

Overcoming Client Resistance to Resource Development and Installation (RDI)

By Shirley Jean Schmidt, MA, LPC
EMDRIA-Approved Consultant

At the 1997 San Francisco EMDRIA Conference Andrew Leeds (1997) made a landmark presentation on Resource Development and Installation (RDI), in which he highlighted a surprising and dramatic shift in a chronically ill client following an RDI intervention. (A full description of this remarkable case study can be found in "Extending EMDR" [Leeds, 1998].) While Dr. Leeds concedes he is not the first or only proponent of RDI, he has certainly done more than any one else to popularize its use. The EMDR Institute has recognized its importance and now includes it in Level II trainings. RDI is a powerful psychotherapy tool. Its ego strengthening effects prepares clients for and lowers resistance to EMDR processing. In my experience, preceding standard EMDR with RDI can increase the likelihood of safe, simple, and successful trauma processing. Unfortunately, for a variety of reasons some clients resist RDI interventions. This article proposes a model for understanding such resistance.

This article begins with a discussion of some fundamentals of the ego state model, the Accelerated Information Processing model, and RDI, with emphasis on how these concepts are related to ego state therapy. This is followed by a brief explanation of how I introduce the ego state therapy model to clients. Finally, I describe several forms of RDI-resistance I have encountered and demonstrate how ego state therapy can be used to address and resolve these resistances.

Ego State Model

RDI is best understood in the framework of an ego state model. In most basic terms, ego states are specialized neural networks that hold specific packages of information related to behavior, emotions, sensations, and information about our life experiences (Braun, 1988). The notion of ego states has been around since Freud proposed an id, ego, and superego. The term "ego state therapy" was used by Watkins and Watkins (1997) for hypnoanalytic techniques used in the treatment of dissociative disorders. Many psychotherapy approaches touch on ego state theory principles, including Object Relations (Mahler, 1978; Kernberg, 1976; Kohut, 1978), Transactional Analysis (Berne, 1961), and Internal Family Systems (Schwartz, 1995), just to name a few. These psychotherapy approaches have in common the idea that different personality parts (ego states) can have different views of reality (for better or worse), and that the relationships between these parts (whether cooperative or conflicted) can be therapeutically significant. Their aim is to increase integration and healthy cooperation between personality parts.

Accelerated Information Processing Model

Francine Shapiro's (1995) Accelerated Information Processing model posits that trauma information is stored in an isolated neuro network¹, and therefore lacks the ability to integrate with therapeutically relevant information stored in other neuro networks. Her model suggests that EMDR links up these neuro networks, resulting in insight and healing. In ego state terms, the ego state(s) holding the trauma *problems* are isolated from the ego state(s) holding the trauma *solutions*. Linking these ego states (with EMDR) results in an adaptive trauma resolution.

Resource Development and Installation

RDI focuses attention on ego states holding the trauma solutions. Since these are the neuro networks to which the trauma must link, it makes sense to highlight them in advance of trauma processing. RDI can help the client feel better prepared for trauma processing. It is also an excellent stand-alone intervention with potential to significantly reduce disturbing symptoms.

¹ The term *neuro network* used by Francine Shapiro (1995) subsumes the neuropsychologist's term *neural network*, and implies an additional strata of cognitive/emotional processing. Unlike a neural network, a neuro network does not have a precise neurophysiological referent.

How RDI is done: The client is invited to think about personally meaningful positives associated with a felt sense of well being. These personal positives may take the form of (a) positive personal experiences of self-soothing, self-efficacy, self-acceptance, courage, etc.; (b) positive self-acknowledged traits such as an ability to be nurturing, compassionate, understanding, resourceful, etc., and/or (c) positive memories or meaningful images of receiving nurturing, compassion, trust, respect, etc. It is best to strengthen resources from the client's own personal experience, but when that is not fruitful it may be helpful to use personally meaningful images and/or characters from books, stories, TV, film, religion, metaphors, etc. Alternating bilateral stimulation is used to strengthen these positive ego states and enhance their accessibility.

We would expect all clients to have a great affinity for RDI - after all it's 'feel good' work. They should be glad we are not dragging them through their traumatic history, descending in highly disturbing material, or asking them about those unpleasant things they believe about themselves. Instead we're asking about the good stuff, fun stuff, the stuff they would be proud to share with their grandchildren. Why then do certain clients resist RDI and what can we do about it?

Introducing the Ego State Therapy Model

I introduce the ego state therapy model to all my clients relatively early in treatment. Bergmann and Forgash (1998) assert that ego state work early in therapy can minimize the risk of treatment failure and can transform many EMDR non-responders into EMDR success stories. While some clinicians think of ego state therapy as an intervention reserved for dissociative disordered clients, I've found it helpful for all my clients, whether highly dissociative or not.

To familiarize clients with the ego state model I briefly describe three points on Watkins and Watkins (1997) differentiation-dissociation continuum. One end of the continuum (adaptive differentiation) is characterized by good communication and cooperation between parts. A middle point (defensive dissociation) is characterized by both good and poor communication, and both alliances and conflicts between parts. The other end of the continuum (pathological dissociation) is characterized by a predominance of ego state conflicts and amnesia between parts. I tell clients that most people fall somewhere in the middle and that ego state therapy helps move clients towards good communication and cooperation between ego states. I find that most clients appreciate ego state theory for providing a helpful framework for understanding apparent contradictions between their self-affirming and self-defeating parts, their hopeful and hopeless parts, their optimistic and pessimistic parts, and so forth.

Addressing RDI Resistance

There are many reasons a client may fear or resist RDI. At one extreme, resistance may be due to a simple misunderstanding, resolvable in a few minutes with an appropriate metaphor. At the other extreme it may reflect a deep-seated, fundamental fear of change, requiring complex, in-depth ego state work over many months. Below I describe four flavors of RDI resistance, including fear of invalidation, fear of losing valued coping strategies, fear of losing internal consistency, and the presence of specific beliefs counter to RDI. I propose strategies for addressing each type of resistance. This is not intended to be a complete and comprehensive coverage of this topic. It would not be possible to cover all contingencies in a single article.

Fear of Invalidation

One possibility for RDI resistance is the client's misconception that resource-focused work means a minimizing, discounting, or invalidation of the trauma. Many trauma survivors have been told to "think positively" (a euphemism for "get over it"), so this fear is understandable. This may be easily remedied with the correct metaphor. Here are three metaphors that have worked in my clinical practice.

Restoring an Old House

Restoring an old house can involve solving many problems by the application of resources. The owner may know how to fix the roof (resource: personal knowledge), but may hire someone to fix the plumbing (resource: money). Just having resources does not solve a problem, the resources must be actively applied to

the problem. RDI is about identifying available resources so they can later be actively used to help other ego states.

Actor in the Spotlight

Imagine a stage with many actors playing their roles. Sometimes the spotlight shines on just one. The roles of the actors outside the spotlight are still vital and important. RDI is about spotlighting resources in order to increase their readiness to help other ego states. It is not about spotlighting resources to eclipse, drown out, or minimize other ego states.

Operating Room

A patient wheeled into an operating room will want to know everything her surgeon needs (lights, knives, nurses, equipment, sutures, etc.) is there. A prudent surgeon is properly prepared, with all needed resources ready to go. RDI is part of prudent preparation for trauma "surgery".

Fear of Losing Valued Coping Strategies

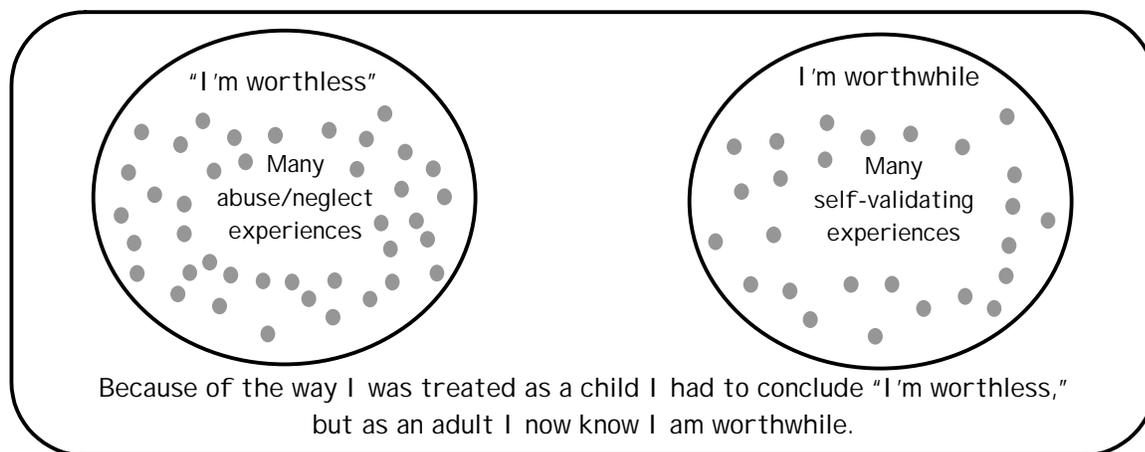
Better to have a dysfunctional coping strategy than none at all. For that reason I address clients' fear of losing familiar coping strategies by introducing the idea of "trading up." This means moving in safe increments from dysfunctional coping strategies to more and more adaptive ones. I advise clients to hold on to their old familiar ways as long as they feel they're needed. I explain that RDI processing will put alternatives out for consideration, but caution them not to embrace any alternative until it truly feels SAFER to do so. An example of transportation trading up, would be going from 'walking barefoot' to 'walking with shoes' to 'riding a bike' to 'driving an old VW' to 'driving a new car'. I offer that riding a bike feels much safer than walking barefoot and the idea of giving up a bike should naturally be upsetting to someone who doesn't understand how much better a VW could be. Clients express great relief when I grant them permission to change at their own rate – a rate that minimizes fear and uncertainty.

Fear of Losing Internal Consistency

A person living in the Middle Ages takes it for granted the earth is flat. This "truth" is internally consistent with all available evidence, including personal observation, cultural assumptions, religious decrees, and popular science. When an astronomer like Galileo makes a case for a round earth, he can be easily dismissed because clearly, if the earth was round everyone would fall off. His new theory must successfully reframe the old assumptions while integrating the new scientific findings, in an easily believable way. Only then can a new, internally consistent theory for the shape of the earth replace the old.

As I see it, children may develop isolated, but internally consistent, ego states from available internal and external information. An abused child's belief of "I'm worthless" may serve her well by helping her make sense of her trauma. "Ah ha, I'm being hit by mommy because I'm worthless... now it makes sense." Such a negative belief may serve as glue to hold together otherwise non-integratable information. RDI may be perceived by some clients as a process of forcing new and contradictory information into a long-standing, internally consistent ego state (however dysfunctional) – rendering it hopelessly confused. If a client fears RDI will result in unresolvable confusion, resistance will follow.

To counter that fear I'll draw a concept map on my white board. My intent is to make it easy for the client to understand we will be going from two smaller internally consistent frameworks to one larger, internally consistent, framework. I start by drawing a circle to represent an ego state associated with a sample negative cognition (NC) such as "I'm worthless." I'll write the NC inside the circle then place dots in the circle to represent an abundance of abuse and neglect experiences over many developmental years. (I'll put the negative cognition in quotes to distinguish it as a idea that can *feel*/true as opposed an idea that *is* true.) I'll point out the internal consistency and apparent validity of the NC within the context of many traumatizing experiences. Next I'll draw a circle to represent an ego state associated with a sample positive cognition (PC) such as "I'm worthwhile." I'll write the PC inside the circle then place dots in the circle to represent experiences or observations one might have, which would support such a PC. I'll point out the internal consistency and validity of the PC within the context of these positive experiences.



Most clients can relate to this graphic. I'll marvel with them about the mystery of feeling at times like a worthless person and at times like a worthwhile person - forcing the question "which is true, worthless or worthwhile?" There may be clear evidence of both – but how can they both be true when the beliefs are contradictory? I'll propose that perhaps our brain has the capacity to store contradictory information in different, isolated neuro networks, such that whenever a neuro network is activated the associated beliefs feel true.

Next I'll draw a box around both circles and offer that it might be possible to integrate both ego states in a way that maintains internal consistency. I'll propose an overarching PC that might safely integrate all the information, such as "Because of the way I was treated as a child I had to conclude 'I'm worthless,' but as an adult I now know I am worthwhile," and I'll write it inside the box. I explain that safe integration of traumatized ego states is our ultimate goal. I'll ask how it feels in the body to consider this. Usually clients respond favorably. I further explain that in order to accomplish this we will focus some attention on both traumatized and resource ego states, focusing first on the most mature adult ego states (which is, of course, RDI).

RDI-Blocking Beliefs

One way to identify RDI-blocking beliefs is to ask, "If I could wave a magic wand and suddenly it felt safe for us to focus on your positive traits, would that be a good thing or a bad thing? Let your body answer." If body feels disturbed then there's probably a blocking belief. Then I'll ask, "What's that disturbance about?" They can usually identify their resistance as coming from a specific belief, such as: "If I focus on positives about myself I'm too self-centered," "I'm so bad I don't deserve to feel good," "If I feel good something bad will happen," or "There's nothing good about me." Some of these beliefs will be more challenging to navigate than others.

One ego state often strongly committed to RDI-blocking beliefs is the Critic. The Critic is (usually) a parental introject that critiques the host's thoughts, feelings, and actions. It is a child ego state mimicking a not-so-skilful adult. Life can be like driving a car – sometimes we need to accelerate and sometimes we need to brake. The Critic's job is to apply the brakes – most often accomplished through unbridled criticism, intimidation, and shame. In my experience the Critic has good intentions and honestly wants to help the host feel safer. She uses the only strategy she knows, which she cannot see is counterproductive. The Critic ego state is a good example of an isolated neuro network. To reduce the isolation I work to make a cooperative connection between the Critic and other relevant ego states. The child Critic needs a good adult role model to provide understanding, compassion, and validation. Once the Critic feels sufficiently validated and understood she can begin to reflect on the outcome of her actions, which can ultimately lead to a change of strategy. Ironically, connecting the Critic to a nurturing adult is a form of RDI. Below is a typical dialogue between therapist and Critic, which might be used to accomplish this. Depending on the client's ego

strength and affect tolerance skills, I might use alternating bilateral stimulation throughout the dialogue, or just at the end to strengthen a positive outcome.

Therapist: It makes perfect sense to me that you would be highly critical of Jane. Considering the role model(s) you had during childhood it makes sense to me you would speak to her this way. I assume you hope to keep her safe by being so critical of her – and I appreciate that intention. You've certainly been devoted to Jane for a long time – doing the best you know how to make her life better. I'll bet this strategy really helped a lot when she was little.

Critic: Yeah it did, thanks, I've never been appreciated for my hard work before.

Therapist: I'm just curious, what if, when you were born, you'd had a choice of being born to your hypercritical parents, or parents who were very kind, patient, and nurturing? Remember, you would eventually mimic your parents, whoever they are. Would you rather be mimicking the critical parents you had or kind and patient parents?

Critic: Kind and patient parents, of course!

Therapist: I can understand that. So what if it were possible to adopt a new parental role model now – one who could treat you now the way you wanted to be treated growing up? Would you be interested?

Critic: Sure.

Therapist: Great. Think of a time your mom or dad criticized you.

Critic: When I was in grade school my mother would sit with me every night when I did my homework. Her favorite subject was math, but I hated it. She was so impatient. When I didn't understand something right away she would yell at me... call me stupid. Eventually she would end up doing my homework for me. I hated her for that.

Therapist: Wow, what a powerful role model for criticizing Jane. How would you like to have been treated?

Critic: I wish she'd encouraged me. I was stressed enough already ... but she made it worse. Doing math with her was a nightmare. I probably could have learned it well enough if she'd just been nice.

Therapist: Close your eyes and imagine a nurturing mom saying to you the words you most needed to hear then.

Critic: She'd say, "Janie, it's okay. You're a good kid. I know you're frustrated... just do the best you can. You don't have to be perfect. Take as much time as you need. I'll be here for you if you have any questions."

Therapist: How does it feel in your body to hear these words?

Critic: It feels weird... and sort of good, but I'm not sure I deserve this?

Therapist: What would a nurturing mom say if you told her you didn't deserve to hear these words?

Critic: She'd say, "Of course you deserve kind words, you're a good kid dealing with tough home work."

Therapist: How does it feel in your body to hear these words?

Critic: It feels good, but very strange.

I'll further validate the Critic by offering examples of how, as a child she may have prevented a critical tirade from mom or dad, by preempting with hypercritical self-talk. I'll shine the most positive light on the Critic to get other ego states to see and appreciate the Critic's good intentions. As this understanding spreads through the system of parts the Critic may begin to feel some safety connecting to other ego states. It then becomes possible to direct attention to strategy changes – such as helping the Critic shift from a counterproductive mode to a more productive mode of interacting with other parts.

I may explain to the Critic that an optimal amount of internal criticism will get the optimal outcome. Both too little and too much self-criticism is counterproductive. This information is both validating and helpful. Validating in the sense that the Critic already knows that too little self-criticism creates problems, but does not yet know that too much can create problems too.

Next I'll get ego states who've been traumatized by the Critic to respectfully suggest preferred interactions. For example, I might say, "Jane, can you tell the Critic how you feel about the way she talks to you?" Jane to the Critic, "When you insult me I want to curl up and die... I definitely don't want listen to you, or do what you say." "Thanks Jane, now can you tell her how would you prefer her to talk to you?" "I wish you would just ask nicely. Sometimes a tap on the shoulder is reminder enough." This is often accompanied by reactions from the Critic such as "Wow! I'm shocked, I had no idea!" This feedback tells me that important neuro network links are being made. When this is successful, clients report feeling calmer and more integrated. This is an excellent experience to strengthen with alternating bilateral stimulation. The hypercritical habit can be a hard one to break. Sometimes it takes many such sessions to build safe and respectful bridges between the Critic and other ego states, but it is clearly worth the effort.

Once it appears the Critic has begun to integrate with other ego states, and this is enhanced by alternating bilateral stimulation, I'll ask "Now, if I could wave a magic wand and suddenly it felt safe for us to focus on your positive traits, would that be a good thing or a bad thing?" I may find more layers of resistance associated with the first blocking belief, I may find another RDI-blocking belief (perhaps associated with another ego state), or I may find the client now ready for RDI.

Closing Remarks

This article is intended to increase awareness of the RDI-resistant client rather than be a complete and comprehensive coverage of this topic. I offer these ideas as suggestions only – these interventions may not be sufficient to overcome all RDI resistance. Clinicians who choose to navigate the ego state labyrinths should let their creativity and good clinical skills guide them.

I welcome comments and discussion about the contents of this article. I can be contacted at (210) 561-9200 and sjschmid@netxpress.com. Special thanks to Carol Forgash for helping me write this article.

References

- Bergmann, U. & Forgash, C. (1998) Working successfully with apparent EMDR non-responders. Presentation at the 1998 EMDRIA Conference.
- Berne, E. (1961). *Transactional analysis in psychotherapy, a systematic individual and social psychiatry*. New York: Grove Press.
- Braun, B. (1988). The BASK model of dissociation. *Dissociation*, 1, 4-23.
- Kernberg, O. (1976). *Object relations theory and clinical psychoanalysis*. New York: Jason Aronson.
- Kohut, H. (1978). *The search for the self (Vols. 1 & 2)*. New York: International Universities.
- Leeds, A. (1997). *In the eye of the beholder: Reflections on shame, dissociation, and transference in complex post-traumatic stress and attachment disorders*. Presentation at the 1997 EMDRIA Conference.
- Leeds, A. (1998). Lifting the burden of shame: Using EMDR resource installation to resolve a therapeutic impasse. In P. Manfield (Ed.) *Extending EMDR*. New York: Norton.
- Mahler, M.S. (1978). *On human symbiosis and the vicissitudes of individuation*. New York: International Universities.
- Schwartz, R. C. (1995). *Internal family systems therapy*. New York: Guilford Press.
- Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.
- Watkins, J. G., & Watkins, H. H. (1997). *Ego states: Theory and therapy*. New York: Norton.