PRIMARY ACTIVATION

by

J. W. H. Bennett

On February 2nd 1962, I had been working with an 18 year old female patient who had re-experienced a severely damaging early trauma between herself at the age of three, and an adult male. Whilst the patient, after this re-experience had 'improved' markedly in her presenting symptoms, she was still a long way from being free of her aberrant behaviour. (1)

Intuitively, I began to look for the existence of another trauma which had perhaps been caused by one of her own sex. From this starting point evolved what is today known as the Primary Activation method of psychotherapy. (P.A.)

The content of many of these scenes (2) is still extremely controversial, in terms of acceptable human behaviour; some even involving actual 'criminal' behaviour. Also, because an objective knowledge of the content of the scenes would pre-empt any subjective re-experiencing (4), I am unable to disclose the specific contents of the scenes to you now. Please bear with me in this. Understandably it is a handicap to the rapid dissemination of the method. And yet, because this very factor makes mandatory the pre-requisite of the therapist having undergone a subjective analysis before practising, the same factor now becomes one of the main strengths of the method, in terms of achieving the full resolution of the patient's problem. We are here postulating that a therapist can/does only take a patient so far as the therapist's own handicaps allow.

Before detailing the P.A. method, perhaps I may comment upon what I hold a scientific method of psychotherapy must involve.

I believe that there must be four essential events occurring in an insight-oriented therapy and that one or more of these four events occurs in most of the other therapies. The four are:

1. The uncovering of repressed material.
2. Some re-experiencing of the affect associated with that material.
3. Attenuation of that affect.
4. Learning how to meet new situations unencumbered by the repressed material or its attendant affect. (The 'working through'). (3)

In their "Preliminary Communication", Breuer and Freud (1893) maintained: "Each individual hysterical symptom immediately and promptly disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked (uncovering), and in arousing the accompanying affect (re-experiencing), and when the patient had described that event in the greatest possible detail and had put the affect into words (attenuation)."

I am in general agreement with the foregoing description of the optimum therapeutic process.

I started off by considering that the ultimate form of psychotherapy would embrace the following:

1. A method whereby the defences and resistances are by-passed.
2. There must be no possibility of pre-empting or 'rehearsing' an early experience by pre-knowledge or fantasising. 'Surprise' must be an element.
3. Whilst therapy is progressing, the patient's self (ego) is strengthened rather than diminished.
4. The patient's confidence in the outcome of therapy must not only be maintained, but reassured so that the required outcome - resolution of the presenting symptoms - is obtained.
5. The patient must be able to have total confidence that the therapist knows the cause of the problem and how to resolve it.
6. It must be a scientific method which is pragmatic and which in no way requires the patient to accept a theory.
7. The method should be such that successful termination can take place with the minimum investment of time and money on the part of the patient.

Primary Activation today has been used to treat in excess of 10,000 cases over as wide a presenting population as there are ills in the human condition. This is in New Zealand alone. We therefore have sufficient experience upon which to base an evaluation of how well P.A. fulfils the foregoing requirements.

Of course all therapy depends upon the ability of the therapist to put into practice the theory of a method. This is the variable. This is what makes an art of a scientific theory. For a therapist to be able to artistically use the theory calls for the therapist to be 'clear' of any subjective handicaps. Before training in P.A. is undertaken, the trainee must undergo a subjective analysis. We have found it necessary to develop and use an intensive form for this purpose in terms of time, because most of those wanting to use P.A., are busy professionals. This intensive subjective experience for trainees (and for those patients who need to complete the major part of their therapy as quickly as possible) can be completed in 4 - 5 days. This does not mean, however, that there will not be some cases in which further work is required. After this subjective experience we have a therapist in full conscious

awareness of what is causing the difficulties the patient is experiencing; the therapist has himself experienced and resolved his own subjective conflicts.

How do we proceed in P.A.? The patient is made comfortable on a reclining chair or couch. A light and refined altered state of consciousness is induced. This sets the stage for a return to a specific early traumatic experience known by the therapist to be relevant to the case. Using simple procedures, a re-experiencing of the uncovered trauma takes place and is attenuated. A similar sequence takes place each session until no symptoms remain.

Should a sympton still be manifesting, or a new one appear, then similar further work ensues. A case terminates when no symptom remains.

Experience shows that most cases reach a satisfactory termination in up to 25 sessions. Some cases may require more, some less.

P.A. has classified, categorised and elaborated upon a finite number of these primary activating mechanisms or 'scenes'. A 'good' case may have a mere 7 or 8 'scenes' which have to be uncovered, re-experienced and attenuated by being accepted into conscious memory and awareness. The present number of scenes 'discovered' totals 39. P.A. shows that there are certain scenes common to every presenting case, and we believe, common across almost the whole population. In other patients the presenting symptoms and behaviour patterns, identify precisely to the therapist, what scenes will be unique in a particular case. So long as the procedure is followed, it can be predicted precisely what will be uncovered up to a particular point in every case, after which, individual variation begins to occur. The theory holds in every case. There are no exceptions.

At this point I would like to present you with a case history summary:

Miss T., aged 28 years, single, school teacher. Her presenting symptoms were: Asthma; eczema; headaches; nail-biting; pre-menstrual tension; and inability to have an orgasm. In addition to the above, she suffered from anxiety; claustrophobia; diarrhoea; distrust of men; hayfever; inferiority complex; pruritis; shyness; sinus trouble; thrush; and tension in the back of the neck, shoulders, and back. She complained too of jealousy towards some other young women of similar age.

In her fourth session she recalled a traumatic 'scene' with an adult male when she was three years old. After this recall there was immediate relief from her headaches, some lessening of anxiety, and an easing of the tension in her neck, shoulders and back.

The fifth session produced a recall of a 'scene' when she was 3 months of age, this time with an adult female; after which her asthma tension, and subsequent attacks ceased, dramatically; her eczema started to clear up, her hayfever attacks did not reappear, and likewise her sinus congestion lifted. When she left the

room she used the lift instead of the stairs!

Next visit, she was able to recall another traumatic, and this time violent scene with an adult female, at the age of two. It was after this scene recall that much of her behaviour and attitudes changed for the better. She was much more confident of herself and her anxiety was markedly reduced.

At the commencement of the seventh session, she complained of having had an attack of diarrhoea upon arising that morning. When asked if she had had any dreams since the last session (as the procedure requires), she described a nightmare regarding vermin. A few minutes into the session, she was recalling a fairly violent scene with an adult male, when she was a girl of five. As a result her diarrhoea abated and has not reappeared; her distrust of men was decidedly lessened, and her shyness was disappearing.

At her eighth session she recalled another traumatic scene at the age of seven, again with an adult female. On this particular day she was home from school as she was sick. At this stage of treatment she was quite confident and outgoing - always looking forward to the next session (as is usual with many similar types of patients). After this recall she excitedly exclaimed, "now I know why I freeze on the point of orgasm; I can also understand why I get pruritis and suffer from thrush".

The [illegible] session uncovered an experience with a male at nine years old. At the end of this session a quiet remark was made: "no wonder I'm not married - there's no-one good enough".

Sessions 10, 11 and 12 were spent recalling three of a series of 'conditioning' (4) scenes with an adult female; these taking place at 9, 13 and 15 years old respectively. While these scenes were virtually similar: they progressively increased in severity. After each of these recalls the patient made remarks along the lines of the following: "The reason why I'm not married isn't only because there's no-one good enough - I'm just not allowed to". "I used to wonder why I couldn't make love with the light on and why I kept looking over my shoulder to see if anyone's watching me".

When Miss T. arrived for her thirteenth session, she remarked, "I seem to be 100% now; even my nails are growing; but one thing troubled me yesterday. I was in the company of my younger sister and I found myself being critical of her; I also felt some deep hostility towards her".

The subsequent recall was one where she had walked in on a scene between her sister and an adult male. This scene was by no means a loving scene. It was violent; it was almost identical to that which happened to her at 3 years of age - the age her sister is as she walks in on the scene.

Upon arrival for her fourteenth session, Miss T. exclaimed, "my period arrived yesterday and I didn't have a clue that it was coming, so I guess that's the end of my P.M.T."

(5) The session was spent in going through her initial case history sheet, and checking that she had resolved all of her presenting problems. So this was the last session.

This case flowed well. Many do. Some require the full artistic ability of the therapist to deal with these primary activating mechanisms.

May I close by inviting anyone interested in learning more about P.A. to write to me. I would be happy to answer any questions arising. My address is c/o P.O. Box 3377, Auckland 1, New Zealand.

Notes

1. This case at termination was free of the presenting problems.
2. 'Scenes' (P.A.) Early traumatic experiences found in each case.
3. Working through. The process where a patient thoroughly explores and understands those conflicts which brought him to therapy.
4. Conditioning. 'Where a command given directly, or by inference is accepted by the child and is thereafter adhered to.
5. You will have noticed that the P.A. therapist does not interpret. The only person who can 'know why' is the patient.

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