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Research Paper

Vehement emotions and trauma-generated dissociation: A Janetian perspective on integrative failure

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ABSTRACT

As the construct trauma-generated dissociation has received a wide range of meanings in recent years, it may be fruitful to re-visit Pierre Janet's original views. Having been the first researcher to study this phenomenon in depth, he concluded that so-called vehement emotions, that is, those that arise when a major challenge is beyond the individual's capacity for efficient and effective action, entail an integrative failure that involves a disaggregation or dissociation of the personality, especially as part of traumatic experiences. This involves a division of the personality into different subsystems, each with its own sense of self and first-person perspective, manifesting in a range of positive and negative dissociative symptoms. This dissociation involves lower-order integrative actions, which substitute for a full integration of the personality but may have survival value. Not only a lowered integrative capacity, but also a range of inner-directed phobias, play a role in the maintenance of the dissociation of the personality. Therapy, as Janet saw it, needs to aim at heightening the integrative capacity, at overcoming these phobias and, similarly, at improving adaptive actions. This goal may best be achieved through the fostering of so-called empowering of "sthenic" emotions.

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> This instability in the equilibrium of cortical functions, this tendency to complete dissociation and to restoration of a new state of equilibrium, is the hallmark of hysteria
> Raymond and Janet (1898, p. 252)

Dissociation is regarded as the essence of trauma (Van der Kolk, 2014). But what does the concept "dissociation" refer to? Attempting to answer that critical question is a major challenge, as the concept has received so many different meanings that one critic felt called upon to state that "it is apparent that clarity is conspicuous by its absence" (Frankel, 1990, p. 827); a view which has since been repeatedly echoed (e.g., Cardeña, 1994; Marshall, Spitzer, & Liebowitz, 1999; Nijenhuis & Van der Hart, 2011; Saillot, 2017; Van der Hart, Nijenhuis, Steele, & Brown, 2004). In their chapter on the history of the concept of trauma-related dissociation, Van der Hart and Dorahy (2009) tried to provide some clarity by distinguishing two different conceptualizations in the current dissociation literature. In line with traditional views, the first one is a narrow conceptualization of trauma-generated dissociation as a division of the personality into at least two different subsystems of the personality, also known as dissociative parts of the personality or personality states that are either trauma-avoidant or trauma-fixated. The second, more recent one, is a broad conceptualization, which pertains to a continuum of phenomenological experiences and which is quite eclectic with regard to the etiology of these phenomena. A posttraumatic divided personality structure is just one of the possibilities, with narrowing of the field of consciousness, parallel streams of consciousness and other alterations in conscious experience as some other possible phenomena. Thus, some authors proposed two types of dissociation: "compartmentalization," in line with the above-mentioned division of the personality, and "detachment," which would not involve such a division of the personality (Brown, 2006; Holmes et al., 2005).

In discussing and understanding trauma-generated dissociation, we adhere to the narrow conceptualization. However, even within this conceptual framework, divergent views do exist. They can be traced back to those that Pierre Janet and Sigmund Freud formulated at the end of the 19th century. For Janet (1889, 1898a), trauma-generated dissociation is constituted primarily of an integrative failure or deficit – a view adhered to by several contemporary authors (Liotti, 2006; Nijenhuis, 2015; Nijenhuis & Van der Hart,

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2011; Nijenhuis, Van der Hart, & Steele, 2002; Van der Hart, Nijenhuis, & Steele, 2006). For Freud (1963), when he still adhered to a trauma-dissociation model, which he soon exchanged for the concept of repression, "the splitting of the contents of consciousness is the consequence of a voluntary act on the part of the patient; that is to say, it is instituted by an effort of will, the motive of which is discernible" (p. 69). This view of dissociation as an active defense (cf., Erdelyi, 1994) is echoed in many more recent publications of authors who may or may not also adhere to a broad conceptualization (e.g., Bromberg, 1998; Dell, 2009, Dell, 2019; Kluft, 1992; Loewenstein, 2018; O'Neil, 2009; Schauer and Elbert, 2012; Spiegel, 1993; Young, 1988). Thus, Kluft (1992) stated that he understands "dissociation pragmatically as a defense in which an overwhelmed individual cannot escape [what] assails him or her by taking meaningful action or successful flight, and escapes instead by altering his or her internal organization" (p. 143). This view overlooks the fact that "being overwhelmed" implies an insufficient integrative capacity for the task at hand. The same problem occurs with Dell (2019) statement that "the dissociative symptoms of a person with a dissociative disorder are motivated acts of autohypnotic, mental distancing from intolerable circumstances – and nothing else" (p. 53).

What does it mean that an individual is overwhelmed by intolerable circumstances, as during a traumatic experience? And when and how does this lead to the development of an acute dissociation of the personality? Is "defense" in this context the most appropriate concept? If dissociation is a defense, like fight, flight, freeze, submit and collapse responses, which is available to the individual, then it would seem that he or she is not overwhelmed, i.e., overcome, submerged, crushed, inundated. An opposing view would be to consider that during a traumatizing event, instead of being able to perform efficient and effective actions, the individual is indeed overwhelmed. This manifests, in Janet's terms, in "vehement" emotions. In this condition, integrative capacity is lowered, rendering the client unable to integrate experience precisely because defenses have failed, which gives rise to experiences of, for example, terror, horror, dread, instead. The dissociation of the personality into dissociative parts could then be seen as following the individual's inability to adaptively defend against threat, the inherent vehement emotions, and the incapacity to integrate these traumatic experiences.

We believe that Pierre Janet's original studies on these issues, particularly concerning his views on what he termed vehement emotions and their relationship with trauma-generated dissociation of the personality, may shed some light on the meaning and implications of events such as traumatic overwhelm. Before proposing a summary of Janet's observations and ideas on this topic, a few terminological clarifications might be useful.

1. Janet and dissociation and related concepts

Some authors believe that it was Janet who was the first author to introduce the term dissociation (e.g., Leblanc, 2001) – one author even believing that he did so only in 1924 (Paris, 2019). One historian went so far as to state that Janet dropped the use of the word dissociation after the 1889 publication of *L'automatisme psychologique* (Hacking, 1995), which did not include it. However, as shown by Van der Hart and Dorahy (2009), this is not true. The concept, as well as a range of similar ones, was used, especially in France, throughout the 19th century. Some other concepts in vogue at the time were the "*dédoublement*" of the personality, a term that cannot be satisfyingly translated[1], division of the personality, double consciousness (*double conscience*). Other authors believe that Janet did not use the term dissociation, but rather disaggregation (*désagrégation*) (e.g., Cardeña, 1994; Decker, 1986). This understanding seems to be based exclusively on his major opus, *L'automatisme psychologique* (Janet, 1889), where Janet indeed used disaggregation only. However, before (Janet, 1887) and after 1889, Janet employed *dissociation* (e.g., Janet, 1893, 1894, 1901, 1904, 1907, 1909a, 1909b, 1911, 1919, 1928a, 1946), sometimes seemingly interchangeably with disaggregation and, a few times, with *dédoublement de la personnalité*.

However, there is a certain ambiguity in Janet's writings, which needs attention. Time and again, Janet emphasized the dissolving or disintegrating role of vehement emotions as in traumatic experiences, resulting in a disaggregation or dissociation of the personality. We have a distinct impression that he used both terms interchangeably. However, Meares and Barral (2019) recently proposed that disaggregation stands for a general dis-integration of the personality, with dissociation referring to a special group of psychological phenomena, such as a traumatic memory that starts to lead a life of its own. They believe that the latter term cannot be regarded as a synonym of the former. While not using the term disaggregation, Farina et al. (2019) distinguish between dis-integration, as manifested in, for instance, depersonalization and derealization, and dissociation as the integrative failure and subsequent re-composition of the [personality] system's constituting elements in a more separate way.

There are two separate ideas being discussed here by these authors. First, did Janet use the terms disaggregation and dissociation equivalently? Second, do disaggregation (or dis-integration) and dissociation refer to equivalent or distinct phenomena? Our reading of Janet is that his notion of the disintegrating force of vehement emotions needs to be distinguished from disaggregation or dissociation – again, terms we believe he seemed to use interchangeably – as an integrative failure. With Nijenhuis (2019), we argue below that the ensuing dissociative re-composition of the personality involves lower-order integrative actions.

2. Janet's studies of vehement emotions

Janet studied extensively the phenomenon of vehement or violent emotions[2], and emphasized over and again that they cause a reduction of the individual's integrative capacity (*la faculté de synthèse psychologique*; e.g., Janet, 1894, p. 501, 1911) and result from it. He also used the term *émotion-choc* (the French word *choc* refers to trauma; Janet, 1909b), thus indicating that vehement emotions are part and parcel of traumatic experiences. He repeatedly found that such vehement emotions exert a disintegrating force on the personality, leading to a dissociation of the personality (e.g., Janet, 1889, 1894, 1898a, 1905, 1909b, 1928a, 1928b).

It is important to understand that Janet distinguished these vehement emotions from so-called empowering or sthenic emotions (Janet, 1905). We return to this sthenic type of emotions below; they play a major role in the psychotherapy of patients with complex trauma-generated dissociation.

2.1. Vehement emotions

According to Janet (1909b), vehement emotions – in short, *l'émotion* – produce their disintegrating effects in proportion to their intensity, duration, and repetition. Individuals experience them when they are faced with life challenges which they perceive, consciously or unconsciously, as being too difficult to master. For

[1] The original meaning of the French term "*dédoublement*" is to divide into two parts (and must be distinguished from the term "*doublement*", meaning doubling). "*Dédoublement*" may also refer to the creation of a copy (duplication) or to the distinction of two aspects within a whole. In psychology, it refers to the existence of several identities, parts, or states within a person or personality.

[2] He also referred to them as "depressive" to express their depressant effect on integrative abilities.

Janet, (potentially) traumatizing events are the prime example of the evocation of vehement emotions, but fatigue and illness may also play significant roles. During his many studies over time, he continued to emphasize their disintegrating effect. For instance, in 1889, he wrote: "Emotion makes people distracted and even anesthetic, emotion has a dissolving effect on the mind and makes it momentarily wretched" ("*L'émotion rend les gens distraits et même anesthésiques, l'émotion a une action dissolvante sur l'esprit et le rend pour un moment misérable*") (Janet, 1889, p. 142). In 1928 (Janet, 1928a, p. 463–464), Janet confirmed his many previous observations (Janet, 1889, 1898a, 1901, 1905, 1909b) that vehement emotions of patients with hysteria always have the same effect: they are not adaptive in the circumstances in which they occur, but are absolute and brutal. They have a dissolvent effect on voluntary decisions (*résolutions volontaires*), on sensitive (*délicats*) feelings, on awareness of feelings, and on memories. In his view, vehement emotions always involve a deep drop (*chute*) in adaptive mental activity.

In short, vehement emotions have a disorganizing power. "However, except in the most extreme cases, they do not really destroy the elements of thought; they let them exist but disaggregated, isolated from each other, sometimes up to a point where their functions are almost suspended" (Janet, 1898a, p. 475). Elsewhere, in the context of his psychology of action, Janet (1909b) stated that people need to adapt to new situations and evolution. This is what one can observe in the will, judgment (*le jugement*), attention, and the development of the personality (p. 1552). There is no place here for vehement emotions. However,

> there are circumstances to which the individual is not adapted by his prior organization and to which he is, for some reason, unable to adapt currently himself, even though he perceives these circumstances and feels the necessity to react. In these cases, one observes instead of a useful reaction, a set [*ensemble*] of disturbances in all functions of the organism and it is this set of disturbances that arise in these conditions that I propose to designate by the word "emotion". (Janet, 1909b, p. 1552)

2.2. Manifestations of vehement emotions

Janet observed that the manifestations of vehement emotions are extremely complex. He distinguished four relevant dimensions (Janet, 1909b, p. 1552–1555), each dimension including so-called agitations and depressions of particular functions. In current language, agitations might be considered as signs of hyperarousal, whereas depressions would reflect hypoarousal. Their manifestations may be emotional, cognitive, or somatic in nature, resulting in modifications of affect, consciousness, ideas, memories, visceral functions, actions, and movements.

2.2.1. Modifications of affect (sentiments) and of the general state of consciousness

Among these modifications, one observes the occurrence of feelings of fear, anger, chagrin, shame, indignation, etc.; feelings of discouragement, despair, etc.; feelings of anguish, pain. Regarding the state of consciousness, Janet adds to them the *feelings of incompleteness* (italics in the original), such as feelings of weakness (*sentiments de faiblesse*), helplessness, irresoluteness, embarrassment (*gêne*), automatism, domination, complexity, derealization, dreaming, etc. Janet's observations not only include derealization, but also seem pertain to depersonalization (see also Farina, Liotti, & Imperatori, 2019).

2.2.2. Cognitive modifications

Janet first distinguished between systematic and diffuse cognitive agitations. In systematic agitations, specific ideas, such as those related to death, danger, injustice, disorder, etc., dominate thinking. In addition, the individual has reproductive or representational experiences of a traumatizing event, which is expressed in the form of hallucinatory images, actions, talking, in which the individual continuously re-experiences and describes the event. These are what Janet subsequently called traumatic memories (Janet, 1919, 1928b). There can also be other systematic mental agitations present without an apparent link to the event, such as obsessions. In diffuse agitations, a multitude of ideas and memories without a clear relationship with the traumatizing event intrude on consciousness, such as the so-called hypermnesia of individuals in mortal danger.

Under cognitive modifications, Janet also includes systematic or diffuse alterations and degradations of cognitive functions. Examples are retrograde amnesias and various localized anesthesias, which Janet apparently regarded as a cognitive function. The level of consciousness is lowered and the narrowing of the field of consciousness determines suggestibility. Attention is strongly reduced and cannot reach a level of certainty; there exists doubt, confusion about what is real and what is imaginary, disturbances in the perception of time, of objects; there may be continuous amnesia and even mental confusion.

2.2.3. Disturbances of visceral functions

Janet distinguished systematic or diffuse agitations and depressions of various bodily functions. He noted various agitated disturbances of the intestines and respiration, and exaggeration of vasomotor constriction. Among the depressions, he includes anorexia, gastro-intestinal atony, constipation; respiratory difficulties, suffocation/asphyxia; lowered heart rate (*ralentissement du cœur*), syncope; various forms of vasodilatation; suppression of various secretions. These can be correlated with sympathetic or parasympathetic activation.

2.2.4. Disturbances of motor functions, in particular of action

Janet again distinguished systematic or diffuse agitations and depressions of motor functions. Among the former, he mentions the complete or incomplete reproduction of old actions, including habitual acts and tics, grimaces, contortions, stiffness, spasms; as well as systematic or generalized agitations of language, such as babbling, shouting, swearing, cursing. Among the latter, Janet included the inability to execute the adaptive action that the circumstances demand, or, in less severe cases, a diminution or degradation of this action, which becomes awkward or insufficient, including loss of determination/resolution and loss of personal awareness. The same insufficiencies can occur with regard to other actions, which are suppressed or simply degraded, with attenuation of actions, loss of precision of movements, slackening, defects, trembling. Also, he noted more serious depressions in the form of paralysis, incapacitation of certain functions; and, finally, systematic or general suppressions of speech, including mutism.

Janet concluded that all these phenomena are not developed to the same degree in all cases of vehement emotions. However, they need to be carefully examined before any theoretical interpretation. Some of the manifestations observed by Janet are also recognized in modern studies. Thus, following Bracha (2004), Schauer and Elbert, 2010 state that at the height of arousal (in the face of inescapable threat), the tendency to flee or fight begins to give way to shut-down responses:

> General fear symptoms are experienced, including dizziness, nausea, palpitation, drowsiness, light-headedness, tension, blurred vision, feelings of irreality, numbing, and tingling appear (prodromal period before "shut-down"/pre-syncope). (p. 112)

Below, we return to Janet's understanding of these manifestations of vehement emotions from the perspective of his dynamic theory and his views on emotivity, before exploring how they relate to acute dissociation and the loss of consciousness.

2.3. Vehement emotions analyzed from the perspective of Janet's dynamic theory

Actions play a central role in Janet's understanding of psychology:

> Practical psychology, especially medical psychology, must above all concern itself with the individual's reactions to his surroundings. And must first and foremost be *a psychology of action*. (Janet, 1909b, p. 1551; italics in the original)

After his many observations over time of the various manifestations of vehement emotions, as in traumatic experiences, Janet applied his own dynamic theory and emphasized a central role of the systematic insufficiency of action for responding to a provocative situation, such as a potentially traumatizing event (as described above). Whatever the other characteristics of vehement emotions, this suppression or deterioration (*dégradation*) of action is always their starting point. Whatever the causes, this insufficiency is always a mental misstep, an arrest of evolution, a downfall of mental efficiency or integrative capacity. Thus, a failed derivation or substitution of inferior actions for adaptive action takes place. The situation presents a problem, which the individual cannot resolve but which elicits failed efforts, and its repetition leads to a new factor, that is, exhaustion. As Janet (1919/25) formulates it:

> Such patients ... 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. 663)

This is particularly the case when traumatic memories are reactivated:

> The subject is often incapable of making with regard to the event the recital, which we speak of as a memory; and yet he remains confronted by a difficult situation in which he has not been able to play a satisfactory part, one to which his adaptation had been imperfect, so that he continues to make efforts at adaptation. The repetition of this situation, these continual efforts, give rise to fatigue, produce an exhaustion, which is a considerable factor in his [vehement] emotions. (p. 663)

The tendency to these "everlasting recommencements" has been recognized in more recent literature. Horowitz (1986), for instance, labels it as the *completion principle*, which he defines as "the human mind's intrinsic ability to continue to process new information in order to bring up to date the inner schemata of the self and the world" (p. 93). He overlooks the exhaustion resulting from repeated integrative failures, but he does envisage that painful emotions, caused by the recognition of the discrepancy between new circumstances and the inner habitual model, may interrupt the completion principle: "Until completion, we assume that there is some type of memory that retains the important but incompletely assessed set of memories and responses, presenting this complex of memories, ideas, and feelings whenever opportunity and inner choice permit" (p. 94).

For Janet (1889), the individual engages in two activities, one innovative and creative, the other conservative. The innovative activity is one of synthesis, combining several phenomena into a new phenomenon that is different from its original elements: knowledge, ideas, opinions; artistic, moral, or scientific concepts. Janet considered "genius" to be:

> A power of synthesis capable of forming entirely new ideas that no previous science could foresee, that is the highest degree of mental strength (1889, p. 478).

The conservative activity, on the other hand, preserves and maintains that which has already been synthesized. Together, these two activities – creative synthesis and conservation – generally maintain a balance:

> Innovative and conservative activity must regulate and limit each other, just as, in the mind, current activity, capable of understanding new syntheses and adapting to new conditions, must balance this automatic force that strives to keep past emotions and perceptions immutable (1889, p. 487).

Vehement emotions, however, weaken the individual's ability to engage in synthesis, and conservative activity becomes the predominant force, where new forms of personal consciousness are no longer formed and instead elements from the past take over, greatly lessening the individual's ability to adapt to new circumstances.

2.4. Emotivity

With this term, which in more recent sources is known as affect dysregulation, Janet (1909b) refers to repetitive patterns of experiencing vehement emotions. It pertains to the tendency to replace superior adaptive operations, which have become impossible, by lower-order substitute actions and physiological dysregulation. Emotivity may have its origins in previous unresolved traumatic experiences but may also involve constitutional factors. However, Janet warns against the tendency to label someone who had a traumatic experience (*choc émotif*) as merely an emotional person. For emotivity to be determined, it must have been present before the actual event took place. We should add that also in pre-existing emotivity (affect dysregulation), previous traumatic experiences may have occurred.

As mentioned above, a core of chronic emotivity may be associated with the ongoing repetition of re-experiencing trauma, that is, the reactivation of traumatic memories. However, as the individual's integrative capacity deteriorated, a depletion of mental energy is taking place, and a pervasive sense of failure develops. Hence, the individual soon perceives other challenges in daily life as too demanding. Exhaustion and posttraumatic decline set in (Tichener, 1986), and the individual ends up with a deep sense of defeat and collapse (Van der Hart et al., 2006).

3. Janet's views on the relationship between trauma and dissociation

Although Janet considered that vehement emotions may arise in other too demanding circumstances, we shall focus here on trauma-related vehement emotions. Over the years, Janet stated repeatedly that vehement emotions involve coarse substitutes of adaptive actions, that is, precise and accomplished actions (e.g., Janet, 1919/25). The main characteristic of vehement emotions is that they have a disintegrative power; they deteriorate the individual's integrative capacity (*la synthèse mentale*; Raymond & Janet, 1898, p. 254), rendering it weak and unstable. Janet noted that vehement emotions "are gifted with a power of *dissociation*"

(Janet, 1898a, p. 476; Janet, 1928a, p. 464). In other words, they dissociate mental systems, especially the most fragile ones, which constitute recent memories, and impede their integration (Janet, 1898a, p. 149). Amnesia may develop, which is not a destruction of memories but rather a "dissociation of systems of ideas and functions which constitute the personality" (Janet, 1907, p. 332; Janet, 1909a). In earlier studies, Janet (1889) clarified that these "systems of ideas and functions," "psychological existences," or "parts of the personality" (Janet, 1898a, p. 145) have their own sense of self, their own first-person perspective, and a degree of emancipation and elaboration.

Concerning the dissociation of these systems of ideas and functions, Janet explained that:

> [t]he expression "mental disaggregation" is simply the description, the summary of these undisputed facts; this expression ascertains only that human thoughts, whatever their deep origins, can separate themselves in a way in which more or less coherent and more or less distinct groups are formed. (Janet, 1898a, p. 395)

Elsewhere, he states that vehement emotions dissociate psychological phenomena, tend to separate them in order to make certain systems of sensations and images "live apart" (Raymond & Janet, 1898, p. 426).

The most frequent case is the separation of the most recently constructed part of the personality from the remainder of the personality, including the defensive or orienting actions the individual is engaged in during the actual threat. This is what happens during and directly after traumatizing events, when the traumatic memories of such events start to, in a sense, lead a life of their own (Janet, 1898a, p. 144), with their own sense of self. Ferenczi (1919), for instance, described WWI cases in which the traumatized person was making a combat-related action, such as shouldering his rifle: "In one patient, the peculiar contractions of the man's shoulder and elbow had probably mimicked the position of his arm at the moment of trauma" (p. 62). In Janet's terms, it was the particular manifestation of this function that was dissociated and became functionally independent.

In more serious or complex cases, further dissociation can bear on the traumatic memories, also labeled by Janet as primary *idées fixes,* which thus become more and more divided. Here we are reminded of his observation that vehement emotions produce their disintegrating effects to the degree of their intensity, duration, and repetition (Janet, 1909b). These repetitions prevent the dissociated mental syntheses from being restored (Janet, 1898a, p. 145).

In continuous amnesia, dissociation can affect even new experiences and memories. Dissociation can also suddenly affect already existing memories, those which are already attached to the personality (Janet, 1898a). That is, after a traumatic experience, more or less extensive retrograde amnesia may develop, even up to amnesia for one's whole life (Janet, 1901, 1907; Van der Har and Nijenhuis, 2001).

Here it seems important to distinguish between acute dissociation and the subsequent maintenance of dissociation, while considering the role of substitute integrative actions.

3.1. Acute dissociation and the loss of consciousness

In short, vehement emotions experienced during traumatizing events involve a range of dimensions in which one's desperate actions are characterized by a pervasive sense of powerlessness and by a lowered level of consciousness and narrowed field of consciousness, leading to mental disaggregation.

Concerning the lowering of consciousness, the lowest level may be a syncope, fainting, which Janet refers to as a complete dissociation, reminding him of Azam's saying regarding his famous DID patient, "*la petite mort de Félida*" (Raymond & Janet, 1989, p. 254). This loss of consciousness may be likened to what authors such as Schauer and Elbert, 2010 and Schore (1994, 2003, 2009) describe as the "shut-down response," which Porges (2011) explains in terms of dorsal vagal activation.

Janet adds that after this "complete dissociation" – involving the actual disaggregation or dissociation of mental systems – consciousness weakly reappears, with heightened suggestibility, and vehement emotions presenting their second characteristic, that is, the *idée fixe*. This is a whole set of experiences dominating consciousness and functions as a malignant hypnotic condition in which the dissociative part of the personality present during the trauma remains fixated (cf. Brenner, 2018; Mott, 1982; Van der Hart, 2019). Thus, the patient's susceptibility to malignant trauma-related post-hypnotic suggestions may be so intense, that therapeutic interventions are not effective, at least initially. An example pertains to sexual abuse in which the victim, as the dissociative part undergoing the abuse, believes the perpetrator's assertion that he will always know if she tells anyone and will then come to punish her. As Janet (1919/25) argues, this part exists:

> *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. (p. 674)

Thus, the result of the acute dissociative acts is, basically, the development of a chronic dissociation of the personality between a major dissociative part functioning in daily life and a minor dissociative part stuck in the trauma, also formulated as "living in trauma time" (Steele, Boon, & Van der Hart, 2017; Van der Hart, Nijenhuis, & Solomon, 2010). During World War I, clinicians working with the military were able to observe many cases of acute dissociation and related loss of consciousness; their reflections will be described below.

3.2. World War I clinical observations of "La Petite Mort"

During the Great War, many clinicians attended to acutely or recently traumatized soldiers. In many cases, those specialized in these phenomena noticed that an initial reduction in level of consciousness resulted in a window of vulnerability for dissociation (e.g., Léri, 1918; Myers, 1940; Simmel, 1918; cf., Van der Hart, 2019). During his work in field hospitals, the French neurologist André Léri (1918), for instance, had the following impressions of traumatized patients – in his language, suffering from *l'émotion choc*; hence "emotional patients" as contrasted with "commotional [i.e., concussed] patients" – which he saw for the first time:

> 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 [i.e., pseudo-obtundation][3]. 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

[3] Obtundation is an altered level of consciousness, a reduced awareness and dulling of the senses, typically resulting from a medical condition or trauma.

> bewildered air, his eyes wide open, haggard, as if the prey of some intense anxiety and of a horrible vision. (1919, p. 94)

Léri regarded this lowered level of consciousness, as it were, as a kind of no-man's land (pun intended) between the then dominant part of the patient's personality stuck in the traumatic experience – the 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) – and the remainder of his experiences, with which he is not in contact.

The British psychologist Charles S. Myers, who coined the term shell shock and soon thereafter regretted it, observed in acutely traumatized soldiers a lowering of consciousness related to vehement emotions, both in their agitated and depressive forms (Myers, 1940):

> Typically the immediate result of the "trauma" is a certain loss of consciousness. But this may vary from a slight, momentary, almost imperceptible dizziness or "clouding" to profound and lasting unconsciousness [Azam's *petite mort de Félida*]. When the "shock" is slight, the patient may be able to "pull himself together", or he may be readily amenable to outside suggestion to this end. When the "shock" is severe, it may be followed by unrestrainable excitement, depression, fugal automatism, or stupor, on recovery from the graver forms of which the patient can recall none of the acts performed by him during that condition. We have no means of deciding whether in the most deeply stuporose states mental processes are completely dormant. But in the states of lighter stupor and in the states of excitement, depression and automatism just mentioned, the attention of the patient would appear to be concentrated on some narrow field, doubtless generally on the scene which produced his condition. (p. 66)

Thus, Myers describes both the agitated and depressive vehement emotions of traumatic experiences that Janet discussed. He continues: "While thus occupied, the stuporose patient lies in a more or less apathetic state, with occasional outbursts of hallucinatory delirium" (p. 66). Again, with his emphasis on the patients' more or less severe drops in levels of consciousness as well as in integrative capacity, he hints at a psychological no-man's land in which the traumatic experiences – the primary *idées fixes* in Janet's terms – cannot be connected with the remainder of the personality. A dissociation of the personality into at least two different prototypical dissociative parts is taking place. In Myers' language, the normal personality has been replaced by an emotional personality. And his subsequent observations clearly indicate how a more structural dissociation of the personality manifests itself:

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 may recall, as in a dream, the distressing experiences revived during the temporary intrusion of the "emotional" personality. The "emotional" personality 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 may have no recollection of the dream state and will at once resume his mutism, paralysis, etc. (p. 67).

4. Contemporary conceptual adaptations of dissociation of the personality

Nijenhuis, Van der Hart, and Steele have found Myers' formulations of trauma-generated dissociation of the personality and its treatment so very much to the point that they are at the basis of their own formulations. These later formulations encompass a wider range of dissociative complexity and treatment, adding age of onset to Janet's observations that disintegrative effects of vehement emotions are in proportion to their intensity, duration and repetition (Nijenhuis, 2015; Nijenhuis et al., 2002; Van der Hart, 2000; Van der Hart et al., 2006). However, from the perspective that each individual has only one personality, however divided it may be, while also realizing that on the other hand they are usually are more complex than merely a mental state, they found the language of apparently normal part of the personality (ANP) and emotional part of the personality (EP) most appropriate (see also Moskowitz & Van der Hart, 2019). This division of the personality among dissociative parts thus may encompass many more EPs and, in the case of dissociative identity disorder (DID), also more than one ANP (Gonzalez & Mosquera, 2012; Moskowitz & Van der Hart, 2019; Nijenhuis, 2015; Steele et al., 2017; Van der Hart et al., 2006).

4.1. Dissociation of the personality and action systems

It is commonly understood that human beings' actions are mediated by evolutionary derived action systems or motivational systems that direct adaptive mental and behavioral actions (e.g., Lang, 1995; Lichtenberg, Lachmann, & Fosshage, 2011; Liotti, 2017; Nijenhuis, 2015; Panksepp, 1998; Van der Hart et al., 2006). There are two basic types of innate action systems: those of daily life – aimed at attaining goals – and those of defense in the face of threat – aiming at avoiding or neutralizing threat. By nature, action systems of daily life occur when people feel safe, and include caregiving, collaboration, exploration, play, sexuality/reproduction, and energy management (e.g., sleep, food intake). When danger is perceived, action (sub)systems of defense take precedence over those of daily life. Fight or flight can ensue, which involve hyperarousal. When actual life threat is perceived, successively flagged and collapsed states may occur, involving "shut-down," extreme hypoarousal (Bracha, 2004; Lang, 1995; Nijenhuis, Vanderlinden, & Spinhoven, 1998; Schauer and Elbert, 2012; Porges, 2011). The defense of freeze involves a combination of hyper and hypoarousal, involving simultaneous activation of both the sympathetic and parasympathetic nervous systems. The need for protection and comfort, especially in young children who may not have the option of fighting or fleeing when feeling unsafe, activates the attachment system when threat is not too great, and also the "attachment cry" defense (Bowlby, 1969; Liotti, 2017).

In traumatized individuals, ANPs' actions are primarily mediated by action systems of daily life; however, when there are no reactivating stimuli for EPs, ANPs may also be able to engage in some defensive actions. EPs are stuck in one or more subsystems of defense, that is, in their failed defensive actions during traumatizing threat, including the vehement – agitated and depressive – emotions these failures evoked as lower-order substitute actions.

4.2. Dissociative symptoms

Briefly, as Janet, Myers, and numerous contemporary students of dissociation (e.g., Loewenstein, 1991; Nijenhuis, 2015; Ross, 1997; Steinberg, 1995; Van der Hart et al., 2006) have observed, dissociation of the personality, whatever its level of complexity, manifests in a range of dissociative symptoms. These dissociative

symptoms can be categorized as negative (functional losses such as amnesia and paralysis), labeled by Janet (1893, 1901, 1911) as mental stigmata, or positive (intrusions such as flashbacks, voices, or certain actions), labeled by Janet as mental accidents. They can also be classified as psychoform (cognitive-emotional symptoms such as amnesia, hearing voices) or somatoform (sensorimotor symptoms such as anesthesia or tics or somatic sensations related to trauma). What is experienced in one dissociative part of the personality is either not experienced by other parts, or experienced as an "intrusion" not belonging to their senses of self.

While all these symptoms are manifestations of a deficient integration of the personality, some of them could be labeled as substitute actions, certain parts' attempts at problem-solving, when the actual required integrative actions are feared or otherwise beyond reach. Addictions, self-injury, and other self-destructive actions can be seen as examples. More pervasive are the many phobic actions, which together maintain the dissociation of the personality. Janet (1904/1911) already pointed out, underneath all substitute actions is the phobia of traumatic memories – which prevents their integration in the whole of the personality – which is highly characteristic of ANPs. But there are many more phobic actions, such as the phobia of dissociative parts, the general phobia of inner experience, the phobia of attachment and attachment loss (see Van der Hart et al., 2006).

5. Maintenance of dissociation of the personality

Traumatized individuals face a hard task to integrate all dissociative aspects of their personality into one relatively coherent whole. The earlier the traumatization occurred, the more intense, long-lasting and repeated it was, the more their personality has been dissociated (Janet, 1909b). Two interrelated factors play essential roles in this maintenance of the dissociation of the personality. One factor is reduced integrative capacity, increased emotivity when facing life's challenges, and even vehement emotions when traumatic memories are reactivated. All this, as we have mentioned above, leads to posttraumatic decline. The other factor is a series of inner- and outer-directed phobias that survivors develop during and following traumatization. These phobias not only involve fear, but also shame and disgust. Janet (1904/11) first described the phobia of traumatic memory. Recent authors have added phobias of trauma-derived mental actions (emotions, feelings, bodily sensations, thoughts, wishes, and fantasies), dissociative parts, adaptive risk-taking and change, attachment and attachment loss, and intimacy (Nijenhuis et al., 2002; Steele et al., 2017; Van der Hart et al., 2006). Confrontation with these feared experiences that are experienced as frightening or shameful evokes not only avoidance behavior but also the vehement emotions when avoidance fails. This further impedes creative actions of synthesis and largely relegate the EPs' functioning to conservative activities and eternal recommencements, while the ANPs' creative activities are greater but nevertheless limited by the avoidance of traumatic memories and associated experiences.

6. Dissociation of the personality and levels of integrative actions

Janet's message is that traumatic experiences, with their vehement emotions, and dissociation of the personality are characterized by a lowering of the integrative capacity, that is, with reduced creative activity and dominant conservative activity. He stated that integrative activity "reunites more or less numerous given phenomena into a new phenomenon different from its elements" (p. 483) and that these elements are "necessary to maintain the organism in equilibrium with the changes of the surroundings" (p. 487; quoted by Van der Hart & Friedman, 1989, p. 5). In other words, this function organizes our experience of the present. Mental health, then, "is characterized by a high degree of capacity for integration, which unites a broad range of psychological phenomena within one personality" (Janet, 1889, p. 336). Van der Hart and his colleagues have subsequently argued that this capacity involves actions of both binding and differentiation (Van der Hart et al., 2006). High levels of integrative capacity can be labeled as actions of realization, which is manifested in two dimensions: actions of personification and actions of presentification (Janet, 1903, 1928b, 1935; Van der Hart et al., 2006). The essence of personification is taking ownership of, and responsibility for one's experiences, connecting them to one's sense of self: "These are my feelings and my actions." Presentification pertains to actions of "being in the present with a synthesis of all one's personified experiences – past, present, and anticipated future – at the ready to support reflective decision-making and adaptive action" (Van der Hart et al., 2010, p. 87).

6.1. Low-level integrative actions

It is clear that when individuals are being traumatized, that is, experiencing vehement emotions, and subsequently develop a structural dissociation of the personality, they are unable, to various degrees, to attain these high integrative levels of functioning. However, this diminished capacity does not mean a complete lack of integrative actions; some integrative actions are still being performed (Nijenhuis, 2019). This is what Janet's (1907) definition of hysteria, that is, a wide range of trauma-related dissociative disorders, implies: "a form of mental depression [i.e., reduced integrative capacity] characterized by the retraction of the field of personal consciousness and a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality" (p. 332). The dissociation is followed by an emancipation – and possibly, as Van der Hart et al. (2006) have added, elaboration – of what they have called dissociative parts of the personality. These lower-order or substitute integrative actions themselves may involve various levels of limited integration. Nijenhuis (2019) thus states that dissociation involves creative acts to re-compose the personality system, which are present in the subsequent processes that keep the dissociative re-composition intact.

6.2. Lowest-level integrative actions in EPs

At a very low level, an extremely traumatizing event may produce in a child a multitude of EPs – "fragments" as Ferenczi (1933) and Braun (1986) called them – each with a very rudimentary sense of self and keeping only a "small" aspect of the traumatic memory. Thus, one dissociative part of Sandra, a survivor with DID and a history of extreme home and organized abuse, eventually reported in the course of therapy a particular traumatic memory experienced as an overwhelming nightmare. Sandra, suffering from DID, described that during a severe rape, she was banging her head and "ever new children come." She related that these little girl parts came one after the other because what happened was utterly unbearable.

EPs characteristically re-enact their experiences, that is the mental and behavioral actions in which they engage during the original traumatizing situations. They may repeat automatic or habitual actions from the past in situations which demand new, adaptive actions. This was repeatedly observed by the World War I clinicians attending their traumatized patients (Van der Hart, 2019, in press). In civilian trauma, Janet referred repeatedly to the example of his patient Irène, who had been severely traumatized by the tragic death of her mother, which she attended in dire

circumstances. She had developed, among other things, amnesia for these traumatic experiences and thus could not realize that her mother had died (e.g., Janet, 1904, 1911, 1919, 1928b; see also Van der Kolk & Van der Hart, 1991, p. 430). Because she started to behave in bizarre ways and made several suicide attempts, Irène eventually had to be admitted to the Salpêtrière, where several times a week she repeated a series of actions. Whenever she looked from a certain direction to an empty bed, she (as EP) took on a bizarre posture, without moving her eyes, became unable to hear, was not in contact with others, and she began to engage in stereotyped activities. She brought a glass to the lips of an imaginary person (her mother), she cleaned her mouth, she talked with this person: "But open your mouth, drink something, answer me." She climbed on the bed to arrange the body, then she cried: "The corpse has fallen on the ground and my father who is drunk, who vomits on the bed, cannot even help me." She busied herself lifting the corpse onto the bed. Janet mentioned that this reproduction of the tragic scene lasted three or four hours. It usually ended with the patient looking desperate, having a convulsion (nonepileptic seizure), and, finally, she would fall sleep. Thus, Irène was stuck in "these everlasting recommencements" (Janet, 1919/25, p. 663).

In the case of Sandra above, so many EPs were created that any given EP would have been able to reproduce only a fragment of the traumatizing event, a minimal existing integration. Irène as EP, on the other hand, had repeatedly and meticulously reproduced all the details of her mother's death: an automatic reproduction of a unique and long sequence of acts, that is, incomplete integrations that were created in that past traumatizing situation. Stuck in trauma time, so to speak, her actions completely lacked presentification. The amnesia experienced by the other dissociative part (ANP) for the death of her mother as well as for these re-enactments and a complete lack of *personification* reflected the highest degree of non-realization (Janet, 1935).

6.3. Substitute integrative actions in ANPs

Janet (1889) had already pointed out that some dissociative parts may interact in the external world, and develop further by absorbing and retaining new experiences. They are thus involved in creative actions to a limited degree. Although he was not so clear in this respect, his examples showed that these dissociative parts could also develop higher psychological functions such as autonomous will and critical judgment (Van der Hart & Friedman, 1989, p. 6). In other words, they could, to some degree, perform adaptive and thus higher-order integrative actions related to changes in the environment, and lead more a life of their own (Janet's "emancipation") and become more "elaborated" (Van der Hart et al., 2006). This is the case especially with ANPs, which by definition are mediated by action systems for fulfilling functions related to daily living. However, they remain hampered by insufficient coordination within the individual's personality as a whole, and by phobic avoidance, which maintains the dissociation of the personality. Given the fact that they have not integrated the traumatic memories and related EPs, such individuals remain vulnerable ongoing triggering and re-enactments.

It should be noted that some EPs, while still remaining stuck in trauma time, have the possibility to develop non-traumatic experiences and some degree of adaptive action in the present. Thus, they could develop some more realistic perceptions of the outer and inner world and, especially in the context of therapy, establish collaborative relationships with other parts and the therapist: higher level integrative actions (Van der Hart et al., 2006). Again, however, as long as dissociative individuals have not integrated their traumatic memories, they remain vulnerable to ongoing dissociation and serious dysregulation.

6.3.1. Substitute integrative actions in the dissociative personality as a whole

In order for individuals with trauma-generated dissociation to function in daily life, at least some implicit integrative actions need to take place. For instance, when a person with DID has a worker part at her job, and perhaps another part that engages in home activities, there needs to be some implicit coordination of these different parts' actions – even when they are not aware of each other's existence. For example, the worker part shows up at work on time, and the part engaged in home activities is not activated during work hours. However, the high levels of integration, that is realization, may still be completely absent.

7. Treatment

Janet was an extraordinarily creative and effective psychotherapist described a wide range of treatment approaches and interventions for many types of patients, including traumatized ones (e.g., Janet, 1898a, 1898b, 1911, 1919, 1923). For example, he was the first to sketch a phase-oriented treatment model with severely traumatized patients (Janet, 1898b, 1911), consisting of:

- stabilization;
- treatment of traumatic memories, and;
- personality integration and rehabilitation (Van der Hart, Brown, & Van der Kolk, 1989).

For detailed descriptions of Janet's therapeutic work, the reader is referred to a number of contemporary sources, e.g., Bühler and Heim (2011), Craparo, Ortu, & Van der Hart (2019), Ellenberger (1970), Ogden (2019). For modern applications of his treatment approaches, readers are referred to Nijenhuis (2017), Ogden et al. (2006), Ogden and Fisher (2015), Steele et al. (2017), and Van der Hart et al. (2006). Here, we focus on Janet's aim of helping patients transform their vehement emotions into an empowering or sthenic type of emotion, which plays an essential role in efficient and effective integrative actions. Janet asserted that "an action is not only the simple physical or mental action itself, but incorporates and expresses a person's beliefs, reflections, and experiences" (Janet, 1903, p. 7). These emotions:

> may induce calmness, strengthen the visceral functions, arrest the useless mental agitation and replace it by an increased activity of attention and will. This improved condition of attention and will strengthen the tenacity of memory; it gives rise to valid representations of reality and to effective reactions upon one's environment. There are emotions which elevate as well as those which depress, emotions which heal as well as those which destroy. (Janet, 1905, p. 108)

Janet emphasized the supportive, encouraging role of the therapist in patients' development and acquisition of such empowering emotions in adaptive actions. Initially he tended to be quite directive in these encouragements, while at later stages, he gave his patients greater responsibility in developing will power and power of action for the efficient and effective execution of increasingly complex and demanding adaptive actions (Steele & Van der Hart, 2019). Janet (1898a, p. 480) quoted W. James in describing a most important treatment principle in the therapeutic relationship: "[O]ur courage is so often a reflex of another's courage, so our faith is apt to be . . . a faith in someone else's faith" (James, 1890, p. 579).

In order to help increase the patient's adaptiveness and integrative capacity, Janet emphasized, especially in the initial stages in therapy, the need to prevent the re-occurrence of

emotivity (affect dysregulation), with its dissolving power. This meant that the tasks suggested to patients should be adjusted to their capacities, including their confidence and will power – not being too demanding. The therapist's slow, gradual instruction in the execution of the task helps patients to "then make correct and automatic reactions which will spare [them] the loss that would be caused by failure, as well as the cost of agitation and emotion (Janet, 1919, p. 737; Ogden, 2019). In other words, therapists should guide patients in performing the tasks well and reach completion and success, and learn the principle of acquiring mastery through repetition.

In short, Janet felt that imperfectly and uncompleted actions lower integrative capacity, while well-performed and completed actions heighten it (Ellenberger, 1970). Such completions involve "acts of triumph" involving feelings of mastery and relief (Ogden, 2019; Ogden & Fisher, 2015; Van der Hart et al., 2006). These positive experiences in daily living may enhance, with careful help of the therapist, patients' ability to overcome their phobia of traumatic memories and integrate them. Patients "suffering from traumatic memory have not been able to perform any of the actions characteristic of the stage of triumph" (Janet, 1919, p. 669). Traumatic memories involve the most threatening experiences, including failed attempts at defensive actions. To complete these actions – in the context of phase 2 work, the treatment of traumatic memories – adequate preparation is essential, especially with patients with a history of early childhood traumatization, complex dissociative disorders, and low integrative capacity through post-traumatic decline.

8. Discussion

Pierre Janet made an essential but often overlooked distinction between so-called vehement emotions and empowering or sthenic emotions. This article emphasizes Janet's views on the nature and relationships between vehement emotions, in particular those involving traumatic experiences, and dissociation of the personality. This distinction has been lost in much of the current literature on the nature of trauma-generated dissociation, in which dissociation is understood as consisting of a variety of distancing maneuvers ("detachment") in the face of threat. Janet's first key understanding is that individuals experience vehement emotions – a wide range of disturbances involving all the functions of the organism (*toutes les fonctions de l'organisme*; Janet, 1909b, p. 1552) – when they are faced with situations that require an adaptive response while actually being unable to provide one. In describing the four dimensions where these modifications take place, emphasizing action, Janet distinguished between agitations (hyperarousal) and depressions (hypoarousal) of various functions.

Janet's second key understanding is that vehement emotions have a disintegrating effect on the entire organism; they constitute an integrative failure, which, especially during traumatic experiences, involves acute division (disaggregation or dissociation) of the personality. This acute division results in a dissociative structure of the personality, consisting of, in Janet's terms, dissociative "ideas and functions," or, in modern language, "dissociative parts of the personality," all with their own, however rudimentary, sense of self and first-person perspective. This dissociative structure of the personality manifests in various negative and positive dissociative symptoms, called by Janet respectively "mental stigmata" and "mental accidents" that may also take on a somatoform (sensorimotor) or psychoform (cognitive-emotional) form. Janet hinted at the role of a phobia of traumatic memory in the maintenance of this dissociation of the personality; in more recent publications, other specific inner- and outer-directed phobias with the same function are discussed.

In many contemporary publications on trauma, Janet's understanding of the underlying integrative failure in trauma-generated dissociation is down-played or even dismissed. Dissociation is rather viewed as an adaptive, purposeful defensive action instead of the outcome of overwhelming experiences, that is, vehement emotions. We have argued that this integrative failure is highly relevant to understanding and treating traumatized individuals, whose capacity for integration is lower. Janet defined mental health as a high capacity for integration, which unites – and also differentiates – a broad range of psychological phenomena within one personality (1889). This involves the experience of ownership of these psychological phenomena, *personification*, and the ability to correctly attribute degrees of reality to one's experiences, presentification. Traumatized individuals are not able to perform such integrative actions with at least some significant experiences, especially not their traumatic experiences. However, such integrative failure manifesting in a dissociation of the personality does not mean that no integrative actions take place; dissociation is not a state of complete disorganization. We have tried to delineate several lower or substitute integrative levels, at the level of the personality as a whole and specifically characterizing different dissociative parts of the personality.

At these lower integrative levels, lower-order, substitute integrative actions may allow for a degree of creativity. However, this creative or innovative activity, when it exists in the EP, is mostly a focused attempt to respond to a past trauma that is neither presentified nor personified by the personality as a whole. In other words, conservative actions are more prominent than the creative activity of synthesis. In ANP, the ability for creative activity is greater but generally restricted to areas unrelated to traumatic experiences.

The restoration of the balance between creative and conservative activities for all dissociative parts, the increase of adaptive actions and integrative ability, if possible leading to a unification/complete integration of the personality, may be achieved in therapy through the development and strengthening of sthenic or empowering emotions.

In conclusion, we argue that it is essential to follow Janet in understanding the dynamic relationship between the disintegrative phenomena of vehement emotions and trauma-generated dissociation of the personality.

Disclosure of interest

The authors declare that they have no competing interest.

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