

Criteria for assuring appropriate clinical use and avoiding misuse of Resource Development & Installation when treating complex posttraumatic stress syndromes.

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Stages of Trauma-Oriented Psychotherapy

- Since Janet (1919/1976) trauma oriented psychotherapy has been organized in stages
 - ego strengthening
 - uncovering
 - resolving
 - integrating

2

The Consensus Model

- In trauma-related syndromes, the “consensus model” recognizes it is essential to provide adequate stabilization and ego strengthening before and during uncovering and resolving traumatic memories to avoid “overshooting the therapeutic window” Briere (1996).
- For more on the “consensus model” see: Brown, Schefflin, & Hammond, 1998; Chu, 1998; Courtois, 1999.

3

Resource Development and Installation

- First proposed as a stabilization strategy for Complex PTSD (and BPD) by Leeds (1997) building on work by EMDR pioneers on the “Safe Place” and related strategies. (Foster et al., 1995; Greenwald, 1993a, 1993b; Lendl, 1997; Martinez, 1991; Wildwind, 1992).
- RDI is similar to Ericksonian ego strengthening (Frederick & McNeal, 1999):
 - looks within the patient for essential, needed resources.
 - assists the patient to find their own solutions
- In RDI the patient is assisted to identify memories and images associated with positive emotional states and adaptive coping behaviors.
- Brief sets of bilateral eye movements (taps or tones) (as in standard EMDR reprocessing) are used to enhance a positive state and associations within and between positive emotional states and coping behaviors.

4

Reports of RDI as an effective intervention for stabilization

- RDI has been described in a series of published case reports as an effective intervention for adult survivors of adverse childhood experiences for
 - intense shame,
 - depersonalization,
 - angry outbursts,
 - self-injurious behaviors,
 - compulsive eating,
 - obsessive self-critical thoughts,
 - persistent negative emotional states (misery),
 - sexual acting out,
 - substance abuse.
- See: Korn & Leeds, 2002; Leeds, 1997, 1998, 2001b; Leeds & Shapiro, 2000; Popky, 2005.
- There are no published, controlled studies of RDI.

5

Variations of the RDI procedure have been widely disseminated

- Since 1995 versions of RDI have been included in basic EMDR trainings, EMDRIA Conferences, EMDRIA credit programs, the EMDRIA Newsletter, journal articles, and books.
- In 2001 RDI was added to Shapiro’s EMDR text.
- Those trained in EMDR have been exposed to RDI either in their EMDR training or afterwards.
- Many criteria have been listed for when to use RDI.
- Until recently (Korn et al., 2004; Leeds, 2005, Shapiro, 2004) little attention has been given to assuring appropriate use and avoiding misuse RDI.

6

Potential misuse of RDI in patients with posttraumatic symptoms

- In her 2004 EMDRIA Conference Plenary Francine Shapiro (2004) expressed concerns that significant numbers of patients with posttraumatic stress syndromes who meet standard EMDR readiness criteria for ego strength and stability have been offered multiple sessions of RDI without being offered standard EMDR reprocessing.

7

Risks in delaying EMDR by continuing RDI sessions

- When clinicians who have completed training in EMDR offer patients with PTSD RDI over significantly more sessions than needed to meet readiness criteria for EMDR:
 - They may convey the message the patient is too weak to tolerate the traumatic material increasing avoidance and anxiety about EMDR reprocessing.
 - They may deplete the patient's resources and thus prevent the patient from being able to receive medically necessary effective treatment for their PTSD.

8

Risks in failing to offer EMDR

- When clinicians who have completed training in EMDR offer patients with PTSD RDI and fail to offer EMDR:
 - they may reinforce patient avoidance of the traumatic material
 - prolong the patient's condition and
 - discourage the patient from obtaining medically necessary effective treatment.
- Such a failure to render care may expose the clinician to the risk of a complaint to the licensing board or a civil law suit for malpractice.

9

What percentage of those with PTSD need RDI before EMDR?

- There are no definitive studies to answer this question.
- Korn and Leeds (2002) suggested that RDI might be needed in the stabilization phase of treatment in a substantial portion of cases of DESNOS subjects meeting criteria for Borderline Personality Disorder.
- Korn et al. (2004) reported that in a large well-controlled (eight session) study of EMDR less than 5% of adult PTSD subjects (even those with childhood onset PTSD) needed RDI and then they generally only needed one session of RDI.
- EMDRIA Approved Consultants generally report only a small percentage of patients presenting with PTSD need RDI before standard EMDR reprocessing of disturbing memories.

10

Indications for use of RDI before starting standard EMDR for PTSD

- Client cannot control tension reduction, avoidant or aggressive behaviors that involve:
 - Risk of serious self-injury, mutilation, death.
 - Life threatening abuse of dangerous substances.
 - Harm to others.
 - Loss of economic stability, housing or essential social support with no acceptable alternatives.

11

Case 1 - "Almost homeless again"

- A 58 year old Viet Nam veteran with a history of treatment for alcohol dependence and suicide attempts (with alcohol and tranquilizers), periods of homelessness and inability to maintain employment due to poor social skills, angry outbursts and moodiness, was referred for treatment after completing a six-month residential program for substance abuse. He had been abstinent for 5 months and reported no suicide urges for 4 months.
- He was referred for EMDR treatment for intrusive memories and episodes of irritable anger when he perceived others as rejecting him. His current housing and employment were being threatened by these outbursts. He was at risk of becoming homeless again.
- His EMDR clinician chose to use RDI at the 2nd, 4th and 5th sessions to improve his ability to manage episodes of perceived rejection, improve self-soothing and reach out for support.
- They began EMDR reprocessing at the 7th session.

12

Indications for use of RDI before starting standard EMDR for PTSD

- Client is afraid or unwilling to start EMDR and
 - Standard self-care and self-regulation methods, such as structured relaxation and guided imagery methods (such as calm or safe place) do not alleviate patient distress in the office or are not useful to the patient between treatment sessions.
 - This inability to regulate anxiety (or other affects) leaves the patient vulnerable to emotional flooding or acting out during and between treatment sessions.

13

Case 2 - “sleepless and alone”

- A 34 year old, self-employed piano teacher presented for treatment with nightmares, intrusive childhood memories of physical and sexual abuse, dysthymia, insomnia, poor self-esteem and a history of short, unhappy sexual relationships. She was in stable recovery from alcohol abuse and had a sponsor in AA. Breathing exercises and progressive relaxation had not helped her manage her symptoms.
- She avoided going to bed at a reasonable hour due to feeling “alone” and had extreme difficulty going back to sleep after recurrent nightmares. She seldom got more than 4 or 5 hours sleep. Notable executive impairments prevented her paying bills, keeping appointments, and marketing her services effectively. She wanted EMDR treatment but feared worsening insomnia and nightmares.
- Her EMDR clinician reviewed sleep hygiene with her and installed resources for self-soothing, feeling connected to others, strength and courage at the 2nd, 3rd, and 5th and 6th sessions. They started EMDR at the 8th session and were able to use it regularly thereafter.

14

Indications for use of RDI before starting standard EMDR for PTSD

- Although the patient has indicated an interest in starting trauma resolution with EMDR, the clinician may determine there is a substantial risk the patient would abruptly terminate treatment if the clinician proceeded to use EMDR due to:
 - Poor ego strength.
 - Inability to tolerate suppressed or dissociated material.
 - Already observed Borderline shifts from idealization to devaluing the clinician.
 - Intolerable shame
 - if they were to resume acting out in non-lethal ways or
 - if they were to re-experience certain painful memories.

15

Case 3 - “no one understands me”

- A 31 year old single man presented for EMDR treatment with a history of childhood sexual abuse and unfulfilling relationships. He had a history of using pornography and starting other sexual relationships without telling his current partner.
- He had repeatedly dropped out of treatment. He initially praised his EMDR clinician effusively. His EMDR clinician determined past treatments had terminated after he hid his infidelity and compulsive masturbation from his therapists and then lost respect for them.
- His EMDR clinician said they would not start EMDR reprocessing unless he agreed to disclose his current sexual behaviors. He initially cancelled his subsequent session, then reconfirmed. His EMDR clinician installed resources for honesty and direct expression of anger and hurt at the 3rd and 4th sessions. They began using EMDR at the 7th session.

16

Indications for use of RDI before starting standard EMDR for PTSD

- The patient has episodes when they cannot speak or can barely articulate their thoughts. The patient appear confused or overwhelmed by emotional states at these times.
- The patient cannot give coherent narrative accounts of events of the week (even with clinician prompting) such as stressful interactions with family members or coworkers. Instead the patient gives fragmentary accounts of these situations and then lapses into vague self-critical comments.

17

Case 4 - “No one can help me”

- A 34 year old nurse in a 5 year-long engagement to be married, presented for treatment with generalized anxiety, nightmares, and passivity in social situations. She was in stable recovery from alcohol abuse. She had been verbally abused by her alcoholic father in childhood. Her mother was kind to her, but was unable to protect her from her father’s verbal abuse and vague threats of violence.
- History taking and treatment planning were initially limited by her tendency to lapse into vague, self-critical statements when asked to describe stressful social interactions or specific traumatic memories. She experienced depersonalization in stressful social interactions.
- The EMDR clinician used RDI at the 2nd, 4th, and 6th and 12th sessions. They began using EMDR reprocessing regularly at the 9th session. Previously installed resources were re-accessed to help close incomplete EMDR reprocessing sessions. Her nightmares and anxiety abated. After the 14th session she announced she had selected a wedding date and finally had a commitment from her fiancée.

18

Invalid reasons to use RDI before starting standard EMDR for PTSD

- The patient is clearly suffering from symptoms of PTSD, meets readiness criteria, and the clinician has:
 - A vague sense the patient is “unstable”.
 - Anxiety about possible patient abreaction.
 - Aversion to the content of patient memories.
 - Preference for helping the patient to “feel good.”
 - Fear of not being able to “complete” the session.
- Instead, the clinician should obtain additional education, training, consultation or EMDR to resolve their issues and make appropriate use of EMDR.

19

Case 5 - “can’t stand the pain”

- A 28 year old woman presented with nightmares, childhood memories of emotional neglect by mother, physical abuse by step-father and two rapes. At the initial visit she wept profusely and protested she could no longer stand the pain of her memories. She asked if EMDR could help her.
- Her clinician had completed basic training in EMDR but had not practiced the standard protocol. She believed memory reprocessing was inevitably re-traumatizing and often unproductive. During her training, she had a distressing and incomplete practicum experience as patient.
- She offered the patient the calm place exercise at the first session. At the 2nd visit she installed a resource of a soothing maternal figure. At the 3rd visit she installed resources for strength and courage. Each subsequent visit she installed a resource for the symptom or issue of the week. At the 18th session the patient said she was doing better and needed to reduce the frequency of sessions because of financial concerns. They met over the next year every few weeks for further installation of resources.

20

Case 6 - “a stitch in time”

- A 33 year old woman requested EMDR for intrusive memories of her mother’s painful death from cancer. She could no longer access her many happy memories of her mother. Her EMDR clinician found the initial EMDR session anguishing as it triggered memories of her own mother’s painful death of 8 years before. Treatment progressed slowly with no further EMDR and a shift to grief counseling.
- The clinician attended a regional EMDRIA conference and consulted informally about her struggles with the case. All three peers with whom she spoke encouraged her to have EMDR for her unresolved traumatic loss. After 5 sessions she resolved her own issues. She was then able to resume and successfully complete EMDR processing with her patient.

21

Indications for use of RDI after starting standard EMDR

- Due to increased recall of residual disturbing material patients may become so flooded with affect, memories or maladaptive urges after standard EMDR reprocessing that their day-to-day functioning is adversely impacted.
 - These patients may become reluctant or unwilling to resume EMDR until their functioning improves.
 - Clinical judgment may indicate that RDI could be useful in restoring patient functioning.
- In standard EMDR sessions some patients occasionally have chronically incomplete desensitization (Phase 4) of selected targets due to persistent blocked responses.
 - One or two sessions of RDI may overcome this difficulty and permit effective reprocessing of previously blocked material.

22

Case 7 - “I can’t face that too”

- A 33 year old man requested treatment for childhood physical and verbal abuse by his mother. He was intimidated by women. He fled relationships whenever a woman became demanding or was angry with him.
- He responded well to the safe place exercise. His EMDR clinician began reprocessing his earliest memory of maternal abuse. The session went well with a completely resolved memory. The next week he reported being more disturbed than ever. He had a series of recurrent nightmares suggestive of sexual abuse. He said he couldn’t face the additional possibility of memories of maternal sexual abuse.
- His clinician offered him RDI. Over the next two sessions they installed resources for self-worth, strength, courage and trust. The next week he reported that he could face whatever might emerge. They resumed EMDR and worked through the remaining disturbing memories. He never was sure about the sexual abuse, but after EMDR reprocessing, the nightmares did not return. He became resilient in the face of relationship conflicts and completed treatment in about 8 months.

23

Case 8 - “lifting the burden of shame”

- Meredith was a young woman with lupus, insomnia, chronic pain, low self-esteem and a history of selecting emotionally unavailable men. Her treatment was complicated by chronic “shame attacks” when she accessed emotionally charged material. She would then hide her face in her hands for long periods. She requested EMDR for memories of verbal abuse by her father and mother and physical abuse by her adopted brother. Each EMDR session was blocked due to tearful “shame attacks.”
- Eventually her clinician decided to offer her resource installation. With few mastery memories or relational resources, she had a remarkable ability to access symbolic resources. After only two sessions of installing 4-6 resources each, Meredith reported being free of chronic pain, sleeping through the night, and having a more resilient and empowered sense of self in social interactions. She was then able to complete reprocessing on a series of disturbing childhood memories. Her lupus went into stable remission. She became engaged and was happily married.

24

Screening before use of RDI (i)

- It is essential to screen (Lowenstein, 1991) for dissociative disorders (notably DID and DDNOS) and to use RDI only with populations where the clinician has appropriate training and experience.
- Clinicians experienced with RDI report patients with undiagnosed DID or DDNOS can have prolonged abreactions or other negative responses to RDI.
- RDI has been used with selected DID or DDNOS patients by some clinicians experienced in their treatment, but with highly unstable patients standard stabilization methods should be used before RDI.

25

Case 9 - “story time”

- A 39 year-old married woman with 3 children was referred for EMDR treatment due to nightmares and persistent social isolation after having been sexually exploited by a male professional 4 years previously.
- The clinician did not administer the DES nor conduct a mental status exam for dissociative disorders prior to offering the safe place exercise.
- She selected the memory of sitting on grandfather’s lap, listening to him reading a bed time story. After the second set of eye movements the patient went into a dissociative fugue. A child alter appeared who was re-experiencing sadistic sexual abuse by the same grandfather.
- It took more than a hour to stabilize and reorient the patient and several weeks to repair the rupture in the therapeutic alliance.

26

Screening before use of RDI (ii)

- Patients with dismissing (Main, 1996) or fearful (Bartholomew & Horowitz, 1991) insecure attachment status may have limited or adverse responses to the RDI protocol and may need a modified RDI approach or a focus on affect tolerance interventions.
- There is no controlled research yet on RDI; appropriate informed consent should be obtained before offering RDI to patients.

27

Case 10 - “home alone”

- A 48 year old divorced woman had persistent emotional and physical neglect in childhood (dismissing insecure attachment). She had no lifetime relationships with genuine emotional closeness. She was referred for treatment with EMDR with presenting complaints of major depression (severe) and suicidal ideation (with a lethal plan) with onset after her husband abandoned her for a younger woman.
- Initial attempts to install a singular memory from childhood of a kind, soothing other led to increased calm. Then the patient became distraught and fled the office. She cancelled several of her next scheduled appointments on short notice. When she resumed sessions, she refused further RDI or EMDR insisting on talk therapy only.

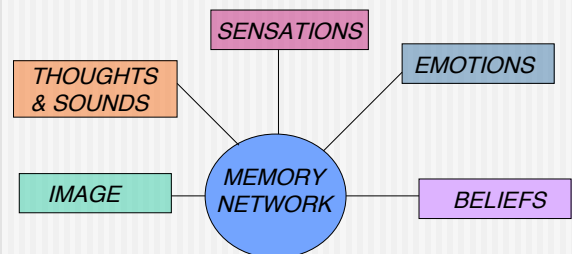
28

The Adaptive Information Processing Model (AIP)

- Francine Shapiro (2001) describes EMDR reprocessing through the organizing framework of the AIP model as:
 - Using the intrinsic human capacity for emotional learning;
 - Occurring through a synthesis between maladaptive and adaptive memory networks;
 - Leading to an complete transformation of the memory within a comprehensive set of adaptive networks
 - In which the memory joins other past experiences that inform and guide adaptive future perceptions, attitudes and behaviors.

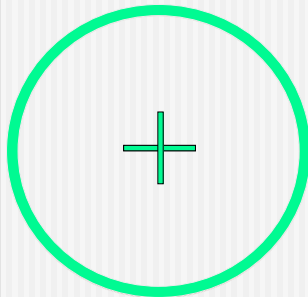
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Memory Networks in EMDR



30

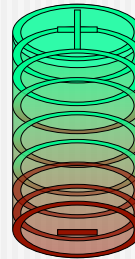
Resources are not static memories



- Resources represent the capacity for adaptive state change
 - from a negative state
 - to a positive state

31

The discrete states view of a resource memory network



- Resources include information about specific events, relationships, physiological states, and functional coping responses.
- Resources consist of series of associated memory networks representing adaptive transitions from one discrete (behavioral and affect) state to another (see Putnam, 1997).
- This illustration shows a resource experience in the transition in a novel situation from fear through risk-taking to mastery.

32

Information Processing Effects in EMDR and RDI

- Elements of a memory network are first accessed
- Sensory orientation is then stimulated with bilateral eye movements (taps or tones)
- This produces a “compelled relaxation response” (Wilson et al. 1996; Barrowcliff et al., 2003)
- Dearth is followed by associative chaining
 - first within the accessed memory networks and
 - then progressively to more unrelated memory networks. (Kuiken, Bears, et al., 2000-2001).

33

Why use fewer movements per set in RDI?

- Why use a reduced number of eye movements (6-12) in RDI compared with standard EMDR reprocessing (24-30) [including Phases 4, 5 & 6 - Desensitization, Installation and Body Scan]?
- Associative chaining in EMDR reprocessing generally leads:
 - First to associations within the initial memory.
 - Then associations to similar memories.
 - Finally to dissimilar memories.
- In RDI we only want to stimulate limited associations within the initial positive memory or to a similar positive memory. Thus we limit the number of movements per set to 6-12.
- In standard EMDR reprocessing (including Desensitization, Installation and Body Scan phases) we want to access and resolve any negative associations to the target memory.

34

Resource Development and Installation overview of 7 main procedural tasks

1. Identify a target situation from a behavioral chain analysis.
2. Select a mastery, relational or symbolic memory that
 - ✓ represents a needed capacity and
 - ✓ is associated with positive affect.
3. Access (through guided inquiry) and enhance (through repetition of patient’s descriptors) as many aspects of the memory as possible.
4. Add several short sets (6 to 12 repetitions each) of eye movements (taps or tones).
 - ✓ If needed to retain access to the positive memory, it’s ok to repeat patient descriptors before each set.
5. Repeat steps 2-4 for as many memories and qualities as needed until:
6. The patient can imaginably rehearse (via future template) making use of these adaptive capacities in the target situation.
7. Verify stability in the target situation with feedback from patient log and repeat steps 2-6 if needed on this or other target situations.

35

Main Task 1 Behavioral Chain Analysis

- A Behavioral Chain Analysis identifies in detail the specific environmental cues, personal antecedents and consequences of dangerous or maladaptive behaviors based on the following hierarchy of importance:
 1. Life threatening, suicidal, and parasuicidal behaviors
 2. Behaviors that interfere with treatment, i.e. non-compliance, canceling appointments, premature dropout.
 3. Patterns that have a severe effect on quality of life, i.e. drug abuse, failure to maintain employment.
 4. Coping skills development.
- See Koerner et al. 1998; Linehan, 1993; Shearin et al. 1994.

36

Template Step 1 Target selection

- 1A) “Tell me about the recent, challenging situation
 - (1) where you would like to have been able think, feel, or behave differently than you did
 - (or 2) where you experienced compulsive urges or intrusive thoughts, feelings or memories.”
- 1B) “As you think about _____ (the target situation), what is the worst part of it now?”
- 1C) “As you hold that situation in mind, how disturbing does it feel to you now on a scale from zero to ten, where zero represents neutral or no disturbance and ten represents the most disturbing you can imagine.”

37

Main Task 2 Potential sources and types of Resources (1)

- 1) **Mastery resources** include:
- memories of recent or past coping responses;
 - experiences of effective self-care and self-soothing;
 - a physical stance or movement that evokes a functional affective state or capacity to respond.

38

Main Task 2 Potential sources and types of Resources (2)

- 2) **Relational resources** include:
- a) memories of positive role models who demonstrated capacities the patient would like to incorporate such as courage, persistence, calm, boundary setting, or truth telling.
 - those the patient has known or now knows personally;
 - figures from books, stories, cartoons, movies, TV.
 - b) memories of supportive others including care givers, relatives, teachers, positive authority figures, peers, or pets from whom the patient has received soothing, care, affection or protection.

39

Main Task 2 Potential sources and types of Resources (3)

- 3) **Symbolic resources** include:
- objects from the natural world: the ocean, a rock or a tree;
 - archetypal, religious, totemic, transpersonal symbols and experiences;
 - images from art work or other creative endeavors;
 - symbols or images from guided imagery;
 - figures or symbols from dreams or daydreams which express the patient’s capacity for adaptive functioning;
 - metaphors or stories offered by the clinician;
 - music (that can be played in the session) that evokes a positive affective state.

40

Template Step 2 Two paths to identifying resources: concrete or abstract inquiry

- **Concrete inquiry:**
 - 2A) What would you like to be able to do in this situation?
 - 2B) What would you like to be able to believe in this situation?
 - 2C) What would you like to be able to feel in this situation?
- **Abstract inquiry:**
 - 2D) When you think about this situation what qualities, or strengths do you need?

41

Template Step 3 Selecting a Mastery, Relational or Symbolic resource

- 3A) Mastery Experiences
 - “Think of a time when . . .”
- 3B) Relational - Role models
 - “Think of people who showed you other choices . . .”
- 3C) Relational - Supportive figures
 - “Think of who you would want helping you to . . .”
- 3D) Symbolic
 - “Allow an image (or symbol) to come to you that would help you to . . .”

42

Main task 3 Access and enhance the selected resource

- Access (through guided inquiry) and enhance (through repetition of patient's descriptors) as many aspects of the memory as possible.
- Bilateral stimulation (eye movements in particular) tends to decrease vividness of sensory memory.
- Therefore sufficient accessing and enhancing of the positive memory network needs to be done through verbal exploration and repetition before commencing bilateral stimulation.

43

Template Step 4 Accessing more sensory and affective information

- 4) "As you focus on _____ (i.e. that experience, person, symbol, etc.), what do you see?
What do you hear? What do you smell?
What sensations do you notice in your body?
What emotions do you feel as you focus on this image (or memory)?
Where do you notice these feelings in your body?"

44

Template Step 5 Checking Ecology and Validity of the Resource

- 5A) "As you focus on _____ (repeat words for resource image) and notice the _____ (repeat words for resource sounds, smells, sensations, feelings), how do you feel now?"
- 5B) "As you focus on the picture that represents the worst part of _____ [the target situation,] how true or helpful do _____ (repeat descriptions of the resource image and feelings) feel to you now from one, completely false or not helpful to seven, completely true or helpful?"

Note: These two steps confirm the absence of immediate negative associations to the resource and assess its initial perceived degree of helpfulness.

45

Template Step 6 Reflecting

- 6A) "Close your eyes if you'd like (or leave them open if you'd prefer) and let yourself be aware of _____ (repeat words for resource image) and notice the _____ (repeat description of resource feelings, sensations, smells, sounds)."
(Repeat and vary the order of patient's words for the image, sounds, emotions, and sensations.)
- 6B) "What do you notice or feel now?"
- Note: Do **not** continue if the patient reports negative associations to the resource.

46

Main Task 4 Installation

- Add several short sets (6 to 12 repetitions each) of eye movements (taps or tones).
- ✓ If needed to retain access to the positive memory, it's ok to repeat patient descriptors before each set.

47

Template Step 7 Installation

- 7A) "Now, as you continue to focus on _____ (say patient's words for the resource image, emotions and sensations), follow my fingers (or tones, lights, taps)".
Do the first set of 6-12 movements. Then: "What are you feeling or noticing now?"
Stop bilateral stimulation if patient reports negative associations or affect. Neutralize and set these aside and start over with an alternate resource. With positive responses continue.
Do a second set of 6-12 movements. Then: "What are you feeling or noticing now?"
Do a third set of 6-12 movements. Then: "What are you feeling or noticing now?"

48

Template Step 8 Linking with verbal or sensory cues

8A) Mastery

- As you focus on that experience think of the most positive words you can say about yourself now.

8B) Models

- Imagine seeing and hearing _____ being as you would most like to be.
- Imagine stepping right into _____'s body, so you can see through their eyes and feel how it is to be able to act, feel and think like that.

8C) Supportive Figures

- Imagine _____ standing near you and offering you what you need.
- Imagine that he or she knows exactly what you need to hear.
- Image a reassuring touch in just the way you need it.

8D) Symbolic Resources

- Imagine holding _____ in your hands.
- Imagine being surrounded by _____.

49

Template Step 8 Continue SEM

Continue with two more sets of stimulation as long as processing appears helpful.

Do a fourth set of 6-12 movements. Then:

“What are you feeling or noticing now?”

Do a fifth set of 6-12 movements. Then:

“What are you feeling or noticing now?”

50

Main Task 5 and 6 Install additional resources as needed

5. Repeat steps 2-4 for as many memories and qualities as needed until:

6. The patient can imaginably rehearse (via future template) making use of these adaptive capacities in the target situation.

If the patient is not able to imaginably rehearse an adaptive response with sufficient confidence (VoR of 6 or 7) install more resources.

51

State specific access to memory

- Bower (1981) showed that memories acquired in a specific affective state are more readily evoked in that same state:
 - mood (a persistent affective state) regulates access to memory;
 - “state specific” access to memory (and to modifying memory).
- Implications of state specific access for the RDI procedure.
 - Start with any accessible resource from any of the three domains.
 - After installing one resource, additional resources in the same or the other domains may become more readily accessible and therefore available for installation.
 - To achieve stable functioning, rather than continuing installation on one resource over too many sets, instead find additional resources and install them.

52

Template Step 9 Future Template

- Orient the patient to imagine being in target situation in the future.
- 9) “Think about _____ (being able to act, think or feel as in the resource experience or possessing this quality) in the future as you next face _____ (the target situation).”
- Select one or more phrases from 9 A, B, C or D, then add two more sets of stimulation.

53

Template Steps 10, 11, 12

10) Checking the Validity of the Resource (VoR):

“And now as you imagine being in _____ [the target situation,] in the future, how true or helpful does _____ (name the resource and self-statement or say patient’s words for the image, sensation, feelings) feel to you now from one, completely false or not helpful to seven, completely true or helpful?”

11) Repeat this process with additional resources until the VoR rises to a 6 and the SUD on the presenting target situation falls to a five or lower.

12) Reassess the target issue

“And now as you think of _____ (name each of the installed resources) and imagine being in _____ [the target situation] in the future, how disturbing does it feel to you now on a scale from zero to ten, where zero represents neutral or no disturbance and ten represents the most disturbing you can imagine.”

54

Use of RDI in the phase oriented model of PTSD

1. In the stabilization phase for a patient who does not meet readiness criteria, install resources to prepare the patient to achieve or regain adequate coping skills.
2. During reprocessing (minimize clinician distortions):
 - To resolve a blocked response only when standard cognitive interweaves are ineffective, consider using a previously installed resource (e.g. "What would a previously installed friend say?") as an additional source for a cognitive interweave.
 - For an incomplete session with a highly unstable patient, change directions to close the session by installing a resource.
 - When faced with an impasse over several reprocessing sessions, install resources until the patient is able to reprocess the challenging material.
 - **Later, reassess and reprocess targets without accessing resources.**
3. To aid in the formation of a new identity, develop and install resources representing new, emerging aspects of self.

55

Successful RDI does not replace resolution of etiological events

- *Using a resource to move the patient into a positive state and out of the distress experienced in a maladaptive memory network does not produce synthesis between memory networks but only a temporary change in state.*
- Clients with unresolved adverse life experiences that are etiological for current symptoms deserve effective treatment that can produce stable treatment effects.
- EMDR has been shown to produce stable, enduring treatment effects for such symptoms. RDI has not.
- For patients who meet readiness criteria clinicians should not offer RDI while avoiding EMDR reprocessing due to a lack of experience, their own affect phobias or vague fears of adverse outcomes.
- Instead, these clinicians should obtain additional education, training, consultation or have EMDR sessions to resolve their issues and be able to make appropriate use of EMDR.

56

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Resource Development and Installation

Select from the **bold phrases** listed in each step those appropriate for each client.

Target situation	
1A) “Tell me about the recent, challenging situation (1) where you would like to have been able think, feel, or behave differently than you did (or 2) where you experienced compulsive urges or intrusive thoughts, feelings or memories.”	
Target situation:	
Worst part	
1B) “As you to think about _____ (the target situation), what is the worst part of it now?”	
Worst part:	
Initial SUD	
1C) “As you hold that situation in mind, how disturbing does it feel to you now on a scale from zero to ten, where zero represents neutral or no disturbance and ten represents the most disturbing you can imagine.”	
SUD level: 0 1 2 3 4 5 6 7 8 9 10	
To identify a resource, select 2A, B and C, <u>or</u> 2D.	
Identifying a Resource (concrete)	Identifying a Resource (abstract)
2A) “What would you like to be able to do in this situation?”	2D) “When you think about this situation what qualities, or strengths do you need?”
Desired behavior:	Desired qualities or strengths:
2B) “What would you like to believe about yourself in this situation?”	
Desired belief:	
2C) “What would you like to feel in this situation?”	
Desired emotion:	
Select one resource from 3A, B, C <u>or</u> D at a time. Then return to step 3 for another resource.	
Exploring Memories and Images of Resource Experiences	
Mastery Experiences	
3A) “Think of a time when you were able to ____.” (Say client’s desired behavior or quality). “Think of a time when you were able to believe ____.” (Say client’s desired belief). “Think of a time when you felt ____.” (Say client’s desired emotion).	
Relational Resources - Models	
3B) “Think of people in your life who possess or embody this quality?” Think of people in the world, who can serve as a role model for you.” Think of people who made a difference in your life by showing you other choices.”	
Relational Resources – Supportive Figures	
3C) “Think of who you would want in your corner, coaching you to do what is best for you, to think what is best for you, and helping you to feel ____.” (Say client’s desired emotion). “Think of any friends, relatives, teachers, or caregivers, animals or pets who encouraged or sustained you?” Think of a spiritual guide, someone who gives you hope or strength.”	

Metaphors and Symbolic Resources

3D) **“Close your eyes if you’d like (or leave them open if you’d prefer) and allow an image (or symbol) to come to you that would help you to be able to _____ (Say client’s desired behavior or quality) or help your to believe _____ (Say client’s desired belief) or help you to feel _____ (Say client’s desired emotion).”**

Resource Development – Accessing More Sensory and Affective Information
(Working with one resource memory or image at a time.)

4) **“As you focus on _____ (i.e. that experience, person, symbol, etc.), what do you see? What do you hear? What do you smell? What sensations do you notice in your body? What emotions do you feel as you focus on this image or memory? Where do you notice these feelings in your body”**

(Write verbatim client’s words and phrases.)

Images:

Sounds:

Emotions & Sensations:

Location of Sensations:

Checking the Ecology and Validity of the Resource (VoR)

5A) **“As you focus on _____ (repeat words for resource image) and notice the _____ (repeat words for resource sounds, smells, sensations, feelings), how do you feel now?”**

Assess the Validity of the Resource (VoR)

5B) **“As you focus on the picture that represents the worst part of _____ [the target situation,] how true or helpful do _____ (repeat descriptions of the resource image and feelings) feel to you now from one, completely false or not helpful to seven, completely true or helpful?”** (Initial VoR of “1” is a caution.)

VoR: 1 2 3 4 5 6 7

Reflecting the Resource

6A) **“Close your eyes if you’d like (or leave them open if you’d prefer) and let yourself be aware of _____ (repeat words for resource image) and notice the _____ (repeat description of resource feelings, sensations, smells, sounds).”**
(Repeat and vary the order of client’s words for the image, sounds, emotions, and sensations.)

Verify the resource has positive associations or affects

6B) **“What do you notice or feel now?”**

When client reports positive feelings and associations, continue to step 7, Installation.
If the client reports negative associations or affect, do not continue with this resource.
Instead, start over with another resource.

Resource Installation

7A) **“Now, as you continue to focus on _____ (say client’s words for the resource image, emotions and sensations), follow my fingers (or tones, lights, taps)”**.

Do the first set of 6-12 movements. Then: **“What are you feeling or noticing now?”**

Stop bilateral stimulation if client reports negative associations or affect. Neutralize and set these aside and start over with an alternate resource. With positive responses continue.

Do a second set of 6-12 movements. Then: **“What are you feeling or noticing now?”**

Do a third set of 6-12 movements. Then: **“What are you feeling or noticing now?”**

Linking verbal or sensory cues (occurs spontaneously sometimes).
Select one or more phrases from 8 A, B, C or D, then add two more sets of stimulation

(For mastery experiences)

8A) **“As you focus on that experience (if needed repeat client’s words of the image, emotions and sensations), think of the most positive words you can say about yourself now.”**

(For models)

8B) **“Imagine seeing and hearing _____ (name model person) being as you would most like to be. If you would like to, imagine stepping right into _____’s (name model person) body, so you can see through their eyes and feel how it is to be able to act, feel and think like that.”**

(For supportive figures)

8C) **“Imagine _____ (supportive figure) standing near you and offering you what you need. Imagine that he or she knows exactly what to say to you, exactly what you need to hear. Image a reassuring touch in just the way you need it.”**

(For metaphoric or symbolic resources)

8D) **“Imagine seeing _____ (name the symbol). Imagine holding _____ (name the symbol) in your hands. Imagine being surrounded by _____ (name the image or feeling). Breathe in _____ (name the feeling). Notice where you feel the positive feelings in your body.”**

Continue with two more sets of stimulation as long as processing appears helpful.

Do a fourth set of 6-12 movements. Then: **“What are you feeling or noticing now?”**

Do a fifth set of 6-12 movements. Then: **“What are you feeling or noticing now?”**

Future Template

Select one or more phrases from 9 A, B, C or D, then add two more sets of stimulation

9) **“Think about _____ (being able to act, think or feel as in the resource experience or possessing this quality) in the future as you next face _____ (the target situation).”**

(For mastery experiences)

9A) **“Imagine being able to act with _____ (name their mastery action) as you remember doing in _____ (say client’s mastery memory). Imagine thinking _____. (Say client’s mastery belief). Imagine feeling _____ (say client’s master emotion).”**

(For models)

9B) **“Imagine seeing and hearing _____ (say client’s model) being as you would most like to be. Or, if you would like to, imagine stepping right into _____’s body, so you can see through their eyes and feel how it is to be able to act, feel and think like that.”**

(For supportive figures)

9C) **“Imagine feeling connected with _____ (say client’s supportive figure) as you face this situation. Notice what that would be like for you. Hear _____ (name supportive person) saying exactly what you need to hear.”**

(For symbolic resources)

9D) **“See and feel your symbol in just the way you need to. Be aware of this symbol in just the way you need to experience it.”**

Continue with two more sets of stimulation as long as processing appears helpful.

Do a sixth set of 6-12 movements. Then: **“What are you feeling or noticing now?”**

Do a seventh set of 6-12 movements. Then: **“What are you feeling or noticing now?”**

Checking the Validity of the Resource (VoR):

10) **“And now as you imagine being in _____ [the target situation,] in the future, how true or helpful does _____ (name the resource and self-statement or say client’s words for the image, sensation, feelings) feel to you now from one, completely false or not helpful to seven, completely true or helpful?”**

VoR: 1 2 3 4 5 6 7

Repeat for each quality or resource

11) Repeat this process with additional resources until the VoR rises to a 6 and the SUD on the presenting target situation falls to a five or lower.

Reassess the target issue

12) **“And now as you think of _____ (name each of the installed resources) and imagine being in _____ [the target situation] in the future, how disturbing does it feel to you now on a scale from zero to ten, where zero represents neutral or no disturbance and ten represents the most disturbing you can imagine.”**

Assess the SUD level: 0 1 2 3 4 5 6 7 8 9 10

Notes on the clinical use of Resource Development and Installation

This template is offered as a quick reference and clinical aid for qualified mental health professionals who are taking or who have completed an EMDRIA™ approved basic training in EMDR. More complete descriptions of this procedure are available in print and on audiotape. For a reference list and reprint availability please see <http://www.andrewleeds.net/>.

Precautions when considering Resource Development and Installation

RDI procedures should only be used by trained EMDR clinicians and only after both screening for a dissociative disorder and a careful assessment of the patient's adult attachment status, affect and state change tolerance.

As in the use of standard EMDR procedural steps, it is essential to screen patients for a dissociative disorder before offering RDI. Use of RDI may put unprepared patients with dissociative disorders at risk of in-session or post-session disturbances. It is possible to use RDI with patients who meet criteria for a Dissociative Disorder, but this should only be considered in accordance with criteria described in Shapiro, 2001, Chapter 4 and Appendix B and the Guidelines of the International Society for the Study of Dissociation (<http://www.issd.org/indexpage/isdguide.htm>).

Also, some patients with histories of early neglect, who may present with a Dismissing or Unresolved-disorganized insecure attachment style (Main, 1996; Stein et al., 1998), have been reported as demonstrating inadequately developed capacities to tolerate and modulate positive affects. During RDI procedures, these patients may show no change or negative responses such as confusion or increasing anxiety due to rapid state changes. These patients also may show delayed negative after-effects from RDI procedures. Alternate strategies should be carefully considered in these cases.

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