The Counting Method for Ameliorating Traumatic Memories

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The Counting Method is a technique for modulating and mastering traumatic memories in which the therapist counts out loud to 100 while the client silently remembers a traumatic event. Immediately afterward, the recollection is reported, discussed and reframed. This method is briefly described and its use within the context of ongoing therapy is explained.

KEY WORDS: Counting Method; traumatic memories; posttraumatic stress disorder; posttraumatic therapy; flooding; eye movement desensitization.

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By definition, posttraumatic stress disorder (PTSD) includes episodic re-experiencing of traumatic events, usually in the form of dysphoric memories. Because these memories are vivid, frightening and unexpected, they have secondary effects, causing sufferers to doubt their sanity, their progress in recovery, their fundamental sense of security. The original traumatic experience had elements of terror, horror, or helplessness. Persistent episodes of traumatic memory continue and compound those elements.

Several clinicians have developed, tested and promulgated therapies designed to prevent or ameliorate traumatic memory and associated dysphoria (Foa, Rothbaum, Riggs, & Murdock, 1991; Keane, Fairbank, Caddell, & Zimering, 1989; Richards, Lovell, & Marks, 1994; Shapiro, 1989). The Counting Method is one such approach. Although the method has been disseminated through instructional videotape (Ochberg, 1993) and subsequent reviews (Bell, 1995; Wilson, 1993), this is the first written description and guidelines.

Rationale and Efficacy

The Counting Method was developed for use in the context of Posttraumatic Therapy (Ochberg, 1988, 1991, 1993) by a skilled clinician who provides a full range of restorative opportunities to a PTSD client. Posttraumatic Therapy is collegial, normalizing, and individualized. Its eclectic approaches include education, holistic health, social support, and search for meaning. The goal is a realistic, enhanced sense of self, rather than merely symptom reduction. Survivor rather than victim status ("I look back with sadness rather than hate, I look forward with hope rather than despair, I may never forget but I need not constantly remember. I was a victim. I am a survivor"; Ochberg, 1988, p. 17) is another way of summarizing the goal of Post- Traumatic Therapy.

The Counting Method is one element of Post-Traumatic Therapy that has been employed for 7 years with several dozen clients by the author, colleagues, and students. In most cases, clients reported reduction in the frequency and intensity of dysphoric intrusive recollections. For example, a 40-year-old teacher was tortured and raped 8 years before beginning Posttraumatic Therapy. Her symptoms included panic attacks, depression, and posttraumatic stress disorder. Medication relieved panic and elevated mood, but flashbacks and intrusive recollections persisted. The Counting Method, begun 6 months after the first encounter, and utilized on seven occasions, resulted in eventual elimination of traumatic memories, sustained at 4-year follow-up.

No clients reported negative consequences attributable to the Counting Method. Approximately 80% reported improvement in the frequency and intensity of traumatic memory.

The Counting Method works, theoretically, in several ways. First, the traumatic memory is connected to the therapist's voice and to the experience of therapy. A terrifying, lonely piece of personal history is associated

with the security, dignity, and partnership of Post-Traumatic Therapy. Future recollection, spontaneous or deliberate, may evoke aspects of therapist and therapy and therefore be less frightening and degrading.

Second, the memory is contained within an interval of 100 counts less than two minutes. This means that a relatively brief dose of traumatic recollection is received. Moreover, some control over the initiation, continuation, and conclusion of that recollection is experienced. With practice and encouragement, the client determines the duration of a particular memory and feels less anxious about future episodes of spontaneous recall.

Third, the intensity of dysphoria is deliberately raised and lowered during the counting. This affords another dimension of mastery, dosing and titrating one's thoughts and feelings, leading to enhanced self-control.

Therefore, the Counting Method shares some elements of Shapiro's (1989) eye movement desensitization (pairing a therapist activity with the traumatic image), of desensitization (relaxation during remembering), and of flooding (tolerating intense affect). But scientific determination of the way the method works and how efficacious it is must await controlled outcome study. This research is underway (Johnson, Lubin, Morgan, & Grillon, 1995), evaluating clients randomly assigned to therapists cross-trained in Foa's (1991) flooding technique, Shapiro's eye movement desensitization, and the Counting Method.

Summary of the Method

Having established that specific traumatic memories are part of a PTSD syndrome, the clinician offers the client an opportunity to recall a memory while the clinician counts to 100. The client is asked not to speak during the counting. After the counting the client is encouraged to tell what has just been remembered. After that, clinician and client discuss, reframe, and digest the traumatic memory and the way the memory was modulated during counting.

Scheduling a Counting Session

PTSD clients may come to therapy soon after a traumatic event or decades late. They may or may not have told details to others. The trauma may have been circumscribed, prolonged, or repetitive. Rapport and trust between client and therapist may develop quickly or slowly. Some clients are reluctant to reveal details; others are grateful for the first chance to vent. For these and other reasons, there are no firm guidelines for timing the first counting session. But it is often helpful to advise the client that the Counting Method is an option for some future date, and can be scheduled when client and therapist agree the timing is appropriate. This demonstrates respect for the power of the traumatic memory and gives control to the client. It allows, metaphorically, elective rather than emergency surgery. It suggests that other dimensions of the therapeutic alliance come before tackling a core problem.

Once therapist and client agree that Post-Traumatic Therapy is underway, that progress is occurring, that the client feels less like a victim and more like a survivor, the Counting Method can be scheduled.

Preliminary Discussions

Some clients are willing to plunge into the Counting Method with little preparation; others want to know exactly how and why the method works. Depending upon the needs of the client, the following points can be discussed:

Counting affords the client a relatively short interval (100 see), with a beginning, middle, and end, in which to deliberately recall an intrusive recollection.

1. Silent recall allows privacy.
2. Hearing the therapist's voice links the painful past to the relatively secure present.
3. Feelings of terror, horror and helplessness may recur during counting, but they will be time limited and, most likely, modulated by connection to the therapist.
4. The traumatic memory itself may be modified. That, after all, is the ultimate objective. If and when the memory emerges spontaneously at some future time, it may be attenuated by the experience of the

Counting Method. The client will associate the dignity and security of therapy with the intrusive recollection.

Most clients who accept the Counting Method appreciate these theoretical points. Many have additional, practical questions:

Will I be able to drive home?
How many sessions will I need?
Must I remember every trauma and every moment?
The therapist can assume that memories evoked during counting will be no worse than spontaneous re-experiencing (however, occasional exceptions occur when forgotten images return). If flashbacks have been recent % vivid and overwhelmingly, a companion to drive the client home is advisable.

The method is different from flooding or extinction of anxiety, in that once a client experiences some mastery over the memory there may be no need for further counting sessions. The experience of connecting one significant portion of a bank of traumatic memories to the therapist's voice may generalize to all traumatic memories. Often, two or three sessions are sufficient.

The Day of the Counting Method Session

When feasible, the first session of counting should be scheduled at a convenient time for client and therapist - e.g., at the end of the day, allowing extra minutes for closure. Counting should commence early in the session, but not before a review of progress. This helps dispel anxiety and pessimism. The therapist should ask which traumatic event will be recalled when several have been implicated in the PTSD. The client should be told to try to fill the 100 see with that memory, letting the worst feelings crest as the counting goes through the 40s, 50s, and 60s, then coming out of the past and into the present as the counting proceeds through the 90s.

The therapist might say at the outset, "Are you comfortable? Just gaze off; you needn't look at me. Let's begin. 1 ... 2 ... 3

During the Counting

The therapist should keep an eye on the clock to maintain a steady rhythm of approximately one number per second. Precision is not necessary, but standardizing the tempo facilitates replication.

Observe the client closely. There may be tears, grimaces, shuddering, clenching of hands or defensive postures. Conversely, there may be no sign of distress, which may mean that traumatic memories were not recalled and the method did not elicit sufficient affect.

Try to count in a clear and friendly voice, a natural voice. The qualities of the therapist and the experience of therapy are transmitted in the counting. Although a recitation of digits is not particularly personal, the fact that the therapist's voice is heard concurrently with recollection of terrible reality brings treatment and trauma together.

At 93 or 94 the therapist can say, "Back here," to assist those clients who need such a reminder. While counting is not meant to be hypnotic, it has that effect in some cases. A partially dissociated client is helped by the suggestion to return to current reality.

After the Counting

When clients succeed at the task, voluntarily recollecting a trauma during counting and, possibly, re-experiencing that trauma, they usually appear dazed, moved or transformed. They may not speak for a while. They may feel some sense of accomplishment, some relief, or some residual terror from the original event. They may have recalled aspects of the trauma that were forgotten or repressed (psychogenic amnesia). They may be embarrassed and unwilling to discuss recovered memories (rarely) or be excited by the chance to share a revelation (more common).

The therapist is advised to wait for clients to speak, but if they do not or if they change the subject, the therapist should ask, "Can you describe what you just remembered?"

Usually, this will uncork the bottle and a detailed narrative will flow. But not always. There may not have been meaningful recollection. Or the recollection may have been too intense for retelling. When the latter is the case, the therapist can assist by asking, "What did you recall when I was counting in the 20s and 30s?" If the narrative is fragmented, further probing by the numbers (e.g., "Now, how about the 40s ... the 50s ... the 60s") can help elicit the whole recollection.

Verbatim note taking during this phase is useful because it allows uninterrupted reporting by the client and captures the images for later discussion. It also allows time between the solitary act of private recall and the collaborative endeavor of redefining a piece of personal history.

This is a time when may clients appreciate seeing their clinicians taking notes. Eye contact is less important than obvious attention to those very details that have been haunting and disrupting the PTSD sufferer.

Reflection and Closure

Finally, the therapist and client discuss what has just occurred. There are several therapeutic objectives and many strategic options at this point. The most important goal in the outpatient setting is to end the session on a positive note, with the client composed enough to leave the office and secure enough to continue therapy. This may require deflection from the trauma scene and concentration on positive performance: "You did well. You remembered. You turned the tape on and you turned the tape off." Or the therapist can ask about the method itself: "Did 100 seem like enough time? Too much time? Did my counting help or distract?" This process discussion diminishes strong affect.

Time permitting, the objectives of abreaction, ventilation, and full disclosure of hidden aspects of the trauma may be accomplished. While the Counting Method is not designed to resemble a sodium amytal interview, it may have certain similar benefits. That is, relaxation may elicit sensations, thoughts, and feelings that were previously inaccessible. The therapist should allow these to emerge as long as they are tolerable, and should express interest in returning to them at a future time.

The central objective of fusing the traumatic memory and the therapeutic experience can be enhanced by explicit direction. For example, In the future, when you recall that awful night, you can remember how you turned off the tape at 94, how you heard the counting, how we revisited the scene together."

But such explicit direction may be superfluous. Clients usually know when they have mastered and ameliorated their traumatic memories.

In those instances when the method clearly fails (usually because the client could not remember, or merely restated the story silently, without emotion) the therapist must determine whether to repeat the effort or abandon it. Again, this should be a collaborative decision, made after exploring the reasons for the failure. Obviously, it is best to suggest that the method failed, not the client.

Further Sessions

The question of whether and when to schedule further Counting Method sessions can be delayed until a later time. The first session usually leaves the client with more than enough to digest.

Some traumatic memories are relatively short and specific. These require relatively few sessions. Some are varied, multidimensional, with multiple meanings for the client. For example, a woman who was raped recently and abused as a child may require sessions dealing with several discrete episodes. She may prefer to have these spaced months apart. A person held hostage for days may have many elements of a prolonged trauma that he or she wishes to remember during a half dozen counting sessions.

Those who experience some relief after counting, but have continuing flashbacks, may request Counting Method sessions dealing with the same memory. In sequential sessions they confront different issues and perfect their sense of control and their courage to remember voluntarily.

Clients may deliberately alter their memories, adding fantasies of successful resolution, or of turning the tables on their assailants. One woman changed her abuser into a cartoon figure who ran away.

Bearing these possibilities in mind, therapist and client may discuss the merits of further sessions, their timing and their intended consequences. Post-Traumatic Therapy concludes when survivor status is achieved. Counting Method sessions, are scheduled to help reach this overarching goal of therapy, and should not unnecessarily prolong the process.

In sum, the Counting Method is one technique that may help clients with PTSD reduce the debilitating effects of traumatic memories. It was developed with outpatients receiving Post-Traumatic Therapy from an experienced clinician. More experience is needed before therapists can know when to expect success by using the method. Outcome research is underway to test the validity of the method as a clinical tool.

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References

Bell, J. (1995). Videotape review. *Journal of Traumatic Stress, 8(l),* 197-199.

Foa, E., Rothbaum, B., Riggs, D., & Murdock, T. (1991). Treatment of post-traumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology, 59,* 715-723.

Johnson, D., Lubin, H., Morgan, A., & Grillon, C. (1995). Brief Treatment for PTSD. Research study in progress, Yale University Department of Psychiatry.

Keane, T., Fairbank, J., Caddell, J., & Zimering, R. (1989). Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. *Behavior Therapy, 20,* 245-260.

Ochberg, F. (Ed.) (1988). *Post-traumatic therapy and victims of violence.* New York: Brunner/Mazel.

Ochberg, F. (1991). Post-traumatic therapy. *Psychotherapy, 28(l),* 5-15.

Ochberg, F. (1993). *Frank Ochberg on post-traumatic therapy.- The Counting Method.* Camden, ME: Varied Directions & Gift From Within, 1-800-888-5236.

Ochberg, F. (1993). Post-traumatic therapy. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 773-783). New York: Plenum.

Richards, D., Lovell, K., & Marks, 1. (1994). Post-traumatic stress disorder: Evaluation of a behavioral treatment program. *Journal of Traumatic Stress, 7(4),* 669-680.

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress, 2,*

199-233. Wilson, J. P. (1993). Videotape review. *Psychotherapy, 30(4),* 705.

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