysteria (cf., Mauran, 1996)—of which Janet, in particular, had emphasized the two basic characteristics: (1) a narrowing of the field of consciousness, and (2) a dissociation of the personality (1909, Janet, 1907).

Léri presented this picture of the typical emotional patient:

The subject looks fatigued; he is often pale, anorexic, has become rapidly emaciated, sleeping by day and not by night. He has frequently nightmares, trembles, has headaches, he is afraid of noise, and weeps spasmodically at the memory of his emotion and perhaps of the danger through which he has passed. His speech is jerky, syllabic or stammering, and finally he often presents some of the numerous hysterical [that is, dissociative] manifestations so often described before and since the war. (1919, pp. 99–100)

When seen for the first time, Léri's impressions of the patient were as follows:

Often, when first seen, he has the appearance of being more depressed than the true commotional patient. He is apparently asleep, and it is necessary to lead him to his bed and put him into it. If questioned, he does not reply. But one must not be deceived; this is only pseudo-inertia, only pseudo-obnubilation. If he is worried during sleep by being moved by someone shouting in his ear, he moans, becomes agitated, then looks at his interrogator with a bewildered air, his eyes wide open,

> haggard, as if the prey of some intense anxiety and of a horrible vision [*EP*]. (1919, p. 94)
>
> Moreover, no matter how somnolent he may appear, he sleeps but little or not at all, and, during the course of nocturnal insomnia, dreams, generally aloud. His nightmares are controlled by a vision, which is always the same, with a few variations, namely of the accident which caused him to be evacuated (the bursting of a shell, gun, or mine, being buried under a trench, dug out, etc.) (1919, p. 95)

Léri emphasized that the patient's condition is the same when he is experiencing an emotional shock while being "a mere spectator" of some scene of carnage.

> Anxiety, dominated and directed by the emotional accident [*traumatizing event*], always surpasses everything, in the physical aspect as in the mental condition, in the preoccupations of the waking state or during sleep. (1919, p. 95)

In short, in our language, an EP has taken over in these situations.

> Further, with regard to the accident itself, no matter what question is put to the patients, the reply, when they will answer, is invariably: "I don't know." They [*ANPs*] know neither the day nor the place where the emotional shock occurred, nor what has happened since, and often what occurred previously; if believed they have apparently lost their memory altogether. (1919, p. 95)
>
> Nearly all state that they are suffering from commotion, a shell fell, or there was an explosion. In fact, one memory survives, that of the accident itself. This recollection haunts their days and nights. . . If the conversation is turned to this subject, the patient is often, as it were, abruptly unlocked, and the account he gives is animated and visualized. To a point which appears abnormal and belies atonic and somnolent appearance of a few seconds previously. (1919, pp. 95–96)

If, by careful questioning, clinician-guided restoration of memories during an acute stage does not take place, soon these memories

> will not be long before they disappear like the imperfect memories of dreams. If such a patient is questioned several weeks or month later, after being evacuated inland, if, moreover, vague, general, badly defined questions as to facts and places are put to him, not only will he reply in quite good faith that he remembers nothing, but in quite good faith also, he will be really incapable of remembering afresh. (p. 99)

Léri's observations with regard to the phenomenal differences between the acute and chronic cases are thus relevant in our understanding of the development over time of trauma-related dissociation. He emphasized that when this is left unchallenged, a veritable (dissociative) amnesia will develop, ever more difficult to resolve as times goes by.

8. Treatment issues

The understanding of most of the WWI clinicians cited here was that the various dissociative symptoms of their patients stemmed from a trauma-generated dissociation of the personality. Thus, the ultimate treatment goal—often quickly realized in acute cases—should be the re-integration of their personality. It should be added that the vast majority of their colleagues, like Roussy and Lhermitte, did not have such a treatment model in mind, but were rather focused on symptom reduction, often using harsh methods such as electric shock therapy. Perhaps Charles Myers (1940) formulated the treatment goal of re-integration best. In his view,

> [t]he treatment to be recommended. . . consists in restoring the [*EP*] deprived of its pathological, distracted, uncontrolled character, and in effecting its union with the [*ANP*] hitherto ignorant of the emotion [i.e., traumatic] experiences in question. (p. 68–69)

Myers (1940) went on to describe the phenomenological outcomes of a complete (re)integration of the personality:

> When this re-integration has taken place, it becomes immediately clear that the [*ANP*] differed widely in physical appearance and behaviour, as well as mentally, from the completely normal [i.e., integrated] personality thus at last obtained. Headaches and dreams disappear; the circulatory and digestive symptoms become normal; even the reflexes may change; and all hysteric [i.e., dissociative] symptoms are banished. (pp. 68–69)

In a post-war discussion called "The revival of emotional [i.e., traumatic] memories and its therapeutic value," in the *British Journal of Medical Psychology*, several contemporaries expressed their agreement with Myers' view, but the group had some differences in opinion as to which essential treatment principle was accomplishing this "re-integration" of the personality (Brown, 1920–1921a,b; Jung, 1921-22; McDougall, 2020-1921; Myers, 1920-1921; cf. Van der Hart & Brown, 1992; P. Brown, Van der Hart, & Graafland, 1999). They all favored the use of hypnosis in uncovering and integrating traumatic memories: a view which, for instance, Simmel (1918) and Hadfield (1940) shared with them. And all of them emphasized the importance of a good therapeutic relationship. Léri did not use the concepts of dissociation and re-integration of the personality. Still, his directive, cognitive approach in his treatment of acute cases, when successful, seemed to have had the same results.

8.1. A directive, cognitive approach toward resolving the emerging dissociation of the personality

Léri's (1918) clinical work seems to have been with traumatized soldiers in the acute stages, mostly in field hospitals. His focus was on assisting the patient, with a cognitive approach, to bridge the experiential gap between the time and place in which the trauma had taken place, and the present and current location—one of relative safety. Without viewing it this way, he was thus focused on overcoming the developing trauma-induced dissociation, by connecting the experiential realms of EP and ANP. Léri summarized his clinical understanding and approach as follows:

> [I]t is just the memory of the accident which dominates and monopolizes all the attention. As a result of this failure of attention with regard to everything which is not connected with the emotional shock itself, all recollections may be blurred of a period following the accident, and rarely of one preceding it, but they exist and can be recalled by appropriate interrogation; it is only later that these memories, already blurred, become more and more effaced. (1919, p. 99)

It follows that the therapeutic way to go is to help the patient redirect his attention to the memories of how he managed to leave the scene of the traumatizing event and arrive in the safety of the clearing station.

> Starting from this emotional accident, which is the sole clear thought and distinct preoccupation monopolizing the minds of these soldiers, it is generally possible to get them to indicate the exact time and place. The result is not always obtained at the onset; they do not always know the date, nor the proximity to such and such town; but with patient insistence, it will be found that they know if it were bright or dull, nightfall or break of day, if they were in a first-line trench or a support trench, and what

its name was (the trenches have often their names marked up like the streets of a town). After all, it is evident they are not astray as to time and space. (p. 96)

Question them still further, instead of being content with the ordinary reply that they became unconscious, ask them where they came to themselves; it is nearly always at the clearing station, sometimes only on arrival at the field hospital. But how did they get to the clearing station? They came because they had seen it when going into the lines, knew where it was and went there direct, or if they were beyond the trench, by first creeping as far as the trench. By skilled and progressive questioning, it becomes evident that, even if they have been thrown down and momentarily dumbfounded by the blow, they have hardly ever lost consciousness at any moment, and did not get themselves out of the affair without reasoning power. If only the doctor knows the places, is acquainted with the trenches to be traversed, the shelters they contain, the ravines to be passed, etc., if he has the patience, as it were, to take the soldier by the hand and lead him in thought to the place of explosion, to the clearing station and field hospital, he will nearly always find that the patient has perfectly retained the whole, or almost the whole, of his memories previous to the accident. (pp. 96–97)

Léri found that subsequently "awakening" memories regarding events before the traumatizing event could proceed the same way, and often more easily.

Thus, it is soon found that a patient, who apparently had retained no recollection prior to his accident and had sometimes lost all memory of a larger or smaller number of days before that, has really not lost it at all: this extremely amnesic patient has no amnesia at all! If we insist upon this fact. . . it is because we have proven it many times, and because, from our point of view, it is destructive of an error frequently made, which it is impossible not to commit if the patients have only been seen as a later date, notably after their evacuation inland. (p. 97)

As mentioned before, Léri seemed to point out that the dissociative amnesia—and related symptoms—were much harder to treat if patients, after some time had passed, had been relocated to a hospital in the rear country. In other words, the trauma-induced dissociation of the personality, of which the dissociative amnesia is a manifestation, has become more structural. His British colleagues made the same observations with regard to patients in the United Kingdom (e.g., Brown, 1919; McDougall, 1926). (See below.)

8.2. The use of hypnosis in treatment

Clinicians such as the above-mentioned Brown (1918, 1919, 1920a,b, 1922, 1934), McDougall (1920-1921, 1926), Myers, 1919, 1940, Simmel (1918), as well as Hadfield (1920) and Jung (1921-1922), were also basically in agreement that the trauma-generated dissociation of the personality was the key problem to be resolved. Recognizing the high hypnotizability of their patients, hypnosis was for them the primary way to join the patient (as *EP*) in his traumatic experiences and in "effecting its union with the [*ANP*] hitherto ignorant of the emotion [i.e., traumatic] experiences in question" (Myers, 1940, pp. 68–69). Simmel (1918, p. 23) formulated it even more clearly when stating that without the use of hypnosis, he didn't get anywhere with the war neurotics.

Myers' view that ANP had, in other words, amnesia for the traumatizing event may not always have been completely correct, but this unification was in any case the ultimate treatment goal these clinicians aimed for. Only, they differed in opinion, to some degree, as to the active principle(s) involved. Thus, Brown emphasized the full expression the traumatic emotions, Simmel added the behavioral dimension of such expression (see below), while McDougall and Myers had their concerns, focusing more on a cognitive dimension (cf. P. Brown et al., 1999; Van der Hart & Brown, 1992).

8.2.1. Encouraging the expression of traumatic emotions: the role of abreaction or catharsis

Simmel (1918) initially employed a symptom-oriented hypnotherapy using suggestions. Because he encountered so much "resistance" in many patients, while still using hypnosis, he resorted to the cathartic method, as described by Breuer and Freud. Thus, Simmel told his patients that "One thing or another which you once experienced has perhaps upset or tormented you. This has not completely entered your consciousness—so terrible it was perhaps a kind of shock, in which because of fright or fear, one remained mentally stuck. You weren't able at all to think it through, and that is why it is stuck deeply in you. And when your leg is paralyzed, your speech lost, then it is grounded [*verklemmt*] precisely there. (1918, p. 21).

Simmel then induced hypnosis and facilitated the hypnotized patient's imaginary return to the traumatizing event, enabling him to re-experience it once again: "Because of the hypermnesia. . . the patient in hypnosis. . . is the experience repeated. The "film" is unwound once more; the patient dreams the whole once again, the sensitized subconsciousness frees the affect, which is discharged in an adequate emotional expression, by which the patient is healed." (1918, p. 25)

He encouraged the patient to fully express his emotions, in particular his anger. For this purpose, he presented him with a stuffed dummy:

I register it always as the beginning of the cure when the patient's initial fear of this dummy finally turned into rage, resulting in the dummy's partial mutilation or complete destruction." (Simmel, 1944, p. 245)

Noteworthy is also that Simmel, at the end of the hypnotic session, did not immediately wake up the patient but allowed him time to re-orient himself. He emphasized that during this transitional phase: "the fear has now become completely redundant, because you will be deferred from military service by order of the War Department. Then the patient does not wake up completely exhausted, but rather with the refreshing feeling of liberation." (1918, p. 27)

Thus, Simmel neutralized any lingering fear of having to return to the front and a need to remain ill. (This was possible in Germany, but not in other countries, where cure led to a return to the front.) And this liberation involved the re-integration of the patient's personality.

Similarly to Simmel, Brown (1918, 1919, 1920-21a, 1934) mentioned the shortcomings of purely symptom-directed suggestions. Often symptoms might disappear initially, only to return in the same or in a different way, as the underlying dissociation of the personality had usually not been resolved. Also like Simmel, Brown emphasized the need for emotional expression while going through the traumatic war experiences in hypnosis:

The patient goes through his original terrifying experiences again, his memories recurring with hallucinatory vividness. It is this which brings about the return of his powers of speech, and not direct suggestion, as in the ordinary method of hypnosis. (1918, p. 198; also quoted by Van der Hart & Brown, 1992, p. 132)

While Brown emphasized the revival and abreaction of traumatic emotions in therapy, he was clear that what he called

the resynthesis of the patient's mind, that is the integration of his personality, was its goal (Brown, 1918, 1920-21a,b, 1922).

8.2.2. Fostering integration without emphasizing abreaction

Other clinicians were critical of the emphasis on emotional expression as the most important therapeutic principle and even pointed out its potential harmful effects. According to Hadfield (1920), the patient "may be greatly relieved by the outburst of feeling produced under hypnosis" (p. 76). In his view, it is not the liberation of the affect or "abreaction" that cures, "but the reassociation [integration] of the event with a healthy emotion" (p. 76). He points out that "very frequently the recollection of his experiences merely throws the patient into a state of deeper misery and anxiety" (pp. 76–77). Likewise, Myers (1920-1921) expressed skepticism about the role of abreaction:

> [M]y own experience, in recovering memories both in the waking and in the hypnotic state, was that the acting out of the emotional experience was of relatively little consequence, but what was of importance was the revival of the unpleasant memory of the scene, i.e., the revival of the dissociated *affective* and *cognitive* experience. (p. 20)

Myers discouraged undue prominence of the emotional response—which we would now call a state of hyperarousal—during the recollection in hypnosis. Instead, he encouraged the patient to remain calm, feel no pain, and not be afraid. The question, then, is what is the essential ingredient of the integration of the patient's personality? Our understanding is that the patient's present experiences as ANP and those of EP—being stuck in trauma—become bound together but also differentiated, with the eventual dominance of present reality (cf., Van der Hart et al., 2006). Incidentally, Myers (1915) also used hypnosis in a way similar to Léri's questioning, that is, to help the patient remember how, precisely, he got from the traumatizing situation at the front to the safety of, for instance, the base hospital:

> By further persuasion I elicited from him full details of the still forgotten interval, how he got back to his billet, took off his equipment, then lay down, and was wrapped in a blanket by one of his comrades. "I remember a jolting ride, and then I lay on a blanket in a big room full of men." By now he recalled the whole of his forgotten experiences, including the train journey down to the base. (1915, p. 67)

McDougall agreed with Myers with regard to abreaction (McDougall, 1920–21, 1926; cf., Van der Hart & Brown, 1992). He found it a highly questionable and improbable explanation for the cure or even the symptomatic relief of the war neuroses. In his opinion, this explanation is contradicted by two facts: (1) Some patients frequently relive their traumatic experiences without securing an "abreaction." Instead, these repetitive episodes seem to worsen the patient's condition, which tends to become chronic and fixed. (2) Some patients, having been made to live through the traumatic experience in hypnosis, showed an increase rather than a relief of symptoms. Influenced by Janet (1919/25), McDougall formulated two essential steps in the re-integration of the patient's personality. The first step is one of exploration, by the use of either hypnosis or free association. Thus, he explored the origin and nature of the [*EP*] and shared this with the patient [as *ANP*]. The second step consisted in assisting the patient in living through the traumatic experience again, and thus the facilitation of the patient's psychological, in particular emotional, readjustment, enabling the patient to overcome his fears and leading to resolution of the "dissociative barrier." McDougall recognized that this could result in a new trauma, which, then, also had to be overcome. He concluded (McDougall, 1926):

> [A]s soon as the dissociation is overcome, though the same train of recollection may recur, its power to produce emotional distress is greatly weakened by the patient's accompanying awareness of his present surroundings and his knowledge that the experience belongs to the past. The process of readjustment of his emotional attitude can then begin, or, in other words, he makes progress in 'autognosis'.[2] (p. 457)

Jung (1921-1922) joined McDougall and Myers in their recognition that in many cases, abreaction not only was of little use but was indeed harmful. He regarded as inadequate the notion that the release of an emotional discharge was as a necessary element of therapy.

In short, the clinicians discussed above, who used hypnosis in the treatment of traumatic memories, converged in the understanding that the treatment goal should be the re-integration of the personality—in Myers' (1940) words, the unification of ANP and EP. While some (Brown, Simmel) felt that complete emotional revival and expression led to better results, others (Hadfield, Myers, McDougall, Jung) expressed their reservations in this regard and believed that this was not an adequate treatment principle. (We shall return to this issue in the Discussion.) However, all agreed that the transition from the hypnotic state to the "waking state" should take place slowly in order for further re-integration to occur. Brown (1934), for instance, looking back at his experiences as a clinician at an advanced neurological center in France during WWI, stated:

> Remembering that his disability is due to a form of dissociation, and that in some cases hypnotism accentuates this dissociation, I always suggest at the end of the hypnotic sleep that he will remember clearly all that has happened to him in this sleep. Moreover, I wake him very gradually, talking to him all the time and getting him to answer, passing backwards and forwards from the events of his sleep to the events in the ward, the personalities of the sister, orderly, doctor and patients—i.e., all the time reassociating and resynthesizing the train of his memories and interests. (p. 93)

In other words, this procedure consisted of re-orientation to the safe present while preserving the memories of the originally traumatizing events and re-integrating ANP and EP. There was another therapeutic principle in a successful outcome: the quality of the therapeutic relationship.

8.2.3. The role of the therapeutic relationship

Indeed, all authors using hypnosis considered the quality of the therapeutic relationship an essential condition for a successful treatment outcome. Thus, Simmel (1918) observed that the therapist's own healthy ego could be engaged as catalyst to restore the coherence [*Zusammenhang*] of the "split" personality (p. 82). He added that the clinician should give a piece of himself, that is, friendship, to the patients. (p. 19) In light cases, the integration was usually accomplished in one session. In general, the authors felt that it was not merely the rehearsal of the traumatic experience that had an unconditional curative effect, but rather its rehearsal in the presence of, and contact with, the therapist. The support and understanding of the therapist increased the patient's integrative capacity and thus his ability to re-integrate ANP and EP. Speaking of an "indispensable and absolutely essential influence," Jung (1921-1922) articulated this in a striking way:

[2] Autognosis means: knowledge or understanding of one's own nature, abilities, and limitations; insight into oneself, knowledge of one's own character, etc. (Autognosis, 2020).

> The intervention of the physician is. . . absolutely essential. One can easily understand what it means to the patient, when he can confide his experience to an understanding and sympathetic doctor. His consciousness finds in the doctor a moral support against these elemental powers, but a trustworthy man reaches out a hand, lending him moral aid in the battle against the tyrannical oppression of the uncontrolled emotion. By this means the power of his integrating consciousness is reinforced until he is able, once more, to bring the rebellious affect under the control of consciousness. (p. 16)

As mentioned previously, in Myers' (1940) view, this moral aid from the clinician is essential in "restoring the [*EP*] deprived of its pathological, distracted, uncontrolled character, and in effecting its union with the [*ANP*] hitherto ignorant of the emotional [i.e., traumatic] experiences in question" (pp. 68–69).

8.3. Treatment of chronic cases

The authors were also in agreement that the treatment of chronic patients, who were sent to the rear country (Léri) or to Britain, was much more difficult, but not per se impossible, than therapy of acute cases. Léri (1918/1919), for instance, concluded that the amnesia manifested by chronic patients had become structural. In other words, the dissociation between ANP and EP, again using Myers words, had become more firmly established. Another British clinician, Hadfield (1940), concluded that

> [t]owards the end of 1916 it was realised that the results of treatment of neuroses evacuated to England had proven very disappointing. The tendency to fixation of the symptoms and the development of an attitude of chronicity had been only too apparent, and a great many of these men had been discharged from the Army and pensioned. (p. 119)

And Brown (1919) stated:

> In cases seen in England and Scotland I found that lost memories were not so easily recalled [using hypnosis], and that the re-instatement of emotion with hallucinatory vividness was very difficult to effect. However, in the few cases in which this did occur, the symptoms showed definite and sudden improvement. Chronic cases pass through a period of later mental development, in which different mental processes, memories and motives, recent and remote, interact and produce the well-known fixation of symptoms. (p. 735)

Thus, it may also have been the case that chronic patients had a more complex trauma history: A possibility for which Kardiner (1941) and Simmel (1918), for instance, provided anecdotal evidence.

8.4. Treatment when current trauma is affected by previous traumatic experiences

Several clinicians observed that in some patients traumatized on the battle field, traumatic memories had already been present and thus also a trauma-generated dissociation of the personality, for instance related to childhood (sexual) abuse (e.g., Brown, 1934; Kardiner, 1941; Simmel, 1918). These traumatic memories (and the EP involved) may have been reactivated during the war-related traumatizing event. Of course, they also needed to be integrated for a complete cure to occur. Simmel (1918) presented a rather simple example taken from the otherwise more complicated case of a petty officer, who with his company had lost his way very close to the enemy during the night. When he fell into a deep, black hole, he screamed in terror: a seemingly innocent experience, certainly on the battle field. Careful exploration under hypnosis led to the discovery that a traumatic memory from childhood had been reactivated: his fall into a deep, black well hole, and the extreme fear it had evoked: The scream was not one made by the adult [*ANP*], Simmel (p. 90) remarked, but by the child [*EP*], that, befallen by the avenging fate, felt itself suddenly thrown in the dark well hole.

9. Discussion

Most of the WWI clinicians mentioned in this article regarded the re-integration of the personality of their traumatized patients, not symptom improvement per se, as the main therapeutic goal; and they included hypnosis in their approaches. Even the French neurologist André Léri, while not thinking in terms of a dissociation-integration model, had in fact the same goal in mind with his careful cognitive approach (in which, of course, the quality of the doctor-patient relationship was also essential), enabling the patient to connect the traumatic experience while being in the safe present. McDougall (1920–21) described this is as follows: "the realisation of the terrifying incident in its past setting and in its true relations to present circumstances. Hence the return of power of voluntary control, i.e., the control of the whole psycho-physical system over the dissociated part [*EP*]" (p. 29). This important statement, however, remains a bit incomplete: the end goal is not merely the control over the EP but rather the complete re-integration of the personality, that is, the unification of ANP and EP.

9.1. The use of hypnosis

All clinicians using hypnosis for the integration of traumatic memories found that most of their traumatized patients easily entered a state of hypnosis. As most clearly expressed by Brown (1934), they related this to the fact that a dissociation of their personality already existed:

> These men already suffered from mental dissociation, as shown by loss of memory or loss of power over various bodily functions, and we discovered that, corresponding to the degree of such dissociation through shell shock, they were more or less readily susceptible to hypnotic methods. (p. 130)

This view is echoed, almost a century later, by Kluft (2013): "The more you know about hypnosis, the more you will understand about dissociative disorders and their treatment, even if you'll never employ formal hypnosis" (p. 212).

Modern studies of hypnosis indicate that hypnosis has three dimensions: dissociation, absorption, and suggestibility (Spiegel & Spiegel, 1978; Kluft, 2013). Thus, as Pierre Janet (1898b) observed, hypnotizability is not the same as suggestibility. In agreement with Janet, Brown (1934) stated that:

> The hypnotizability of people is not merely a matter of suggestion, but it is a matter of the extent of their dissociation, and the ability to be dissociated is not the same thing as suggestibility. Some people easily become dissociated, easily get loss of memory, for example, and loss of other mental functions, quite apart from any increased suggestibility. When one finds an extreme state of dissociation, the suggestibility, instead of being increased, may be actually decreased. Patients can be found so extremely dissociated that they are no longer susceptible to suggestion—they have temporarily lost touch with the outer world altogether. This occurs extremely seldom, and can be dealt with by letting the patient "sleep off" his hypnosis. (p. 131)

As mentioned above, the WWI clinicians using hypnosis for the integration of traumatic memories and thus the personality, were in agreement that the patients' transition from the hypnotic state to the so-called waking state should, for integrative purposes, be drawn out; and that the patients should remain in contact with the

therapist throughout the process. Moreover, during this transitional period, therapists should suggest that patients will remember everything they experience in hypnosis. If not, "they failed to remember anything that had taken place during the hypnotic trance. They were all pronouncedly dissociated to begin with as a result of the shell fire and the other conditions of the fighting" (Brown, 1934, p. 131). In other words, the existence of posthypnotic amnesia would strengthen the existing dissociation [between EP and ANP] (Brown, 1922). However, in more recent applications of hypnosis in the treatment of chronically traumatized patients, the view is that rapidly overcoming posthypnotic amnesia might be too ambitious, as patients' integrative capacity might still be too low to take in (as *ANP*) all that they have experienced in hypnosis. (Brown also implied this when he remarked that in some cases, "though the experience is completely recovered, the patient has not managed to adjust himself to it" (Brown, 1992, p. 145).) Then, for example, the suggestion might be given that "when you awaken from hypnosis, you will remember only what you are prepared to remember" or " . . . are able to handle" (D. Brown & Fromm, 1986, p. 189).

Pierre Janet (1898b), 1911, 1919/25) had already observed that when his patients suffering from hysteria, that is, from a dissociative disorder, integrated, they were no longer susceptible to hypnosis. Brown (1934) observed the same phenomenon with his patients.

9.2. Phase-oriented treatment

These WWI clinicians seemed to have used a kind of phase-oriented treatment, which appeared already in the earlier work of Pierre Janet (1898a,b; cf., Van der Hart, Brown, & Van der Kolk, 1989), consisting in (1) preparation, including establishing a positive therapeutic relationship, psycho-education and motivating the patient to overcoming his phobia of the traumatic memory (and thus EP); (2) uncovering the underlying traumatic memory and having the patient re-experience the traumatizing event in a more or less controlled manner; and (3) helping the patient further integrate these experiences in his personality, involving the re-integration of the patient's personality. Such re-integration was in many cases successful, resolving the various somatoform (sensorimotor) and psychoform (cognitive/emotional) dissociative symptoms. (It should be mentioned that, for various reasons, these WWI practitioners were much more attuned to the somatoform dissociative symptoms than most mental health professionals today; cf., Van der Hart et al., 2000.) Sometimes, however, some extra therapeutic work, such as physical stimulation, suggestions for the removal of residual symptoms and for confidence, was needed for the resolution of residual symptoms (e.g., Hadfield, 1940; Myers, 1940). In other cases, certain aspects of the target traumatic experience had been overlooked so far and also needed to be integrated; or the cycle of phase-oriented treatment had to be repeated with regard to previous traumatic experiences which continued to render the patient symptomatic. Several authors also mentioned that when such a therapeutic approach was successful, it also fostered the patient's autognosis (e.g., Brown, 1934; McDougall, 1921-1922, 1926).

Strikingly, none of the cited authors emphasized severe difficulties, in phase one treatment, in overcoming the phobia of traumatic memories (and thus of EP). Maybe the military culture, in which soldiers have to obey their superiors, played a role in this. However, Hadfield (1940), also reflecting on his use during WWI of hypnosis and focusing on "abreaction," made it clear that it was not always that easy:

> These traumatic experiences are sometimes released with the greatest ease; in other cases, even under deep hypnosis, considerable patience and persistence are required to recover the experience, and frequent interviews may be necessary to overcome the resistance to the emergence of the painful experience. (p. 142)

In other words, the patient's phobia of traumatic memory, and perhaps other inner-directed phobias (see below), were too strong, and his integrative capacity too low.

9.3. Pathways to the integration of traumatic memories

As mentioned above, the clinicians who used hypnosis differed in opinion about the essential factors/principles in establishing this integration: full expression of the traumatic emotions (abreaction; Brown, Simmel) or a more modulated approach (Jung, McDougall, Myers). While McDougall was probably right that in some cases abreaction evolved into re-traumatization, the clinicians' personality factors may also have played a role. Those who were comfortable with full emotional expression would adopt a supportive and encouraging role in the therapeutic relationship, while those who were keen to prevent emotional crises and re-traumatization were probably much more cautious. In any case, for the work with traumatic memories to be successful, the patient's experiences should not exceed his integrative capacity (Janet, 1898a,b, 1911); in other words, they had to remain within his window of tolerance (Siegel, 1999). However, as Jung (1921-1922) emphasized, this capacity was also influenced by the specific qualities of the therapeutic relationship.

9.4. A Janetian perspective on trauma-generated dissociation and its resolution

Janet's unique studies of trauma-generated dissociation and subsequent integration of traumatic memories and thus the personality might perhaps be helpful in developing a clearer understanding of the dynamics of traumatic memories and their resolution, that is, integration. In his definition of hysteria—as a wide group of dissociative disorders was labeled at the time—, Janet (1907, 1909) emphasized the lowering of integrative capacity ("mental depression") as the basic characteristic, which was characterized by: (1) the retraction of the field of personal consciousness and (2) a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality. As formulated in this paper, these dynamic subsystems of the personality, that is, dissociative parts can be distinguished in the prototypes of ANP and EP. Compared to a fully integrated personality, both dissociative parts have a retracted field of consciousness. It was mentioned above that ANP is mainly dedicated to functioning in daily life and is phobic of traumatic memories (Janet,19191911) and, thus, of EP: in ANP's field of consciousness, there is no place for trauma or EP.

When reactivated, EP—in its most restricted field of consciousness—is absorbed in the traumatic experience; in other words, is fixated upon the trauma (Kardiner, 1941) or "living in trauma time" (Van der Hart, Nijenhuis, & Solomon, 2010). McDougall (1920–1921) described this as being caught in an *uncontrolled vicious circle* (p. 27). Also emphasizing the dissociative nature of traumatic memories, Janet's (1919/1925) formulation was: "Such patients [i.e., their EPs]. . . are continuing the action, or rather the attempt at action, which began when the [trauma] happened, and they exhaust themselves in these everlasting recommencements" (p. 633); attempts at action that are, as Simmel (1918) had pointed out, in the service of defense. Thus, the traumatized patient [as EP] "remains confronted by a difficult situation, one to which he has not been able to play a satisfactory part, one to which his adaptation has been imperfect, so that he continues to make efforts at adaptation" (Janet, 1919/25, 663). Those suffering from

traumatic memories have not been able to bring these defensive actions to completion, "to perform any of the actions characteristic of the stage of triumph" (p. 669; see also Ogden, 2019; Ogden, Minton, & Pain, 2006). And this vicious circle, consisting of these everlasting recommencements, continues because the EP's experiential world remains dissociated from the remainder (i.e., ANP) of the personality and:

> [exist] *in isolation*, apart from the totality of the sensations and the ideas which [comprise] the subject's personality. It [develops] in isolation, without control and without counterpoise; the morbid symptoms [disappear] when the memory again [become] part of the *synthesis* that makes up individuality. (Janet, 1919/1925, p. 674)

We could add that the EP's dissociative condition and the fact that it is, with its traumatic memory, fixated in trauma, mean that this is a (malignant) hypnotic state. Simmel (1919) explained the origins as follows: during the traumatizing event, the individual succumbed to autosuggestions, that is, overvalued hot cognitions [*überwertigen Gefühlsbetonten Vorstellungen*], which developed in himself at a time in which the Ego Complex was weakened or completely neutralized in its control [*Herrschaft*] (p. 47). Whatever, then, is experienced in this condition may have such a suggestive power that therapeutic suggestions would stand no chance of being accepted. Indeed, Simmel regarded the dissociative symptoms of his patients as "realized posthypnotic autosuggestions" (1919, p. 49).

The resolution, or integration, of traumatic memories, then, involves beginning and continuing the (failed) traumatic actions, including perceptions, emotions, sensations, and—whether actually (Simmel) or in one's imagination—motor actions, under the guidance or support of the therapist, in order to bring them to *completion*. Completing them, Janet noticed, could involve some degree of actions of "triumph," at least of some relief; it could also involve the more complicated actions of resignation and grief. However, this could only lead to successful integration of the personality, if the whole process was also shared with ANP, driving the unification of EP and ANP.

9.4.1. Synthesis and realization

Theoretically, two levels of integration of traumatic memories can be distinguished: guided *synthesis* and *realization* (Van der Hart et al., 2006). First, the traumatic memory must be *synthesized*, that is, shared among dissociative parts of the personality via modulated exposure to unintegrated aspects of it. Gradually or more rapidly, the sensorimotor and affective reexperiences will develop into to a symbolic verbal (narrative) account that is not depersonalized, but is a genuine autobiographical narrative. The latter involves realization, as McDougall (1920–21), quoted above, pointed out. Following Janet (1928, 1935; cf. Van der Hart et al., 2006), realization has two components, that is, *personification* and *presentification*. They involve the patient taking personal ownership of the memories of the traumatizing event(s) ("it happened to *me*, with those consequences for my life"), and full knowledge that the actual present is different from the past and far more real. As mentioned above, McDougall (1921–22) defined the latter component as: "the realisation of the terrifying incident in its past setting and in its true relations to the present circumstances" (p. 29). Formerly "incapable of making with regard to the event the recital which we speak of as a memory" (Janet, 1919/25, p. 663), the patient can make a coherent and flexible narrative of the memory while being present in the moment and without sensorimotor reliving. Realization involves very demanding and high level cognitive and affective work, particularly grieving, leading to acceptance of what is, and the capacity to change and adapt in the present.

9.5. Complexity of trauma-generated dissociation of the personality

Myers (1940) seemed to have been aware of the existence of one EP and one ANP in his patients, and the studies of the other clinicians cited in the paper give the same impression. However, this description of dissociation of the personality may have been too restrictive in some cases, especially in the chronic ones and those with an history of previous traumatization. The South-African officer Stuart Cloete (1972) described a slightly more complex dissociation, one in which a so-called observer part also emerged. During the 1916 Battle of the Somme, after he had killed an enemy soldier and was seriously wounded by him, he had to try and return to (relative) safety:

> There were hundreds of bodies—our own and Germans. There were torn and bloody bandages, burst haversacks, equipment, abandoned rifles driven muzzle first into the churned-up soil to mark a body, a wounded man perhaps who had died before he got help.. . . There was no grass here, only mud and duckboard tracks winding their way between the craters, many of them ten feet deep and filled with mud and water. If I slipped I should drown. I still felt no pain but I was tired. At this point I became two men. My mind left my body, went ahead and stood on a hill. From there I watched, quite objectively and with some amusement, the struggles of this body of mine staggering over the duckboards and wading through the mud when a salvo of German shells came over. I saw it fall flat on its face when a concealed battery of our own whizzbangs opened up within a few yards of it. I saw it converse with the gunners who, stripped to the waist, loaded, pulled the lanyards of their guns and jumped away from the leaping recoil. The gunners were too busy to talk but a corporal gave my body some rum which seemed to strengthen it. I was most interested in the process. I then rejoined my body. The rum may have done it. (p. 242)

The acute dissociation involving the emergence of the observer part may have saved Cloete's life, as it remained able to orient itself on the way towards safety while he was seriously wounded. The reunion that subsequently took place may have happened because Cloete sensed he was now safe and not alone anymore. However, as he was still symptomatic some time later, the integration of ANP and EP had not yet taken place.

The recently developed theory of structural dissociation of the personality (TSDP) presents a hierarchy of degrees of complexity of the trauma-generated dissociation (Nijenhuis, Van der Hart, & Steele, 2002; Van der Hart et al., 2006). *Primary dissociation of the personality* refers to the existence of one ANP and one EP. In modern psychiatric parlance, this level characterizes patients with simple posttraumatic dissociative disorders, including PTSD. *Secondary dissociation of the personality* develops when traumatizing events are increasingly overwhelming and/or prolonged: further division of the EP may occur, while a single ANP remains intact. This degree may characterize patients with Complex PTSD and other specified dissociative disorder, subtype 1 (OSDD; APA, 2013; formerly known as dissociative disorder not otherwise specified [DDNOS]; APA, 1994), the most common form of dissociative disorder encountered in clinical practice. According to TSDP (but not according to DSM-5), *tertiary dissociation of the personality* refers only to patients with dissociative identity disorder (DID), and involves not only more than one EP, but also more than one ANP. Thus, the simple war neuroses or PTSD can be seen as the simplest dissociative disorders, and DID as the most complex posttraumatic stress disorder.

9.5.1. Action systems

Janet (1907) stated that dissociation pertains to "the ideas and functions that constitute personality" (p. 332). These functions

involve behavioral and mental actions. As Simmel (1919) suggested, the EPs of his patients were engaged, and became stuck, in abortive actions of *defense* during traumatizing events—dissociated from the remainder of the personality. This pioneering insight has become part and parcel of modern trauma-dissociation theories, such as TSDP, which propose that trauma-generated dissociation is not random, but is strongly influenced by evolutionarily prepared psychobiological action systems, also known as motivational systems or emotional operative systems, that guide adaptive mental and behavioral actions (Lang, 1995; Lichtenberg, Lachmann, & Fosshage, 2011; Nijenhuis et al., 2002; Panksepp, 1998; Van der Hart et al., 2006). Thus, one major action system is defensive in nature and involves a variety of efforts to survive imminent physical threat and threat to life itself (Fanselow & Lester, 1988). The *defense action system* includes flight, freeze, fight, and total submission (Porges, 2001). In traumatized individuals, the EP is stuck one subsystem of defense—while, in more complex trauma-generated dissociation, different EPs may be stuck in different subsystems. (In his hypnotic therapies, Simmel tried to help his patients to effect dominance of their fight system, in having them physically express their anger at a dummy of the enemy.) Other action systems pertain to *functioning in daily life* (Panksepp, 1998). These systems include energy regulation, exploration, sociability, attachment and caretaking (Porges, 2001), play, and reproduction. In traumatized individuals, ANP's actions are primarily mediated by action systems of daily life. The integration of the action system of defense and the action systems of daily life, and thus of EP(s) and ANP(s) that are mediated by these respective action systems, is a major challenge, particularly when the action system of defense is strongly and recurrently activated because of chronic abuse or other traumatizing events, and when the survivor's integrative capacity is limited.

9.5.2. Maintenance of dissociation of the personality and phase-oriented treatment

Ongoing dissociation of ANP and EP and the prevention of their re-integration, as shown in the clinical studies of the WWI clinicians cited in this paper, is based on ANP's phobia of traumatic memory (Janet, 1911). This phobia may be more powerful because of the patient's lowered integrative capacity and the lack of the clinician's support in overcoming it. As discussed above, a good, supportive therapeutic relationship and appropriate interventions may, in many cases, help rather quickly in overcoming this phobia and fostering the necessary integration. However, in more complex cases, such as those involving chronic childhood abuse and neglect, the maintenance of dissociation involves a wider range of phobias: for instance, phobia of attachment and attachment loss, particularly with the therapist; phobia of mental actions (e.g., inner experiences such as feelings, thoughts, sensations, wishes, fantasies); phobia of dissociative parts of the personality; phobia of normal life; phobia of healthy risk-taking and change; the phobia of intimacy, including sexuality and body image (Van der Hart et al., 2006). This complex of dissociation-maintaining phobias, together with related developmental deficits, need to be addressed in a systematic way. Thus, phase-oriented treatment of chronically traumatized patients must be much longer than the more simple cases, in which overcoming the phobia and integration of traumatic memory is the main goal (e.g., Brown, Scheflin, & Hammond, 1998; Courtois, 2010; Herman, 1992; ISSTD, 2011; Steele, Boon, & Van der Hart, 2017; Van der Hart et al., 2006). Such phase-oriented treatment does not proceed in a linear fashion; the three phases mentioned take the form of a spiral, in which each of these phases are re-visited over and again. Especially in the treatment of patients of DID, that is, the most complex trauma-generated dissociative disorder, this may involve many years.

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