The Hypnotherapeutic Relationship with Traumatized Patients: Pierre Janet's Contributions to Current Treatment

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Abstract

In 1897 Pierre Janet (1859-1947) publicized his important contribution on the trauma patient's deep involvement with the therapist. The patient develops intense feelings toward the therapist, termed *la passion somnambulique*. During this period of *passion* the patient experiences intense need of and dependency on the therapist. Synthesizing Janet's work with contemporary treatment of trauma, an attachment paradigm is described in which the trauma patient suffers from the inability to tolerate aloneness, and the need for psychological and relational connection and guidance from the therapist is paramount. Issues of attachment, dependency, and intolerance of aloneness and their management throughout phase-oriented treatment will be discussed.

Pierre Janet's meticulously recorded clinical and experimental observations serve as an extensive data base regarding the nature and course of the therapeutic relationship with traumatized patients. These notes documented his observations of dissociative and traumatized patients undergoing treatment at the

psychiatric hospitals of Le Havre and the Salpêtrière in Paris. They offer intriguing insights into transference, attachment, and dependency issues in trauma, hypnosis and dissociation, and the manifestations of suggestibility, all salient issues in the current treatment of trauma patients.

Other authors, notably Haule (1986) and Brown (1994) have previously commented on Janet's observations regarding the hypnotherapeutic relationship and early transference phenomena described in his publication, "*L'influence somnambulique et la besoin de direction*" [Somnambulistic influence and the need for direction] (Janet, 1897/98a). In this paper we will broaden the focus on Janet's works to elucidate their relationship to current treatment paradigms for trauma, with a particular emphasis on the roles of attachment and dependency in the therapeutic alliance, and the evolution of the alliance over the stages of treatment.

Of course, it is essential to note that hypnotherapy is only one treatment technique used with traumatized patients; there are a number of other theories and techniques commonly employed in contemporary treatment. Thus, although Janet discussed the therapeutic relationship primarily within the context of hypnotherapy—a treatment technique in heavy use during his time at Le Havre and the Salpêtrière, his observations are relevant for all treatment approaches to traumatized individuals. As we discuss below, *la passion somnambulique* may be a manifestation of insecure attachment that may be heightened by hypnosis, rather than an expression of hypnosis per se. Although Janet's observations on the therapeutic relationship are astute and remain relevant today, he did not have the benefit of contemporary understandings of attachment at his disposal to place *rapport magnétique* within an attachment framework.

As Janet has already observed, and others have noted later, many trauma patients have a distressing *intolerance for aloneness* that creates an atmosphere of crisis and excessive dependency needs for the therapist (Adler & Buie, 1979; Gunderson, 1996; Janet, 1897/98a; Linehan, 1993; Modell, 1963). Janet emphasized that the nature of the alliance should follow a particular course over the stages of treatment--Symptom reduction and stabilization, Treatment of traumatic memory, Integration and Rehabilitation (Van der Hart, Brown, & Van der Kolk, 1989/95; Van der Hart, Steele, Boon, & Brown, 1993)--such that the therapist initially is quite active, particularly in helping the patient understand and regulate feelings of aloneness and dependency, and gradually becomes less so over time. Eventually intolerance of aloneness

and dependency issues are resolved and the patient becomes increasingly more active and autonomous in treatment and in life.

Following a brief overview of Janet's major observations of the hypnotherapeutic relationship, comments and discussion relating them to contemporary therapeutic issues will conclude this article. Case examples from Janet, as well as contemporary ones will be included**.** It is important to note that Janet's use of certain terms may be quite different from the way in which we currently use them. To prevent confusion, those readers unfamiliar with Janet should note that there is a brief definition of terms in the appendix.

Although Janet's observations were astute, he rarely made interpretive comments, but instead, left it to his readers to formulate ideas about the intrapsychic dynamics and meaning of the relational process in hypnosis (Haule, 1986; Schwartz, 1951). Also, the concept of transference was only just developing during this time (Kravis, 1992; Makari, 1992). Janet, at the time of his very late 19th century publications--along with Breuer and Freud, and about a decade later, Ferenczi--was on the earliest cusp of the movement toward a more sophisticated conceptualization of transference and alliance problems. During this period there was not any certainty that negative transference having to do with early traumatic conflicts and subsequent difficulties of symbolization should be expected, especially with trauma. Nor were there particular ways to manage it (Bokanowski, 1996). Indeed, as a fascinating example, Bokanowski traces the history of Ferenczi's interrupted analysis and relationship with Freud, elucidating the intense and unresolved negative transference (Ferenczi's) and countertransference (Freud's) in the relationship, and some of the historical genesis of these feelings in both of these men in light of more current understandings of early transference. In fact, there remains to this day a progressive and continuing debate about what constitutes the transference/countertransference matrix within the therapeutic relationship, as well as what defines the therapeutic alliance (Makari & Michaels, 1993; Meissner, 1992).

Janet begins his chapter, "*L'influence somnambulique*" (1897/98a, p. 423) with a comment that the abnormal sentiments present in the hypnotic process are merely exaggerated elements of natural human dependency, and that their study would illuminate the naturally occurring forms of dependency in human nature. Dependency, and its larger context of attachment, are currently central themes in the

conceptualization of trauma and dissociation (Barach, 1991; Bokanowski, 1996; Davies & Frawley, 1994; Deitz, 1992; Hill, Gold, & Bornstein, 2000; Liotti, 1992; Olio & Cornell, 1993; Steele, Van der Hart, & Nijenhuis, 2001; Van der Kolk & Fisler, 1994; Van Sweden, 1994; Walant, 1995).

Rapport Magnétique

The early magnetizers, such as Puységur, Bertrand, Dupotet, Charpignon, Noizet, and Despine, noted the special characteristics of the hypnotic relationship (Crabtree, 1993), and this formed the basis for Janet s observations on the *rapport magnétique* (Janet, 1897/98a, 1919/25). There are three characteristics of this relationship: (1) the hypnotic subject tolerates touch only from his/her magnetizer and suffers if touched by another; (2) the subject obeys only the suggestions of the one who hypnotizes; and (3) in extreme cases, the subject only perceives the magnetizer and negatively hallucinates all others as if they do not exist (Janet, 1897/98a, p. 424).

Janet determined that it was posttraumatic dissociation, feelings of helplessness, a severe narrowing of attention, and absorption with the therapist that created the negative hallucinatory experience and the inability to work with other hypnotists (Van der Hart et al., 1989/95). He referred to this absorption as an "act of adoption" in which patients are convinced that their therapists are the only ones who fully understand them (Janet, 1919/25, p. 1154). The manifestations of the *rapport* will depend on the suggestions of the magnetizer along with the habits and ideas of the subject. That is, what the subject brings of him/herself to the therapy will inevitably interact with therapeutic interventions. The sentiments expressed by the patient are unique to the therapist, and disappear on awakening from trance. *Rapport* is a function of the frequency and duration of the hypnosis, and the subject eagerly seeks hypnosis and is excessively preoccupied with the hypnotist.

L' influence Somnambulique and la Passion Somnambulique

Janet observed a predictable succession of psychological states following hypnotic sessions in which significant symptom alleviation eventually occurs. These states include fatigue, somnambulistic influence, and passion. This process roughly coincides with Janet's phase-oriented treatment of trauma: Symptom reduction and stabilization, Treatment of traumatic memory, and Integration and rehabilitation (Van der

Hart et al., 1993; Van der Hart et al., 1989/95). First, the immediate post-hypnotic period is characterized by marked lethargy and fatigue, usually only lasting a few minutes up to one or two hours. This lethargy does not appear to be related to the phenomenon of somnambulistic influence, but is merely an indication that the patient had entered very deep trance and is highly hypnotizable.

Second, following this is a period of relative health and sense of well-being with variable durations, usually hours to months, and very rarely years, as in the case of Léonie, whose cure lasted 30 years (Janet, 1897/98a, p. 441; 1919/25). This initial and *temporary* symptom abatement is the result of efforts in early treatment to provide symptom relief and stabilization for the patient, and composes the first phase of treatment: Symptom reduction and stabilization. For example, Janet's patient Gu, who had a hysterical contracture of her arm went for two days with normal arm movement (Janet, 1897/98a, p. 426). Lz, who entered spontaneous and lengthy somnambulistic states, did not fall asleep in the day for eight days following treatment (Janet, 1897/98a, p. 426). This is the state of *somnambulistic influence*. During this time the patient approaches a normal state, and *fixed ideas* (See Appendix) disappear. Memory, attention, motivation, will, and intellectual functioning improve. During this time the patient does not seem interested in further hypnotic sessions, and although s/he may think about the therapist, these thoughts are not experienced with any emotional intensity.

Most patients showed remarkable positive changes in attention, focus, intellectual functioning, psychological tension [ego strength] and the resulting ability to conduct daily life during the time of somnambulistic influence. For example, Janet's patient, Marguerite, who regularly had one or two hysterical attacks a day, was able to be symptom-free for 8 to 12 days following a hypnotic session (Janet 1897/98a, p. 426). Another patient, M. [possibly Marcelline, who became Janet's prototype of double or multiple personality (Janet, 1910)], had a history of chronic vomiting [quite possibly bulimia], and after hypnotic sessions could feed herself and keep it down for up to three weeks. For days, his patient Justine did not think of cholera on which she had been previously fixated, nor did she have any secondary fixed ideas related to it (Janet, 1894/98, 1897/98a, p. 427).

However, this apparent move toward health does not last, and its temporary nature is indicative of the need for complete treatment of trauma that goes beyond initial symptom management. Following a

stressful event or emotional upset, the patient relapses into a full hysterical state again in which there is a return of *original (primary) fixed ideas* (See Appendix), as well as additional secondary ones, and experiences a state of helplessness and despair (Brown, 1994). The patient experiences an intense need to see the hypnotist and to be hypnotized: Janet compared the urgency of this need with "*morphinomanie*", an addiction to morphine, and describes the drive toward hypnosis and the hypnotist as an addiction (1897/98a p. 429).

This is the period of *somnambulistic passion*: The need of and the relationship with the therapist become paramount. We perhaps could consider Janet's observations on *somnambulistic passion* as the root of Freud's concept of the transference neurosis. Thus, this intense dependency is no mere aberration or iatrogenic phenomenon. Janet emphasized that this *passion* was a critical and natural component of the patient's process that *must* occur in order for the patient to fully heal, despite the symptom exacerbation with which it was accompanied.

The therapist's successful management of the *passion* over the course of treatment is critical. Janet believed that it was not only a symptom in and of itself, but also the means by which cure took place (Van der Hart et al., 1989/95). He noted that the therapist must not position him or herself in the role of surrogate parent or caretaker, but instead, be a skilled agent of change (Janet, 1919, p. 1112; Van der Hart et al., 1989/1995). There are two simultaneous and contradictory activities in which the therapist must engage in order to balance the therapy: The patient must be led to accept the guidance and authority of the therapist, and the therapist must continually minimize control over the patient (Haule, 1986; Janet, 1897/98a; Van der Hart et al., 1989/95). Every action of the therapist must be directed toward using the patient's dependency as a vehicle for the patient's increasing control over his/her own life. Over-reliance on the therapist can lead to regressive (maladaptive) dependency and only temporary improvements, and sometimes decompensation and a failure to improve (Gunderson, 1996; Modell, 1985; Modestin, 1987; Steele, Van der Hart, & Nijenhuis, 2001; Van der Hart & Friedman, 1989; Van der Hart et al., 1989/95). The patient's intense sentiments do not mean it is necessary to enact such feelings behaviorally in the therapy, but rather to modulate them within a secure attachment.

Janet described a patient who experiences somnambulistic passion as one who feels the therapist is no mere human, and nothing can balance this extreme idealization: "The patient waits in agony for my arrival, shakes when one talks about me, imagines to see me enter, begins to write me a letter in order to disclose to me details of her life which I hadn't asked her" (1897/98a, p. 431). The awe the patient feels also may be mixed with fear for a being much more powerful than s/he is. If the patient is not hypnotized, s/he gradually forgets the hypnotizer and resorts mainly to the pre-treatment condition, with some patients becoming a little worse, and some a little better. Thus, the original symptom abatement during the period of somnambulistic influence is entirely temporary without the appearance and resolution of the *passion*.

Janet also commented on the amnesia that occurred between the somnambulism (hypnotic state) and awakening. The alternation between memory and amnesia that follows somnambulism is the result of periodic changes in state. This amnesia for the somnambulistic state must be resolved for healing to occur (Janet, 1889, p. 344). This is consistent with Janet's phase-oriented treatment of trauma, in which the amnesia for the trauma must be alleviated as part of the integrative process (Van der Hart et al., 1989/95, 1993).

In (formally or spontaneously) hypnotized patients the onset of somnambulistic passion is variable, sometimes gradual and sometimes sudden. As the passion develops, an occasional form of serious relapse may occur in which the patient deteriorates to complete mental confusion. Janet believed this was an extreme form of somnambulistic passion rather than a more serious mental disorder. The *passion* is apparently manifested in the following current example, which involves a highly hypnotizable patient who developed intense and unremitting attachment to her therapist. The particular therapist was unable to resolve the intensity of the patient's feelings and transferred her to one of the authors. The patient spoke of nothing but the former therapist for four months after the transfer and later described her mental condition during that time as "a complete gray fog...I couldn't think, see, feel, or do.... couldn't recognize my own husband, forgot how to drive the car....it was as if nothing in my mind worked....the simplest task was completely confusing."

The duration of influence (as opposed to intensity) is also important, and determines the frequency of need for hypnosis. In some cases the duration is very short, so as to apparently require daily sessions. For

example, in 1850/51, Dr. Andries van Hoek's trauma patient, Rika van B., suffering from dissociative amnesia, depression, suicidal urges, pseudoseizures, and mania, required daily hypnotic sessions for 11 months (Van der Hart & Van der Velden, 1987). It is interesting to note that Rika herself determined that she would be cured on a certain date provided van Hoek hypnotize her every day. We do not recommend such frequent sessions in modern treatment.

Janet commented on the frustration of intensively working several hours each morning with a patient called T., only to have her symptoms fully remit by the next morning (Janet 1897/98a, p. 439). The therapist attempts to extend gradually the duration so that less frequent interventions are required. Today, we might question the necessity of such intensive interventions, and instead, process more of the dependency issues and instill more self-management skills. We currently understand that patients experiencing passion actually need a *secure* attachment, i.e., a sense of *felt security*, rather than a *constant* attachment (e.g., Ainsworth, 1989; Bowlby, 1988; Steele et al., 2001). The earlier therapists did not have our current appreciation of attachment issues in traumatized patients, and thus did not fully understand the implications of increased contact with the therapist and its potential positive and negative impact on secure attachment.

Several key components of somnambulistic influence and passion--the influence of suggestion, the persistent thought of the hypnotist, the need for direction, and the illness of isolation--will be discussed in more detail below.

The Influence of Suggestion

Janet believed that hypnosis and the extent of influence depended on neurophysiological modifications, in contradistinction to the Nancy School of Hypnosis which believed hypnosis was a purely psychological phenomenon related to suggestion (Ellenberger, 1970; Van der Hart & Friedman, 1989). He was convinced that somnambulisms depended on "cerebral modifications" and that some of these modifications continued during awakening. It followed that the end of the period of influence and the somnambulistic passion and need for direction were also driven physiologically as well as psychologically. This belief now fits well

with our increasing understanding of the physiological basis for attachment (Bowlby, 1969, 1973; Deitz, 1992; Holmes, 1993; Reite & Fields, 1985; Van der Kolk, 1987, 1996).

Suggestion and influence appear and disappear at the same time, Janet observed. They are intimately related in that suggestion gives a command for cure. However, the duration of the posthypnotic suggestion is indefinite and variable. Prolonged influence is a function of highly hypnotizable patients, and is not the general rule. But for the duration of influence, healing may extend to the whole character, including behavioral issues that were not addressed with hypnosis. Thus, symptom reduction occurs in areas in which hypnosis and influence have not been applied. These are perhaps related to autosuggestion. Conversely, there is a limitation to the duration of suggestions, so they must be repeated again and again, sometimes without cure. Janet did not believe this was related to mistakes made by the therapist in most cases, but again was a function of lack of influence, and also in our current understanding, is related to the extreme difficulty in extinguishing old behavioral patterns and developing new ones.

The patient may be susceptible to the influence of one hypnotist, but not to others, thus the influence is selective and therapist dependent. If there is a succession of different hypnotists, the patient does not develop an attachment to any one therapist, and becomes immune to suggestion. Suggestion explains the cure phenomenon, but does not explain relapses, limitation of effect, mental confusion, and amnesia.

The Persistent Thought of the Therapist

Janet observed that the patient has a natural inclination toward developing feelings for the hypnotist, given the nature of the influence of the therapist. Some sentiments, however, may be intense and otherwise unusual. Sentiments will be interpreted by patients within the context of their own particular world views, and they may be determined developmentally as well. Some will think of the therapist as a parent, some as a sibling, some a friend, some merely with great respect. The influence will mix with these various sentiments to provide a cure. Janet believed it was crucial that the therapist understand the nuances of these sentiments and their meanings to the patient. If a patient must be transferred to another hypnotist, the thought of the hypnotist must also be transferred to the new therapist. Some patients will feel intense

affection; this is the most common sentiment. But some will feel terror or fear; some feel humiliated at being controlled; a few will eroticize the feeling. The positive and negative aspects of the relationship may blend: Fear, awe, love, hatred, admiration, envy, humiliation, and gratitude form convoluted and complex sentiments about the therapist, today easily recognized as the complex transference pattern of the traumatized patient (e.g., Kluft, 1992; Dalenberg, 2000; Loewenstein, 1993).

The patient begins to have dreams in which the therapist watches and judges him or her. Hallucinations of seeing and speaking with the therapist commonly occur, and arise spontaneously from the patient without suggestion from the therapist. Janet described several patients who believed he was near them all day (though he was not), and they talked softly to him. They felt Janet spoke back to them although they could not precisely hear his voice (1897/98a, p. 448). These autosuggestive hallucinations may take the form of persecutory delusions, in which the patient believes the therapist has the overt intent to harm. The subconscious fixed idea during this time is not so much related to trauma, but to the therapist, although actual thoughts may be conscious and obsessive or subconscious, manifesting occasionally in automatic movements or by hallucinations.

The intense thought of the therapist now directs the patient's behavior. It has an inhibitory influence on fixed ideas, motivates action, and indirectly determines movement toward health, the development of awareness and consciousness, and the abatement of amnesia. Following initial obsessive thoughts of the therapist, further symptoms manifest. When the period of influence ends, whatever positive sentiments change to negative ones. The hypnotist, ever present in the patient's thoughts, dreams, and hallucinations now disappears. The patient feels abandoned, neglected, and alone. The thought of the hypnotist is now painful rather than curative. Once these sentiments have changed, all negative symptoms return, until once again the therapist intervenes. It is the relational influence of the therapist that indeed determines the suggestion itself.

The Need for Direction (Dependency)

Janet noted that the sentiments regarding the hypnotist are analogous to the normal and abnormal sentiments within other relationships, except the therapeutic sentiments develop more quickly and more

intensely. Neither somnambulism nor suggestion determines the need for affirmation and the fear of isolation: These are psychological phenomena found in the more general population as well. He found that somnambulistic passion was similar to love in its passion, need, and expression. Yet it is essentially different in that it is only one expression of influence among others. A patient's love relationship with a partner is not necessarily diminished by somnambulistic passion directed toward the therapist. Within the sentiments of somnambulistic passion there exists an intense need of the therapist. This is not dissimilar to what non-hypnotized patients experience toward their therapists. The need for the therapist to soothe and cure is paramount. At times the patient completely regresses without the therapist on which to depend.

Janet commented on patients who exhibit this dependency: "They show themselves to be extremely demanding; they want their physician to be everything for them, and for the physician not to confer with anyone else, to see them every moment, to remain a long time with them and take their smallest preoccupations to heart" (Janet 1897/98a, p. 447). Janet also observed that dependency on institutionalization is a related phenomenon, a common struggle for contemporary therapists who work with severe borderline and other extremely dependent patients. He relates the case of Am, who behaved quite normally on the ward, but as soon as she was given leave for a day or two, she engaged in "absurd and delirious acts" to be readmitted, and was thus confined to the Salpêtrière for 30 years. She reported that she desperately needed "a rule, a domination" to control her own behavior (Janet, 1897/98a, p. 460).

The Illness of Isolation

What is remarkable about the need for direction described by Janet is the intensity and persevering nature of the dependency. In one case reported by Janet, a 45-year-old man insisted his wife accompany him wherever he went, even to the toilet. He could only be reassured and calmed by her, only directed by her. The need for another to care, to love, is evident, and *intolerance of aloneness* is striking (Gunderson, 1996). Janet referred to this as "the illness of isolation: "The psychological symptoms related to being alone when there is a severe need of another (1897/98, p. 462). Intolerance of aloneness has been identified as a core borderline characteristic (Gunderson, 1996), and is the precipitant of many therapy crises, such as self-harm gestures, suicidality, unhealthy or dangerous relationships, and substance abuse, among others. One of Janet's patients, Zy, poignantly explained her promiscuous behavior in this way: "It must be that

somebody takes care of me, is interested in me, no matter how..." (Janet, 1897/98a, p. 463). Another patient, Qe, described her unbearable aloneness and accompanying derealization: "I feel myself alone like a big emptiness, as if the world does not exist. I have only an automatic life, I dream while completely awake..." (Janet, 1897/98a, p. 465).

Again, Janet made it clear that dependency (need for direction) and intolerance of aloneness (illness of isolation) are not a function of hypnosis or suggestion, but exist apart from them as more universal psychological dynamics in certain people, hypnotizable or not. Today we may understand these in terms of attachment disorders that manifest in particular symptom constellations common in some of the more severe character disorders; such symptoms are certainly prevalent among many chronic trauma survivors. However, hypnosis and suggestion give a specific intensity and precision to these dynamics, and in many cases they can be utilized in the service of therapeutic cure.

In order to manage and direct dependency in a therapeutic manner, Janet believed the therapist must initially provide the outside influence that directs the patient's mental process, which s/he is unable to manage alone. The hallucinatory or imaginative image of the therapist urges, supports, threatens, and encourages the patient. The image of the therapist and his/her consistent presence in the therapy provide a secure base for attachment, and somewhat alleviate the intolerance of being alone. And for a while this is effective, but eventually breaks down and the patient doubts the availability and even the existence of the therapist over and over.

Janet believed that strong emotion destroys or suppresses therapeutic work. Emotions, particularly of a traumatic nature, are endowed with a capacity for disorganization and dissociation rather than synthesis; they take elements of thought and separate them one from another (Janet, 1889, 1907, 1909; cf. Van der Kolk & Van der Hart, 1989). In contrast, will and attention create synthesis, a new construction of complex systems built with elements of thought, feeling, sensation, and image. These systems form beliefs, perceptions and judgments, as well as memory and personal consciousness. Through appropriate direction, the therapist facilitates synthesis. S/he helps organize solutions, beliefs, and emotions, and helps the patient attach dissociated contents to the personality. The memory and image of the therapist serve as a center

around which this whole experiential system of thoughts organizes, until the point at which the patient's own ego can serve as the principal organizer.

Such work, by necessity, involves the resolution of traumatic memory. Janet noted that following personality integration--including trauma resolution--all the symptoms of hysteria disappear, including suggestibility and the ability to go into deep hypnotic trance with amnesia. This perhaps implies that the *somnabulistic passion*--a hypnotic phenomena--resolves along with symptoms of traumatic memory, and that the mid and last stages of treatment are necessary in the final cure of the *passion.*

In summary, Janet's conception of the therapist's work with traumatized patients contain many seeds of contemporary treatment. He believed that hypnosis, suggestion, and psychological treatment are almost always of long duration in cases of chronic trauma because they consist of a methodical and precise (re)education of the mind. During the course of treatment therapists need to work toward two simultaneous and seemingly contradictory goals: (1) the therapist must be willing to take direction of the patient's mind; to tolerate dependency in order to facilitate attachment; to teach the patient to be willing to submit to authority; and (2) the therapist must gradually reduce this influence to a minimum, and teach the patient to function without it.

Early in the course of therapy, when symptom reduction and stabilization are the focus and when the *passion* has intensified, the therapist must be especially active, but with definite boundaries and limits. Janet was clear that the therapist should not attempt to reparent, but was to be an agent of change, and provide a stable relationship for the patient. As a function of increasing the patient's psychological tension (ego strength) and sense of mastery, the therapist must pace the therapy, constantly gauging the patient's need for dependency versus his readiness for autonomy. The therapist must constantly promote a synthesis of emotion and thought, with the expectation of increasing awareness on the part of the patient. In order to facilitate these capacities, the therapist must assist the patient in at least temporarily simplifying his/her life in order to diminish the effort of adaptation and provide increasing psychological tension toward healing. If and when the patient has achieved an adequate degree of psychological tension and stabilization, the second stage of treatment may then proceed to alleviate traumatic dissociated memory. The patient may

then begin the long process of realization and integration for a more complete healing than temporary symptom reduction alone may give.

Discussion

Many of Janet's patients came to him with a history of trauma (Crocq & De Verbizier, 1988); others had no discernible trauma, but often a clear pattern of attachment disruption could be found, if one studies their histories carefully. The traumatized patient usually carries some propensity for hypnotizability and will enter trance states whether formal hypnosis is used or not (Butler, Duran, Jasiukaitis, Koopman, & Spiegel, 1996; Nash & Lynn, 1986; Rhue, Lynn, Bukh, & Boyd, 1990-91; Spiegel, 1990). Janet himself was convinced that hysteric somnambulism (i.e., dissociated states) was synonymous with hypnotism. He stated that "the hypnotic state has never any character which cannot be found in natural hysteric somnambulisms" (Janet, 1907, p. 114). However, Janet also noted that the relationship of suggestion and hypnosis was not simple: Suggestion could occur without hypnosis, and hypnosis does not always confer suggestibility. He concluded: "The phenomenon of suggestion is independent of the hypnotic state; outspoken suggestibility can be completely outside artificial somnambulism, and suggestibility can be competely absent in somebody who is in a state of complete somnambulism" (Janet, 1889, p. 171).

In highly hypnotizable patients, the transference (and countertransference) will be produced within the hypnotic surround whether formal hypnosis is utilized or not, as the autohypnotic process of dissociation naturally occurs in traumatized patients (Loewenstein, 1991; Peebles-Kleiger, 1989; Spiegel, 1990). What we observe in Janet's hysterical patients is the oscillation between a so-called apparently normal part of the personality (ANP), dedicated to daily life functioning, and a so-called emotional part of the personality (EP) fixated in trauma that may have hypnotic characteristics (cf., Myers, 1940; Nijenhuis & Van der Hart, 1999; Nijenhuis, Van der Hart, & Steele, 2004, 2002; Steele, Van der Hart, & Nijenhuis, 2001; Van der Hart, Van der Kolk, & Boon, 1998; Van der Hart, Van Dijke, Van Son, & Steele, 2000). Thus, the relationship of Janet with his patients would have been developed within a strong hypnotic context. The hypnotic qualities of therapy with trauma patients should not be underestimated nor neglected, and play an important role in the transference/countertransference process.

It is clear that Janet's writings are replete with observations that hypnosis enhances the transference process as well as fosters transference regression, although expressed in other words (1897/1897a, 1919/25). Twentieth century clinicians have noted the same (Brown & Fromm, 1986; Gill & Brenman, 1959; Kubie & Margolin, 1944; Smith, 1984). Hypnotic effects on the transference can create a primary process world in which the patient freely interacts with hallucinatory and imaginative perceptions of the therapist. In this state the patient may not make distinctions between internal and external reality, past and present, thought and action. The patient may perceive conversations with the therapist that have actually never occurred, and may act on these imaginary conversations, and develop whole belief systems in relation to them. For example, a patient of one of the authors insisted that she had had a phone conversation with the therapist the prior evening in which the therapist had told her not to visit her parents. In fact, the therapist neither had a phone conversation nor told the patient not to visit her parents. Nevertheless, the patient developed a strong belief that the therapist was "protecting" her by forbidding her to visit her parents, and she took several actions to avoid contact with her parents for many months thereafter, all based on an imagined conversation. Janet's observations of such phenomena indicate he was well aware of the fact that these hallucinations were not a function of the therapist's own suggestion, but seem to emanate entirely from the patient.

The therapist may possibly suggest some such hallucinatory experiences as a therapeutic intervention. For example, the therapist may ask a patient to imagine at home, when relevant, what the therapist might say in regard to a difficulty the patient is experiencing. If the therapist has promoted consistently the mastery of the patient over the course of treatment, the patient might well imagine the therapist answering that the patient has the knowledge inside his/herself to solve the problem.

As noted earlier, the idea of transference was in its early conceptual stages during Janet's time. However, much of his observations regarded the feelings, thoughts, and experiences of the patient that were directed toward the therapist. Janet's ideas about the *rapport magnétique* parallel the basic trusting transference given little heed by Freud, but later was explored as the "primordial transference" (Greenacre, 1954), the "basic transference" (Stone, 1967), the "narcissistic transference" (Kohut, 1966), and the "background transference" (Modell, 1990). Treurniet (1993) notes that the patient, in this transferential state, must "surrender" to the transferential object (therapist) in order to experience transformation, as

Janet before him said the patient must give himself over to the therapist for "direction" and "moral guidance" (Janet, 1897/98a; 1919/25). Janet wrote, "[The therapist] must take the complete direction of the patient's mind, habituate him/her to submit to an authority, to constantly live under the influence of somebody else" (1897/98a, p. 478). However, he directly adds, "[The therapist] must reduce this domination to minimum and little by little teach the patient to do without it" (Janet, 1897/98a, p. 478). He was clear that a balance of direction must occur. On the one hand, if submission to the moral guidance of the therapist did not occur, then only temporary cures would ensue, and on the other, if the therapist did not minimize and gradually decrease such guidance the patient would develop a maladaptive dependency that would prevent successful treatment.

In its subtle and more usual form, this transference allows the patient to engage with the therapist with the belief that the therapist is benign, skilled, and helpful. In its more concentrated and intense form, such a transference will move the patient toward a more total dependence on the will of the therapist. This intense form is more likely to occur in patients who are more disturbed in their attachments, and the more disturbed the attachment, the more severe the psychopathology, and the more difficult the treatment (Fonagy, Leigh, & Steele, 1996). Given that many of Janet's patients were traumatized, and given the description of their feelings, it now seems clear that what was being expressed were intense transferences toward the therapist consistent with severe attachment disruption.

Chronic early trauma and neglect inevitably disrupt early attachment patterns in the child. In addition, disrupted attachment, in and of itself, may become traumatic: We prefer to call this "traumatic attachment." The impact of attachment disruption has been described amply in the professional literature, and has included perspectives from various theoretical orientations (Ainsworth, 1989; Barach, 1991; Birtchnell, 1984; Bowlby, 1969, 1973, 1988; Cohen & Sherwood, 1991; Deitz. 1992; Freyd, 1994, 1996; Holmes, 1993; Liotti, 1992, 1999; Main, 1996; Pettem, West, Mahoney, & Keller, 1993; Van der Kolk, 1987, 1996; Van der Kolk & Fisler, 1994; Walant, 1995; West, Rose, & Sheldon, 1993; Winnicott, 1965). These attachment disruptions continue to produce significant symptoms in the adult without treatment intervention. Symtoms including affective dysregulation, disorders of impulse control, disturbances in self concept and image, substance abuse, self-mutilation, aggression, eating disorders, dissociation and

relational disturbances (both of enmeshment and distancing varieties) have been described (Petem et al., 1993; Van der Kolk & Fisler, 1994; Walant, 1995; Freyd, 1994, 1996).

It is important to note that regardless of developmental history, severe trauma at any time of life may disrupt a secure attachment base in an individual (Cohen, 1985; Laub & Auerhahn, 1989). Human-induced trauma creates a state of "failed empathy" in which one loses connection with self, other, and internal representations (Laub & Auerhahn, 1989). The traumatic state "operates like a black hole in the person's mind because in it, that is, in the absence of representation of need-satisfying interactions, there is no basis for symbolic, goal-directed behavior and interaction" (Laub & Auerhahn, 1989, p. 391). Attachment appears to be the *sine qua non* of the healing process in trauma (Olio & Cornell, 1993), and indeed Janet was well aware of this concept in his notion that the rapport was necessary for healing to occur**.** The attachment to the therapist becomes the initial re-establishment of object relationship following trauma that eventually allows the capacity to process the traumatic experience and re-enter the relational world of self and other. The patient may need to enter into a fusional transference with the therapist, and hypnosis may enhance this process (Diamond, 1984).

Because trauma disrupts attachment patterns and leaves the patient bereft of internal mediating objects, it is necessary for the therapist to step in and become an attachment figure, which Janet described as automatically occurring in many cases. The resolution of attachment disruptions requires that the therapist be very active, particularly in the early to mid stages of treatment. By no means does this imply that the therapist does the work for the patient, but instead the therapist must provide avenues for connection that the patient does not yet possess, and must provide ego structure while the patient is building ego strength. Janet viewed the therapist as extremely active and directive in early treatment, and wisely pointed out that such direction should be relinquished gradually over the course of treatment, with the minimum amount of direction used (Janet, 1897/1898a, 1898b/1911). In traumatized patients the therapist must "take the integrative step and lead the reconstructive process more actively than he or she would normally" because the patient is unable to take for granted the benevolence of the therapy nor the essential goodness of the therapist enough to proceed with the working through process (Laub & Auerhahn, 1989, p. 392). Janet first observed that it must always be an outside influence that directs a patient incapable of doing things alone

(1897/98a, p. 471). Cohen (1985) later clarified this from an object relations point of view by noting that the traumatic state can "only be modified by interactions with need-mediating objects" (p. 180).

During the early stage of treatment of symptom reduction and stabilization Janet's patients experienced limitations in the duration of hypnotic influence, that is, Janet's interventions to reduce symptoms only worked for brief periods and he would have to return for another session again and again to do the same work. It is possible that this limited influence may be--at least partly--a function of the unresolved attachment and dependency needs in which the patient continues to require the therapist as an external need-mediating object.

It is also interesting to note that Janet found this symptom exacerbation occurred simultaneously along with the patient's shift from an initial idealization of the therapist to a feeling of abandonment and neglect. It is perhaps possible that the very attachment to the therapist is a trigger for the unmitigated pain of traumatic (or past disrupted) attachment, and this distress exacerbates symptoms. Thus, the patient would consciously experience missing the therapist, and feel the therapist was perhaps uncaring: A classic transference in trauma patients in which the intensity of the patient's need creates internal shame, disgust, and fear, and is subsequently projected onto the therapist. In addition, the patient is often enacting early scenes of abandonment. It cannot be emphasized enough for the therapist to attend not only to symptoms and their appropriate alleviation, but to the attachment process (including transference and countertransference) that is occuring simultaneously (Olio & Cornell, 1993; c.f., Davies & Frawley, 1994). The therapist should note that many symptoms and exacerbations of symptoms have a relational context. Perhaps Janet's patients would have further benefited if he had thoroughly processed their need of him as part of the therapeutic process in the treatment of their symptoms. However, some of his patients were so dysfunctional and exhausted that symptom reduction and stabilization were perhaps the only option. One current patient described her years of remitting symptoms in retrospect: "They were real, I definitely wasn't faking, or doing it just to get attention. But now I know they were also the bridges to you that I didn't know how to make otherwise. I was so far gone from human connection that they were the only things that held me to you." The therapist must provide a relationship that can be verbally processed as it develops, and that can be meaningfully connected to the context of treatment.

Janet noted in his description of the *passion* that beyond a need for attachment, patients develop intense dependency striving as well. The patient will experience him or herself as emotionally needy and dependent, or may present intense defenses and resistances against these experiences. More commonly, trauma patients present with the alternation of both opposing experiences, what is now termed disorganized/disoriented attachment (Cassidy & Mohr, 2001; Liotti, 1995; Main & Solomon, 1986). There may be (and often is) a simultaneous wish for and fear of dependency which creates double binds and becomes fertile ground for continued dissociation and resistances in the therapy.

The patient simultaneously experiences intense need (both genuine and perceived) and intense helplessness (both genuine and perceived). The world, both internal and external, is experienced as terrifying, dangerous, chaotic, and overwhelming. Countertransference and cultural aversions and fears of dependency often obscure the very real attachment needs that underlie desperate affects and behaviors, and may steer the therapist away from working with dependency. Yet, dependency issues must be addressed in therapy as well as the attachment issues in order for the patient to heal. They cannot be addressed unless the patient is allowed to feel and experience them. Such feelings may be disconcerting for the therapist. One current patient insisted that the therapist was "my universe, my life breath, the new DNA structure of my cells." As intense as this sounds, this particular patient made a full and healthy recovery in therapy and successfully terminated treatment after a number of years.

Janet was well aware that when working with dependency, therapeutic safeguards must be taken to prevent malignant regression. He suggested that the therapist employ certain safeguards, such as minimizing suggestions, carefully monitoring the interval between and the length of sessions, and stilmulating the patient to raise his/her level of psychological tension (1897/98, p. 478). He also mentioned techniques which parallel the enhancement of mindfulness, an important skill needed for the development of affect regulation and distress tolerance (Janet, 1897/98a; Linehan, 1993a, b).

The therapist constantly must be mindful of the difference between *gratifying* the patients wishes and *processing* them. Yet, there is evidence that *some* flexible meeting of the patient's needs within a proscribed range of limits is very helpful, such as giving an extra session, offering predictable (not constant) availability, and other attachment-inducing behaviors (Bornstein & Bowen, 1995; Gunderson,

1996; Laub & Auerhahn, 1989; Linehan, 1993a; Steele et al., 2001; Van Sweden, 1994; Walant, 1995). It should go without saying that any deviation from the usual therapeutic frame can be a complex and precarious process that ought to be thought out thoroughly and be theoretically sound, and if necessary, consultation should be sought by the therapist.

Integrating Janet's works with modern treatment approaches, we have observed that intense dependency in trauma patients may arise from four distinct underlying problems. Each problem must be addressed with specific therapeutic interventions:

1. *The patient has genuine ego deficits and dissociative lacunae regarding critical thinking, interpretation of perceptions, affect tolerance, tolerance of aloneness, impulse control, internal processing of mental contents, and general coping skills.* The therapist must engage in affective regulation and cognitive work, as well as other ego strengthening techniques early in therapy (e.g., Linehan, 1993a & b; McCann & Pearlman, 1990). The therapist should be active in establishing coping skills early in therapy occasionally serving as an "alter ego" for the patient. Janet established very clearly that the somnambulistic passion must emerge in its full intensity; it must be tolerated by the therapist. He directed the therapist initially to encourage the patient to allow direction and to seek "moral guidance" from the therapist (Janet, 1898b/1911, 1919/25). Yet the therapist must contain this process and gradually work to reduce the dependency and suggestibility of the patient.

2. *Emotional / physical need and literal survival become inextricably linked in the psyche during neglect and trauma such that "wishes" becomes confused with "biological need" and both are experienced as a life and death issue* (Cohen, 1985; Krystal, 1988; Laub & Auerhahn, 1989). Janet (1897/98a) determined that the need of the therapist was paramount to cure, and that it was necessary for the therapist to be directive and engaged. The gratification of need becomes synonymous with a secure attachment, and the therapist's failure to meet needs is experienced as abandonment and annihilation (Cohen & Sherwood, 1991). The patient gradually must be assisted to differentiate needs and wishes, and to disentangle intolerable affect from needs. The therapist must become a constant object (attachment figure) and provide a secure base for exploration, one who provides structure, and can tolerate becoming

an object of intense affects without losing therapeutic boundaries (Cohen & Sherwood, 1991; Farber, Lippert, & Nevas, 1995).

3. *The patient has a chronic tendency to re-enact the moment of helplessness, confusion, and chaos of the trauma in which the synthetic and organizing capacities of the ego (psychological tension) are lost*. *In addition, the development of the ego may be arrested or significantly impaired at the time of trauma*. Janet noted that dissociated traumatic memories continued as subconscious fixed ideas and sometimes emerged as behaviors, thoughts, feelings, and impulses that were a repetition of the past trauma, and unrelated to the present time (Van der Hart & Friedman, 1989; Van der Hart et al., 1989/95, 1993). Janet also observed that trauma patients seemed unable to assimilate new experiences because "it is...as if their personality which defintely stopped at a certain point cannot enlarge any more by the addition or assimilation of new elements" (1919/25, p. 660). A complete working through of the trauma, though a mid-phase treatment, is inevitably necessary to entirely reduce such enactment. Until such time as that difficult work can be undertaken, the therapist must provide constant counterpoint to the re-enactment with directives toward critical thinking, impulse control, stability, consistency, predictability, boundaries, and containment.

4. *The emergence of the patient's experience of previous traumatic deprivation and pain activates a powerful resistance to painful grief work: the hope that the past can be remediated by current gratification.* Janet described the trauma patient's fear and avoidance of the trauma as a *phobia of the traumatic memory* (1904). This is indicative of the extreme nature of the avoidance, and the intensity of the fear of the pain of loss. But confronting the loss is absolutely necesssary in order to heal. We have stated elsewhere that "integration and realization involve confronting enormous loss.... The patient must learn to grieve deeply...the loneliness and pain that have been and must continue to be endured.... Yet grief... enables the survivor to relinquish unrealistic expectations...and therefore, to move fully into the present with new clarity and purpose" (Van der Hart et al., p. 172).

The therapist must engage in much preparatory work early in therapy. Then in the mid-phase treatment, the alleviation of the dissociation and the subsequent process of realization can gradually move the patient toward grief work. Much resistance is directed toward avoiding it, and the patient must gradually come to

terms with the fact that the therapist (nor any other) can not, will not, does not, and should not meet every need; thus the losses must be endured and grieved (Stark, 1994).

The illness of isolation described by Janet--what we would now term *intolerance of aloneness* (Gunderson, 1996)--is an integral part of the attachment and dependency issues. Traumatized patients feel entirely unable to meet any of their own needs, acutely feel the depth of their lack of internal ego resources (although this cannot usually be verbalized). And they often feel terrified of their own mysterious and powerful internal process that includes intense traumatic material, unrelenting affects, and frightening impulses and needs. In addition, they lack both object constancy of a soothing external other and an internal soothing introject, so that when alone they cannot remember human contact and are unable to soothe themselves or modulate the intensity of their internal process. One patient reported that her experience of being profoundly alone was one of "absolute certainty that I am the last person on earth and you [the therapist] have gone into the great abyss along with the rest of the human population. I am sure I will walk out my door and the street will be empty, just like a science fiction novel, but only real. I do walk out and it's not empty, but as soon as I come in and close the door it starts again." It is quite understandable that patients struggling with such enormous and difficult issues would feel and behave dependently. The therapist's struggle will be to accept the patient's need for dependency while setting clear limits on behavioral enactments of such dependency, and to gradually help the patient gain enough ego strength to verbalize and master the process.

Gunderson (1996) has suggested that the therapist must understand the underlying attachment difficulties of the patient, then proceed to create a consistent but "nonintensive" availability to the patient. Each intersession contact must, in the next session, be fully explored and processed with the patient regarding the attachment functions of the contact and the reason the therapist was helpful. He went on to suggest that all intersession contacts or use of transitional objects be initiated by the patient rather than the therapist, that decreasing use of contacts was an indication of improvement, and that it was crucial to process all the patient's responses to the therapist's absences or unavailability (Gunderson, 1996, p. 757).

Conclusion

Janet's observations provide a rich description of relational issues in the therapy of trauma. His notions of *rapport* and *somnabulistic passion* highlighted the intense transferences and dependencies of the trauma patient, and his observations on these phenomena made it clear that such processes were not only symptomatic, but indeed, were a means for cure in themselves. Janet clearly supported the therapist's steady provision of a consistent, active, and supportive relationship which offered the patient opportunities to re-establish attachment, to eradicate symptoms, to develop internal capacities to soothe, modulate, and control impulses and affects, to alleviate and realize traumatic memories, and to explore increasing autonomy and self-initiated activities. In summary, Janet described the early stage of treatment as a time when the therapist will be most directive and active, guiding the patient to rest, simplify his or her life, and to reduce distressing symptoms. Ego building and support is a crucial component of this early treatment.

Hopefully, the patient will become stable enough to begin work on traumatic memories--the second stage of treatment. During this stage, the therapist encourages the patient to continue use of new coping skills, perhaps reverting back to early stage treatment if a decline is imminent. However, the therapist continues to be active along with the patient. Gradually, as traumatic memory become liquidated and assimilated into the personality, the patient will be more able to live in the present. The final phase of treatment--integration and rehabilitation--includes the ongoing relationship with the therapist as a reinforcement for a stable soothing internal introject, and the patient--now able to soothe him/herself, tolerate aloneness, and better manage dissociation--becomes increasingly less reliant on the direction of the therapist. The therapist is continually monitoring the appropriateness of his/her level of activity and direction with the patient, and encouraging the patient in every possible way to be active and take charge of his/her life. Finally, the patient will be able to move on and terminate the therapeutic relationship, although minimal contact may continue for years.

Appendix

DEFINITIONS

Animal magnetism: "Mesmer's term for the universal force through which hypnotic effects were hypothesized to be mediated" (Reber, 1985, p. 36).

Idées fixes: "Fixed ideas (idées fixes) are thoughts or mental images which take on exaggerated proportions, have a high emotional charge, and, in hysterical patients, become isolated from the habitual personality, or personal consciousness. When dominating consciousness, they serve as the basis for behavior" (Van der Hart & Friedman, 1989, p. 8). *A primary fixed idea* is "the total system of complex if images of a particular traumatic event plus the corresponding emotions and behaviors" (Van der Hart & Friedman, 1989, p. 8). *Secondary fixed ideas* have similar characteristics of primary fixed ideas, but are present after the successful treatment of the primary ideas. They may derive from the original trauma *(derivative fixed ideas)*, be related to an earlier or different trauma *(stratified fixed ideas)*, or may be absolutely new and related to something in present day life *(accidental fixed ideas)* (Van der Hart & Friedman, 1989, pp. 8-9).

La passion somnambulique: "The patient's overpowering need to be hypnotized by his own therapist" (Van der Hart & Friedman, 1989). The patient is obsessed with thoughts of the hypnotist, may hallucinate suggestions or conversations with the hypnotist, and the obsession can become a dangerous addiction, analogous to "morphinomanie" or morphine addiction (Haule, 1986).

Psychological force: A concept first proposed by Janet in which he describes "the quantity of elementary psychic energy, that is the capacity to accomplish numerous, prolonged, and rapid psychological acts. It exists in two forms: latent and manifest. To mobilize energy means to have it pass from the latent to the manifest form" (Ellenberger, 1970, p. 378).

Psychological tension: "An individual's capacity to utilize his psychic energy at a more or less high level in the hierarchy of tendencies [the hierarchy of more simple, automatic actions to very complicated and creative actions--or the tendencies towards these various actions] as described by Janet. The greater the number of operations synthesized, the more novel the synthesis, and thus the higher the corresponding psychological tension." (Ellenberger, 1970, p. 380). Janet insisted that "in order to act calmly, one must preserve a *certain proportion between the psychological force and the tension* (Janet, 1903, 1919/25).

Rapport magnétique: “The hypnotic phenomenon in which the subject responds only to suggestions from the hypnotist and from no one else unless the hypnotist so directs” (Udolf, 1987, p. 361).

Sentiments (as opposed to emotions): “Sentiments are above all *regulations* of action, which action can be increased in strength, diminished, modified, or arrested in different ways" (Janet, 1937, p. 67). Emotions, on the other hand, are the expenditures of a surplus of energy. Actions are regulated by sentiments (feelings), which also give them some degree of activation (Janet 1937).

Somnambulism: “A phenomenon whereby two or more states of consciousness, dissociated by a cleft of amnesia, operate with seeming independence of one another” (Haule, 1986, p. 88). This may include a broad range of processes, including hysteria, hypnosis (artificial somnambulism), multiple personality, spiritualism, and the more narrow definition of the word as we use it today - sleepwalking (Van der Hart & Friedman, 1989, p. 8).

Suggestion: “The complete and automatic development of an idea which takes place outside the will and personal perception of the subject” (Janet, 1901, p. 251). As such, suggestion is considered to be a psychological process. Suggestion should not be confused with other forms of influence, such as persuasion.

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