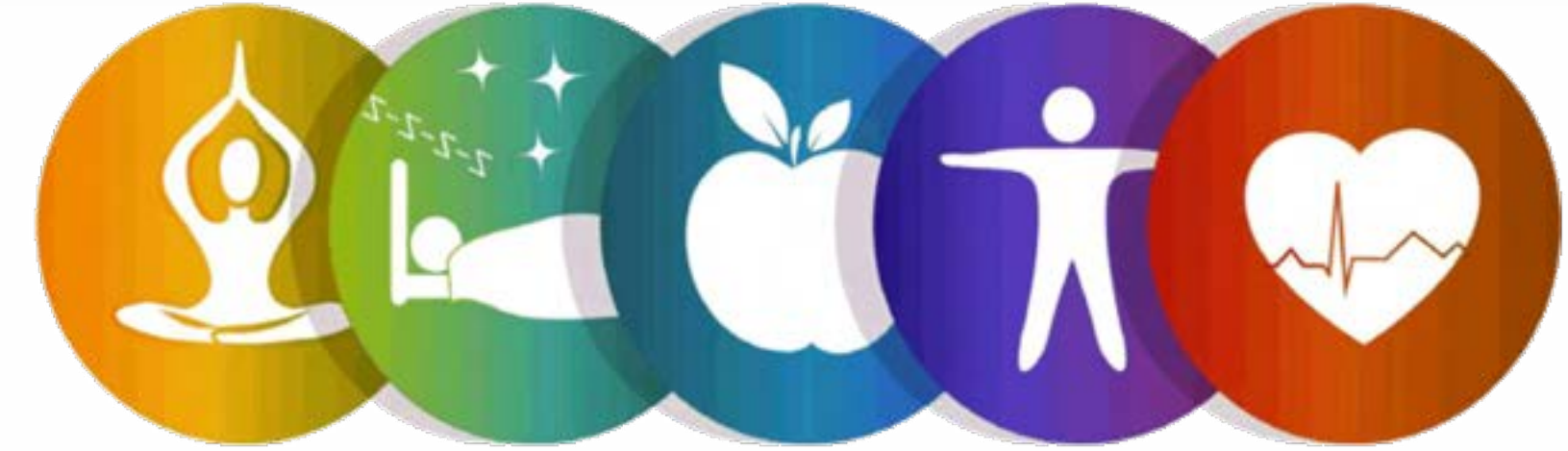
Repairing Attachment with Resource Development and Installation



Increasing access to capacities for
emotional and behavioral self-regulation

RDI Antecedents

- RDI was first proposed as a stabilization strategy for Complex PTSD and BPD by Leeds in 1997.
- Expanding earlier work by EMDR pioneers on the "Safe Place" and related strategies (See Foster et al., 1995; Greenwald, 1993a, 1993b; Lendl, 1997; Martinez, 1991; Wildwind, 1992)
- Leeds (1997) named and elaborated RDI.

Expanding the "Safe Place" exercise

RDI Foundations

- RDI is similar to Ericksonian ego strengthening (Frederick & McNeal, 1999)
- RDI looks **within** the patient for essential resources.
- RDI assists the patient to find their own solutions

The essence of RDI

- 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 (or taps or tones – slower than in standard EMDR reprocessing) are used to **enhance access to states of well-being** and **associations with and between positive emotional states and coping behaviors**.

The goals of RDI

- The two goals of RDI are to assist the person to be better able to make use of resource memories and images
- **To support emotional and behavioral self-regulation in daily life** and
- **To support synthesis of adaptive memory networks with maladaptive memory networks during reprocessing.**

- The goal is **not** to make resource memories and images more vivid. (See Leeds and Korn, 2012).

RDI Defined

- ***Resource Installation*** refers to using short sets of bilateral eye movement (taps or tones) at a slower speed than in standard EMDR reprocessing while the person focuses on sensory and somatic aspects of 1) a personal memory (of self or other engaged in adaptive coping responses) or 2) an image evoked from an internal source (e.g. a symbol or archetype) or 3) external image from a film, painting, photograph or from a book that represents adaptive coping responses.

RDI Defined

- ***Resource Development*** refers to the slow building up of the basic elements of adaptive coping responses through psychoeducation or exposure to and discussion of healthy models of coping responses from external sources (film, paintings, photographs, books, etc.).



- Many individual can directly engage in resource installation.

- Some can only do this after a period of resource development or other preparatory steps (such as the Positive Affect Tolerance protocol).

RDI – More than Attachment repair

- RDI can be used in a variety of ways
  - To directly address deficits related to **insecure attachment**
    - Negative self-image
    - Toxic shame
    - Impaired self-soothing
  - And for *non-attachment* related **coping skills** such as emotional and behavioral self-regulation
    - Boundary setting and assertiveness
    - Healthy risk-taking
    - Trusting one's own perceptions and speaking up

Variations of RDI

- Variations on RDI have been proposed including:
  - Imaginal Nurturing (Steele, 2001, 2003)
  - Somatic RDI (Leeds, 2002)
  - Best Foot Forward (Kinowski, 2002)
  - Developmental Needs Meeting Strategy (Schmidt, 2004, 2007)
  - Nurturing, Protective and Spiritual Resources (Parnell, 2006 – this follows the DNMS model)
  - The Absorption Technique (Hofmann, 2009)
  - Dyadic Resourcing (Manfield, 2010)

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Case Reports on RDI 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.

First Case Reports on RDI

- Korn and Leeds (2002) reported treatment of two patients with RDI and included an RDI script.
- Both patients met criteria for complex PTSD, major depressive disorder and borderline personality disorder.
- Weekly **behavioral measures** were taken during a three week history taking baseline, during six weeks of RDI and at a follow-up period at 10 weeks.
- Behavioral measures and standardized testing showed **clinically significant reductions on measures of depression, anxiety, avoidance, dissociation and global symptoms**.
- Without a no EM condition, the role of EM on treatment effects could not be evaluated.

First Report on RDI

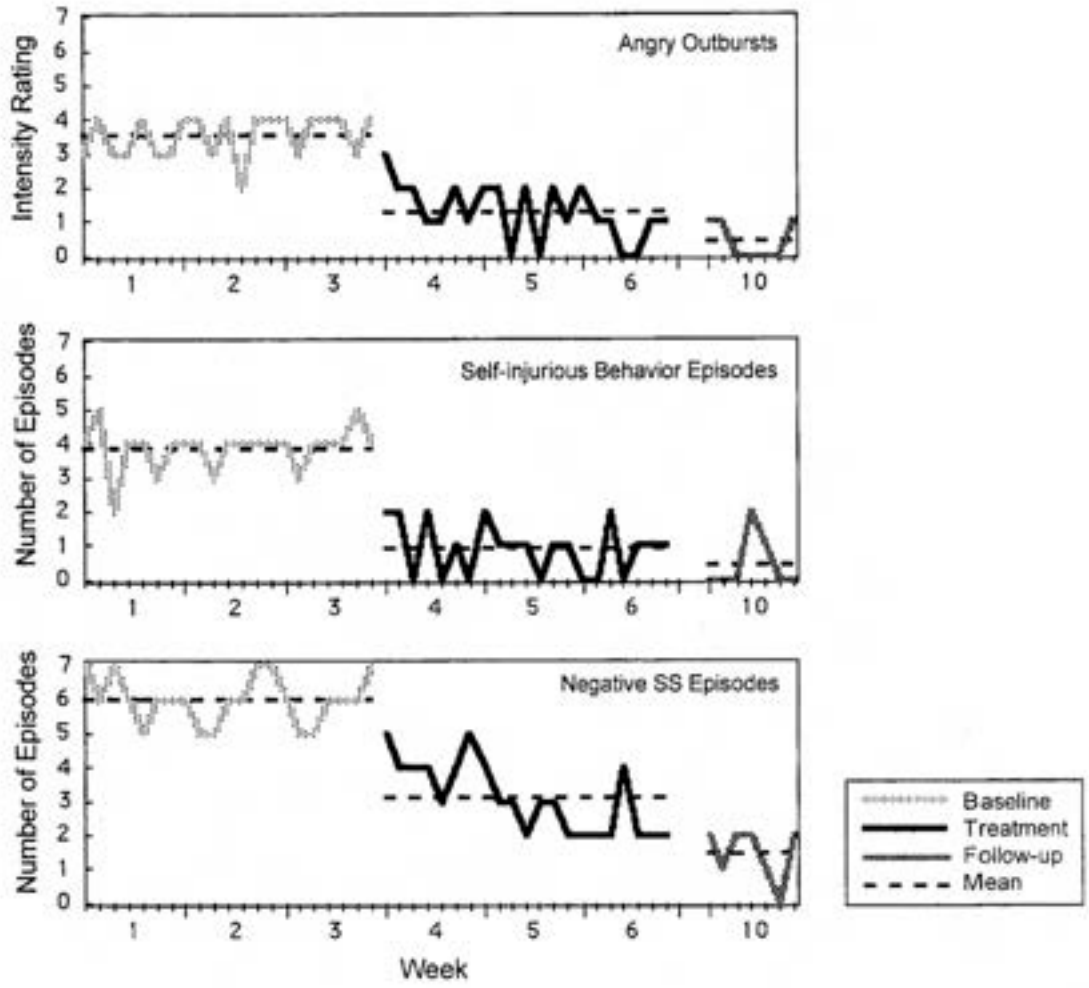


Figure 2. Patient 2 symptom alleviation across time. Angry outbursts (top), self-injurious behavior episodes (middle), and negative self-statement episodes (bottom) are shown for Patient 2 across three baseline weeks, three weeks of treatment, and one week of posttreatment follow-up.

Research Support for RDI (1 of 4)

- An experimental study by Ichii and Nakajima (2014) found that **slow** EM increased vividness and emotional intensity on positive imagery.

- Their results were inconsistent with an earlier experiment by Hornsveld et al. (2011) which used *fast* EM on experimenter selected positive images and found decreased vividness, pleasantness, and strength of quality.

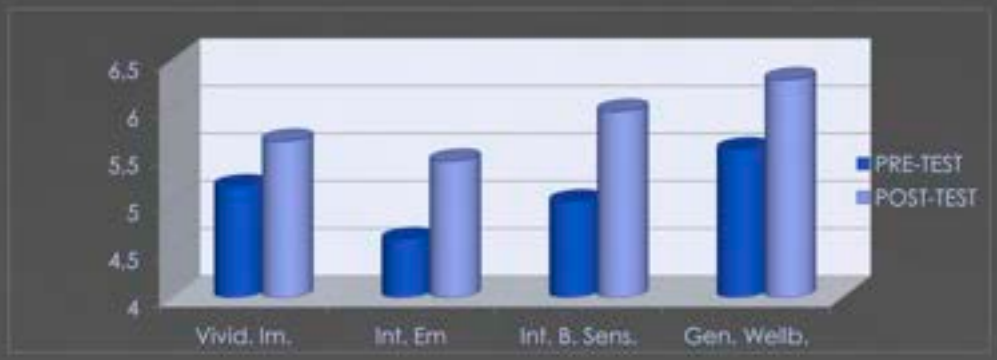
Both of these studies failed to investigate the main purpose of RDI, which is to make resources more **accessible** and to **improve** patients' emotional and behavioral coping skills.

Research Support for RDI (2 of 4)

- A randomized control trial of RDI with and without slow bilateral EM by Taboada et al. (2014) examined teen and adult responses to EM on individually selected positive memories. **Adults benefited from slow EM.** Teens in both groups showed similar benefits.
- Small sample size limits generalizability of findings.

DIFERENCES PRE-TEST VS. POST-TEST:

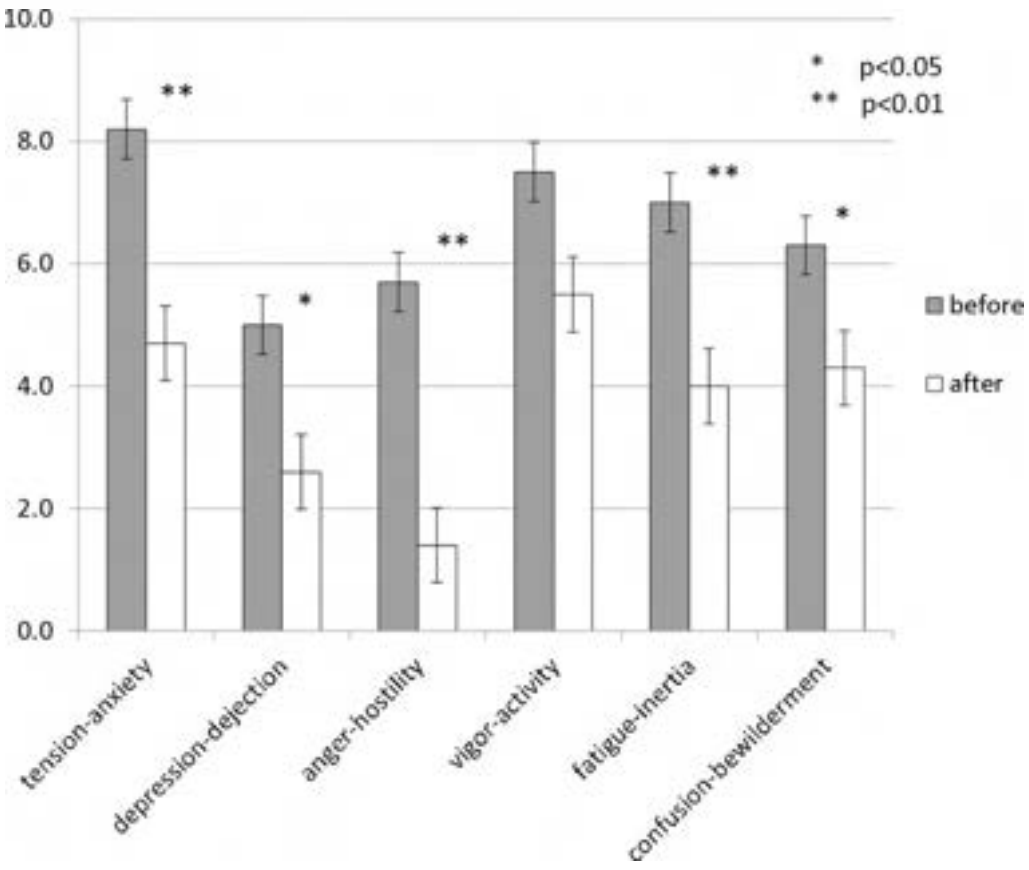
There are statistically significant differences in adults between pre and post-test in the eye movements (EM) group in the condition "vividness of image" (Sig.=0,038), "intensity of emotions" (Sig.=0,010), "intensity of body sensations" (Sig.=0,000) and "general well-being" (Sig.=0,004).



Research Support for RDI (3 of 4)

- An experimental Study with Near-Infrared Spectroscopy with and without BLS by Amano and Toichi (2016).
- Bilateral *tactile* stimulation increased memory accessibility and relaxation.

"**Clear differences between using and not using BLS were observed based on the subjective interview and the NIRS biological data. Our results indicated that using BLS increased the effectiveness of RDI over not using BLS.**" (p 9)



Research Support for RDI (4 of 4)

- A randomized clinical trial with wait-list control by Steinert et al. (2016a. 2016B) evaluated ROTATE which made use of RDI – with slow EM – calling it "resource activation."
- The clinical sample of 86 Cambodians with complex PTSD were given five weeks of wait list or ROTATE. There was no trauma confrontation.
- Results showed **clinically significant PTSD remission, reduced anxiety and depression with no trauma memory reprocessing**.
- These results clearly indicate RDI can be effective for enhancing resilience in those with complex PTSD.

Research Summary 1

- Laboratory research by Hornsveld et al. (2011) with **non-clinical subjects** using an **incomplete version** of the RDI procedure failed to provide useful information on two essential questions about RDI. See discussion in Leeds and Korn (2012).
  - Does BLS made the RDI procedure a more effective intervention?
  - Does RDI produce clinical gains for those Complex PTSD?

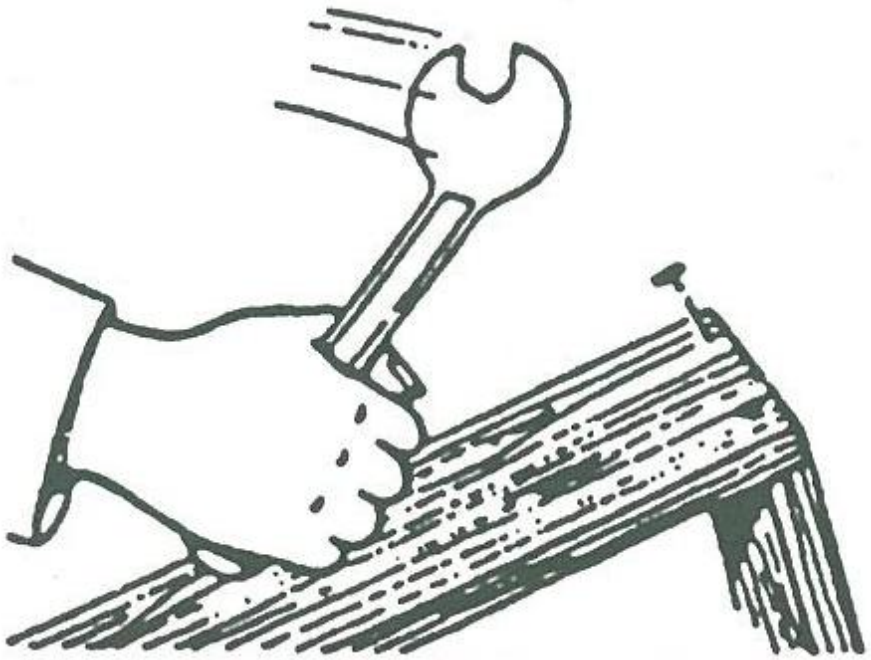
- **Controlled research with clinical subjects directly addresses these two questions.**

Research Summary 2

- **BLS enhances RDI effects.**
  - Using brain imagery (NIRS) and self-report Amano and Toichi (2016) showed BLS increased the effectiveness of RDI over not using BLS.
- **RDI produces stable clinical gains in Complex PTSD**
  - Steinert et al. (2016a, 2016B) showed resource activation compared with a wait-list control produced stable reductions in Complex PTSD symptoms using standard measures and without any trauma confrontation.

Questions - Comments?

Avoiding misuse of RDI



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 met standard EMDR readiness criteria for ego strength and stability had been offered multiple sessions of RDI without being offered standard EMDR reprocessing.

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 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 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.

Is stabilization needed?

- van den Berg, et al. (2015) studied treatment of PTSD in those with *a psychotic disorder or a mood disorder with psychotic* features using prolonged exposure, EMDR and waitlist (treatment as usual).
- The study reported it was possible to reduce PTSD symptoms without any specific stabilization intervention (such as RDI).
- This study is often cited as evidence that RDI or other stabilization interventions are not necessary for any patients to be treated with EMDR therapy.
- It should be pointed out that all subjects had been receiving TAU in the Netherlands for an extensive period of time including antipsychotic medication, treatment and/or supportive counseling and **were already medically and socially stabilized**.
- Such pre-treatment stabilization is generally not the case in most other countries' outpatient settings.

Is stabilization needed?

- In van den Berg, et al. (2015) D**ropout rates** were 24.5% in PE (a typical rate) and **20.0% in EMDR**.
- A subsequent re-analysis reported on the dropout rate for a combination of EMDR and PE subjects.
  - In the PTSD no-dissociative subtype group the dropout rate was **20.7%**.
  - In the PTSD, **dissociative subtype group the dropout rate** was **26.9%.**
- Consider dropout rates in other EMDR therapy for PTSD:
  - **Ironson, et al. (2002) 0%**
  - **Rothbaum (1997) 9%**
  - **Marcus, S., Marquis, P., & Sakai, C. (1997) 1%**
  - **Lee, et al., (2002) 17%**
  - **van der Kolk, et al. (2007) 17%**

The phase oriented model remains the standard of Care

Despite conclusions of a critical review de Jongh, et al. (2016) "The ISTSS Expert Consensus Treatment Guidelines For Complex PTSD In Adults" as currently posted on their website continue to state

> "The recommended treatment model involves three stages or phases of treatment, each with a distinct function. Phase 1 focuses on ensuring the individual's safety, reducing symptoms, and increasing important emotional, social and psychological competencies."
>
> (Cloitre, et al. 2012)

Also see Korn (2009) EMDR and the treatment of complex PTSD: A review.

When stabilization is needed before starting EMDR reprocessing for PTSD

- Patient cannot control tension reduction, avoidant or aggressive behaviors that involve risks 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.

Case 1 - Almost homeless again

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.

Indications for use of RDI before starting standard EMDR for PTSD

- Patient 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 session.
  - This inability to regulate anxiety (or other affects) leaves the patient vulnerable to emotional flooding or acting out during and between treatment sessions.

Case 2 - sleepless and alone

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.

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.

Case 3 - no one understands me

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 reprocessing at the 7th session.

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.

Case 4 - "No one can help me"

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.

Invalid reasons to use RDI before starting standard EMDR for PTSD

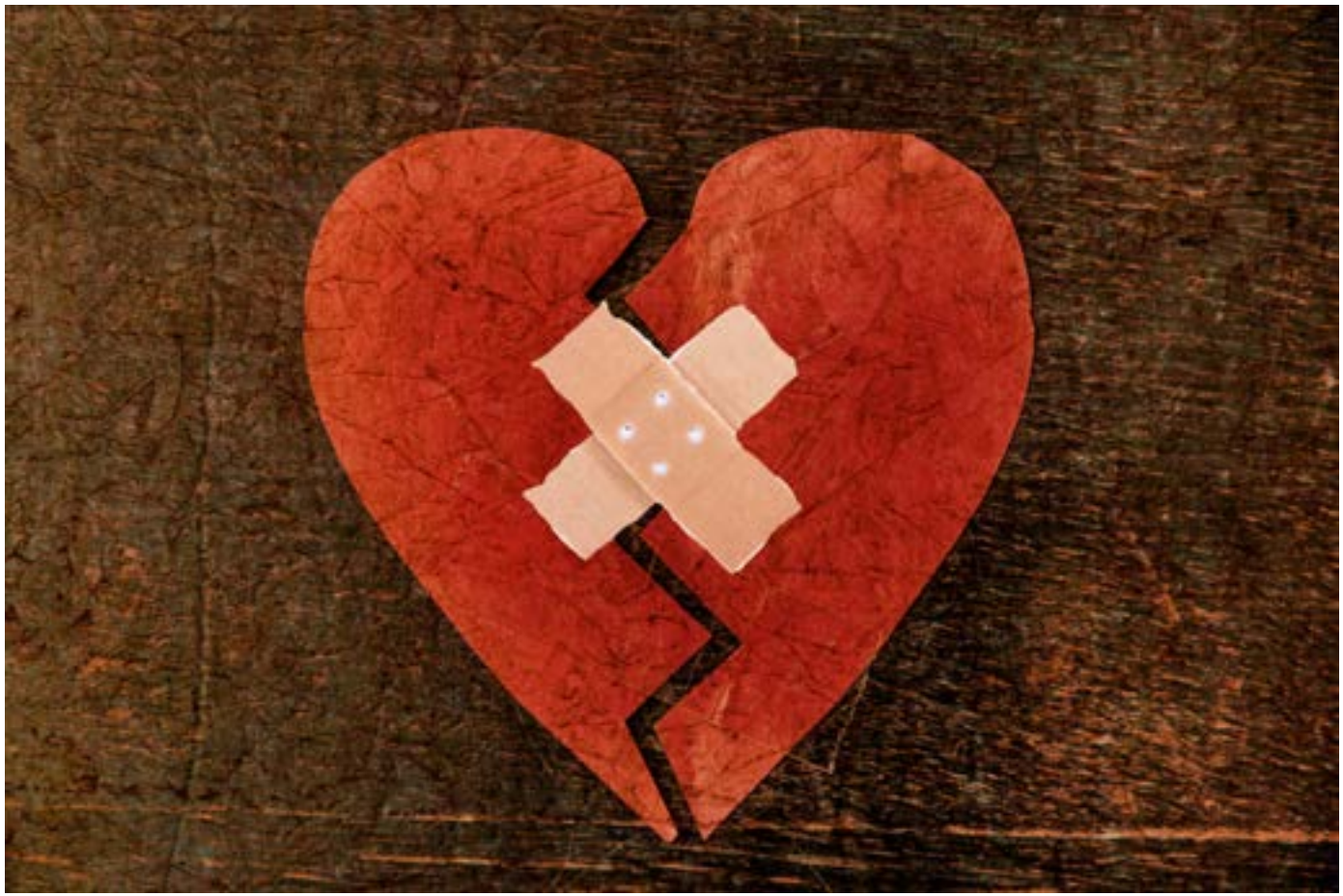
- The patient is clearly suffering from symptoms of PTSD, meets readiness criteria, and the clinician has:
  - A vague sense the patient is "unstable".
  - Anxiety about possible patient abreaction.
  - Aversion to the content of patient memories.
  - Preference for helping the patient to "feel good."
  - 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.

Case 5 - can't stand the pain

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.
- They never went on to reprocessing any of her trauma memories.

Case 6 - a stitch in time



Case 6 - "a stitch in time"

- A 33 year old woman requested EMDR therapy 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 reprocessing session anguishing as it triggered memories of her own mother's death of 8 years before. Treatment progressed slowly with no further reprocessing 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 reprocessing with her patient.

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.

Case 7 - I can't face that too

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.

Case 8 - lifting the burden of shame

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.

Screening before use of RDI

- 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.
- Note that low DES-II scores are inadequate evidence of an absence of a dissociative disorder when patients have early histories indicating chronic, severe, early neglect and abuse.
- 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.

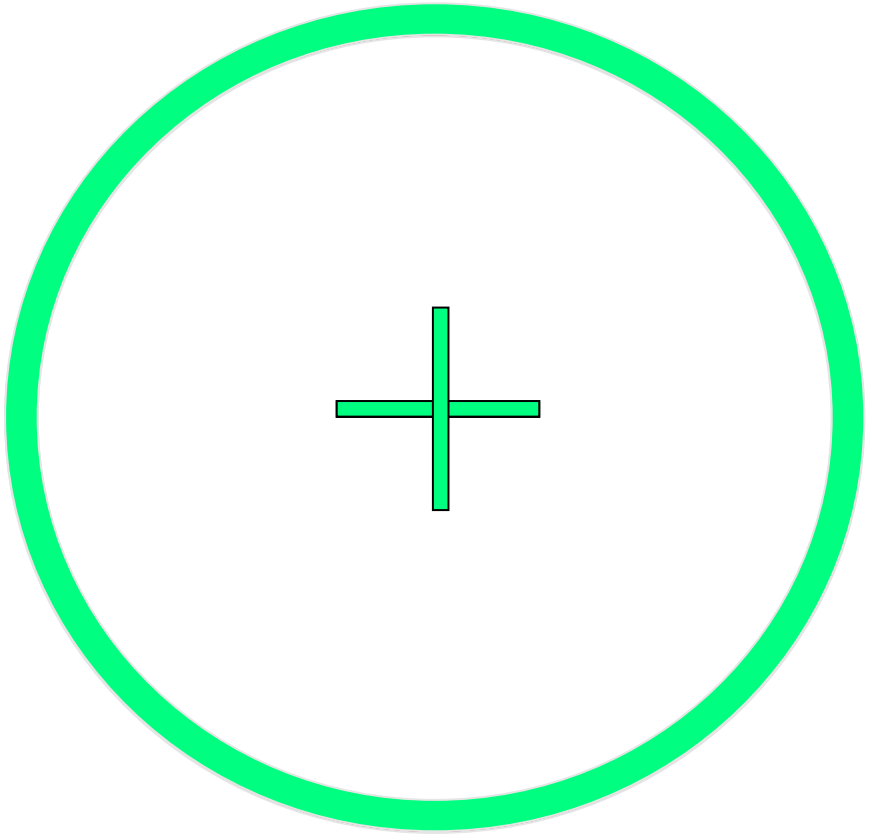
Case 9 - story time

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 emotional part 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.

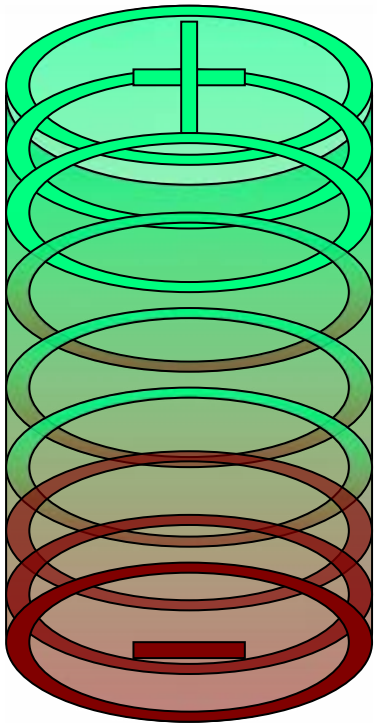
Resources are not static memories

Resources are not static memories



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

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.

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)
- Dearousal 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).

Questions - Comments?

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 imaginally 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.

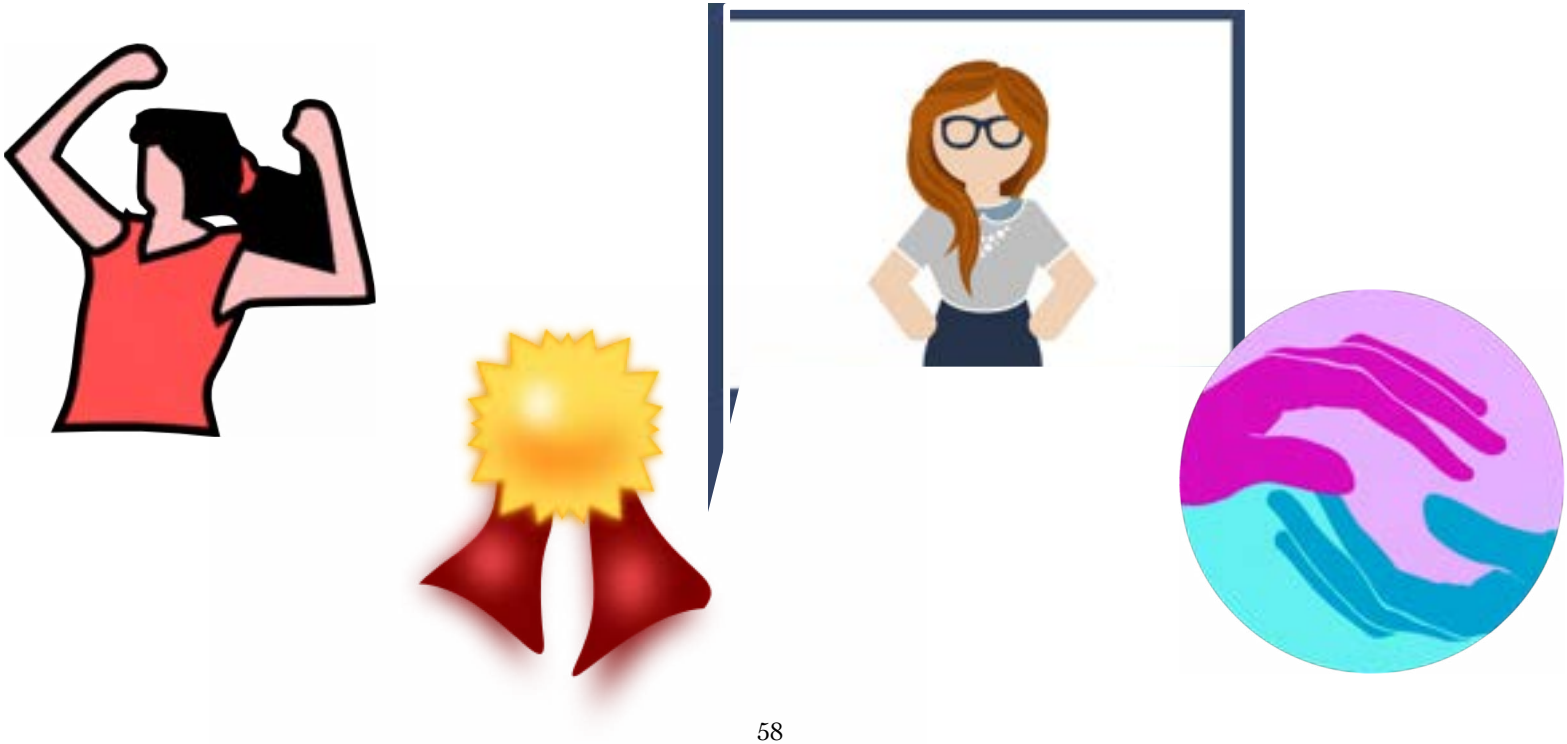
Three Domains from which to select resources

- Historically, hypnotic ego strengthening focused on mastery memories of past positive experiences of the individual. (Frederick and McNeal, 1999)
- Hofmann (2009) also limits the Absorption Technique to mastery memories.

- Since not all patient have ready access to relevant mastery memories, in developing RDI Leeds (1997) expanded this option to three domains from which to select resources:
  - Mastery
  - Relational
  - Symbolic

Mastery Memories

- Mastery experiences are memories of past successes and achievements, effective boundary setting, assertiveness, and self-care.



Relational Resources

- Relational resources are of two varieties

Supportive others have provided direct care, empathy, support, validation, mentoring, or guidance. There is a certain degree of implied dependence, trust, and direct relationship with supportive others.

Role models demonstrate ways of being and capacities that the patient wants to emulate. There need not be any direct contact or relationship with role models who can be historic or fictional figures, as well as individuals from the patient's community or extended family.

Symbolic Resources

Symbols can be derived from cultural, religious, and meta-physical sources as well as those that are generated directly by the patient from dreams, guided imagery, or art therapy.

Two Scripts Provided

- The one page Exhibit B6 "Basic Procedural Steps and Script for Resource Development and Installation" offers a simple script for patients who can easily identify a "positive resource, skill, or strength [that] will help you to deal better with this stressful situation".

- The four page Exhibit B7 "Detailed Procedural Steps and Script for Resource Development and Installation" provides a second detailed and "concrete" option for patients to describe what they would rather be able 1) **to do**, 2) **to believe about themselves** or 3) **to feel** in the target situation.

Explore all three domains perhaps in reverse order

- The detailed script explicitly explores mastery, relational and symbolic domains.
- For patients who report few mastery memories, clinicians may find these patients can more easily access resources by inquiring and installing resources in this order:
    - Symbolic
    - Relational
    - Mastery
- This option is also possible with the simple script.

Working with Predefined and Individualized Resources

- My own approach has always been to explore for and locate unique individualized resources to meet each patient's needs for their unique challenges.
  - Later, multiple resources can be combined in a "three-dimensional" framework.
- Other approaches work with predefined resource types.
  - Schmidt (2004), and later Parnell (2006), identifies a Nurturing Adult Self, a Protective Adult Self, and a Spiritual Core Self. These Resources are joined together to form a Healing Circle.

A possible typology drawn from Panksepp (2011)

- For seeking a comprehensive typology, it is possible to explore for resources to address each of the seven basic mammalian emotional circuits.
- SEEKING
- RAGE
- FEAR
- LUST
- CARE
- PANIC/GRIEF
- PLAY

Seeking

- The future self
- Independence - the right to self-determination
- Discovering one's identity
- The seeker

Rage

- Protector
- Warrior
- Body Guard
- Guardian Angel
- White knight
- Armor
- Shield
- Buffer
- Patron

Fear

- The observer
- The runner
- Dodging
- Sidestepping
- Evasion
- Breakout
- Liberator

LUST

- Mutual gaze with desire
- Sensual kissing
- Embracing with passion
- Sexual excitement
- Sexual vulnerability
- Release

CARE

- A positive mother, father or other parental figure
- A positive aunt, uncle, grandmother, grandfather etc.
- Guardian
- Ancestor
- A nurturing person
- A hidden spring

PANIC/GRIEF

- Allowing oneself to be seen
- Sharing one's emotional and needs with trusted others
- Allowing oneself to be held by a trusted other
- Accepting praise or appreciation from a respected other
- A mentor
- A trusted friend
- A spiritual or religious figure offering acceptance

PLAY

- Puppies at play
- Playing with blocks, Legos, play figures, dolls, etc.
- Playful team sport – hide and seek, etc.
- Building sand castles with friends
- Costume dress up – assuming an imaginary role

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. Toward the end of treatment to support a new self-concept, develop and install resources representing new, emerging perceptions of self.
   - Ask patient for a collage of gains from therapy: install each image, then install all together with a word or phrase representing gains.

Questions - Comments?


Thank You!