populations via the differential diagnoses of PTSD and CPTSD. Both DSM and ICD diagnoses are recognised by third party payors for mental health services, so either diagnostic approach can be use. The potential benefit in using the ICD system is expected to be in its translation to treatment protocols that are tailored to the symptom profiles and level of impairment associated with each disorder. The development and testing of such protocols is a critical next step in the ICD-11 research agenda.

Although investigations thus far indicate consistency in the presence of a PTSD/CPTSD distinction across several countries, evaluation across other regions of the globe is important as is assessment of invariance in the currently accepted symptom profiles for each disorder. Refinement of the organisation and nature of the symptoms associated with each disorder may need to be considered as more research is conducted.

**Marylène Cloitre**, National Center for PTSD Dissemination and Training Division, VA Palo Alto Health Care System, USA; and Department of Psychiatry and Behavioural Sciences, Stanford University, USA

**Correspondence**: Marylène Cloitre. Email: marylene.cloitre@va.gov

First received 6 Dec 2019, final revision 15 Jan 2020, accepted 22 Jan 2020

## Supplementary material

Supplementary material providing additional citations related to the above text is available online at https://doi.org/10.1192/bjp.2020.43

## References

1 World Health Organization. *International Statistical Classification of Diseases and Related Health Problems (11th Revision)*. WHO, 2018.

2 Reed GM. Toward ICD-11: improving the clinical utility of WHO's international classification of mental disorders. *Prof Psychol Res Pract* 2010; **41**: 457.

3 Maercker A, Brewin CR, Bryant RA, Cloitre M, Reed GM, van Ommeren M, et al. Proposals for mental disorders specifically associated with stress in the International Classification of Diseases-11. *Lancet* 2013; **381**: 1683–5.

4 Brewin CR, Cloitre M, Hyland P, Shevlin M, Maercker A, Bryant RA, et al. A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clin. Psychol. Rev* 2017; **58**: 1–5.

5 Cloitre M, Shevlin M, Brewin CR, Bisson JI, Roberts NP, Maercker A, et al. The International Trauma Questionnaire: development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatr Scand* 2018; **138**: 536–46.

EXTRA CONTENT ONLINE

psychiatry in history

# The Amsterdam Suggestive Psychotherapy Clinic

**Stephen Wilson**

In the 6 years between 1887 and 1893, Drs A. W. Van Renterghem and F. Van Eeden treated more than a thousand patients. They published their results in French in *Psycho-Therapie* (1894).[1] Its larger purpose was to counter prevailing materialistic conceptions of the human mind. Both authors allied themselves to the therapeutic methods of Ambroise August Liébeault and Hyppolite Bernheim. But they wanted to distance themselves from the dramatic hypnotic séances given by Jean-Martin Charcot in Paris, and the dubious, but undeniably popular, activities of various stage hypnotists, magnetists and mountebanks. For this reason they preferred the use of the term psychotherapy.

> Several years ago[2] we maintained that the first concern of the doctor practicing psychotherapy should be to try to increase the psychological stability of his patient. We had no argument with the view that a certain link exists between hysteria and hypnosis or suggestibility, and we thought it could be detected in the psychological dissociation or instability which is innate in the hysteric and artificially induced in the hypnotised.
>
> But at the same time we pointed to the deplorable fact that psychotherapy, whose theoretical basis was founded by Hack Tuke and whose practical application we learned from Liébault, has been confused and conflated with hypnotism. In fact, the two should be distinguished as clearly as possible. We are absolutely convinced that the word hypnotism, in Charcot's sense, has nothing to do with psychotherapy, and only produces confusion.
>
> The only clear and durable way of conceptualising psychotherapy seems to us to be the following: that psychotherapy combats illness through the mobilisation of the patient's psychological organ; suggestion, exercise and strengthening through encouragement are its instruments. This conception would surely be seen as an obvious fact, and the most innocent in the world, were it not for the confusion brought about by the abnormal practices of hypnotism.
>
> That it is possible to induce a state of sleep in many patients by verbal influence, and that experience teaches us the influence exercised over a sleeping person or one half asleep, or in a passive state, acts more powerfully than in the waking state; constitutes moreover a simple fact, not in any way frightening, and is a useful ingredient in the application of psychotherapy. It permits us to apply psychological therapy methodically.
>
> For the doctor who practises psychotherapy, hypnotic experiments simply constitute a warning that he could harm his patients if he doesn't stick strictly to therapeutic aims. That is to say, he could increase abnormal suggestibility and thus produce an undesirable lasting state of instability, whereas normal suggestibility is absolutely sufficient for his ends, notably cure.

## References

1 Société d'èditions scientifiques, 1894. In Wilson S. (trans.) *Psycho-Therapy*. Lamad Vav Press, 2019.

2 van Eeden F. *The Principles of Psycho-Therapy*. London International Congress of Experimental Psychology, 1892.



The British Journal of Psychiatry (2020) 216, 131. doi: 10.1192/bjp.2020.6



https://doi.org/10.1192/bjp.2020.6 Published online by Cambridge University Press