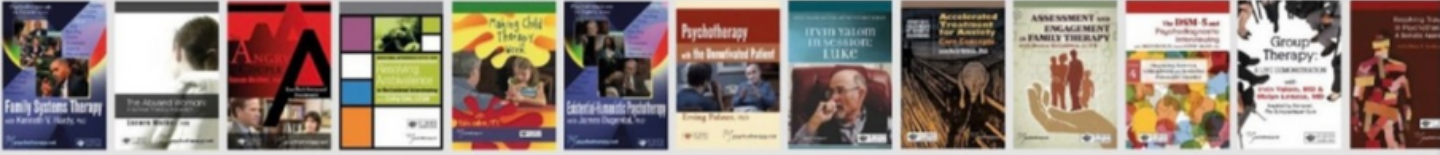


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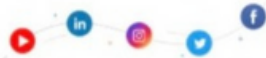


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**Instructor's Manual**

for

# PSYCHOTHERAPY FOR CHRONIC PTSD

with

Frank Ochberg, MD

Manual by

Ali Miller, MFT, and Frank Ochberg, MD





The Instructor's Manual accompanies the DVD *Psychotherapy for Chronic PTSD*, with Frank Ochberg, MD (Institutional/Instructor's Version). Video available at [www.psychotherapy.net](http://www.psychotherapy.net).

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*Instructor's Manual for Psychotherapy for Chronic PTSD, with Frank Ochberg, MD*

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Instructor's Manual for

# PSYchOTheraPY FOR chrOnIc PTSD WITH Frank Ochberg, MD

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# Tips for Making the Best Use of the DVD

## 1. FACILITATE DISCUSSION

Pause the video at different points to elicit viewers' observations and reactions to the material presented. There are several **Discussion Questions** included in each segment summary. These questions provide ideas about key points that can stimulate rich discussions and learning.

## 2. ENCOURAGE SHARING OF OPINIONS

encourage viewers to voice their opinions; no therapy is perfect! What are viewers' impressions of what works and does not work in the sessions? We learn as much from our mistakes as our successes; it is crucial for students and therapists to develop the ability to effectively critique this work as well as their own.

## 3. SUGGEST READINGS TO ENRICH VIDEO MATERIAL

assign readings from **Related Websites, Videos, and Recommended Readings** prior to or after viewing.

## 4. ASSIGN A REACTION PAPER

See suggestions in the **Reaction Paper** section.

## 5. CONDUCT A ROLE-PLAY

The **Role-Play** section guides you through an exercise you can assign to your students in the classroom or training session.

## 6. SELECT A SEGMENT IF TIME IS LIMITED

If, due to time constraints, you are not able to show this video in its entirety, you may want to review the **Summary** and select one or more of the 14 segments to show and discuss.

## **PERSPECTIVE ON VIDEOS AND THE PERSONALITY OF THE THERAPIST**

Psychotherapy is an intensely private matter. Unlike the training in other professions, students and practitioners rarely have an opportunity to see their mentors at work. but watching therapy on video is the next best thing.

Psychotherapy portrayed in videos is less off-the-cuff than therapy in practice. Therapists may feel put on the spot to offer a good demonstration, and clients can be self-conscious in front of a camera. Therapists often move more quickly than they would in everyday practice to demonstrate a particular technique. Despite these factors, therapists and clients on video can engage in a realistic session that conveys a wealth of information not contained in books or therapy transcripts, including: body language, tone of voice, facial expression, rhythm of the interaction, quality of the alliance—all aspects of the therapeutic relationship that are unique to an interpersonal encounter.

**One more note:** Therapists' personal styles are often as important as their techniques and theories. Therapists are usually drawn to approaches that mesh well with their own personalities. Thus, while we can certainly pick up ideas from master therapists, students and trainees must make the best use of relevant theory, technique, and research that fit their own personal styles and the needs of their clients.

## **PRIVACY AND CONFIDENTIALITY**

because this video contains actual therapy sessions, please take care to protect the privacy and confidentiality of the client who has courageously shared his personal life with us.

# Diagnostic Criteria for Posttraumatic Stress Disorder (PTSD)

## WHAT IS PTSD?

PTSD is classified in the DSM-IV-Tr as an anxiety Disorder. The category of Posttraumatic Stress Disorder includes three specifiers: acute, chronic, and With Delayed Onset. acute is used if the duration of symptoms is less than three months, and chronic is used if the duration of symptoms is three months or more. With Delayed Onset indicates that at least six months have passed between the traumatic event and the onset of symptoms. To learn more about PTSD, refer to the DSM-IV-Tr, pp. 463-468.

The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal. The full symptom picture must be present for more than one month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

## ASSOCIATED FEATURES

Individuals with PTSD may describe painful guilt feelings about surviving when others did not survive, or about the things they had



to do to survive. avoidance patterns may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job. auditory hallucinations and paranoid ideation can be present in some severe and chronic cases. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationship with others; or a change from the individual's previous personality characteristics.

PTSD is associated with increased rates of Major Depressive Disorder, Substance-related Disorders, Panic Disorder, agoraphobia, Obsessive-compulsive Disorder, generalized anxiety Disorder, Social Phobia, Specific Phobia, and bipolar Disorder. These disorders can either precede, follow, or emerge concurrently with the onset of PTSD. In addition, chronic PTSD may be associated with increased rates of somatic complaints and, possibly, general medical conditions.

### **DIAGNOSTIC CRITERIA FOR PTSD**

#### **A. The person has been exposed to a traumatic event in which both of the following were present:**

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness, or horror. note: In children, this may be expressed instead by disorganized or agitated behavior.

#### **B. The traumatic event is persistently re-experienced in one (or more) of the following ways:**

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

**C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:**

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma.

(3) inability to recall an important aspect of the trauma.

(4) markedly diminished interest or participation in significant activities.

(5) feeling of detachment or estrangement from others.

(6) restricted range of affect (e.g. unable to have loving feelings).

(7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

**D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:**

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

**E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.**

**F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

\*adapted from DSM-IV Tr. reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, Text revision (© 2000). american Psychiatric association.

# Posttraumatic Therapy

by Frank M. Ochberg, MD

## INTRODuCTION

Most victims of violence never seek professional therapy to deal with the emotional impact of traumatic events. If they did, they would be sorely disappointed. There are not enough therapists in the world to treat the millions of men, women, and children who have been assaulted, abused and violated as a result of war, tyranny, crime, disaster, and family violence. When people do seek help suffering with posttraumatic symptoms, they may find therapists who are ill-equipped to provide assistance. The credentialed clinicians in psychiatry, psychology, nursing, social work, and the allied professions are only recently learning to catalog, evaluate, and refine a therapeutic armamentarium to serve traumatized clients. My purpose in this chapter is to enlarge upon the foundation of Posttraumatic Therapy (PTT) and clarify some of the clinical techniques that stand upon this foundation.

## FuNDAmENTAL PRINCIPLES

Several principles are fundamental to Posttraumatic Therapy, and discussing these at the outset of therapy is usually advisable. Since traumatized and victimized individuals are, by definition, reacting to abnormally stressful events, they may confuse the abnormality of the trauma with abnormality of themselves.

The first principle of PTT is, therefore, the normalization principle:

There is a general pattern of posttraumatic adjustment, and the thoughts and feelings that comprise this pattern are normal, although they may be painful and perplexing, and perhaps not well-understood by individuals and professionals not familiar with such expectable reactions.

The emotional healing process often includes re-experiencing, avoidance, sensitivity, and self-blame. These symptoms are easily

described, explained, and “set” in a context of adaptation and eventual mastery. By sharing such information, the second principle of PTT, the collaborative and empowering principle, is recognized: The therapeutic relationship must be collaborative, leading to empowerment of one who has been diminished in dignity and security. This principle is particularly important in work with victims of violent crime. The exposure to human cruelty, the feeling of dehumanization, and the experience of powerlessness create a diminished sense of self.

A third principle is the individuality principle: Every individual has a unique pathway to recovery after traumatic stress. This principle suggests that a unique pathway of posttraumatic adjustment is to be anticipated and valued, and not to be feared or disparaged. Therapist and client will walk the path together, aware of a general direction, of predictable pitfalls, but ready to discover new truths at every turn.

These three principles can be expressed in various ways and supplemented with other important tenets. For example, an appreciation of coping skills rather than a focus on personality limitations allows therapy to proceed without undue emphasis on negative characteristics, and the devastating implication that victimization is deserved. PTT begins with the assumption that a normal individual encountered an abnormal event. To ameliorate the painful consequences, one must mobilize coping mechanisms. How dramatically different this is from the hypothesis that posttraumatic stress disorder and victimization symptoms are products of personality flaws and neurotic defenses that must be identified and treated according to traditional paradigms!

Furthermore, an interdisciplinary approach, recognizing the contributions of biology, psychology, and social dynamics, stimulates clinician and client to see beyond any singular explanation for posttraumatic suffering and to search for remedies in many different fields. The contributions of pharmacology, education, nutrition, social work, law, and history are recognized and valued. Intervention may include introduction to a self-help network, exposure to inspirational literature, explanation of the victims’ rights movement, establishment

of an exercise regimen, or prescription of anxiolytics. Practitioners should therefore be aware of community resources that are of potential benefit and be willing to assess the merit of these adjuncts to their direct clinical intervention. Often, this requires personal meetings with colleagues from disparate fields. To some degree, it also requires a cognitively flexible attitude as to how to best serve the patient suffering from PTSD who may need many special (yet nont traditional) therapeutic interventions to facilitate the stress recovery process.

## **TECHNIQUES OF POSTTRAUMATIC THERAPY**

Many techniques have been used effectively to help survivors readjust after traumatic events. While not comprehensive, I have found it useful to classify the various methods into four categories:

1. The first category is educational and includes sharing books and articles, teaching the basic concepts of physiology to allow an appreciation of the stress response, discussing civil and criminal law with new participants in the process, and introducing the fundamentals of holistic health. The educational process is one of mutual exchange (i.e., a “two-way street”). The client may also have resources that he or she finds helpful and wants to share with the clinician.
2. The second grouping of techniques falls within the category of holistic health. Physical activity, nutrition, spirituality, and humor contribute to the healing of the whole person. The clinician who promotes these aspects of healing serves as a teacher and a coach, offering concepts that might be new to the client, and shaping abilities that may be latent.
3. The third category includes methods that enhance social support and social integration. Family and group therapy could be included here. exposure to self-help and support groups in the community is another example. but most important is the sensitive assessment of social skills, the enhancement of these skills, the reduction of irrational fears, and the expert timing of encouragement to risk new relationships.



4. Finally, there are clinical techniques that are best categorized as therapy. These include working through grief, extinguishing the fear response that accompanies traumatic imagery, judicious use of medication for target symptoms, the telling of the trauma story, role-play, hypnotherapy, and many individualized methods that are consistent with the principles of PTT.

## **EDuCATION**

### **Reading the DSm Together**

I will never forget the first time I brought out my green, hardbound copy of the DSM-III, moved my chair next to Mrs. M., and showed her the chapter on PTSD. Mrs. M. was a thin, soft-spoken woman in her thirties who was assaulted and raped in South Lansing, Michigan. She was referred by a colleague and had just finished telling me her symptoms, eight or nine weeks after the traumatic event. She was frightened, guarded, perplexed, and sad. She had no basis for trusting me. But after she saw the words in the book, as I read them aloud, she brightened, sat up tall, and said, "That's me, in that book! I never thought this could be real."

Seldom have I found such a reversal of mood and such a sudden establishment of trust and rapport since Mrs. M., but I have never missed an opportunity to read the criteria list with a client, when it seemed appropriate. The responses vary, from satisfaction that the symptoms are officially recognized, to surprise that anybody else has a similar syndrome. Some clients take pride in making their own diagnoses, pointing out exactly which symptoms apply.

Reading the DSM together begins the educative and collaborative process. It opens the door to further education about the physiology of stress and the range of human responses to adversity.

### **Introducing Civil and Criminal Law**

A therapist need not be a lawyer to know about the law. When our clients face the criminal justice system for the first time, understandably they may be concerned, confused, and overwhelmed.

Usually, I offer clients who are victims of violent crime several resources, articles, and brochures that explain their rights under state law and the role of the victim-witness in the American judicial system. A client who is in the middle of a trial, cooperating fully with the prosecutor, may know nothing of his or her right to sue the assailant, to have a court injunction against harassment, to receive workers' compensation, and, in some instances, to receive representation from the pro bono committee of the county bar association. Moreover, finding the right lawyer is as difficult as finding the right therapist, so I pay close attention to my clients' experiences with attorneys and maintain an up-to-date referral roster. Sharing information about legal resources is part of the education process.

### **Discussing Psychobiology**

Few clients are interested in reading about autonomic nervous system activation, but some read voraciously. To understand the physiology of mammalian arousal during stress is to begin mobilizing the mind in pursuit of recovery. It is relatively easy to impart a basic understanding of the fight/flight mechanism and the General Adaptation Syndrome. Without turning therapy into a didactic exercise, without burdening the client with unsolicited instruction, one can convey the fact that lethal threat has a powerful impact on body chemistry; that our adrenal glands are stimulated; that we are prepared to fight or to flee as if we were facing a wild beast, millennia ago; that all this circuitry is out of date and usually destructive when we face threats in modern society—that PTSD is the predictable outcome in general after extraordinary stress; and that everyone's individual pattern is different.

Furthermore, vigorous use of the large muscles is the intended result of adrenal activation, and physical activity is an advisable measure to ameliorate the effects of PTSD. This point leads to the next objective.

### **PROMOTING HOLISTIC**

#### **HEALTH      Physical**

Activity  
relatively early in therapy, I will evaluate the client's potential for super-vised physical activity. I want to know that a recent medical examina-

tion has been performed and there are no limitations or restrictions. If there are limitations, I may still promote allowable activity, but only after consultation with the examining physician.

Often, the client and I develop an exercise plan, with goals and methods listed in the record. Usually, this process occurs after a preliminary discussion of stress physiology and before agreement on overall treatment objectives. (The client may be ready to take daily walks, but not ready to discuss the details of victimization.) agreeing on an exercise plan and fulfilling the agreement are separate issues.

When there is resistance to exercise, the resistance itself must be confronted. The therapist should not assume to know an individual's underlying motive for avoiding healthy activity. a gentle, collaborative search for the obstacles and the construction of a path around these obstacles comprise an important chapter of PTT.

Therapists are advised to become familiar with supervised, structured fitness programs in their communities. a referral to a specific YMca, health club, or aerobic instructor can assure that the milieu is appropriate, the regimen is reasonable, and the opportunity for reinforcement is available.

### **Nutrition**

It makes sense to evaluate a client's eating habits and look for the common mistakes that contribute to anxiety, irritability, and depression. In general, this is part of good clinical work, but particularly important for posttraumatic clients who are vulnerable to mood swings and who may have neglected their nutrition.

### **Humor**

The goal in adding humor to PTT is not for the therapist to be witty, but for the client to have the capacity to laugh. a clinician can facilitate the recovery and the improvement of a client's sense of humor by setting an example, by searching for instances when the client used humor well, and by providing a good audience when spontaneous humor arises.

### **Spirituality**

although I once felt that religion and spirituality had no place in the clinical sciences, I am now convinced that clinicians must evaluate

their clients' spiritual potential. by this, I mean their ability to benefit from their own beliefs, particularly a sense of participation in universal, timeless events. For adherents to the major religions, this spiritual dimension may be conceptualized as feeling god's love. For others, spirituality may be described as a transcendent feeling of harmony and communion with humanity or nature or the unknown reaches of space.

My role is not to promote any specific spiritual approach. but after a relationship is established, after some progress has been made, I express interest in the client's experience of spirituality. Often I am surprised by the strength of religious conviction that coexists with pessimism and helplessness. In therapy, the issue then is not creating a spiritual capacity, but identifying and overcoming the obstacles to feeling the embrace of one's faith.

holistic health recognizes that the healing process is more than chemical re-equilibration. attention to exercise, nutrition, humor, and spirituality are important elements of the holistic approach. beyond these elements is the human group, whether it is a family, a support network, or a community. The individual who is victimized cannot recover in isolation. Therefore, the clinician must attend to the demands of social integration.

### **Social Integration**

a supportive family is the ideal social group for healthy posttraumatic healing. There is an important role for the posttraumatic therapist in assessing family strengths and weaknesses, and in assessing in the design and implementation of strategies for optimum recovery. referral to support groups and self-help networks may complement or supplement the healing function of the family.

### **POSTTRAUMATIC FAMILY THERAPY**

The formula for posttraumatic family therapy includes an assessment phase and four distinct treatment phases. however, I must emphasize that family therapy is not necessarily the best approach, particularly when violation occurs within the family. In assessing the family, standardized protocols can supplement clinical judgment, but

ultimately the clinician and client together must decide whether family therapy is feasible.

eleven criteria distinguish functional from dysfunctional families:

1. the traumatic stressor is clear, rather than denied;
2. the problem is family-centered rather than assigned completely to the victim;
3. the approach is solution-oriented rather than blame-oriented;
4. there is tolerance;
5. there is commitment to and affection among family members;
6. communication is open;
7. cohesion is high;
8. family roles are flexible rather than rigid;
9. resources outside of the family are utilized;
10. violence is absent; and

#### **Treatment Phase I: Building Commitment to Therapeutic Objectives.**

When the clinician and the client agree that family therapy is indicated, the first phase of treatment requires that as many family members as possible disclose their individual ordeals, and the therapist demonstrate recognition of their suffering. highlighting differences in individual responses leads to the next phase.

#### **Treatment Phase II: Framing the Problem.**

now each family member is encouraged to tell his or her view of the traumatic event, and to understand how each member was affected. The therapist reinforces discussion that shifts the focus away from the victimized individual, toward the impact on the family as a whole. This is the time to recognize, explore, and overcome feelings of "victim blame." When positive consequences of the ordeal are mentioned (e.g., a greater appreciation of life after a close brush with death), they are duly noted.

**Treatment Phase III: Reframing the Problem.**

after individual experiences, assumptions, and reactions are expressed and understood, the critical work of melding these viewpoints into a coherent whole begins.

**Treatment Phase IV: Developing a Healing Theory.**

The goal of posttraumatic family therapy is consensus regarding what happened in the past, and optimism regarding future capacity to cope. an appraisal that is shared by all family members, that accounts for the reactions of each, and that contributes to a sense of family cohesion is a healing theory. however the therapist chooses to clarify the closure of successful therapy, the family will know that they have fulfilled their potential as a healing, nurturing human group.

**SELF-HELP GROUPS**

Self-help groups are another resource that can be particularly effective. They tend to be specific, rather than generic; it is unusual to find a group for all victims of violent crime, but common to have groups for parents of murdered children, adult survivors of incest, and victims of domestic assault.

Therapists who work with victims of violence should become familiar with community groups that offer opportunities to share experiences, promote normalization, combat victim blame, and provide a nonthreatening social experience. Some groups will complement individual therapy. Some provide unique opportunities to help others, restoring a sense of purpose and potency. but some groups do more harm than good, encouraging premature ventilation, allowing self-styled "experts" to dominate, confusing and demoralizing the new participant.

**DYADIC SuPPORT**

I have found several ex-clients who were willing to meet with current clients to share experiences. Usually, this worked best one-on-one, at the ex-patient's home or at a restaurant. Since I knew both individuals, I could arrange the meeting, giving a bit of background information



to each. I would choose the pairs carefully, thinking about compatible personalities, common traumatic events, and timing with respect to each. I recommend that any attempt to promote contact between ex-clients and current clients be made with caution, knowing the current status of each, and protecting confidentiality by withholding names and personal information until each has been consulted, each agrees, and the timing seems appropriate. However, a carefully screened dyadic “support group” can be extremely beneficial, and is well worth the effort on the part of the therapist. Most of my clients tell me they would appreciate an opportunity to assist others, and I believe them.

## **SuPPORT SERVICES FOR VICTImS**

Social integration refers to the use of sensitive, supportive companions in the course of recovery from traumatic events, and also to the goal of reentering society without fear. Victims of violent crime who participate in the criminal justice system have little choice about the timing of some stressful social experiences. They are questioned, cross-examined, brought to crowded court roomscourtrooms, and sometimes forced to share a waiting room with the perpetrator. For them, social integration can be sudden and traumatic. Fortunately, efforts are underway in most states to provide specialized services for victims facing these stressful ordeals.

There are victim-witness specialists who are trained to support an individual throughout the criminal justice gauntlet, but caseloads are overcrowded, budgets are tight, and too often, the victim-witness specialist is ignored. I have not hesitated to meet with prosecutors and to attend court hearings when my clients felt it would help. PTT objectives are advanced, particularly the objective of sensitive facilitation of social contact. Some colleagues argue that this type of intervention fosters dependency and interferes with the therapeutic relationship. They would be correct if psychoanalysis were the modality. But PTT recognizes the reality of re-victimization by busy bureaucrats and officious officials. Partnership between clinician and client in the pursuit of justice is both ethical and professional.

## PSYCHOTHERAPY

Good therapists establish rapport easily, facilitate discussion of painful material gently, and help their clients to make informed choices about critical decisions, such as use of medication. PTT requires and employs these basic skills. There are several additional specialized psychotherapy tools that deserve mention. These are: the timing of the telling of the trauma story; symptom suppression; the search for meaning; and the handling of coexisting problems.

### Telling the Trauma Story

PTT is never complete if the client has not told the details of traumatization. This does not mean that a person who has seen several therapists must tell every detail to every clinician. Nor does it mean that one unemotional synopsis will suffice. Persons who suffer PTSD are unable to recollect the trauma without fear of overpowering emotion. And they recollect what they do not want to recollect, recall, or remember, especially when they are least prepared to remember. As a therapist, the purpose of hearing the details of the trauma story is to revisit the scene of terror and horror and, in so doing, remove the grip of terror and horror. The client should feel your presence at that moment. The purpose is more than catharsis. It is partnership in survival. It is painful, and it is necessary and unavoidable.

There is no sense in exploring these corridors before a bond of mutual trust is established. Usually, I know some details from a referral source before beginning my first session with a client, and I will mention them in a matter-of-fact manner, but I make it clear from the beginning that there will be a time for sharing the details, and that will come later, when the client feels comfortable.

I believe that highly charged events are filed in the brain's special filing system according to emotional tone, not chronology. My objective with respect to the traumatic memory is to file a memory of the two of us--client and clinician--revisiting the trauma, right next to the original file. The co-location of this experience of controlled, shared recollection, with the original, terrifying event, allows mastery and respect to permeate the experience of lonely dehumanization.

Obviously, a mechanical retelling of events will not produce a memory file that ends up in that “special” drawer reserved for extreme emotion. And an uncontrolled, unanticipated abreaction lacks the healing quality of guided, collegial re-exploration. There is an optimal emotional intensity, strong enough to assure association with the original trauma, but not so strong as to obliterate the recognition of mastery and respect.

It is crucial to set up this partnership between therapist and client characterized by trust and respect, where the client feels comfortable sharing his or her trauma when he or she feels ready. I developed the Counting Method (described in detail in another section of this manual), which is a tool that provides a collaborative, precise, and time-limited format for clients to experience a poignant reliving of their trauma in a new way, with the healing support of the therapeutic relationship. I have also employed hypnosis and guided imagery to facilitate recall of trauma scenes, but always with continual reassurance that we are proceeding together and that safety is assured.

With female sexual assault survivors, I have always used a female co-therapist during hypnotic revisiting of trauma scenes.

Frequently, the telling of the trauma story is not curative. One re-enactment with a trusted clinician is not enough. Aspects of the trauma are still hidden. Implications of victimization are profound. Symptoms remain entrenched. PTT continues, with all relevant tools applied.

### **Symptom Suppression**

Whether medication, biofeedback, or behavior modification are offered to suppress symptoms, the client should have the opportunity to make an informed choice among effective options. Common posttraumatic symptoms that can be suppressed at any stage of PTT include insomnia, panic, and generalized anxiety. Medication can help with each of these, but there are pitfalls and contraindications.

I have found that judicious use of sedatives often restores a normal sleep pattern without creating dependency. The dosage may be increased, but the client avoids using medication nightly, and

discontinues the drug within a month. Some sleep disorders are very difficult to treat, however, with or without drugs.

Similarly, moderate use of SSRIs for panic and benzodiazepines for anxiety have allowed many of my clients to accelerate recovery, reenter social groups, and restore self-esteem. Both of us know that symptoms are being suppressed to facilitate PTT, not to replace it.

### **Individualized Search for meaning**

By definition, catastrophic stress shakes one's equilibrium, breaks one's attachments, and removes a sense of security. Inevitably, confrontation with deliberate human cruelty strains one's sense of justice, shatters assumptions of civility, and evokes alien, sometimes bestial, instincts.

It is a rare privilege to work with a client who reaches the philosophic stage of PTT, consciously formulating a new attitude toward life. But when clients are overwhelmed with symptoms, discussion of life's meaning has little relevance. However, as normalization restores a sense of dignity, as empowerment restores a will to endure, and as individuality restores a sense of self, clients do take responsibility to find the "right answer" for themselves.

The therapist, however, should have the aptitude to guide a search for meaning, to recognize existential despair, to confront self-pity, to reinforce recognition of one's responsibility for one's own life. A final phase of PTT includes articulation of the meaning of life in terms that are specific to the individual, not general or abstract.

### **COEXISTING PROBLEMS**

PTSD may be confounded by coexisting problems or may mimic personality and anxiety disorders. It may precipitate physical and psychiatric conditions or may exacerbate preexisting disorders. Therefore, it is important for posttraumatic therapists to recognize coexisting problems and to clarify these in therapy.

Certain coexisting disorders, particularly borderline personality, may be impossible for the posttraumatic therapist to manage according to the principles of PTT. Where borderline cases are at issue, for

example, collegiality may be misinterpreted as intimate friendship, and a willingness to intervene with criminal justice officials may lead to insatiable requests for help with personal affairs. Unfortunately, abused children may evidence combinations of borderline personality, multiple personality, and PTSD. This presents enormous challenges to the therapist. A treatment strategy must be individualized, and may involve several therapists, concurrently or in sequence.

It is not unusual for a traumatized patient to request help with psychological issues that antedate the trauma. Several clients have embarked upon long-term therapy for dysthymia, avoidant personality disorder, or dependent personality disorder, after achieving mastery of PTSD and victimization symptoms. In these cases, I continually clarified the contract and the objectives, to avoid self-blame when working with victimization issues, and to promote self-reliance when treating the preexisting condition. There is no way to untangle completely PTSD and a personality disorder, treating one first and then the other. But the therapist can maintain the fundamental principles of PTT and use tools in the general armamentarium of techniques, as long as there is no contraindication that is due to coexisting problems.

## CONCLUSION

The clinician and the client have no difficulty realizing when posttraumatic therapy approaches its conclusion. Symptoms subside, although they may be present to some degree. There is an understanding of the causes and significance of autonomic echoes. There is a sense of mastery and control. But most significantly, there is a shift from victim status to survivor status. To clarify this change of self-perception, I wrote the Survivor Psalm and use it with clients to gauge progress and to mark termination:

*I have been victimized.*

*I was in a fight that was not a fair fight.*

*I did not ask for the fight.*

*There is no shame in losing such fights.*

*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.*

With every client who travels that painful path from victim to survivor, I feel a surge of hope for all of us who are engaged in the larger struggle for survival.

## **Endnotes**

Figley, c. r. (1988). Post-traumatic family therapy. In F. M. Ochberg (ed.), *Post-traumatic therapy and victims of violence* (pp. 83-109). new York: brunner/Mazel.

\* This is an abridged and updated version by the author based on previous published works in *Psychotherapy, Volume 28*, no. 1, Spring, 1991, and *International Handbook of Traumatic Stress Syndromes*, edited by John P. Wilson and beverley raphael. Plenum Press, new York, 1993. The complete version can be found online at <http://www.giftfromwithin.org/html/trauma.html>.



# The Counting Method for Ameliorating Traumatic Memories

**by Frank M. Ochberg, MD**

*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.*

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, and 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. The Counting Method is one such approach.

## **RATIONALE AND EFFICACY**

The counting Method was developed for use in the context of Posttraumatic Therapy by a skilled clinician who provides a full range of restorative opportunities to a PTSD client. The counting Method is one element of Posttraumatic Therapy that has been employed for 20 years with hundreds of clients by the author, colleagues, and students. In most cases, clients reported reduction in the frequency and intensity of dysphoric intrusive recollections.

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 Posttraumatic Therapy. Future recollection, spontaneous or deliberate, may evoke aspects of the 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.

### **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 have 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 later. They may or may not have told the 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 Posttraumatic 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 seconds), with a beginning, middle, and end, in which to deliberately recall an intrusive recollection.
- Silent recall allows privacy.
- hearing the therapist's voice links the painful past to the relatively secure present.
  - 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.
- 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, such as:

- 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 overwhelming, 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 seconds 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, friendly, and 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 a 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 many 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.

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 understanding of the client's experience in its totality, and to allow the client to hear the trauma again, but now from a 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 the client's behavior during the traumatic event.

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.

### **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 and, 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. Posttraumatic 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 to reduce the debilitating effects of traumatic memories. It was developed without patients receiving Posttraumatic 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.

## **ACkNOWLEDgmENTS**

The author gratefully acknowledges the support of The Dart Foundation of Mason, Michigan, and the assistance of David read Johnson and hadar Lubin.

## Endnotes

- <sup>1</sup> Johnson, D.R. & Lubin, H. (2005). The Counting method as exposure therapy: Revisions and case examples. In *Traumatology*, Vol. 11, No. 3.
- \* This is an updated version by the author based on a previous published work in *Journal of Traumatic Stress*, Vol. 9, No.4, 1996. The complete version can be found online at <http://www.giftfromwithin.org/html/counting.html>.

# Summary with Discussion Questions

## SECTION 1: WHAT IS PTSD?

The video begins with Dr. Victor Yalom interviewing Dr. Frank Ochberg about Post-Traumatic Stress Disorder. Dr. Ochberg is a leading expert on PTSD and its treatment and was on the team that originally defined PTSD for the DSM. He has also played a critical role in educating both mental health professionals and journalists in PTSD and its effects. Yalom asks Ochberg to define PTSD, and Ochberg summarizes it this way:

*The three parts of the PTSD syndrome—"syndrome" just means it is more than one symptom—is, first, having an altered memory system, and having bad memories come back and feeling, "I'm crazy. My mind isn't working under my own control." And the second part is being numb and avoidant, and reduced in your personal sense of humanity and responsiveness. And the last part is being easily made fearful, easily aroused, irritable, jumpy, and nervous.*

Yalom and Ochberg then discuss the high incidence of self-blame and survivor's guilt in people with PTSD, even though this is not listed in the DSM criteria. Ochberg states that the guilt is something that every therapist should look out for and learn how to work with.

Next, Yalom asks about chronic PTSD. Ochberg states that if the symptoms last for a month, it is considered PTSD. If symptoms last for more than three months, it is considered chronic PTSD. He states that if someone has this condition for one year, the odds are they will have it for three years, and if they have it for three years, the odds are they will have it for five or ten years. As time goes on, the prognosis for overcoming it goes down. Chronic PTSD means that people have learned to live with the symptoms, which become part of their identities. Ochberg says:

*Chronic PTSD means that you have learned to live this way. You think of this as who you are... And sometimes a sense of*

*honor can have a person feeling, "I don't really want to get better. I want to suffer. I deserve to suffer."*

Dr. Ochberg then speaks about the life stressors that many people with PTSD face, such as dealing with physical pain, or soldiers converting back to civilian life after returning home from the wars in Iraq and Afghanistan. Part of the therapist's role is to help the client with PTSD deal with these challenges.

### **Discussion questions for Section 1: What is PTSD?**

1. **Challenges and rewards:** have you had experiences working with clients with PTSD? If so, what have been some of the challenges you have faced? What has been rewarding about working with people with this diagnosis? Looking back, do you think that you may have had clients with PTSD whom you failed to diagnose as such?

2. **Artificial distinctions:** Dr. Ochberg stated that the criteria for chronic PTSD used to be six months but is now three months, and that these are "artificial distinctions." What was your reaction to this? How do you make sense of the "artificiality" of some of the diagnostic criteria in the DSM? What do you think about the criteria changing?

3. **Honor and guilt:** What reactions did you have as Ochberg spoke about some people who don't want to get better because they believe they deserve to suffer? Have you come across this in your work with clients? If so, how have you handled this? If not, how do you think you would respond to a client who said that to you? What are some ways you work with survivor's guilt or guilt in general?

4. **Working with veterans:** have you worked with any veterans of war? If so, talk about your experiences. If not, how do you imagine you would feel if you were working with a veteran? Do you think any of your political views or opinions about war might impact your ability to effectively work with a veteran? Why or why not?

## SEGMENT 2: TREATMENT APPROACH

In this segment, Ochberg discusses his approach to treating clients with PTSD. Unlike some approaches that focus exclusively on symptoms and symptom relief, Ochberg approaches the whole person and the various components of being human. He says:

*I want that person who sits in that chair and talks to me to have the feeling that they are comfortable with me knowing them, and they want to come back and be in a room where it is safe to be yourself. And I end up getting an appreciation of who that person is and what they can be.*

Of course, he does attend to symptoms as part of the whole, and since he is a psychiatrist, he can and will prescribe medication to ameliorate symptoms, such as a minor tranquilizer to help with shaking. But, he says,

*It's really all about their evolution toward a self that they can be confident in.*

Ochberg describes what he attends to in treatment, starting with education. He begins by asking clients what they already know about PTSD, and he finds that many clients have a real appetite for learning. He mentions that he takes out the DSM and reads the criteria with clients, and that this can be validating for them. He gives the example of how one of his clients, (who had been raped at gunpoint,) responding to the DSM criteriaed by saying, "That's me in that book. Oh!, Now I know it is real." When someone people with PTSD understands the symptoms, they have more of a handle on it. Also, Ochberg points out that when clients know they are being treated by someone "who has been there a thousand times before," this in itself gives them confidence that they will get better.

The second component of education is teaching about eating, exercising, and general healthy habits that, in addition to better physical health, also contribute to having a better sense of self and mastery of self.

Related to health, Ochberg's next step is an assessment of the person's humor and spirituality. With some clients, he will try to find out what makes them laugh and when they most recently laughed. He wants to help clients recover an ability to "lighten up."

Ochberg says he used to pay little attention to a client's religion and spirituality, partly because he himself does not come from a religious background, but that he has learned to pay a lot of attention to this aspect of his clients' lives. He remarks that, for many people with PTSD, it is easier to recover feelings of love for God than feelings of love for a spouse:

*If you pick that up as a therapist, that is the low-hanging fruit. That's what you should go for to talk about this, to help somebody remember and recover the feeling of being loved by God. If that's part of their life, it's important to be the one who helps reintroduce them to that feeling.*

He goes on to say that it is important to get a sense of the client's relationships: who is significant in the client's life, what is present and what is missing in terms of attachments and interpersonal fulfillment. For many people with chronic PTSD, it is very difficult to find a whole new social outlet, but worth trying. Dr. Ochberg sometimes will pair up former and current clients in what he calls dyadic support. Sometimes he will step outside the traditional doctor-patient frame because he is involved in groups of veterans helping veterans, where he will collaborate with clients on projects.

### **Discussion questions for Segment 2: Treatment Approach**

**5. The whole person:** What do you think of Ochberg's approach, in which he attends to the symptoms, but "it's really all about their evolution toward a self that they can be confident in"? If you were to describe what your approach to psychotherapy "is really all about" in one sentence, what would you say?

**6. Experience:** Ochberg has many years of experience working with people with PTSD and is an expert on treating people with this disorder, which likely gives most of his clients a lot of confidence in him and arguably contributes to accelerated

healing. If you are a new therapist and do not have a lot of experience, how do you think this plays into the treatment? What is it like for you to offer your services as a new therapist without having the expertise that comes with experience? how have you dealt with this?

**7. Psychoeducation and the DSM:** how much do you focus on educating clients about the disorder? have you taken the DSM out with a clients to educate them about their disorders? If not, can you imagine doing so? If you have, how did your client(s) react? Other than feeling validated and understood, what are some other reactions you can imagine a client having to this?

**8. Spirituality:** What do you think of Ochberg's statement about the importance of asking about the client's spirituality? Does it make sense to you that people with PTSD might have an easier time reconnecting with god's love than with more personal love? Why or why not? how much attention do you pay to your clients' spirituality?

**9. Outside the box:** how do you feel about Ochberg pairing up his former and current clients together for support? What are your thoughts about how he collaborates with some clients in veterans' organizations? can you see yourself stepping outside the box like this with your clients, or are you more likely to maintain the traditional psychotherapeutic boundaries? What do you think the benefits and risks are of introducing your clients to each other? What are your overall thoughts about the kind of "dual relationship" he described?

### **SEgment 3: THE CASE OF TERRY**

In this segment, we learn about Dr. Ochberg's experience treating one of his clients, Terry, a Vietnam veteran. Dr. Ochberg saw Terry for about 29 sessions. Ochberg, as a side note, explains that there are more people who have been seriously traumatized than qualified therapists to treat them, and that knowing how to treat someone with PTSD should be a part of every therapist's repertoire. Returning to the description of Terry's case, Ochberg recounts that the treatment was



initiated by Terry's wife, Cathy, who was concerned that not only had he been suffering since Vietnam, but now he wasn't doing well at work, and he was becoming anxious and depressed.

Ochberg met with Terry and described him as a "garrulous, intelligent, likeable man" who had a management job in the auto industry helping to find jobs for auto workers who had been laid off. He took his job very seriously, and when the economy in Michigan declined and he could not find jobs for people, he became filled with guilt about his failure to help them. Through the therapy, they discovered that this guilt about letting people down was connected to his trauma as a soldier in the Vietnam War.

Ochberg discusses the timing of discussing the trauma in detail with new clients:

*I have learned through time never for me to be the one who opens that door, if that door isn't open already. I really want the other person to trust me and to feel that I know them before that is the way they introduce themselves to me. Now, sometimes it goes the other way. The person is so anxious to tell, they want to tell. So I don't want to say there is a formula.*

Then we learn about Terry's trauma, which took place on April 1, 1970, in Vietnam. Terry's father was a World War II veteran, and Terry thought if he got killed in action his dad would be proud, which contributed to his decision to go back to the front even when he was told he could wait out his tour of duty. It wasn't that he wanted to be killed, but that he wanted to do something noteworthy for his father. Terry's best friend, Billy Joe, was in the same circumstance, and when Terry decided to go back, Billy said he would go with him.

On April 1, their company was overrun. One of the generals was killed. There were large civilian casualties around them. Billy Joe took a bullet in front of Terry and bled out. He didn't die right in front of Terry, but he died a bit later after he was evacuated from the scene. Terry saw it all and believed that he caused Billy's death. That was the gravest and greatest part of Terry's Vietnam trauma.

**Discussion questions for Segment 3: The Case of Terry**

**10. Specialist?** What do you think of Ochberg's statement that treating PTSD should be a part of every therapist's repertoire, as opposed to something only trauma specialists should treat? how confident do you feel in your ability at this point to effectively help someone with PTSD? If you experienced a serious trauma, do you think you would look for a trauma specialist? Why or why not?

**11. Never open the door:** What do you think of Ochberg's advice never to be the one to open the door to the client's recounting of the traumatic event? Why do you think it is so important to Ochberg to allow clients to reveal their stories in their own time? can you recount a time when you have struggled as a therapist with whether to push clients to reveal information, versus waiting for them to talk about it in their own time?

**12. Personal feelings:** What feelings did you have as you listened to Ochberg recount Terry's trauma? Did you find yourself emotionally engaged, or, conversely, having a hard time connecting? What are some of the traumatic events your clients have recounted to you? how did you feel when you heard about their experiences?

**SEGMENT 4: LIVING WITH PTSD**

In this segment, Yalom sits down with Dr. Ochberg's former client, Terry, to talk about his experience with PTSD and his treatment with Dr. Ochberg. Terry begins by talking about how difficult it was for him when he returned home from Vietnam. "I knew that I was not right—That things were not right in me." he was having nightmares, flashbacks, difficulty sleeping, and feelings of failure. he had asked other veterans how they dealt with their experiences in the war, including his father, and the general consensus was, "Don't talk about it. nobody really wants to talk about it. Just forget it." but Terry was not able to forget it. It was with him every second of his life, and he didn't know what to do:

*So I did what so many other guys did when they came home from war: I shoved it down inside me, and I tried to pretend that it was just gone. So I went out to try to lead a normal life. That's what I wanted to be. That's all I wanted to think about when I was first home and I was having all these feelings. I kept thinking to myself, "You've just got to be normal. You've just got to find a way to be normal."*

In his attempt to live a normal life, Terry got married and had two children, but still things "weren't right." He didn't feel comfortable with crowds, and continued to have nightmares and feelings of low self-worth because he felt that he had not done enough to save the people he lost in the war.

after five years, he and his wife divorced, and he began abusing alcohol and drugs:

*I felt like I was standing in water with it up to my lip, and I was standing on my tip-toes. If I ever left the tip-toes, ever allowed myself just to drop down, I would go under.*

*I felt like I was in a funnel and that I was circling down, as it does in a funnel. And when they would ask me, "Where are you going with that?" I would always say I didn't know, but in my mind I knew that it meant there is some finality.*

Terry felt as if his life was going to end because the feelings were so intense and there was no relief. It got worse as time went on, despite remarrying, creating a new family, and working in various jobs.

Terry describes keeping all his military souvenirs in a box, such as letters from family when he was in Vietnam, photos of people, and all of his awards. His routine was to take out the box and revisit the memories of his time in war, triggered by the smell of Vietnam that lingered in the box. He would spend up to ten hours at a time going through the materials in the box, revisiting the details of the traumas he experienced, reliving the feelings, and trying to figure out what had happened to him and to his friend Billy Joe and the other soldiers.

Terry would come home from work feeling irritated or edgy, triggered by a smell or comment that reminded him of Vietnam “I would just bee line right into the bedroom and get the box... It was all part of just enhancing this feeling in me of being right there, and trying to figure it out.”

We start to better understand Terry’s motivations for engaging with the box when he says, “I was caught between a feeling of not wanting to let it die, because in letting it die, I would let my friend die. I promised him I would never let anybody forget him.”

Friends and family members encouraged Terry to get help, but he was scared of what he would find if he started talking to a therapist, such as suppressed memories of even more horrific experiences.

#### **Discussion questions for Segment 4: Living with PTSD**

**13. Struggle:** What came up for you as you listened to Terry talk about how much he struggled? Did it sound to you like he was suicidal? Why or why not?

**14. The box:** What is your understanding of why Terry spent so many hours with the box? Did this seem odd to you, or did it make sense? If you were treating Terry, how might you incorporate the box into the therapy?

#### **SEgment 5: “I NEED HELP”**

After becoming a grandfather, Terry became more motivated to get some relief. He finally called his sister, who worked in mental health, and said, “I need help. I can’t keep going on, and I’m afraid of what is coming.” His sister set him up with a therapist who helped him recognize that he had PTSD and that he was not alone. They worked together for about six months, during which Terry made progress, until his therapist left and referred him to another therapist. He didn’t click with this man, so he stopped going and “started stuffing it down again.” As work became more stressful and he struggled more and more with feeling like a failure to his coworkers, this guilt was compounded with his guilt that he had let down Billy Joe and his other friends in Vietnam. The belief that he was a failure got so bad

that he could no longer go to work or face people:

*I just went and got in bed, pulled the sheets over my head and said, "That's it. I can't do it anymore." I became very anxious and very nervous all the time... I couldn't even go to the store.*

Coworkers and family reached out to him again, encouraging him to get professional help. Terry agreed to see another therapist, who then referred him to Dr. Ochberg. Still, Terry was unable to reach out, but luckily his wife was very supportive and made the call, which got the ball rolling. Terry and Ochberg began treatment in October, 2009.

#### **Discussion questions for Segment 5: "I Need Help"**

**15. Reaching out:** as a clinician, have you ever received a call from a loved one of someone who needs help? how have you handled this? Why do you think it was so difficult for Terry to reach out?

### **SEGMENT 6: THE FIRST SESSIONS**

In this segment, Dr. Ochberg and Terry discuss the therapeutic work they did in their early sessions. Ochberg shares that his first impressions of Terry were that he was talkative, not guarded, but deeply troubled, anxious, and very hard on himself. Ochberg spent the first sessions learning about Terry, showing interest in the details of Terry's life and experience, particularly focusing on his work and home life, rather than diving into the Vietnam trauma immediately. In the beginning, Ochberg wrote several letters that helped Terry with his benefits and with getting medical leave from work. He helped him sort out in his own mind whether he could work and whether he should work.

Next, Terry recalls his experience of starting therapy with Ochberg, recounting the various methods they used, such as talk therapy, the color wheel, and the Counting Method. Building trust was a key aspect of the first sessions for Terry:

*I knew he was a bright and brilliant man and he knew a lot, but that doesn't mean he knew me, and he didn't know how I was. So, I had to learn that. And we kind of learned each*

*other. I think he found that there was a goodness in me that I could never see.*

### **Discussion questions for Segment 6: The First Sessions**

**16. Initial goals:** What do you usually focus on in the first few sessions with your clients? at what point do you find out about past traumas? What are your goals for the first sessions? If you were working with Terry, how do you think you would begin the treatment?

**17. Trust:** how did you react when Terry said of Ochberg, “I think he found that there was a goodness in me that I could never see”? how do you think this contributed to Terry’s trust in Ochberg?

**18. Advocating for your clients.** Ochberg wrote several letters on Terry’s behalf to help him with benefits and medical leave. have you had clients ask you to help them in ways such as this? If so, how did you feel about these requests, and how did you respond?

### **SEGMENT 7: USING THE CLIENT’S FAITH**

In this segment, we enter the consulting room and witness Ochberg and Terry during treatment, discussing the role of religious beliefs in the treatment of PTSD. Terry talks about feeling cut off from God’s love, and Ochberg responds:

*Largely through you, and maybe a couple of other clients, I’ve come to realize that a doctor who fails to recognize and value his patient’s faith is not a particularly good doctor.*

Ochberg goes on to describe how PTSD is putting up a filter between Terry and God’s love:

*One of the things that PTSD does is it blunts our ability to have the full range of feelings, and to perceive the feelings that are sent to us from others.*

In the next exchange, Ochberg helps Terry reframe his sense of guilt and responsibility about Billy Joe’s death, using his religious beliefs in

the service of relieving his survivor's guilt. According to Ochberg, this was the most important part—"the crux" and "the turning point"—of Terry's therapy.

Terry and Ochberg reflect on the revelation they had together that brought chills to their spines, triggered by Ochberg asking Terry, "Do you think you are responsible for how long someone lives?" to which Terry responded, "No. It's out of my hands." This question led Terry to reconsider his own sense of responsibility for Billy Joe's death, and to reconnect with his belief that "we all have a separate walk with Christ," and that whether someone lives or dies is "in God's hands." Terry says:

*It suddenly hit me that if that is true, and that's how I felt, then how could I be responsible for Billy's death?*

This revelation made a significant impact on the burden of survivor's guilt that Terry had been carrying for 40 years. While Terry still had PTSD symptoms such as nightmares and anxiety, the survivor's guilt was lifted after this insight.

### **Discussion questions for Segment 7: using the Client's Faith**

**19. Using religious beliefs:** how did you react when Ochberg and Terry were talking about god's love? Is this a kind of intervention you can see yourself making? Why or why not? Do you use your clients' religious beliefs in the service of their healing? If so, how?

**20. Working with guilt:** If Terry didn't believe in god, what are some other ways Ochberg could have helped relieve some of his survivor's guilt? What are ways you help your clients deal with guilt?

**21. Done with therapy?:** What came up for you when Ochberg said that Terry still had symptoms of PTSD but that he was competent to handle them on his own? Did this surprise you? If one of your clients still had symptoms, would you consider the treatment complete?

**SEgment 8: DEVELOPING SELF-ESTEEM**

In this segment, we see another interchange between Terry and Ochberg during treatment, focusing on the feelings of failure Terry was facing at work. Here we learn more about Terry's job in the auto industry helping people look for work and get training, and how difficult this became in Michigan as the economy declined. We learn how Terry took his job responsibilities very, very seriously, and it ate away at him when he was unable to find work for people. Terry links his experience of failure at work to his experience of failure on April 1 in Vietnam:

*That's probably how it got intertwined with my feelings from Vietnam, and certainly April 1. But it's just that feeling of failure, feeling of not being able to help people, not being able to help them with their needs, and crossed swords, so to speak, with the feelings I had coming home from Vietnam.*

Then Yalom and Ochberg discuss how Ochberg helped Terry with his work stress and how it interplayed with his PTSD. Ochberg focused on three things: reducing Terry's self-punishment, guilt, and shame; legitimizing his medical retirement from his job; and helping him find avocational outlets where he could help other veterans.

**Discussion questions for Segment 8: Developing Self-Esteem**

**22. Disability:** Do you think it was a good idea to encourage Terry to take a medical leave from work and eventually get disability so that he didn't have to work at his job? Why or why not? Do you think of PTSD as a disability? Why or why not? have you ever helped any of your clients get on disability? What was that process like for you?

**SEgment 9: PuTTING THE TRAUmA INTO WORDS**

In this segment, which is another clip of Terry's treatment, Ochberg reads Terry a poem that he wrote in his attempt to put into words the experience of Terry and his other clients with PTSD. Here is his poem, called "My Wounds are Not for You to See":



*My wounds are not for you to see  
 although I wish you knew  
 without the grief that hollows me  
 what holds me back from you.  
 It wasn't want of hope or faith,  
 for these I still possess,  
 but muted love that lies too deep  
 to summon and express.  
 You hear the dreams that end in  
 screams and tolerate my pain with  
 fortitude.  
 You grace the mood that I cannot  
 restrain. And that same mood  
 can make me brood on all that I have  
 lost— my friends, my youth, my naïve  
 truth.  
 Oh, what a dreadful cost!  
 I know that I can weather this, and  
 laugh and love and live without regret,  
 and yet I have not much to give.  
 I need to find the voice I lost,  
 the song I used to sing.  
 I need to feel the warmth of friends  
 and smell the breath of spring.  
 I will. I know I will.  
 And we shall share the day  
 when this chill thaws and I return,  
 and I return to stay.*

Terry responds with admiration and appreciation for Ochberg's ability to understand his inner experience. Ochberg calls the pain of PTSD the "invisible wound." He explains that it keeps people from being able to fully express what is so important and poignant, and that he is trying to help people put the experience into words. And when they can't, he does it, so that "together we make the statement."

In his discussion with Yalom that follows, Ochberg reflects on why it is especially healing for people with PTSD to give voice to their suffering. Ochberg says:

*PTSD is more than the pain of PTSD. It is the isolation and the shame and the stigma, the separation that is added to the individual's condition. ... If any one of us can help put it into words, and they are true words, they work, the person with PTSD can say, "Yeah, okay, that's what I feel. That's what I think." And they can actually begin to feel closer to their loved ones.*

In addition to restoring interpersonal connection, helping put their experience into words also helps people with PTSD feel alive and fully human again, since their emotions have been so muffled and numbness has blocked their feelings. Ochberg calls it "dialing up the volume" on emotions, as opposed to providing a corrective emotional experience.

### **Discussion questions for Segment 9: Putting the Trauma into Words**

**23. Poem:** What did you think of Ochberg sharing his poem with Terry? how did you feel as you listened to it? can you see yourself sharing your feelings through a poem or other form of self-expression with your clients if you thought it would help them? Why or why not?

**24. Other ways:** What are some other ways, besides poetry, you could help your clients with PTSD "dial up the volume" on their emotions? What helps you feel more alive when you are feeling numb or disconnected?

### **SEgmENT 10: INVOLVINg FAmILY mEmBERS**

This segment is composed of two clips of a session in which both Terry and his wife, Cathy, are present. But first, Ochberg addresses the question of bringing family members or significant others into treatment:

*It's usually advisable. They have so much more access than we do one hour a week or a couple of hours a week. And if they are informed, and if I as a therapist have a sense of who they are, they are helping me with the therapy. It's really not about identifying their problems. It is enlisting them as*

*helpers.... In general, PTSD is a problem for both the person who has it and the one who cares for them.. If I can meet the caregiver, I am ahead of the game.*

In the clips, we get to see how supportive Cathy is and what a difference she made in Terry's recovery. She talks candidly about her frustration and helplessness, and says that if they weren't as bonded through love as they were, she would have given up a long time ago because it was so difficult to live with his unpredictable mood and behavior.

She sits by Terry's side as he tells Dr. Ochberg about his box (also described in Segment 4) and how the way he would use its contents and the memories they triggered as an opportunity to beat himself up. Cathy shares that she did not try to keep him away from the box:

*No, there was no keeping him away from the box. And if he didn't get to the box, then the kids and I suffered for it because it just built up in him more, whereas if he went to the box and just did his thing for a little bit, we walked away and left him alone, then we could come back in and everything would ease back in.*

In an effort to understand Terry's relationship with the box, Dr. Ochberg makes an interpretation about what Terry got out of continually beating himself up:

*If you were frustrated at work, it could have tapped into a need for you to accept some punishment for failure in Vietnam. It was better to be punished than to feel like a failure unpunished. And by going back to the box, there was a certain amount of, "I'm punishing myself. I'm taking my punishment. And I don't have to worry about the punishment coming at me when I'm not ready for it. I'm doing it myself."*

Cathy agrees that this hypothesis makes sense, and Terry then shares that the box is gone, and that he no longer needs to punish himself. With the help of his family, now all of his medals from the war are displayed on the wall, no longer hidden in his box.

After this clip, Ochberg makes two key points. First, he broadens our understanding of Terry's relationship with the box, saying that it wasn't just a way to punish himself, but also a way to connect with the love of his comrades and to work through some of his feelings. Secondly, he states that the reason Terry was able to display his once-hidden awards is that he is over his guilt and shame, and his family's love and patience contributed significantly to this.

In the next clip, Ochberg educates Cathy about the brain changes that occur with PTSD. He frames PTSD as a brain injury:

*It's like someone being deaf or blind. That is the PTSD injury. Your brain has been exposed to such extreme reality that it shuts down, it does other strange things. It's a body organ that has been injured. It's not that you are lacking courage or character.*

In his discussion with Yalom, Ochberg elaborates on the benefits of framing PTSD as an injury:

*An injury is more honorable than a disease. An injury also allows certain benefits that emotional distress does not. So for legal, financial, political, public understanding reasons there are a lot of us now who want PTSD to be known as an injury, an invisible injury, just like a shattered ear drum.*

### **Discussion questions for Segment 10: Involving Family members**

**25. Involving the family:** What are your thoughts on involving family members in treatment in general and in PTSD treatment in particular? Is this something you have done? Why or why not? If so, what were some benefits and challenges of this?

**26. Injury:** What do you think about Ochberg's framing of PTSD as a brain injury? Does this conceptualization make sense to you? Why or why not? Is this how you think about PTSD? What, if any, objections do you have to viewing PTSD this way?

## SEgment 11: mANAgINg ANXIETY

In this segment Ochberg describes the Color Wheel, a technique he invented to help clients manage their anxiety. It is a way to help people focus on positive feelings, like serenity, as opposed to the negative experience of anxiety. We see a clip from Terry's treatment in which Ochberg describes the Color Wheel in detail and Terry talks about his experience utilizing it. Ochberg describes the feeling that each color on the wheel represents:

- Yellow: jumping for joy
- Blue: serenity
- Red: love
- Green: self-love/self-respect
- Orange: sensual pleasure
- Purple: spiritual connection

Terry talks about his experience with the Color Wheel:

*I have one in my bedroom so I sometimes will visualize it myself, just look at it, stare at it, and try to use the colors to alter my anxiety at the moment...*

*I start with the reds, because to me that is love and the warm feelings of connection. So when I start the wheel, I just try to relax myself, first of all, and immerse myself into that feeling that I am loved and that I love. And then I go to the spiritual thing, because I bring in God at that point, a. And trying to make myself less anxious by trying to focus more on God's love and the feelings I have when I think of the Lord and God in my life.*

When Terry shares that he goes from purple to yellow, Ochberg encourages him to go to blue, because relaxation is the opposite of anxiety. Terry shares that it is difficult for him to experience relaxation, and together they practice that. Ochberg wants to help Terry learn to calm himself down when he is feeling nervous. He guides Terry through the Color Wheel while Terry's eyes are closed.

When Terry states that he feels protected by God's love, Ochberg gets curious and asks, "Protected from what?" This leads to an exploration of Terry's general anxieties and realistic fears.

### Discussion questions for Segment 11: managing Anxiety

**27. Color Wheel:** What do you think of the color Wheel? Is this a tool you can see yourself using with any of your clients? Why or why not? What other tools do you use for helping your clients manage anxiety? What has worked well and not so well?

## SEGMENT 12: THE COUNTING METHOD

In this segment, we are introduced to the Counting Method, a technique that Ochberg invented for helping clients process trauma.

### What is it?

Ochberg describes the Counting Method this way:

*The Counting Method essentially involves me counting out loud to 100, having prepared my patient for this in advance. They know that when I count to 100, they are going to allow themselves to have a flashback, a traumatic memory. They are not going to be talking. They are going to be recalling. And because they have PTSD, this recollection is going to have a lot of force. It is going to be the thing that ordinarily happens to them, at home, out on the street, when they don't want the scene to return. And they have it with me in the office, and it is modulated, because they are hearing me counting— they know it has a beginning, a middle, and an end. And they have a sense of mastery. They turn it on, they turn it off.*

*I explain as part of the counting method that after we are finished with the counting, they will then tell me what they just recalled, and I will write it down, and I will go over it with them.*

**Research** Ochberg shares that research done on the Counting Method shows it to be as effective as other methods used for processing trauma, such as EMDR and prolonged exposure. He states that it is the simplest and

most user-friendly method, with a relatively short period of distress for the client.

**When to use it**

Ochberg uses the Counting Method when the flashback or the unwanted memory is a problem, and only when it is indicated to help somebody master the trauma memory. It is crucial that the client feels respected and understood, and to not do it until the client is ready to bring their pain right into the office. Additionally, Ochberg likes to do it after his client has experienced some improvement and some comfort with him, which increases its chances of working.

**Preparation**

In this segment, we watch Ochberg prepare Terry for the counting Method by selecting a specific memory that he will recall. To help identify an event to work with, Ochberg asks Terry two key questions:

*What else was there from that day that's worth bringing into the present so that we can diminish its grip on you?*

*Were there other real hard traumas that come back and haunt you, take you back to that day or maybe the day after?*

Terry selects a memory and gives Ochberg a summary of it, before they decide to work with that memory in their next session. Ochberg offers Terry psychoeducation on his theory that some memories are stored in the “trauma memory system” and how the Counting Method can help the memory become more of an autobiographical memory and less of a trauma memory:

*The Counting Method helps reduce the way this ‘trauma memory system’ If we end up essentially curing you of the trauma memory, you will still remember it, but it will be less likely to come and hurt you and make you feel like a kid again, and make you feel like you are crazy.*

**Demonstration**

In the next session, Ochberg guides Terry through the counting Method. he begins by giving instructions so that Terry knows what to do. his instructions are:

- *I'm going to count aloud to 100.*
- *You let yourself go back to that day, April 1, 1970, and to that part of the day.*
  - *And when I'm counting, '40, 50, 60,' let yourself have the feelings from that interaction with the captain..*
- *But when I'm up in the late 80s, 90s, bring yourself back here, get to where you are finally calmed down.*
- *You can close your eyes. You can stare off. The important thing is that what you are seeing in your mind's eye is from back there.*
- *No talking, just feeling it.*
- *And then after it's over, I'd like to hear what you just went through and I will write that down and we will go over that.*

Ochberg then counts to 100, with each number taking up about one second, evenly pacing himself like the second hand on a clock. Terry's breathing is heavy at 34, and at 70 he is shaking his head and muttering something. At 93, Ochberg says, "You're past it, Terry. You are coming back here." At 100, Terry asks for a second before he talks about what he experienced. Ochberg comments on this moment:

*This is a very important point. He is finished having his memory. He is ready to start to tell me what he just remembered. You want to give the person a bit of space, but not too much. And you don't want them, as sometimes happens, to go off and talk about something different. So, this is the turning point from the trauma memory to his more autobiographical recollection of what happened and what he just recalled.*

While Ochberg takes notes, Terry recounts an incident in Vietnam in which he almost killed his captain who had threatened to leave him stranded. Terry describes the trauma itself and how he dissociated on the battlefield, holding an M-16 up to his captain's chin:



*I had an M-16 in my hand and I stuck the barrel up underneath his chin. I told him, 'Captain, you are not going to leave me here. You are not going to leave me here, because I'm going to blow your fucking head right off.' ... I remember staring right into his eyes and it's funny I felt like I was away from my body. I felt like somebody was talking through a barrel to me, or through some kind of a tube or a tunnel.*

he also shares another traumatic memory that followed immediately, when he dissociated after coming upon a bus full of civilians that had been blown up:

*It was just smoking, and all of those charred bodies and all of these things. – I was sitting on the track and we pulled up, and we had to stop very near the bus. At the time, they were trying to take out any living people out of the bus, or any of those that weren't completely dead.... They pulled two young kids. I can remember sitting on the top of the track and staring at the kids as they went by, because I could look right down into the ponchos and see their mangled bodies. And I had no feeling. I had no feeling for these children. I wasn't mad at them. I didn't hate them. I just couldn't feel anything. I couldn't feel any hurt for them.*

Ochberg comments in the voiceover that when this lack of feeling persists, it is a symptom of PTSD. he says, "It's the failure to have the feelings that you know you should have."

When Terry starts describing more of the scene than he experienced in the 100 seconds, Ochberg stops him. he gives his rationale for interrupting him:

*I had suspected that Terry was going on in his narrative beyond the point that was covered during my counting up to 100. I want him to just frame that part that he remembered while I was counting. I want to be there with him as we digest that. The Counting Method is all about modulating a traumatic memory, going into it, coming out of it, talking about it later, mastering it. So that is why I am trying to keep*

*his conversation now to the point that he covered while he was silently remembering this piece of 40 years ago.*

as Terry recalls the events, Ochberg praises him for the vividness of his memory and his ability to tolerate it.

next, Ochberg reads back what Terry recounted, from the notes he took. Ochberg describes the reason for this phase of the counting Method:

*The purpose of reading this back to him is to have another iteration, another chance for him to hear what he remembered in my words, my writing. It further integrates the actual traumatic scene with the comradeship of having it heard and recorded by a therapist and with that part of his mind that remembers in a much more logical and conventional way. We are translating a trauma memory into an autobiographical memory.*

Ochberg continues reading back to Terry what he recounted, interspersing his comments and thoughts about what Terry said and engaging in conversation with Terry about it. For example, he tells Terry that what he described is a classic case of dissociation and that Terry is not crazy. When Ochberg reflects back Terry's dilemma—that he both wanted and didn't want to shoot his captain—Terry responds enthusiastically, "It's just exactly that, Frank." Terry obviously feels deeply understood by Ochberg in this moment. As part of this conversation, Ochberg contextualizes this application of the Counting Method for Terry:

*Part of what I'm trying to do I'm thinking of this day that has been in your head for 40 years, and there's so much connected to this day. It's like this day is a piece of the whole Vietnam experience. And where we are going is to lay this day to rest. It's in the past. It doesn't have to define you, haunt you, cause you PTSD symptoms anymore. You have been dealing with this day and everything else in a very effective way through the years that we have known each other. Now we are giving it one last whack, and we are putting it away.*

Ochberg brings in another dimension of his work with Terry when he brings up Terry's desire to measure up for his father. Ochberg says Terry's deceased father had every reason to be proud of him, and that he, himself, is proud of Terry. Terry responds, "I know my dad was proud of me." Ochberg says, "Connect that thought." Ochberg interprets Terry knowing his dad was proud of him as Terry being proud of himself—that he is no longer blaming himself, and that his self-esteem has improved. To sum up and leave Terry feeling good about himself, Ochberg says:

*It's okay if you are a little bit obsessive and you are a little bit nervous. What the heck? We all have our days. But you don't need ever again to feel that you were inhuman, less than decent, less than normal.*

Next, Yalom and Ochberg debrief the session. Ochberg reflects on his theory of why the Counting Method works:

*...it brings the experience of being with me into the traumatic memory so that, were he to have that flashback or re-experiencing on his own, it would never be quite so lonely and frightening. Grafted to that is his experience with me, and his sense of being able to turn it on and turn it off.*

This segment ends with Ochberg emphasizing that the therapeutic relationship and the sense that progress is being made are key aspects to the effectiveness of the counting Method. he sees himself as a coach who is building the client's confidence in his ability to shorten bad memories, reduce their volume, and eventually remember in an autobiographical way rather than a traumatic way.

#### **Discussion questions for Segment 11 : The Counting method**

**28. The method:** What do you think of the counting Method? If you are familiar with eMDr, prolonged exposure, or other techniques for processing trauma, how do you think it compares? What did you like and dislike about the way Ochberg guided Terry through the traumatic memory? What might you have done differently?

**29. Taking notes:** how do you feel about the fact that Ochberg took notes while Terry recounted his traumatic memories? If you were a client recounting a trauma, would you prefer your therapist look at you? What factors do you consider when you take or don't take notes in therapy sessions?

## **SEgment 12: ENDING THERAPY**

next is an exchange between Terry and Ochberg in which they discuss the goals of therapy. They make the point together that therapy for PTSD is not about erasing the pain, but about learning how to live with the pain and how to handle it. Ochberg shares that, when he asked Terry what he really wanted him to teach the medical students about PTSD, Terry said, "Make sure they understand that it hurts."

Yalom then asks Ochberg a question about when he decides to end the therapy, and Ochberg replies that he likes to make the decision collaboratively with the client. he never cuts off the therapy when the client still needs it, but the goal is not to get your client to be pain-free in order for therapy to end. he says:

*When your client can walk out that door feeling, "I can tolerate the feelings that I have; these are human feelings," they don't have to be a client. Life is full of ups and downs.*

next, we see a clip of Ochberg and Terry's second-to-last session, in which Terry reports on the progress he has made over the course of his treatment with Dr. Ochberg. as they prepare for termination, Terry says:

*When we talk about ending sessions, and seeing where we go with this, I feel good about that because I've seen the change in me, as much as everyone else has seen it. And I can feel that difference. And I can feel now I have some tools [to deal with the anxiety].*

Then, with Yalom, Ochberg reflects on Terry's termination, and on what Ochberg has learned as a therapist in general. he explains that he will continue managing Terry's medication and seeing him as

a colleague working on veteran's issues. his care for Terry comes through powerfully when he says:

*Therapists obsess over whether you can and ever should call a patient a friend. In this case, Terry is a friend. I'm glad he is my friend.*

**Discussion questions for Segment 12: getting BetterEnding Therapy**

**23. Goals:** What do you think of Ochberg's statement about the goals of therapy? What do you think the goals of therapy should be with someone with chronic PTSD? how do you determine when a client with PTSD or another diagnosis is done with therapy? have you and a client ever disagreed about when therapy should come to a close? Talk about this experience.

**24. Friend:** What reactions did you have to Ochberg calling Terry his friend? What do you think of his statement that, "Therapists obsess over whether you can and ever should call a patient a friend"? What are your thoughts on this topic? have you ever had a client whom you consider a friend, or have you ever developed any kind of relationship outside of the therapeutic one? If so, how did that work out for you and the client?

**25. Termination:** What did you think of Terry and Ochberg's decision to terminate therapy? Do you agree that Terry is "good to go" at this point? how do you determine when a client with PTSD or another diagnosis is done with therapy? What process do you usually go through when ending therapy with clients? have you and a client ever disagreed about when therapy should come to a close? Talk about this experience.

**26. Key points:** What are some of the key points you learned about chronic PTSD by watching this video? Did anything surprise you?

**27. The approach:** What are your overall thoughts about Ochberg's approach to working with people with PTSD? What aspects of his approach can you see yourself incorporating into your work? are there some components of his approach that seem

incompatible with how you work? What in particular would you do differently from Ochberg?

**28. Personal reaction:** how would you feel about having Ochberg as your therapist? Do you think he could build a solid therapeutic alliance with you? Would he be effective with you? Why or why not?

# Related Websites, Videos, and Further Readings

## WEB RESOURCES

Gift from Within: An International Nonprofit Organization for Survivors of Trauma and Victimization, founded by Dr. Ochberg  
**[www.giftfromwithin.org](http://www.giftfromwithin.org)**

Dr. Ochberg's website on The Counting Method  
**[www.countingmethod.com](http://www.countingmethod.com)**

Posttraumatic Stress Center, offers trainings in The Counting Method  
**[www.ptsdcenter.org](http://www.ptsdcenter.org)**

International Society for Traumatic Stress Studies, cofounded by Dr. Ochberg  
**[www.istss.org](http://www.istss.org)**

The National Center for Victims of Crime  
**[www.NCVC.org](http://www.NCVC.org)**

Gateway to Posttraumatic Stress Disorder Information  
**[www.ptsdinfo.org](http://www.ptsdinfo.org)**

Dart Center for Journalism and Trauma  
**[www.dartcenter.org](http://www.dartcenter.org)**

United States Department of Veterans Affairs: National Center for PTSD  
**[www.ptsd.va.gov](http://www.ptsd.va.gov)**

## RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

*Explaining PTSD & The Counting Method (2-DVD set) with Frank Ochberg and Angie Panos*

*PTSD and Veterans: A Conversation with Dr. Frank Ochberg*

*PTSD in Children: Move in the Rhythm of the Child with Frank Ochberg*

*Resolving Trauma in Psychotherapy: A Somatic Approach with Peter Levine*

*Healing Childhood Abuse and Trauma through Psychodrama (2-DVD set) with Tian Dayton*

*Invisible Child Abuse with Robert Firestone*

*Emotionally Focused Couples Therapy in Action with Sue Johnson*

*When Helping Hurts: Sustaining Trauma Workers with Charles Figley*

## RECOMMENDED READINGS

Armstrong, K., Best, S., & Domenici, P. (2006). *Courage after fire: Coping strategies for troops returning from Iraq and Afghanistan and their families*. Berkeley, CA: Ulysses Press.

Foa, E. B., Keane, T. M., & Friedman, M. J. (eds.) (2004). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York: The Guilford Press.

Johnson, D. R. & Lubin, H. (2005). The Counting method as exposure therapy: Revision and case examples. *Traumatology*, Vol. 11, No. 3.

Johnson, D. R. & Lubin, H. (2006). The Counting method: Applying the rule of parsimony to the treatment of posttraumatic stress disorder. *Traumatology*, Vol. 12, No. 1.

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



- Ochberg, F. M. (1989). Cruelty, culture and coping. *Journal of traumatic stress*, 2(4), 537-541.
- Ochberg, F. M., & Fojtik, K. M. (1984). A comprehensive mental health clinical service program for victims: Clinical issues and therapeutic strategies. *American journal of social psychiatry*, 4(3), 12-23. National Organization for Victim Assistance.
- Scurfield, R. M. (2004). *A Vietnam trilogy: Veterans and posttraumatic stress*, 1968, 1989, 2000. New York: Algora Publishing.
- Shay, J. (2005). *Achilles in Vietnam: Combat trauma and the undoing of character*. New York: Scribner.
- Slone, L. B. & Friedman, M. J. (2008). *After the war zone: A practical guide for returning troops and their families*. Philadelphia: Da Capo Press.

## Role-Play

After watching the video and reviewing “The Counting Method for Ameliorating Traumatic Memories” and the summary of The Counting Method segment in this manual, break participants into pairs and have them role-play a Counting Method session with a client who fits the diagnostic criteria for chronic PTSD (see criteria in this manual).

One person will start out as the therapist and the other person will be the client; have participants switch roles halfway through the time allotted. Since this involves the very sensitive work of processing trauma, advise those people playing clients not to choose a severe trauma of their own to work on, given the limitations of the setting. Rather, they may role-play Terry, another veteran, a client or friend of their own, or they can completely make up a character and trauma. The primary emphasis here is on giving the therapist an opportunity to practice facilitating the Counting Method, not on helping the student process an actual trauma.

Clients and therapists should assume that there is already a basic sense of trust in the competency and concern of the therapist, giving the client confidence in the method.

### **PRELIMINARY DISCUSSION**

begin by discussing the counting Method. Therapists should practice making the following theoretical points to prepare the client for the process:

- Counting affords the client a relatively short interval (100 seconds), with a beginning, middle, and end, in which to deliberately recall an intrusive recollection.
- Silent recall allows privacy.
- Hearing the therapist’s voice links the painful past to the relatively secure present.
- 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.

- 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.

## PREPARATION

The client should come up with a discrete traumatic event that is currently the subject of distressing symptoms involving spontaneous re-experiencing. The chosen memory should have a beginning, middle, and end, as opposed to ongoing abuse that occurred over many years. To help the client choose a specific traumatic memory to work with, the therapist can ask a variation of these two questions:

- What event from the past is worth bringing into the present so that we can diminish its grip on you?
- Is there a memory that comes back and haunts you, and takes you back to a difficult time in your past?

The therapist should then ask the client to briefly describe the outlines of the trauma, without details that might arouse too much affect prior to the procedure. The therapist should help the client identify a specific moment just prior to the traumatic event, and also an end point—a time in which the client was no longer in acute danger. Once the memory is anchored, the therapist will indicate that he or she is ready to begin, and say, “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?”

**INSTRuCTIONS**

next, the therapist will give these instructions to the client:

“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, 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 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.”

**DuRING THE COuNTING**

The therapist should keep an eye on the clock to maintain a steady rhythm of approximately one number per second. Try to count in a clear, friendly, and natural voice, to transmit the warmth and support of the therapeutic relationship.

Observe the client closely. There may be tears, grimaces, shuddering, clenching of hands or defensive postures. Do not stop counting until you have reached 100.

At 93 or 94 the therapist can say, “Back here,” to assist the client in returning to the present.

**AFTER THE COuNTING**

after the therapist has reached 100, clients may 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.

The therapist should wait patiently for the client to speak. Look directly at the client and nonverbally convey warmth and support

as a way of acknowledging the client's pain and communicating admiration for his or her courage to do this work. Once the client speaks to the therapist, the therapist should then respond with an affirmation such as, "That was something. You made it there and back again."

The therapist should then ask the client to describe what was remembered during the counting. The client can then describe what was recalled during the 100 seconds. If the narrative is not flowing, therapists can help this process along 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.

During this phase, therapists should take verbatim notes of what the client recalls, to allow uninterrupted reporting by the client and to capture the images for later discussion.

next, the therapist will read back the notes they took, in as close to a word-by-word repetition as possible. This communicates understanding of the client's experience in its totality, thus integrating the actual traumatic scene with the comradeship of having it heard and recorded by a therapist.

after reading back the story, the therapist should affirm the client's experience, saying something like, "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 of, "You are a survivor, and you have the ability to gain control over your traumatic memories," is reinforced.

## **REFLECTION AND CLOSURE**

The purpose of this final stage of the process is to help clients distance themselves from the memory and diminish strong affect. Therapists want to focus on ending the session on a positive note, with the client composed enough to leave the office and secure enough to continue therapy. To do this, therapists can concentrate on positive performance by saying something like, "You did well. You

remembered. You turned the tape on and off.” To diminish strong affect, the therapist can ask about the method itself: “Did 100 seconds seem like enough time? Too much time? Did my counting help or distract?”

Therapists can end by saying something like, “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.”

after the role-plays, have the pairs rejoin the larger group come together to discuss their experiences. What did participants learn about the counting Method? Invite the clients to talk about what it was like to role-play someone with PTSD and how they felt about the counting Method. Did they feel the therapists’ warmth and admiration for their courage? Talk about how they felt during each phase: preparation, instructions, during the counting, after the counting, and reflection and closure. In particular, how did they feel during the transition from recounting the memory silently to talking about it with the therapist? When did they feel particularly supported by the therapist? Were there any times they did not feel supported by the therapist?

Then, invite the therapists to talk about their experiences: how did it feel to facilitate the counting Method? What stages were particularly enjoyable or challenging? how did it feel to take verbatim notes? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about ameliorating traumatic memories with the counting Method.

## Video Credits

**Producers:** Victor Yalom, PhD, and Marie-Helene Yalom, PhD

**Interviewer:** Victor Yalom, PhD

**Video Production:** Future Media Corporation

**Post-Production & DVD Authoring:** John Welch

**DVD Artwork:** Julie Giles

**Subtitles:** VideoJump, Inc.

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Terry, for generously sharing his story

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# About the Contributors

## VIDEO PARTICIPANTS

**Frank M. Ochberg, MD**, has been a leading authority on the treatment of Posttraumatic Stress Disorder since the 1960s and helped define PTSD for its inclusion in the DSM. he has received many awards for his work, most recently the Lifetime achievement award from the International Society for Traumatic Stress Studies. he founded *Gift from Within* and is currently a clinical professor of psychiatry at Michigan State University. he is the editor of several books, including *Posttraumatic Therapy and Victims of Violence*.

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**Frank M. Ochberg, MD**, has been a leading authority on the treatment of Posttraumatic Stress Disorder since the 1960s and helped define PTSD for its inclusion in the DSM. he has received many awards for his work, most recently the Lifetime achievement award from the International Society for Traumatic Stress Studies. he founded *Gift from Within* and is currently a clinical professor of psychiatry at Michigan State University. he is the editor of several books, including *Posttraumatic Therapy and Victims of Violence*.

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## **Population**

adolescents	Men
african-american	Military/Veterans
children	Parents
couples	Prisoners
Families	Step Families
gLbT	Therapeutic
Inpatient clients	communities Women

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## Therapeutic Issues

addiction	...and more
anger Management	grief/Loss
alcoholism	happiness
aDD/aDhD	Infertility
anxiety	Intellectualizing
beginning Therapists	Law & ethics
child abuse	Medical Illness
culture & Diversity	Parenting
Death & Dying	PTSD
Depression	relationships
Dissociation	Sexuality
Divorce	Suicidality
Domestic Violence	Trauma
	Weight Management