

[Promising Practice for Traumatic Memories: An Update on the Counting Method](#)

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The Counting Method is a new clinical technique for the treatment of the symptoms of PTSD, originated by Frank Ochberg (Ochberg, 1993; 1996). Specifically, the procedure aims to desensitize clients to their traumatic memories. Because traumatic memories are vivid and frightening, and they arise unexpectedly, they can cause significant secondary effects on the sufferer, including diminished self-confidence, decreased sense of security, and compromised beliefs about one's own sanity. With the goals of ameliorating the anxiety accompanying traumatic memories and enhancing the sense of mastery over intrusive recollections, the Counting Method can contribute to the overall therapeutic endeavor with PTSD clients (Ochberg, 1988).

The method is perhaps the most streamlined means of applying imaginal exposure to decrease the fear response to traumatic memories. The value of a more parsimonious justification for a therapeutic intervention is that often complexity in theory or technique can obfuscate the essential similarities among successful treatments. Apparent differences in methodology that give rise to impassioned debate may not involve the critical therapeutic factors. Through our study of the Counting Method, we believe that its therapeutic effect relies on imaginal exposure. In order to accomplish this, the client's avoidant defenses need to be overcome, which is achieved largely through the structuring effects of counting from 1 to 100.

Imaginal Exposure

In the counting procedure, the client is asked to recall the traumatic event

from beginning to end, as vividly as possible. The recollection of the trauma is paired with an experience of relaxation and safety. As in many forms of exposure therapy, the recall of the unconditioned stimuli (the trauma) while in a state of relaxation and safety serves to diminish the conditioned fear response to the memory (Foa & Kozak, 1986; Foa, Steketee, & Rothbaum, 1989). By encouraging the client to re-experience the memory in detail, from beginning to end, the client's fear of remembering the trauma is diminished.

Two additional components of the method are used to intensify the imaginal exposure. First, the event is recalled with eyes closed and without speaking, thus reducing the interpersonal demands during imaginal exposure. This feature is included because clients may be distracted from the memory while speaking to another person and monitoring their reactions. Second, by not requiring the client to translate an embodied and visual experience into words, the exposure to the original sensory experience can be maximized.

Structuring Effects

Control. The sense of mastery and self-control over the traumatic memory is utilized to decrease the need for avoidance. The specific and culturally-familiar sequence of counting from 1 to 100, paired with the chronological organization of beginning, middle, and end, provide defining structure to the remembering. The counting provides a strong sense of predictability and reliability to the recall, as well as constraining the activity of the therapist. The client can then feel more secure in closing their eyes and turning their attention inward onto the memory.

Linearization of the Narrative. Traumatic memory is usually fragmented and disordered; chronological time often jumbled up (van der Kolk & Fisler, 1995). In contrast, normative experience is structured in chronological, linear

format. By repeatedly applying the linear structure of the counting to 100 to the traumatic memory, clients progressively map the chaotically-represented memory onto the numbering frame, locating aspects of their experience in the 20s, the 60s, etc. Over time, the memory returns to a linear form, and this is associated with greater ease of processing and retrieval, and with less arousal (Amir, Stafford, Freshman, & Foa, 1998; Foa, Molnar, & Cashman, 1995).

Nevertheless, we believe that such linearization is the result, not the cause, of the therapeutic effect of imaginal exposure. However, the presence of the linear structure provides the client with a powerful structuring device that helps them to reduce their avoidance during exposure. Clients report that their attention shifts back and forth between the numbers and the memory. Because the numbers are being said out loud by another person, automatically, the counting serves as a reliable guide to the remembering.

Procedure

Timing

In the early phases of development of this method, it was assumed that the counting procedure should not be implemented until a solid therapeutic alliance had formed (Ochberg, 1996). We have since learned that this is not necessary, and that counting procedure can be employed as early as the first session (Johnson & Lubin, in press). However, certain conditions are important. First, the client must have a discrete traumatic event that is currently the subject of distressing re-experiencing symptoms. The counting method cannot be effectively used on multiple, ongoing abuse such as childhood neglect that extended over years. Second, the client must be in a reasonably stable state of mind so that they can concentrate on trauma-focused work, and to agree to do such work. Clients in the midst of life crises that demand immediate attention

are generally not good candidates. Third, the client needs to demonstrate a basic sense of trust in the competency and concern of the therapist, so that a basic confidence in their recommendation of this procedure is present.

Step I. Set Up

The therapist begins by reviewing the rationale for the method with the client as part of the preparation phase. The therapist will emphasize the role of avoidance in maintaining the arousal to the stimulus, and the need to remember the trauma from beginning to end. The established effectiveness of exposure therapies will be explained. The therapist will underscore how the counting procedure will help by having a definite end, and by allowing for private recall. Generally the counting procedure is introduced early in the session to allow sufficient time for adequately processing the memory. Most procedures require about a half hour to complete.

The procedure is applied to one, specific memory at a time; thus this memory must be identified prior to the procedure. The therapist will ask the client to briefly describe the outlines of the trauma, without details that might arouse too much affect prior to the procedure. Next, the therapist helps the client identify a specific timepoint just prior to the traumatic event, and also an end point--a time in which the client was no longer in acute danger. Too narrowly defining the time period will leave the client too aroused at the end of the counting, while too broadly defining it (e.g., over days) does not allow the client sufficient time to engage with the worst part of the memory. The middle or most traumatic part of the memory is not anchored because this is likely to arouse affect and unnaturally define an often chaotically-experienced moment. It is often surprising what becomes the most arousing part of the memory.

Once the memory is anchored, the therapist indicates that they are ready to begin, and says, "What we are about to do is to go back and remember this event. I will be with you, counting slowly from 1 to 100. Together we will re-visit the scene and then return. OK?" This both emphasizes the collaborative nature of the endeavor, and demarcates a boundary between the normal interaction of client and therapist, and the special interaction to be experienced during the counting procedure. The instructions follow:

"I am going to count from 1 to 100, at a rate of about one number per second. I would like you to recall the memory from the beginning, at about the point that you, letting the worst part of the memory crest as the counting goes into the 40s through the 60s. Try to reach the end of the memory, the point at which you....., as the counting approaches the 80s. Midway through the 90s, I will say "back here" to let you know that we are near the end, and that you should be coming out of the past and returning to the present. I ask you not to talk during the counting. It is usually best if you close your eyes or look away from me. OK, I'd like you to sit in a comfortable, resting position. Are you comfortable? Then let us begin."

Step 2. Counting

The therapist uses a calm and friendly voice and counts out loud from 1 to 100, maintaining a steady rhythm of about one number per second. The therapist speaks "to" instead of "at" the client, and looks at them so as to monitor their bodily reactions. It is important to notice if the client is becoming aroused, that is, showing tears, making grimaces, shuddering, clenching hands, or breathing more deeply or quickly. In contrast, there may be no sign of distress, which may mean that the client was unable to recall the traumatic memory, or that the method did not elicit a great deal of affect.

Normally, the memories evoked during counting will be no more intense than spontaneous remembering. If the client becomes overwhelmed during the counting and is in tears, the therapist continues, since catharsis is common. In the unusual circumstance where the client stops the procedure and opens their eyes, the therapist needs to assess whether something is distracting the client (e.g., the counting is too loud), or whether they need more preparation before attempting the procedure.

On 94, the therapist says, "back here" to help remind clients to bring themselves from the memory back to the present. This is especially helpful for those clients who have had a deeply engaging experience, or who have become partially dissociated.

Step 3. The Moment After the Counting

Clients often look dazed or thoughtful after the counting and may not speak for some time. They may feel some sense of accomplishment, relief, or some residual terror from the original event. They may have remembered aspects of the event that were forgotten or repressed. They may be embarrassed or unwilling to discuss what happened. The therapist should respect this moment of silence and stay silent until addressed by the client. Some clients may remain so deep in thought that they do not speak for several minutes. The therapist will not ask the client to remember or describe the memory, make evaluative or analytical comments, or indicate an expectation of a response from the client.

This moment parallels the homecoming experience of traumatized clients, when they first face other people to report their trauma. Many clients will be filled with feelings of humiliation or shame over what happened to them. They cannot believe they are worthy as people, having been "soiled" by the

experience. By looking directly at clients and nonverbally conveying warmth and support, the therapist acknowledges their pain, as well as communicates admiration for their courage to do this work. The therapist's calm patience during this moment also demonstrates his/her tolerance for the traumatic material: an absence of the need to contain his/her anxiety with a burst of helpful advice or reassurance. Once the client speaks to the therapist, the therapist will then respond with an affirmation such as: "That was something. You made it there and back again." Instead of a shaming or rejecting "welcome back," the therapist specifically puts words to the look and smile, affirming the courage of the client to revisit the trauma.

Step 4. Review

The therapist then asks the client to describe what they remembered during the counting. It is important to note that a description of the event per se is not requested, only what was remembered during the procedure. Usually a detailed narrative from the client follows. The therapist takes notes in order to allow uninterrupted reporting by the client and a more accurate accounting. It allows time between the solitary act of private recall and the collaborative endeavor of redefining a piece of personal history. Many clients appreciate their therapist taking notes, since eye contact is less important than careful attention to the details of the story.

Sometimes the client has difficulty remembering or is still dazed by the intensity of recall. Their narrative may be fragmented, or described in a vague and general manner. The therapist can aid the recall if necessary by asking, "What did you recall in the 20s and 30s?...."

After the client has concluded, the therapist reads back from the notes in as close to a word-by-word repetition as is possible. The purpose is to

communicate their understanding of the client's experience in its totality, and to allow them to hear their trauma again, but now from the more distanced perspective as a listener. We have found that clients are extremely sensitive to even minor paraphrasing or interpretive insertions that do not exactly match their experience. As in client-centered therapy, the intent is to communicate that the client has been accurately heard and to avoid evaluative comments about their behavior during the traumatic event. We have found this to be especially difficult for many clinicians learning this technique. Apparently there is a tremendous pressure experienced by therapists to insert themselves into the trauma narrative, most likely out of a desire to help the client, but also possibly out of discomfort with taking in the traumatic material.

After reading back the story, the therapist affirms the client's experience, "You went through a terrible experience. Yet you survived it, and are able to remember it when you wish." By concluding the review of the trauma with an affirmation, the important message-- you are a survivor, and you have the ability to gain control over your traumatic memories--is reinforced. Often the client will have difficulty accepting such support due to the shame or embarrassment occasioned by remembering the trauma.

Step 5. Reflection and Closure

The purpose of this step is to help clients distance themselves from the memory and diminish strong affect. The therapist asks the client about the procedure itself, rather than the traumatic memory, and draws the client's attention onto the present. Questions concerning whether the counting was too loud or distracting, whether 100 was long enough, are asked. It is very common for clients during their first counting session to have difficulty simultaneously listening to the counting and engaging in their memory. Later, most have been

able to integrate the two channels, weaving the counting into their remembering. Clients that initially do not hear the counting are often deeply immersed in the trauma; while clients that cannot engage with the memory because of the counting are relying on more avoidant defenses. Many clients report periods of both experiences during the counting.

At the end of the session, the therapist gives another affirmation, such as "You did well. You remembered. You turned the tape on and you turned the tape off." The purpose of this affirmation 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 comment also underscores the sense of mastery embedded within the technique.

Length of Treatment

When the traumatic memory is circumscribed and uncomplicated, three to five counting sessions are usually sufficient to help the client feel a sense of mastery and control over their intrusive recollections of that particular trauma. Some traumatic memories, however, are multidimensional and complex, with many meanings for the client, and may require a number of consecutive sessions or several sessions spaced months apart. Anchor points may be shifted to "zoom in" on more specific sections of a memory, or extended to take in important aspects not previously included. Even when relief is experienced, some clients may request additional sessions to confront other issues related to the trauma or to specifically work on modifying their memories. Some clients have benefited in later stages of treatment by adding creative modifications to their memory during the counting, such as changing the ending so they escape the injury, are rescued, or are able to punish their assailants. These interventions appear to increase the playability of the memory for the client, being very much associated

with the reduction of fear.

Research

In a recent study, the Counting Method was compared with Prolonged Exposure, (Foa, Rothbaum, Riggs, & Murdock, 1990), Eye Movement Desensitization/Reprocessing, (Shapiro, 1989) and a waitlist control group among 38 female trauma victims with posttraumatic stress disorder (Johnson & Lubin, in press). Each subject was randomly assigned to one of the three treatments and seen for 5 to 9 sessions. All three types of treatment performed exceptionally well in reducing both PTSD and general psychiatric symptoms. Interestingly, all three treatments were more effective in reducing re-experiencing and avoidance symptoms than hyperarousal symptoms. The study suggests that the Counting Method may be as effective as the other techniques in lowering PTSD and psychiatric symptoms.

Case Examples

Witness to Violent Death

Joseph was a 52 year old police officer in a small Connecticut town. He was happily married with two grown children. He came to treatment for depression and burnout. He had over the past six months lost all interest in his job, not wanting to get up in the morning, sitting in his police car for hours, listening to the police radio, and often not responding to calls. "Hours would go by and I wouldn't know it," he said. Other than several incidents during his police work, he had had no traumatic experiences. He identified three major stressful incidents at work: witnessing the death of a man during his birthday party while all his family and friends looked on; being the first responder to a double homicide in an office, where the two men had been shot in the head; and

fighting off a father who was brutally beating his 8 year old son with iron rod.

The counting procedure was used on all three memories and within three weeks Joseph reported feeling much improved and much less depressed about work. After six weeks he reported feeling completely better, and in fact said that while he was waiting in his patrol car, he was using the counting method himself to go over these memories. Treatment was terminated after eight sessions with complete remission.

Witness to Violent Death

Eleanor is a 36 year old married woman with two children who was nearly struck head-on by a drunk driver late at night on her return from work. The driver barely missed her, but struck the car immediately behind her, killing the driver and giving severe brain injury to the passenger. She witnessed the wreckage, the ambulances arriving, and the bodies being taken away. Shortly afterwards, she became immobilized with anxiety, unable to drive, fearful for her children, with nightmares and flashbacks about the incident. She became depressed, listless at home, and extremely irritable. Five months later, despite antidepressant medication and good family support, she was referred for psychotherapy.

During the first two counting procedures, Eleanor had a difficult time engaging with the memory, either being distracted by the counting, or "going blank", especially in the 40s and 50s, or getting stuck "in a loop, seeing the car coming over the hill, again and again." She complained that she could not remember major parts of the event, especially when she was waiting for the ambulance to come. During the next four counting procedures, however, she progressively engaged in the memory, and began to fill in much of her memory

for the event. The worst part had been seeing the body of the driver who had been killed, falling out of the car door "like a rag doll" and the pool of blood forming. By the sixth week, she had resumed driving (though not past the accident site), and her flashbacks had significantly waned. By the tenth week, Eleanor had been able to restore a highly detailed account of the event, and was nearly asymptomatic. She had resumed driving by the accident scene, and in fact had placed a small memorial near the road where the driver had died. Treatment was terminated after 12 sessions.

Motor Vehicle Accident

Sandy is a 55 year old married woman whose car was struck suddenly from the side in an intersection, causing her car to rotate several times, and then striking a fence where it came to a halt. Her two passengers were severely knocked around and initially appeared unconscious, terrifying Sandy who had been the driver.

The counting procedure progressed without difficulty but consistently Sandy remained highly aroused at the end. The anchors had been just prior to being hit, and then when the ambulance had come to take them to the hospital. The therapist finally inquired whether anything else had happened after that, for example on the ride to the hospital, and Sandy burst into tears and related a horrible series of events: rude behavior, going to the wrong hospital, and nearly getting into another accident while careening around a sharp turn. A separate counting procedure had to be implemented for the second half of the traumatic memory before significant symptomatic relief was achieved. This example indicates the importance of properly locating the anchors to the beginning and ending of the event, and the potential need for dividing an event up into discrete

episodes.

Train Accident

Peter is a 48 year old businessman who was a passenger on a train, which hit an obstacle and was derailed during his commute home. He became acutely symptomatic, unable to travel on any form of transportation, and developed severe sleep disorder, irritability, nightmares, and hyperarousal. As a business consultant, he had to fly at least once a week, so he considered quitting his job because of his inability to fly. His boss insisted he be seen for treatment.

Peter denied any prior traumatic events in his life, initially. During the counting procedure for the train accident, however, he became overwhelmed with affect in the 50s, hyperventilating and grasping the arms of his chair like his life depended upon it. The therapist assumed he was reliving his train accident. However, during the reporting phase Peter said he had shifted to another memory "from long ago" when he had been a passenger in a small commuter plane that crash-landed on a frozen lake. This had been 30 years ago. The plane burst into flames, and he had had to kick through the door to get out. Unable to make a hole wide enough, he used his rigid briefcase to finally escape. Two passengers died in the flames. He had been written up as a hero in the local newspapers, and said that he had had no serious anxiety symptoms after the event, so had not thought about it when he had been asked by the therapist.

Peter then realized that he had used his briefcase to push out the window on the train to get out, and that perhaps that had been the evocative link between the two events.

Once the counting procedure was used on the plane crash incident (for which he had had no symptoms), he quickly showed improvement and was asymptomatic after only four sessions. He returned to his flying schedule and

his position at work.

Childhood Emotional and Physical Abuse

Jesse is a 44 year old single woman employed as a secretary at a large hospital. She was a passenger on an elevator when it suddenly jerked up, then fell down a few feet, coming to rest and opening between floors. She became panicky and had to be sedated in the hospital's emergency room. Very rapidly she developed severe anxiety symptoms, body pains, and dissociative symptoms, and eventually left her job of twenty years on disability. In treatment, she presented as highly dissociative, with severe somatization disorder, hysterical outbursts, and increasing depressive symptoms. A trauma history revealed severe childhood abuse from her father, who had been extremely and sadistically violent to her and her brother from an early age. The father had also been astonishingly brutal in verbally humiliating his children publicly, including tying them on the dog chain in his front yard and kicking them; hitting her in the knees with a tire iron; stabbing her with a fork at the dinner table when she had spoken out of turn.

The therapist used supportive and educative methods in the beginning of treatment due to the intensity of her dissociative picture and his fears that she would not be able to use exposure therapies effectively, without becoming overwhelmed. Though these proved able to help her stabilize, her overall condition continued to weaken, with increased bodily impairments, hopelessness, and anger. Whenever she discussed either the elevator accident or the childhood abuse, she became flooded and hysterical. Nevertheless, Jesse gained some insight into the impact of her early experiences, and had a good alliance with the therapist.

After over a year of psychotherapy, the therapist decided to try the

counting procedure on the elevator accident. Surprisingly, Jesse was able to follow the directions, and during the counting clearly was immersed in the memory, to the point of jerking her body as if it was re-occurring. During the 80s she clearly was coming to the end of her memory, and when the therapist said, "back here," she clearly responded by returning to the present. The structuring provided by the counting procedure had contained her experience. She showed great relief after the counting, but said that she did not remember much of the procedure. Apparently, she had partially dissociated during the counting, though still following the counting. Several counting sessions repeated the above experience.

The therapist then attempted the counting procedure with one of the early childhood memories. Jesse compliantly followed the instructions, only more fully lived out the memory, screaming and grabbing her cheek as though she had just been hit (her eyes still closed), crying out, "don't hit me again, daddy," as she held her hands up to protect her from the next blow. Yet, as the counting progressed into the 80s, she moved to the pre-established end of the memory when she was in her bedroom crying, and then in the 90s, coming back to the present and returning to a calm state. She said she had no memory of what just had happened, just that she was very tired. The therapist continued with a dozen more counting sessions on various childhood traumas with similar results.

Though Jesse's condition continues to remain impaired, due to the complexity of her psychological situation, her re-experiencing symptoms surrounding the elevator and her childhood have greatly diminished. She is capable of remembering both without becoming overwhelmed, and the frequency of intrusive memories has significantly decreased.

Training

A training program has been established to teach the method to clinicians and certify those who have shown mastery. Generally, the training includes 16 classroom hours of didactic and role-playing experience, followed by practice in one's own clinical setting, and feedback based on submitted audiotapes of counting sessions. A Training Manual is used to guide the learning (Ochberg, Johnson, & Lubin, 1996). Interested clinicians or agencies can contact the authors at: Post Traumatic Stress Center, 19 Edwards Street, New Haven, CT 06511 (203-624-2146).

References

- Amir, N., Stafford, J., Freshman, M., & Foa, E. (1998). Relationship between trauma narratives and trauma pathology. *Journal of Traumatic Stress, 11*, 385-392.
- Foa, E., & Kozak, M. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20-35.
- Foa, E., Molnar, C., & Cashman, L. (1995). Change in rape narratives during exposure therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 8*, 675-690.
- Foa, E.B., Rothbaum, B.O., Riggs, D.S., & Murdock, T.B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology, 59*, 715-723.
- Foa, E.B., Steketee, G., & Rothbaum, B.O. (1989). Behavioral/cognitive conceptualization of post-traumatic stress disorder. *Behavior Therapy, 20*, 155-176.
- Johnson, D., & Lubin, H. (in press). Brief treatments for posttraumatic stress disorder: A comparison of Prolonged Exposure, Eye Movement Desensitization and Reprocessing, and the Counting Method. Submitted for publication.
- Ochberg, F. (1993). "The Counting Method." Videotape available from Gift from Within, 800-888-5236. Reviewed by John Wilson, Ph.D., *Psychotherapy, 30*:4, 705, 1993; and by Janet Bell, Ph.D., *Journal of Traumatic Stress, 8*: 1, 197-199, 1995.
- Ochberg, F. (1988). *Post-traumatic therapy and victims of violence*. New York:

Brunner/Mazel.

Ochberg, F. (1996). The Counting Method. *Journal of Traumatic Stress, 9*, 887-894.

Ochberg, F., Johnson, D., & Lubin, H. (1996). *The Counting Method: Training Manual*. Available from Post Traumatic Stress Center, New Haven, CT.

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress, 2*, 199-233.

van der Kolk, B., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress, 8*, 505-526.

Dr. David Johnson Is a member of Gift From Within's professional advisory board.