Janet and Freud: revealing the roots of dynamic psychiatry

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Objectives: Interest in the work of Pierre Janet is presently undergoing a scholarly revival and, in the process, his contribution to dynamic psychiatry is increasingly being recognised. This article compares and contrasts Pierre Janet's early studies on hysteria and the neuroses with those of Freud.
Method: The study surveys original works by Janet and Freud and contemporary scholarly exegeses. It particularly focuses on ideation and memory, consciousness and dissociation, psychological trauma, the self, therapeutic influence, and treatment by integration versus abreaction.
Results: Grounds are presented for either preferring Janet's notions to Freud's, or for integrating them.
Conclusion: It is concluded that a number of Janet's contributions to psychopathology and psychotherapy, particularly in the field of dissociative disorders, deserve further exploration and application.

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Dynamic psychiatry was conceived at the Salpêtrière just over 100 years ago. First Janet [1] and then Breuer and Freud [2] published studies on the dynamics of hysteria. For the following half a century Freud's influence on psychiatry eclipsed that of Janet. Two publications spanning the last 25 years reflect a reversal of that process: Ellenberger's chapter on Janet in his *The Discovery of the Unconscious* [3] and Van der Kolk and Van der Hart's *Pierre Janet and the Breakdown of Adaptation in Psychological Trauma* [4]. What had been a slow trickle of re-publications and articles on Janet's work following his death in 1947 became a veritable stream of scholarly studies [5]. There are now four centres of Janet scholarship in France, the Netherlands, the USA and Australia. This paper is an expanded conference report, integrating three papers by Australian researchers, which explores related aspects of Janet and Freud's work on the psychodynamics of hysteria and the neuroses [6].

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Janet and Freud: parallel interests, disparate models of consciousness

Fundamental to the debate between Janet and Freud were their views on non-conscious processes. Initially there were a number of similarities, but they diverged early, Janet developing a more structural model based on lateral splitting of the psyche [7], and Freud the more familiar depth model with vertical division. For Janet, consciousness normally consists of a central active state in free contact with inactive subconscious states at the periphery. His model allows for co-consciousness in which peripheral states may, under certain conditions, become sublim-

inally active and then consciously aware. In the dissociated state (e.g. following psychological trauma) subconscious ideas, emotions and memories are pathologically split off from the main focus of attention. There they remain active, coexisting with and mostly secondary to primary consciousness. Subconscious mental states become semiautonomous in dissociative symptoms such as fugue, or completely autonomous in multiple personality, frequently then becoming the dominant consciousness. Janet's model is currently undergoing a renaissance of interest, particularly in regard to posttraumatic states [4,8] and dissociative disorders [9,10].

Hysteria and ideas

Janet divided the symptoms of hysteria into stigmata, which are the core phenomena, and accidents, which are contingent symptoms associated with psychological trauma [1]. Both are characterised by an underlying defect in the process of psychological synthesis, manifesting in stigmata with motor and sensory dissociation (traditionally known as conversion), and in accidents with dissociation of ideas, memory and consciousness. Although stigmata were considered to be essentially endogenous, stress and trauma were also seen as capable of playing a role in their psychogenesis, specifically through the medium of memory and related ideational processes.

Prior to Janet, for example in the work of Charcot, a negative characterisation of hysterical symptoms predominated [11,12]. Since the clinical phenomena did not correspond to anatomically determined lesions, they were seen as lacking positive characteristics of their own. Thus in 1888, following his 1885–1886 visit to Paris, Freud continued to promulgate the theory of hysteria as ignorance of anatomy, both in his entry on hysteria in Villaret's influential *Handwortebuch* [13] and in the preface to his translation of Bernheim's *Suggestion* [14]. It was only 5 years later in 1893, following the seminal publications by Janet in the previous year [15–17], that Freud was able to begin developing his own positive characterisation of hysteria.

In 1892, Janet read a series of papers at the Salpêtrière, covering the major symptoms of hysteria [1]. He made the revolutionary proposal that it was the idea representing the organ or its function that was lost to consciousness. Neither Charcot nor Freud had previously differentiated between actual organ dysfunction and the popular notion of it. Janet proposed that it is the latter which gives rise to the peculiar symptomatic distribution. He also pointed out that determination of the details of the symptom by ordinary, everyday ideas of the organ indicates that hysterical symptoms are not entirely organic maladies but also have an important psychological component. In a proportion of cases, the latter consists of a process of symbolisation following psychological trauma. One year later in 1893, Freud incorporated Janet's thesis and developed his posttraumatic ideational model to cover all hysterical symptoms. At first he acknowledged his debt to Janet for the positive characterisation of hysteria, but 30 years later he indicated that psychoanalysis was not based on these researches of Janet's [18].

Hysterical accidents and traumatic memories

Throughout the 19th century increasing clinical interest was shown in the contingent or accidental symptoms of hysteria. They were principally recognised in somnambulism, fugue and multiple personality. However, the link between these mental states and posttraumatic maladies of representation awaited the work of Janet. He recognised that a substantial proportion of cases were posttraumatic in origin. Thus, Crocq and de Verbizier recently estimated that nearly 50% of Janet's cases of neurosis in his first four major works (257 of 591) were posttraumatic in origin [19].

The first case which Janet attributed to a traumatic event was Lucie, reported in three papers between 1886 and 1888 [20–22]. Her somnambulism, characterised by 'hallucinatory terrors', was traced to the emergence of a second personality, Adrienne, following a sudden fright at the age of 9. Another case, Marie, published in 1889 in *L'automatisme Psychologique*, also suffered recurrent somnambulistic crises [23]. In these, the accidental symptoms commenced 2 days after the onset of each period with a rising sensation of cold up to her waist. This was traced back to her menarche when she attempted to staunch the flow of blood by immersing herself in a tub of ice cold water. Two further antecedent traumas were subsequently uncovered: seeing an old woman fall down stairs and die, and sleeping with a child who had impetigo. Janet thus acknowledged the contribution of psychological trauma early, but later

discouraged the Freudian psychoanalytic tendency to conceptualise all hysterical symptomatology in terms of transformation of traumatic ideas.

Following Breuer's investigation of hysteria in Anna O in 1889, Freud explored with hypnosis the dynamics of hysteria in Emmy von N. These and three further cases of Freud were the basis of these authors' recognition of the contribution of psychological trauma to hysteria, particularly that of a sexual nature (e.g. Breuer and Freud [2, p.213]).

It was only a short step for both Janet and Freud to propose the elimination of the pathogenic non-conscious basis of posttraumatic hysteria using hypnosis. In parallel with Delboeuf in Belgium, they employed a combination of uncovering, direct and indirect suggestion, and therapeutic modification [24].

Dissociation and posttraumatic hysteria

Janet began to conceptualise posttraumatic hysteria in *L'automatisme Psychologique* [23], but did not use the term 'hystérie traumatique' until his publication *Les Médications Psychologiques* some 30 years later [25, p.710]. His formulations of the natural history of this disorder were recently summarised in a three-stage model [26]. The acute stage can follow not only objective but also subjective psychological trauma. In it, the self is overwhelmed by intense emotion. For Irène, this was horror when her mother suddenly fell dead from her bed after she had nursed her for a prolonged period [27,28], while for Justine it was disgust at coming into contact with cholera corpses [1]. Heightened emotionality and suggestibility subsequently impede reflective appraisal and adaptive action and result in the failure to assimilate the primary experience of trauma.

In the second stage, consciousness is narrowed as traumatic memories are dissociated as subconscious fixed ideas. These memories emerge in flashbacks, nightmares and somnambulistic crises, particularly when triggered by closely related stimuli. They are otherwise masked by the more protean manifestations of hysteria including the stigmata. This gives the illness its essentially biphasic character in which re-experiencing the trauma in the form of accidental symptoms alternates with amnesias, phobias and other avoidance phenomena. In the final stage, emotional exhaustion leads to the emergence of non-specific manifestations which Janet called 'forced agitations', and ultimately results in defects in the will or abulia, depression and other psychological end states.

Janet thus considered the mechanism of posttraumatic hysteria to be dissociation with a progressive deficiency in the capacity for synthesis, first of traumatic images and emotions, then of traumatic memories as subconscious fixed ideas, and ultimately of a progressively wider range of personality functions and variables. Failure to synthesise and integrate psychological trauma could account for a proportion of hysteria, but in others the failure in psychological synthesis appeared to be primary. Janet postulated a defect in personal perception to explain these putative endogenous cases. However, contemporary research into the aetiology of dissociative disorder indicates that occult early childhood traumatisation may account for a proportion of such cases, which might have therefore been undetected by Janet [29].

Breuer and Freud initially employed Janet's concepts to formulate their model of posttraumatic hysteria, and then hysteria and the neuroses in general [2, pp.170–172]. Thus, Freud linked Janet's notions of the role of conscious and subconscious ideas in hysterical symptom formation with his own concept of associative inaccessibility. In this, the idea of the organ or function is lost as a result of association with unconscious traumatic memories, and is fixated at the unconscious level by the emotional charge of the memory. Uncovering of traumatic memories in light somnambulistic states, for example under hypnosis, and abreaction of the associated quota of affective charge, restores the lost hysterical function. Up to 1894, Freud held a similar but unstated notion to Janet that subconsciousness is due to a failure of psychological synthesis. In this, the emotionally charged event is experienced in this secondary consciousness due to a dissociative splitting of the psyche, rather than as the result of the persistence of the quota of affect itself. He subsequently substituted his theory of repression.

Psychological synthesis, insufficiency and defect in personal perception

Janet and Freud held increasingly disparate notions of aetiology and psychogenesis in hysteria and the neuroses. Janet referred to psychological synthesis and dissociation, which are functions of the self, while Freud, in relinquishing the latter conceptions, spoke of ego strength and weakness, and of defences and repression.

Both Janet and Freud acknowledged the contribution of biological and social factors, but only Janet's model truly spanned each of the biological, psychological and social domains. It anticipated Engel's conceptualisation early, which was itself an attempt to transcend the biomedical model of psychological illness by drawing on a multidimensional biopsychosocial approach [30]. By way of contrast, Freud adhered to a more purely internal psychobiological determinism, tending to exclude factors which are external (objectively traumatic) and social (therapeutically suggestive) in origin.

Following criticism by Freud and his followers, Janet's conceptualisation of psychological insufficiency was increasingly misunderstood as essentially biological due to a constitutional vulnerability. Janet acknowledged that the understanding of the genetic contribution to mental illness was then rudimentary, and only referred to it briefly in his theoretical discussions, for example in the resume of *The Mental States of Hystericals* [1]. However, he regularly cited the family background in his case vignettes. A representative history is that of Marcelle [31]. A woman of 22 years, she was admitted to the Salpêtrière under Falret for the treatment of hysteria with suicidal depression, abulia and fixed ideas. The main precipitants for her illness were a serious bout of typhoid fever, the subsequent death of her father, and then an amorous disappointment. The family history was very extensive: the maternal grandmother and maternal aunt both suffered from paranoid disorders and died in an asylum; the mother, although not formally diagnosed, was 'weak minded', easily excited, and given to loss of self-control, and the father had a paralysis of uncertain aetiology. Of the six out of 10 children surviving, the three brothers were given to narcissistic traits, and the two sisters frequently manifested an air of distraction and apathy. The younger sister had periods of depression with mutism, often almost to the point of psychosis. In Janet's words, Marcelle united and augmented all of these family features! Clearly, both heredo-familial and exogenous stress factors combined in her case to produce her severe hysterical and affective disorder.

However, the genetic element was never regarded as more than one of several contributing to the essential mechanism, a failure of psychological synthesis. In order to understand this failure, Janet proposed a unifying psychoeconomic model [32]. It comprised an empirically based hierarchy of personality variables extending across the entire psychological domain, from reality functioning to those in the psychophysiological arena. In it, behaviour at the top is characterised by complexity of novel mental synthesis and has the highest degree of reality contact, or in Janet's economic terms, high psychological tension and high psychological force or energy. In a process known as realisation, voluntary and adaptive action is unified with psychophysiological responsivity, and integrated with personal awareness in the formation of identity. The highest synthetic functions are also those most readily lost in hysteria and mental illness in general, giving way to behaviours such as automatism with a much lower coefficient of reality, and correspondingly lower psychological tension. In hysteria, while constitutional factors provide a backdrop of biological vulnerability, oscillations of the mental level are mediated by intercurrent emotional stresses in the more endogenous cases, and by acute psychological trauma in those which are more exogenous.

Failure of the mechanism of psychological synthesis in hysteria results in biological and psychological deficits. Thus, Janet reported changes in heart rate and sweating. In hysterical anaesthesia he described a predilection for the left hand side, capillary vasoconstriction, and a reduction of the symptom during sleep and following administration of alcohol, chloroform, and morphine.

In regard to psychological deficits, Janet considered the reduced capacity to assimilate elements of sensation into complex personal perceptions to be at the root of narrowing of the field of consciousness and the consequent attentional deficits. Thus, patients who are unable to attend to their sensations cannot recall them as part of their personal perception and are therefore anaesthetic.

Psychophysiological changes in hysteria such as these were the basis of a series of studies by Meares *et al.* which tended to support Janet's hypotheses. They showed that patients with hysteria failed to habituate to a meaningless sound [33,34]. In Janet's terms, they manifested a defect in personal perception. This was also demonstrated in failure of habituation of the galvanic skin response, by increased amplitude of auditory evoked response potentials [35–37], and by a technique called mismatch negativity [38]. The authors proposed that hysterical patients are hyperoriented towards stimuli, and accounted for this by a deficiency in higher order cerebral inhibitory mechanisms.

Turning from hysteria *per se* to posttraumatic cases, for Janet the failure in psychological synthesis is manifested in the dissociative unavailability of traumatic memories. These are relegated to the status of subconscious fixed ideas, which only emerge in the symptomatic state as hysterical accidents.

These deficits notwithstanding, many of Janet's cases had previously achieved the highest levels of psychological synthesis and personal sufficiency only to lose this under the burden of stressful life-events such as traumatic loss. Freud noted similar paradoxes in his cases. Thus, just as Emmy von N did not previously show psychological insufficiency, neither did many of Janet's cases, either before or after their illness, and in moderate cases during it.

Repression

While criticising Janet for his perceived biologism, Freud followed Breuer arguing for an 'innate breeding ground' in the psychological development of hysteria. Paradoxically, three out of the four cases which Freud published with Breuer between 1893 and 1895 could well have had organic bases [39]. Elizabeth von R had a spinal disorder, Lucy R suffered from the consequences of ethmoiditis and purulent rhinitis, and Emmy von N had long-term neck cramps, verbal tics and athetosis. Only one patient whom Freud saw only once, Miss Katharina, was clearly suffering from a primary psychological disorder, anxiety hysteria. Nevertheless for Freud, only the minority of cases were either neurological or due to direct somatic conversion of affect. Instead he generalised Janet's posttraumatic 'accidental' theory to all of the neuroses, seeing by far the majority as ideogenic following sexual traumatisation. In contrast to Janet, Freud proposed an excess of excitation as opposed to psychological weakness. In consequence, the ego becomes active in defensive splitting and repression of the posttraumatic conflicts, rather than succumbing and fragmenting. The exogenous model of hysterical neurosis was relinquished in 1897 to be replaced essentially by the theory of unconscious sexuality [40]. In this, intrapsychic sexual conflicts divert and distort instinctual development. In so far as psychological synthesis was seen to be impaired, this was only in the sense of disrupted ego development rather than as a fluctuation in ongoing functional capacities [41].

Repression is more of an inferred theoretical concept than dissociation, which, as Hart noted, is descriptive of observable phenomena [42]. As Breuer implied, repression rather expresses a relation: we only know what it does, not what it is. Freud postulated early the deliberate suppression of ideas incompatible with central consciousness. He later played down the role of conscious phenomena, proposing the mechanism of repression which operates through the unconscious detachment of affects from ideas, specifically traumatic memories. In hysteria, the affect becomes linked with and thereby converted to bodily or other mental symptoms. Freud's postulation of unconscious, often lifelong, cumulative mechanisms unavailable to either clinical or experimental retrieval undermined his theory. There need not be objective historical data or psychological referents, and there were frequent theoretical inconsistencies, for example in treatment. Thus, abreaction of traumatic memories is supposed to occur with affect, but contradicting this, repression is said to have separated these memories from their affects. By way of contrast, Janet's failure of psychological synthesis and deficiency in personal perception were regarded as interim abstractions awaiting further research in the biopsychosocial arena.

Self and ego

The term 'ego' originated in the mid-19th century and by way of Freud became a cornerstone of western psychiatry [43]. He proposed further subdivision into a tripartite structure to include the superego and the id. Subdivision of the self also had a long ancestry, particularly in regard to sub-selves and multiple personality. The origins of modern self psychology are to be found in the contributions of a group of psychiatric researchers prior to World War I. Janet was a key member, and others included Baldwin, Prince, James, Bergson, Claparede and Piaget. The latter regarded himself as Janet's pupil.

For Janet, the self follows a developmental path [44]. Between the ages of 2 and 4 years it evolves from a primitive 'spatial' differentiation of self and other to a complex unified innerness founded on psychological synthesis of the stream of consciousness.

The self is based on temporal as much as spatial continuity. Janet wrote: 'The duration of the present is the duration of a story' [45]. Synthesis of memory into the stream of consciousness is thus essential to the coherent temporal experience of self. Janet recog-

nised two forms of memory: experiential memory, in which past experiences are re-lived as if they are occurring in the present; and narrative memory, which records and maintains the historical record, and which is continuously reconstructive. Each of the two different forms of memory is based on a different experience of time. Whereas narrative memory is static, experiential memory relates to the continuously evolving present, and to the stream of consciousness. The resulting sense of innerness provides the core sense of self, or identity.

A major manifestation of hysteria is a disturbance in the stream of consciousness and its recurring contents, particularly percepts and memories, and thus in the experience of the self. There is a derangement in the way subjects tell the story of their lives. Hysterical consciousness lacks imagination and is monotonously chronological. This is because when traumatic events occur, particularly sexual abuse, these are often poorly integrated due to the persistence of strong emotions such as overwhelming anxiety. There is a failure of the unity of experience, the sense of self, and psychological life in general. When the failure in psychological synthesis occurs during psychological development, it may also correlate with disruption and delay of brain maturation, particularly of the pre-frontal cortex. Fragments of this unintegrated experience and related aspects of the self remain unavailable to narrative memory, episodically intruding into consciousness as either 'accidental' symptoms or alter-personalities.

Psychological determinism, therapeutic influence and rapport

The contribution of endogenous versus exogenous factors in symptomatic and treatment responses has been a scientific concern since the time of Mesmer. Notions of internal psychological determinism gradually prevailed during the 19th century and were predominant by the time of Charcot. He proposed uniform stages of hysteria and hypnosis independent of suggestion, time or culture.

The tide began to turn with the independent studies of Delboeuf, Binet and Bernheim. Delboeuf too visited Charcot at the Salpêtrière in the late 1880s, and studied the mechanism of hypnotic 'transfer' [46]. He came to the conclusion that hypnotic influence is a psychological demand characteristic. At first Janet did not accept Delboeuf's views, and argued against suggestion in hysterical symptom formation. Rather, it was through his studies of therapeutic influence in the rapport that he began to understand the contribution of direct and, more importantly, indirect suggestion, although he did not explicitly use this term. By 1919 Janet was able to reconsider Charcot's findings and reconstruct his mentor's deception [25].

In his seminal conference paper of 1896, published as *The Somnambulistic Influence and the Need for Direction*, Janet explored subconscious transmission of the clinician's ideas [31, vol. 1, p.423–480]. He first linked the notion of the magnetic rapport with contemporary studies of somnambulistic influence in the treatment of hysteria. This was reported in *L'automatisme Psychologique* as the principal of electivity, in which the patient's dependency on the therapist was linked with narrowing of the field of consciousness [23, pp.190–199]. In the chapter, Janet further analysed the patient's responses to the therapist in terms of indirect hypnotic suggestion.

Janet first outlined three well-defined sequential stages of hypnotic influence: fatigue, influence proper, and passion. The stage of fatigue is very brief and characterised by relief from symptoms. During somnambulistic influence, the patient becomes preoccupied with the therapist. It is during this stage that the subject adopts the therapist's ideas and intents. Improvement is then reinforced and maintained by repeated treatment contact. However, the influence and resulting benefits are not very durable. Recrudescence often following trivial emotional upsets leads to an obsession with re-hypnosis and a corresponding passionate desire to see the therapist.

Janet noted that these stages of therapeutic influence are common to all the neuroses, not just to hysteria alone. He acknowledged the possibility of inaccessible cerebral cellular changes but felt that psychological factors contribute no less than the organic. Direct suggestion only partly accounts for therapeutic influence, nor does posthypnotic suggestion, which corresponds to it. Both processes require explanation in their own right. Janet raised the possibility of autosuggestion and subconscious suggestion of influence and passion by the hypnotist without realising it. Contrary to this notion, he cited the considerable but only partially successful conscious therapeutic efforts to limit unwanted effects and enhance specific therapeutic outcomes. Rather, Janet opted for distinct phenomena under the rubric of 'the

persisting ideation of the therapist', a process which he felt elicits sentiments of affection or even blind obedience. It is manifested in dreams of the therapist and hallucinations of the therapist's voice, and enhances suggestibility, improves the mental state, and reduces symptomatology. It is as if the hypnotist's ideation continues to speak through the subject in these varied ways. In order to become established it requires a process of education, but this frequently meets with resistance. Termination of influence is associated with a passionate desire for the restoration of this curative internalised ideation. It is specific to the hypnotist rather than simply an organic effect. The three stages are sequential manifestations of indirect suggestion made possible by psychological and related cerebral insufficiency. This weakening of mental synthesis leads to the insufficiency of will called abulia. Patients then seek to fortify or replace their will, and this is achieved by carrying the memory of the therapist, acting indirectly as a 'director'. The task of the therapist is to stimulate and ensure mental synthesis by organising this process around their persona. However, this iatrogenic mental synthesis is poorly adapted to ever-changing reality, and when it fails it must again be restored. Hypnosis is neither the basis for restoration nor direction in abulic patients, but rather an adjunct to it. Instead it contributes to the overall psychoeducational process. Dependency gradually diminishes in treatment as the patient's own powers of mental synthesis and self-direction are substituted.

Transference

Freud recognised the influence of the therapist no less than Janet. One hundred years on, Makari has anlysed Freud's concept of the transference. He felt that it developed independently of Janet's rapport and somnambulistic influence [47]. Instead he linked it to late 19th century debates on the inherent suggestibility of the hysterical patient. Freud regarded transference early as the 'sine qua non to a solution of the (hysteria) problem' [2, p.266]. In keeping with Charcot's notions of internal determinism, he conceptualised the transference as a spontaneous aspect of neurosis, resulting from inbuilt resistances: reluctance to be influenced, perceived therapeutic neglect, and fear of transferring to the therapist distressing ideas arising in the content of analysis.

Transference initially relied on Janet's conceptualisation of splitting of consciousness or dissociation. Freud saw the basis of the 'false connection' between transference aspects of the therapeutic interaction and the patient's pre-existing mental contents in two phenomena: associative inaccessibility to mental awareness of the true unconscious causative factors, specifically the dissociated traumatic past, combined with a compulsion to associate these phenomena with, and transfer them to, the therapist. He emphasised an increasingly unconscious and more purely psychophysiological determinism founded on changes in emotional excitation within the nervous system, and alterations in the unconscious agencies of the mind, both relatively impervious to ongoing outside influences. Neither direct nor indirect external suggestion had a role to play in either symptom formation or removal. Freud later proposed that these unconscious factors are sexual, and related specifically to the unconscious persistence of residues of the subject's infantile sexual drives [48]. While acknowledging the connection with normal manifestations of human affection, Janet could not extend this influence to sexual love [25, pp.611–622]. Rather he developed a general theory of therapeutic attachment 'avant la lettre'. Instead of focusing on internal determinism and unconscious psychosexual factors, he emphasised external attachments and expectancy factors, in particular direct and indirect suggestion. Not long after Janet died, Macalpine and Hunter considered the transference to be due to suggestion, a demand characteristic of object deprivation in the psychoanalytic setting [49].

Emotion and abreaction

Freud's treatment of hysteria by emotional abreaction differed markedly from the integrative approach adopted by Janet and Delboeuf [24]. Van der Hart *et al.* comprehensively summarised Janet's de facto, three-stage model of psychotherapy for posttraumatic hysteria [26]. Following a preparatory phase aimed at overall stabilisation of the patient and general symptom reduction, the core treatment stage consisted of integration or 'synthesis' of traumatic memories. He called this process liquidation. The essence of treatment was the facilitation of recounting, reconstruction, and controlled re-experiencing of the trauma. Hypnosis was frequently used as an adjunct to uncovering and modification. Two indirect techniques were developed and used when liquidation

could not be directly applied: substitution of positive for negative images, and conceptual re-framing. The final stage pursued the goals of personality integration and rehabilitation. Clearly, Janet's second stage differed markedly from that of Freud, who opted for ventilation of affects over Janet's synthesis and integration of memories and associated personality functions.

Macmillan [11,24] explored the origins of Freud's abreactive model which was purportedly rooted in Breuer's treatment of Anna O in 1881. A thorough reading of the primary sources revealed that Freud's publication followed the findings of Janet in 1892. Breuer's original case notes emphasised the efficacy of verbal expression and narration over emotional arousal and release, which were in fact later interpolations incorporated into the completed case report. There is little indication in the description of Anna O's 'talking cure' of her being required to abreact emotionally charged memories while recapitulating the circumstances in which she had acquired them. Abreaction did not seem to form part of the necessary and sufficient conditions of the partial alleviation of her symptoms which Breuer was able to achieve. It was only in late 1892 that Freud gave any credence to emotional expression. Macmillan proposed that Freud's re-interpretation of treatment in affective terms derived from Hughlings Jackson's model of emotional equilibration of the nervous system grafted on to Janet's thesis that ideas determine the details of hysterical symptoms [12]. Freud aimed to link these posttraumatic pathogenic ideas and affects in a cathartic therapeutic discharge. Macmillan postulated that the basis for Freud's proposed linkage was due to the unconscious transmission of expectations to the patient that talking with emotion could effect a cure. The theory of treatment thus clearly anticipated the observation of clinical facts.

Later commenting on Freud's notion of abreaction, Janet noted that treatment by emotional 'discharge' had been in practice long before Freud [25, pp.681–693]. He conceptualised this therapeutic discharge in terms of his hierarchical economic model of the personality. Thus, with traumatic memories which have been dissociated as subconscious fixed ideas, discharge and rechannelling of their associated mental energies (in Freudian terms, 'decathexis') also contributes to liquidation of the trauma. Janet regarded this as an example of specific discharge aimed at conservation of mental energy. More general methods of emotional discharge were aimed at either augmenting or diminishing mental energy and restoring equilibrium between psychological force and psychological tension. Concepts of abreaction and therapeutic integration were critically examined in two recent articles by Van der Hart *et al.* [50,51].

Conclusion

Janet and Freud developed the first modern psychological concepts of hysteria. Marked theoretical and practical differences arose between them. Janet linked conscious and subconscious ideas with psychological symptoms under the rubric of dissociation theory. Freud initially pursued the same course, but branched off early via associative inaccessibility to repression and the dynamics of the unconscious. Freud's psychological models remained illness-orientated. The model of traumatic stress was generalised to all the neuroses, and the ego was regarded as a 'deus ex machina', orchestrating defence mechanisms and symptoms. By way of contrast, Janet evolved a health-oriented model based on growth and maintenance of the self. This was founded on synthesis of personality factors along a functional economic hierarchy, particularly of memory, but also percepts and other psychological elements. Psychological illness was conceptualised in terms of impairment of synthesis, for example dissociation of consciousness, and consequent psychological insufficiency. Janet also described the process of repression, but he saw it as distinct from dissociation, and a consequence rather than a cause of hysteria [25, pp.608–611,640–651].

Janet and Freud both continued to focus on intrapsychic processes, but Janet emphasised the interaction of exogenous and psychosocial factors within the biogenetic matrix over Freud's more purely endogenous psychological and physiological approach. Thus, while Freud acknowledged the role of combat in the war neuroses [52], he relinquished the theory of objective sexual traumatisation early for the theory of infantile sexual fantasy. He rarely alluded to the external factor, and unlike Janet eliminated this from the central tenets of his theory.

In the treatment domain, Janet and Delboeuf failed to confirm the fundamental role of emotional ventilation *per se*, and their methods of psychological synthesis diverged widely from those of Freudian abreaction. Treatment with adjunctive hypnosis was

aimed at facilitating psychological synthesis, of percepts in anaesthesias, and memories in posttraumatic states. This contrasted with Freudian emotional abreaction with equilibration through the discharge of affect.

Janet's views on determinism and the role of emotion are more in line with some current ideas about mental functioning and psychotherapy than are Freud's. In this regard, of central import is the role of indirect suggestion and psychological demand characteristics. Behaviour can be shaped by unconscious imitation of other patients, unconscious divination, and meeting the therapist's expectations. Determinism in the formation of hysterical symptoms reveals itself in the lawfulness and regularity with which ideas act whatever their source, including the therapist. Janet was more aware of this fact than Freud.

The work of Janet clearly often anticipated that of Freud, and in some cases is now replacing it. It is particularly informing current studies of psychological trauma and dissociative disorder and their psychological treatment. It is frequently asked why it has taken half a century to rediscover Janet. The following hypotheses have been considered: Janet was before his time; he was eclipsed by Freud, and he discouraged establishment of a psychological school [5]. Communication was Janet's greatest strength both in the clinical, didactic, and research domains. The clarity of his writings in their native French and their accessibility in translation to the modern reader enable us to mine their many riches. Now is the time for further translation so that Janet can be profitably re-read. The current Australian authors are contributing to this worthy cause.

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Comment

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This is an important paper and it is a privilege to be asked to add a commentary. Understanding creative individuals who have been overshadowed by their contemporaries in the forward movement of history is always appealing. Wallace and Darwin come to mind. Gregory's *Companion to the Mind* [1] classes Pierre Janet with William James and Wilhelm Wundt among 'the handful of thinkers ... who established psychology as a discipline'. Janet was elected to the Collège de France, traditionally the highest academic honour in France. One could say that he touched the pinnacle of fame. Ellenberger [2], to whom Brown *et al.* make passing reference, writes: 'Janet stands at the threshold of all modern dynamic psychiatry. His ideas have become so widely known that their true origin is often unrecognized and attributed to others' (p.406). Ellenberger comments on Janet's influence on Bleuler, Jung, Adler, Freud and the leading French psychiatrists, Henri Baruk, Henri Ey and Jean Delay. Henri Ey devotes a section of his classic *Manuel de Psychiatrie* [3] to Janet's ideas. Janet and the philosopher Henri Bergson had a profound influence on each other and Bergson refers to him in *Matter and Memory* [4].

Nevertheless, Ellenberger [2, p.407] writes: '... in spite of the constant development of his work, it is as if he slowly slipped from the general current ... Comparatively few seemed to notice that he was creating a synthesis of immense scope and dimensions. ... Explanations may be found in Janet's enemies, in Janet himself, and in fluctuations in the spirit of the times.' He was caught up in the reaction against Charcot 'which went so far as to promote a rigidly organicist, antipsychological spirit amongst French neurologists'. Further attacks came from Catholic theologians and laymen. Ellenberger continues (p.408): 'Though Freud had summarily acknowledged Janet's previous research in 1893 and 1895, he became increasingly critical of him. Janet's report on psychoanalysis at the London Congress in