

## **The Implementation of Resource Development and Installation (RDI) for an Adolescent with Non-Suicidal Self Injury (NSSI)**

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## **The Implementation of Resource Development and Installation (RDI) for an Adolescent with Non-Suicidal Self-Injury (NSSI)**

This study examines the application of Resource Development and Installation (RDI) for Non-Suicidal Self Injury (NSSI) as applied to the case of a 16-year-old female adolescent using pre- and post-test design. NSSI, negative feelings and positive resources were assessed before and after RDI sessions were provided. RDI is the second phase of Eye Movement Desensitization (EMDR) therapy provided to a client for psychological stabilization before trauma confrontation sessions. During RDI, the therapist facilitates the client in identifying positive emotions and positive coping strategies to be used when facing problematic or challenging situations that trigger negative emotions. In this study, we applied two RDI techniques to activate and strengthen the client's positive resources: Point of Power and Absorption Technique. The purpose of the RDI application is to reduce the NSSI by increasing positive resources and decreasing negative feelings, especially anxiety. After the RDI session, the client reported an increase in positive resources and a decrease in negative feelings as evidenced by a decline in scores of the Harvard Trauma Questionnaire (HTQ), the Hopkins Symptom Checklist (HSCL), and the Child Behavior Checklist for Age 4-18 (CBCL/4-18). The client also reported a positive change in behavior, as she feels more able to regulate her negative feelings by diverting her mind into a positive direction and perceiving her feelings more positively.

Keywords: adolescent; Resource Development and Installation; Point of Power; Non-Suicidal Self Injury

### **Introduction**

*Non-Suicidal Self injury* (NSSI) is defined as deliberate and direct destruction of body tissue without the intention to die; it is not a suicidal attempt (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006; Kerr, Muehlenkamp, & Turner, 2003; Peterson, Freedenthal, Sheldon, & Andersen, 2008). The etiology of NSSI falls into three categories: social, biological and psychological (Whitlock & Rodham, 2013). The social factor views NSSI as an attention-seeking behavior or attempt to connect socially. The primary focus of the biological factor is the NSSI function within the regulation of an endogenous opioid (Whitlock & Rodham, 2013). The psychological factor sees NSSI as functional or purposeful, such as to remove or avoid punishment from others (negative social reinforcement), to gain access to resources or gain affection from others (positive social reinforcement). Psychological factors of NSSI are based on traumatic events experienced by the individual. Farber (2000) concluded that any form of self-injury always conveys personal trauma. Moreover, Yates (2004) stated that self-injury is a compensation strategy for adapting to regulation and relational problems resulting from individual deficits in adaptive function caused by traumatic experiences. Trauma is not only caused by severe and dreadful experiences, but also from subtler yet destructive experiences such as verbal abuse, emotional neglect, and any form of behavior implying that a child is not worthy of love and affection (D'Onofrio, 2007).

The *Adaptive Information Processing* (AIP) model shows that belief, behavior, and negative personality traits are outcomes of stored dysfunctional memory related to traumatic events (Oren & Solomon, 2012). Furthermore, Shapiro (2007) added that stored dysfunctional memory also

inhibits an individual's access to the memory of positive experiences. Memories of traumatic events create a difficulty for an individual to feel positive emotion because the positive memories are inhibited. Thus, the person is dominated by negative emotions elicited by negative events. As a result, maladaptive behavior such as NSSI emerges as a coping strategy for the trauma-induced feelings.

There are diverse interventions available for trauma-related disorders, including trauma-focused Cognitive Behavioral Therapy (CBT), problem-solving therapy, and dialectical behavior therapy (Turner, Austin, & Chapman, 2014). However, research conducted by Klonsky and Muehlenkamp (2007) suggested that individuals who engage in NSSI experience more intense negative emotions in everyday life compared to those who do not engage in NSSI. As explained by the AIP model, negative emotions caused by traumatic events inhibit an individual's access to positive memories and feelings. Therefore, to treat a client with NSSI, the intervention must not only decrease negative effects but also strengthen positive resources.

The strengthened positive resources are expected to facilitate individuals in accessing their memories of positive feelings. In turn, memories associated with traumatic events and negative feelings will not dominate the individual's mind. The term 'Resource' in EMDR refers to a) ego resources, abilities used to connect to or relate with the outside world, and b) self-capacity, the ability to maintain consistent positive self-esteem and self-identity (Leeds, 2009). Consequently, RDI is assumed to be an effective intervention for NSSI. Furthermore, as compared to CBT, the amount of time needed for RDI is relatively shorter, as it is commonly held over 2 to 4 sessions and does not require plentiful homework (Adler-Tapia & Settle, 2008).

RDI is the psychological stabilization technique that comprises the second or preparation phase of eight EMDR therapy phases. EMDR is a psychotherapeutic intervention for trauma-related disorders or clinical problems caused by adverse life situations (Shapiro, 2009). RDI refers to a set of protocols that focus primarily on enhancing positive memory resources, while deliberately avoiding stimulation of the dysfunctional traumatic memory networks (Korn & Leeds, 2002; Leeds & Shapiro, 2000). In general, resources are developed through caregivers and authority figures modeling activities and setting and enforcing rules with explanation of the moral reasoning underlying the rules (Leeds & Shapiro, 2000). RDI helps clients find essential resources they need to help them identify memories associated with positive emotions and adaptive coping strategies that provide solutions (Frederick & McNeal, 1999).

In this study, two types of RDI were implemented to a client with NSSI. The first was the RDI Point of Power, which worked to activate and strengthen the client's positive resources. During this RDI type, the client is trained to remember all previous positive feelings related to positive experiences. The second was RDI Absorption; this was delivered to facilitate the client's ability to identify their positive resources. Positive resources include *experiences and images, relational resources, metaphors, and symbols*. Having positive resources to refer to helps clients when they encounter psychological or emotional problems.

## Methods

### Participant

The participant in this study was a female teenager; we refer to her as N. Her age at the time of intervention was 16 years, 5 months. She has been engaging in NSSI for the past five months, at

least twice a week. She performs NSSI every time she feels anxious about academic and peer problems, which include 1) unsatisfactory school exam results; 2) difficult school assignments; 3) failing an admission test for a science major classroom in high school; 4) whether or not she will graduate and be accepted in university; 5) negative rumors about herself; and 6) anxiety that rumors will spread around school. She feels neglected and less favored by her parents, especially her mother. She reported that since she was in third grade, her mother has been very busy and was often away on business trips. While in junior high school, she felt that her mother and sibling frequently criticized her academic performance and her limited number of friends. Her complaints and symptoms met the criteria of NSSI as stipulated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5<sup>th</sup>; American Psychiatric Association, 2013).

### Research Design

A pre-test-post-test design was employed in which the participant was assessed before and after delivery of the intervention program to evaluate the program's effectiveness (Graveter & Forzano, 2009). The post-test was taken twice (in week 1 and week 3) after the intervention was provided.

#### *Intervention target and indicators of target achievement*

The general aim of this intervention program was to decrease the frequency of NSSI thoughts and behavior through:

- a. Increasing the client's positive resources, evaluated by two indicators: *Subjective Unit of Comfort (SUC)* with a targeted *Validity of Cognition (VOC)* score of  $\geq 5$ .
- b. Decreasing the client's negative feelings, particularly anxiety, indicated by a decline in *Subjective Unit of Disturbance (SUD)* with a targeted *VOC* score of  $\geq 5$ .
- c. Increasing the quantity of positive feelings identified by the client, and latency decline in identifying positive resources.

The increase in positive resources and decline in negative feelings are also indicated by the decline in the client's maladaptive behavior, as shown in the regression of her Harvard Trauma Questionnaire (HTQ) score, Hopkins Symptom Check List (HSCL) score, and Child Behavior Check List for Age 4-18 (CBCL/ 4-18) score in post-tests 1 and 2. In addition, the client's improvement in observed/perceived behavior was also evaluated by her family and confirmed by the client herself.

### Measures

In this study, eight instruments were employed during the RDI sessions at pre- and post-test sessions (see Table 1).

**Table 1**  
**Instruments applied in the RDI sessions.**

Instruments	Session	Activity
Child Behavior Checklist for ages 4-18 (CBCL/4-18) Hopkins Symptom Checklist (HSCL) Harvard Trauma Questionnaire (HTQ)	1	History taking and pre-testing
Subjective Unit of Comfort (SUC) Validity of Cognition (VOC) Outcome Rating Scale (ORS) Session Rating Scale (SRS)	2-5	RDI Point of Power

**Table 1, cont.**  
**Instruments applied in the RDI sessions.**

Instruments	Session	Activity
Subjective Unit of Disturbance (SUD) Validity of Cognition (VOC) Outcome Rating Scale (ORS) Session Rating Scale (SRS)	6-7	RDI Absorption
Child Behavior Checklist for ages 4-18 (CBCL/4-18) Hopkins Symptom Checklist (HSCL) Harvard Trauma Questionnaire (HTQ)	8	Post-test 1
Child Behavior Checklist for ages 4-18 (CBCL/4-18) Hopkins Symptom Checklist (HSCL) Harvard Trauma Questionnaire (HTQ)	9	Post-test 2 and follow-up

*Child Behavior Checklist for Ages 4-18 (CBCL/4-18)*. CBCL/4-18 is an instrument developed by Achenbach (1991) to measure client competence and problematic behavior. CBCL/4-18 is comprised of two subscales: the Competence scale and the Problem scale. However, this study only utilized the Problem scale. The Problem scale contains 112 items divided into six categories of internalized and externalized behavioral and emotional problems. Internalized problems include withdrawn behavior, somatic complaints, anxiety, and depression. Externalized problems include delinquency, aggressive behavior, social problems, thought problems, attention problems, and sex problems. CBCL/4-18 is completed by the parents or caregiver, with each item scored on a scale of zero to two, where zero is Not True; one is Somewhat or Sometimes True; and two is Very True or Often True. A study conducted by Nakamura et al. in 2009 indicated that when the CBCL/4-18 score is favorable, the value of Cronbach's  $\alpha$  ranged from 0.71 to 0.89.

*Hopkins Symptom Checklist (HSCL)*. HSCL is a self-report inventory established by Parloff, Kelman, and Frank (1954; see also Lhewa et al., 2007) to assess anxiety and depression symptoms. HSCL encompasses 25 items divided into two subscales: Anxiety (10 items) and Depression (15 items). Each item is scored through a Likert-type scale ranging from 1 = "not at all" to 4 = "extremely." To perform the scoring, the mean from the total score and the mean from each subscale score (Anxiety and Depression) are obtained. A cutoff score of 1,75 is used to identify whether the clinical symptoms presented are classified as significant or not (Lhewa et al., 2007). Previous studies found that HSCL was a valid and reliable measure for adolescents when the value of Cronbach's  $\alpha$  ranged from 0.85–0.91 (see Kleppang & Hagquist, 2016).

*Harvard Trauma Questionnaire (HTQ)*. The HTQ was developed by Mollica et al. (1992) to measure the severity level of Post-Traumatic Stress Disorder (PTSD) symptoms. The HTQ contains 16 items that are scored through a Likert-type scale ranging from 1="not at all" to 4="extremely" (Lhewa et al., 2007). The cutoff score for HTQ to identify whether the symptoms presented are classified as significant or not is 2.5 (Mollica et al., 1992). HTQ was adapted into 42 diverse languages, and these studies confirmed that HTQ is valid and reliable across different populations. The coefficient of Cronbach's alpha was found to be between 0.74–0.93 (Kleinj et al. 2001; Darzi, 2017).

*Subjective Unit of Comfort (SUC), Subjective Unit of Disturbance (SUD) and Validity of Cognition (VOC)*. SUC and VOC are rating scales developed by Shapiro (2001), whereas SUD was established by Wolpe (cited in Shapiro, 2001). The client's feeling of comfort as assessed by

SUC was evaluated after each RDI Point of Power; meanwhile, the client’s feeling of distress as assessed by SUD was provided after the RDI Absorption session. SUC evaluated the degree of comfort elicited by positive feelings induced by memories; scores ranged from 1="uncomfortable" to 10="very comfortable." The SUD is commonly used to assess the client’s disturbed experiences or memory. The score ranges from 1 "not disturbing" until 10 "very disturbing." A study conducted by Kim, Bae, and Park (2008) found that SUD was correlated with the client’s level of anxiety and depression, and that the SUD has good reliability and validity. Another instrument used to evaluate the intervention session is VOC, which measures the client’s belief in positive cognition. The VOC is a semantic differential scale and has scores ranging from 1="not sure" to 10="very sure." The Validity of Cognition (VOC) scale has documented adequate validity and reliability (Emmerson & Neely, 1988).

*ORS and SRS*

The Outcome Rating Scale (ORS) and Session Rating Scale (SRS) were developed by Duncan and Miller (2003). ORS measured the therapeutic impact of the intervention session on perceived individual well-being, interpersonal well-being, social role, and general well-being. ORS reliability was evaluated using Cronbach’s  $\alpha$  with an overall coefficient range of 0.91–0.97 (see for example Miller et al., 2003 and Bringhurst et al., 2006). Finally, SRS is a four-item scale designed to evaluate the therapeutic relationship between the client and therapist during the session. Research on SRS demonstrated good reliability with Cronbach’s  $\alpha$  of 0.88 (see Champbell & Hemsley, 2009; Duncan et al., 2003).

*Unstructured interview and observation.* An interview was conducted during every session to evaluate the client’s ability to identify positive feelings in her daily life, as well as to identify the client's feelings, NSSI thoughts, and behavior. The interview guideline was adapted from *Self Injurious Thoughts and Behaviors Interview* (SITBI; Nock et al., 2007); specifically, the questions from NSSI section were asked. Meanwhile, an observation was conducted to assess the client’s latency in response and the number of positive feelings elicited.

**Procedure**

This program plan was based on eight EMDR phases, comprised of 1) the history taking and treatment planning phase; 2) the preparation phase; 3) the assessment phase; 4) the desensitization phase; 5) the installation phase; 6) the body scan phase; 7) the closure phase; and 8) the reevaluation phase, as seen in Figure 1.

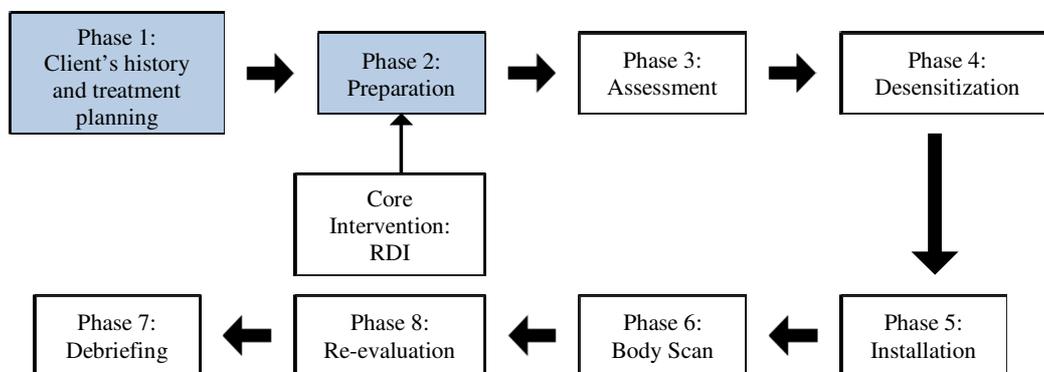


Figure 1. EMDR Therapy Procedure

The core intervention in this program is from the second phase of EMDR, the ‘preparation phase’, where RDI; that is, RDI Point of Power and RDI Absorption, would be given. Before entering the preparation phase, the ‘client history and treatment planning phase’ was required to be completed. The pre-test was administered in the first phase; meanwhile, the post-test measurements were taken after the RDI sessions were completed. The detailed description of session activities was available from the corresponding author on request. A short description of sessions and procedures delivered to the client in RDI is presented in Table 2.

**Table 2**  
**Procedures, activities, and objectives of RDI Sessions**

Session	Activity	Objective
1	History taking and pre-testing	To gain information regarding consent, client life history, and to identify behavior target
2-5	RDI <i>Point of Power</i>	To identify positive feelings and strengthen the positive feelings using bilateral stimulation
6-7	RDI <i>Absorption</i>	To identify clients’ positive resources and other positive qualities
8	Post-test 1	To gain information regarding the client’s condition and feelings after the intervention sessions were complete
9	Post-test 2 and follow-up	To gain information regarding the sustainability and impact of the intervention

### Data Analysis

The CBCL/4-18, HSCL, and HTQ scores gained in the pre-test, post-test 1, and post-test 2 were compared. The frequency of NSSI thoughts and behavior were also examined at pre-test, post-test 1, and post-test 2. Additionally, the number of positive feelings, latency in identifying positive feelings, and SUC and VOC were evaluated and analyzed throughout the intervention sessions.

### Results

The aim of this intervention was to lower the frequency of the client’s NSSI thoughts and behavior through an increase in positive resources and a decline in negative feelings. The client’s development with regard to NSSI thoughts and behavior before and after the intervention is presented graphically in Figure 2. Figure 2 shows the frequency of the client’s engaging in NSSI before the intervention at twice a week and thoughts about NSSI occurred almost every day in a week. After the RDI sessions, NSSI behavior stopped, although NSSI thoughts were still present at least three times a week for approximately 15 minutes each time. Other than that, the client was able to successfully shift her NSSI thoughts to positive memories and activities (i.e., reading comics, watching humorous videos, etc.). Every time the client could not detach herself from NSSI thoughts, she would talk to her sister or cousins about her daily activities. A more detailed explanation based on indicators of target achievement will be discussed below.

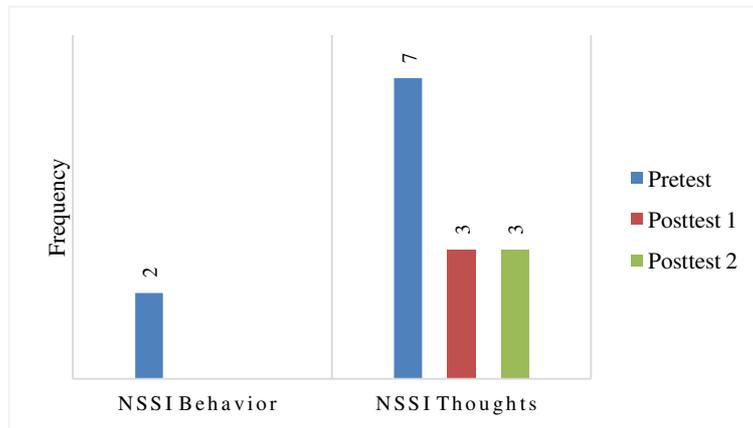


Figure 2. Frequency of NSSI thoughts and behavior

**Target 1: Increase client’s positive resources**

The increase in positive resources is shown in the increase of the client’s SUC score (see Figure 3) and VOC score (Figure 4), the increased quantity of positive feelings identified by N, and a decreased latency in identifying positive resources.

Figure 3 shows that the mean score of SUC kept rising from session one onwards. This result implies that N felt more comfortable with positive memories and feelings she identified successfully in each session. Some examples of N's positive experiences are the memories of getting good scores, being entertained by her sister, and her vacations and cultural tourism.

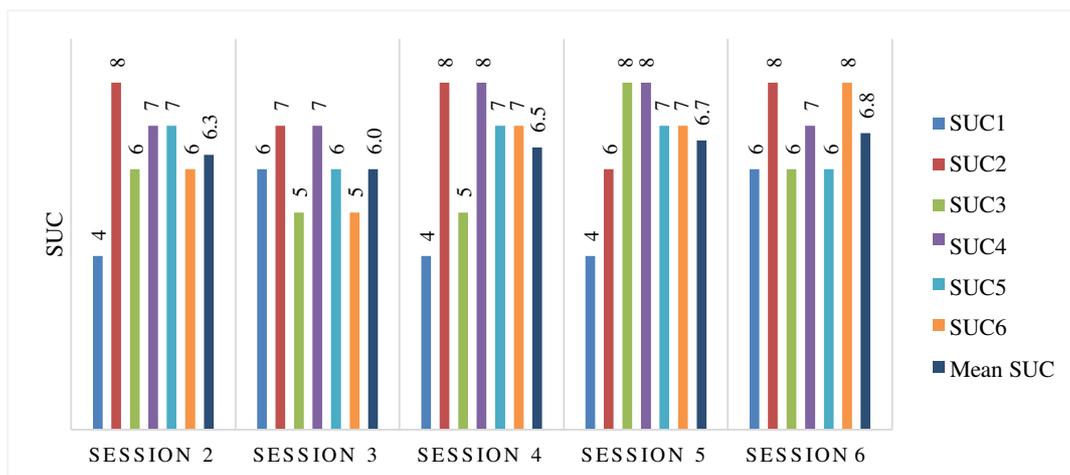


Figure 3. Subjective Unit of Comfort. Note. Throughout Sessions 2–6, six SUCs were measured in each session. The first six bars in each session indicate the SUC as reported by the client. The seventh bar is the average SUC for the session.

Figure 4 indicates that the Validity of Cognition (VOC) value tends to increase from one session to the next. In the early intervention period, the VOC score ranged from 2 to 4, while at the end of the session, N was able to maintain a score of 5 to 6. This result implies that N is more assured

that positive memories would elicit positive cognition; thus making her more comfortable. In general, from various positive cognitions that she successfully identified, N perceived herself as competent and valuable. She was able to experience fun things, feel happy with her life, and believes she deserves all that. Besides, she was also aware that she is loved and cared for. Furthermore, she also felt like she is capable, diligent, and able to achieve her goals.

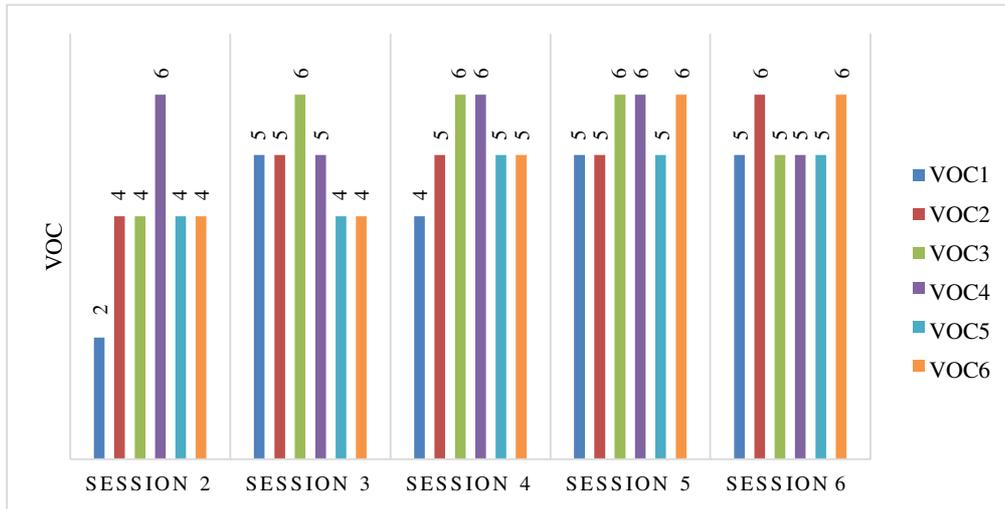


Figure 4. The Validity of Cognition. Note. Throughout Sessions 2–6, six VOCs were measured in each session. The bars in each session indicate the VOC reported by the client.

*Number of positive feelings*

Figure 5 reveals that N was able to identify six positive feelings in Session 2 and that an escalation in the number of positive feelings started to emerge at the fifth session, with an increase to eight in the sixth session. Some examples of positive feelings reported by N were “I am lovable because my sister asks me to watch television together. My sister wants to spend her time with me”; “I am smart enough because I can finish my physics homework on time”; “I feel happy and excited to see beautiful scenery and paddy fields”; “My parents allow me to have a mobile phone; I can get what I want.”

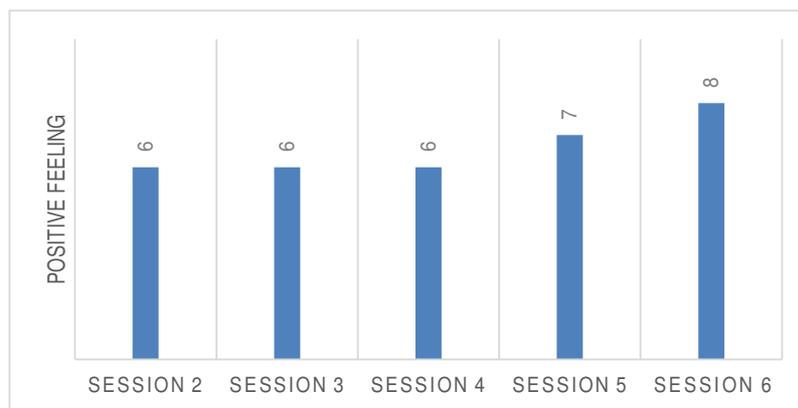


Figure 5. Number of Positive Feeling

*Latency in identifying positive sources*

The latency in identifying *resources* is measured to evaluate how fast N could achieve positive feelings after the instruction was given. As seen in Figure 6, the latency from sessions 1 to 3 (using the *Point of Power* technique) on average was higher as compared to the sessions afterwards. In sessions 1 to 3, N seemed to have difficulty recalling positive feelings that she had previously had. N needed help from PI to recall anything she did in the past few hours, including what things she tasted, heard, saw, smelled, or touched, and the instruction to look into her personal belongings successfully triggered N's positive feelings. She often said that there was no positive feeling in her experience and then later she got confused. The PI then guides her to discover neutral experiences, which do not produce negative or uncomfortable feelings. Improvement started happening in sessions 4 to 6, where N became fluent in discovering positive feelings as compared to her previous sessions. Convenience in accessing positive resources indicates that N's own positive resources were established.

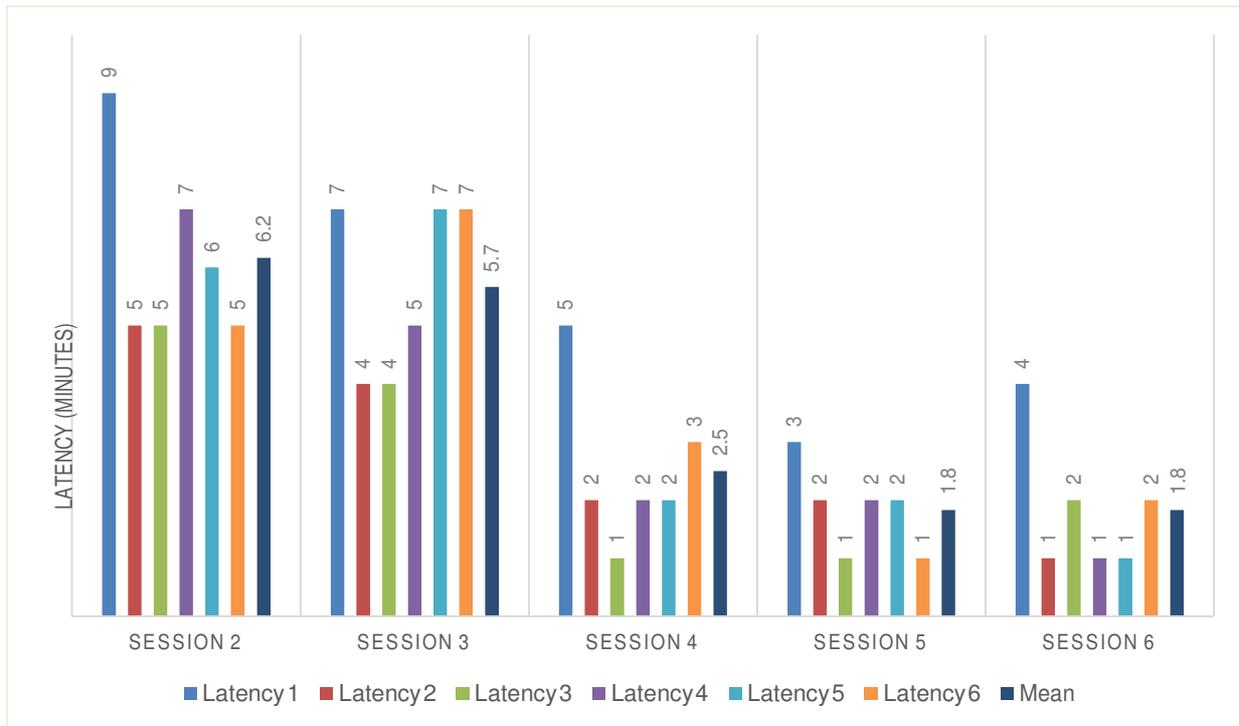


Figure 6. Latency in identifying positive sources

**Target 2: Decline in client’s negative feelings**

The decline in client's negative feelings, particularly anxiety, can be seen from the results of the RDI *Absorption Technique* session, which showed a regression in SUD with a VOC score of  $\geq 5$ . Other than that, there was also a decline in CBCL/4-18 and HTQ and HSCL scores. The details of those indicators will be elaborated on in the following paragraph, as well as the comparison of pre-test and post-test results.

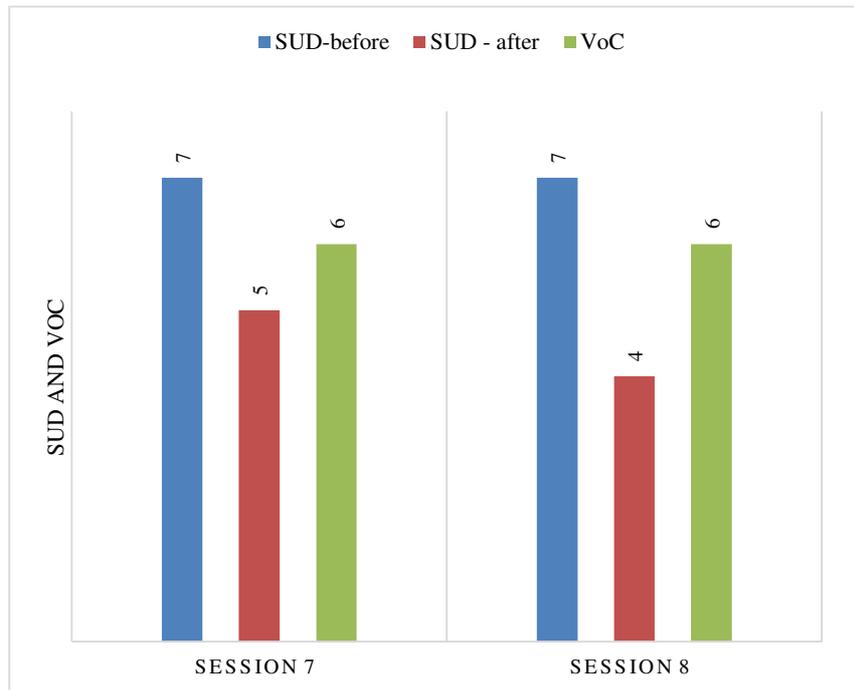


Figure 7. SUD and VOC

Figure 7 shows the result of the RDI session with the *Absorption* technique. Figure 7 indicates a decline of SUD from one session to another, showing that N felt less uncomfortable. Previously, N was asked to list all the things that bothered her and that she perceived as sources of anxiety. After that, all things mentioned were given SUD scores; then the two with the highest SUD scores were chosen. These were 1) N's experience in handling mathematics; and 2) her learning in the science major. The SUD scores for both situations were 7.

In Session 7, the unfavorable experience processed was dealing with mathematics. After that, N was asked to identify what resources she needed to conquer the unfavorable situation, memory, or thoughts, whether it was skills, abilities, or something else. N reported that she believed that she needed to feel calmer in handling mathematics. She symbolized feelings related to being 'calm' as water. After the resource was strengthened with BLS, the PI asked N to find another resource that she needed; then strengthen that one through BLS, and repeat that procedure until she had three strengths or skills for handling mathematics. Other than calm feelings, N wanted to feel 'spirited' which she symbolized with a panoramic view. She also symbolized her 'confidence' with a trophy. After every resource was strengthened through BLS, the PI asked N to imagine the three resources all together, to be intensified through BLS later. As a result, the SUD of her memory in facing mathematics at school declined from 7 to 5, with a VOC score of 6.

In Session 8, the unfavorable experience or source of anxiety was N's worry that she could not keep up with the required subjects in the science major. N needed to explore a variety of resources to select the ones she needed to face her anxiety. N chose 'mastery experience' as the resource that would be strengthened, such as her experience in fourth grade where she was able

to catch up all the materials given in school when she was sick for a week. From that particular resource, positive cognitions that she was able to recreate were “I am smart” (keyword: smart); “I am persistent” (keyword: persistent); and “I can do my best” (keyword: can). The SUD for anxiety about keeping up with subjects in the science major decreased from 7 to 4, with a VOC score of 6.

**Table 3**  
**The result of pre- and post-test 1 for CBCL/4-18.**

No	Symptom	Score in Pre-test	Category	Score in Post-test 1	Category
I	Withdrawn	9	Borderline	6	Normal
II	Somatic complains	9	Clinical	1	Normal
III	Anxious/depressed	9	Normal	8	Normal
IV	Social problems	7	Borderline	3	Normal
V	Thought problems	2	Normal	0	Normal
VI	Attention problems	9	Normal	6	Normal
VII	Delinquent behavior	2	Normal	0	Normal
VIII	Aggressive behavior	5	Normal	2	Normal

Problem	T score pre-test	Category	T score post-test 1	Category
Internalizing (Scale I + II + III-103 items)	72	Clinical	60	Borderline
Externalizing (Scale VII + VIII)	53	Normal	42	Normal

Results presented in Table 3 revealed a significant decline in N’s CBCL/4-18 scores. Several symptoms that were classified as ‘borderline’ in pre-test developed to ‘normal’, and symptoms classified as ‘clinical’ turned into ‘normal’. In addition, there was also improvement from ‘clinical’ to ‘borderline’ in internalizing symptoms; internalizing problems scored from ‘clinical’ (T = 72) to ‘borderline’ (T = 60).

#### HTQ and HSCL results

The result of HTQ and HSCL are presented in Table 4; they show a comparison of mean scores obtained from the pre-test, post-test 1, and post-test 2. HTQ has a cutoff score of 2.5 to classify symptoms presented as clinical (Mollica et al., 1992, cited in Lhewa et al., 2007). Results indicated that there was a decline from 3 to 1,8 in post-test 1; however, it increased to 2,4 in post-test 2. Although there was an increase at the end, results of post-test 2 were still lower compared to the pre-test, which indicates that N's PTSD symptoms that had been classified as *clinical* were now improved after the intervention was delivered.

**Table 4**  
**Mean score of HTQ and HSCL.**

Mean Score	Pre-test	Post-test	Post-test 2
HTQ	3.0	1.8	2.4
HSCL	2.72	2.0	1.9

HSCL has a cutoff score of 1.75 to classify symptoms presented as clinical (Mollica et al., 1992 in Lhewa et al., 2007). Results indicated that there was a decline from 2.72 to 2 at post-test 1, with a further decline to 1.9 at post-test 2. Such results implied that anxiety and depression

symptoms were still classified as clinical after the intervention was given. However, the severity level decreased compared to N's condition before the intervention.

#### *The result of unstructured interview and observation*

In addition to all of the measurement results that have been explained above, there was also an alteration in N's behavior. Before the intervention was provided, N tended to seclude herself by staying in her room. After the intervention, her parents reported that she had become more open and interacted with the family more frequently. Her parents also reported that she initiated interaction with people around her. She talked more openly about her feelings and problems, especially to her older sister. N's parents also noticed that she and her sister started to spend more time together watching television or discussing a film they had seen.

The client reported some improvement after going through the intervention. Before the intervention, N often felt lethargic and anxious that her friends were spreading negative rumors about her in school and criticizing her academic achievement. After the intervention, she felt more relaxed and had more positive thoughts about herself. Whenever she thought of her peers or problems, N was able to shift her thoughts to other things that were more pleasant. She was also able to set aside her problems and focus more on things that made her comfortable, such as her few good friends and a teacher who understood her. When she could not handle her negative feelings, she would share them with her sister. She felt more content and comfortable when surrounded by her family. Moreover, she became aware of her strengths, to never give anyone a hard time, never be vicious to other people, and enjoy helping others.

## **Discussion**

This intervention aimed to decrease NSSI behavior by enhancing the client's positive resources and decreasing her negative feelings. Overall, the intervention succeeded at this objective. Nevertheless, the client still felt anxious with regard to peer problems at school.

N engaged in NSSI behavior as a response to unfavorable experiences, such as feeling offended by negative rumors at school that led her to feeling rejected. Rejected feelings were the main issue in her life that already happened repeatedly, accumulating since she was a child. The first rejection she had was during her kindergarten year, where she felt distant from her parents. That experience was the origin of her current NSSI behavior. Shapiro (2007) stated that a traumatic event that was not processed in a healthy manner is often the root of or touchstone event for future maladaptive behavior to occur.

Based on the AIP model, maladaptive responses to adverse experiences happen because of prior traumatic experiences creating negative cognitions. Negative cognitions identified from N's assessment were "*I am not important*"; "*I am not smart*"; "*I am a disappointment*"; "*I am not good enough*"; "*I am different*"; "*I deserve only bad things*"; "*I deserve to be miserable,*" and all of these blocked her access to positive experiences. Any new positive information, experiences, or feelings are then not able to connect to the memory network (Shapiro, 2004). The client's prior aversive experiences from parental neglect and abuse caused negative cognitions to develop, which hindered her ability to access positive effects in her memory that are important and required for emotion regulation. The client had difficulty regulating her negative emotions;

she tended to dwell on her negative views about herself and felt alienated from her surroundings because she could not access any positive resources in her mind.

After completing the RDI intervention, N's NSSI thoughts and behavior decreased, her positive resources were strengthened, and the negative feelings (particularly anxiety) decreased. The improvement was caused by the RDI sessions, where N was trained to access her positive resources and use them to handle anxious situations. RDI with bilateral stimulation helps the individual face situations that elicit similar emotions. In N's case, she was able to respond adaptively and shift her thoughts into more positive areas; she is now able to access memories about positive things. Additionally, she is able to use resources to overcome negative feelings that she could not handle alone. Strengthened resources are also seen from her change in behavior; she is now more open to her family, and especially to her sister.

Furthermore, the decrease of negative feelings was also visible from the client's data analysis, where SUD, CBCL/4-18, HSCL, and HTQ scores decreased after the RDI session. This change suggests that she is now able to use her inner positive resources to regulate negative emotions elicited by adverse memories. She is now able to shift her thoughts into more positive areas to help her handle situations that produce negative feelings. In other words, RDI helped the client regulate negative emotions, which aligns with the attentional deployment strategy described by Gross and Thompson (2007). In their attentional deployment distraction strategy, the individual shifts his or her focus internally into thoughts or memories that are inconsistent with unwanted emotions (Watts, 2007), or into thoughts and memories related to positive emotions (Gross & Thompson, 2007).

Although N's behavior was visibly improved after the intervention, she was still experiencing anxiety related to friendship problems, though the intensity had decreased. This is caused by her main issue, which is feeling rejected by her surroundings, along with the traumatic events she experienced, which were not processed during this RDI session. The objective of this intervention was to equip to be able to stabilize and control herself and do self-mastery before processing traumatic events (Shapiro, 2009), but this objective did not include entering a trauma-processing phase.

The efficacy of the RDI implementation in this client's case was also due to her contribution to the process. N showed a good level of commitment by showing up for every session. Although she encountered several obstacles such as school exams, she still committed to finishing the program at attended every session. Family support was also undoubtedly crucial for this NSSI case treatment. In addition, available media was also a supporting factor for this treatment process; having a mobile phone and school equipment helped N remember things she went through and which experiences brought out her positive feelings. Of course, there were also obstacles in the process of the intervention itself. N had difficulty verbally expressing her emotions and found it hard to recall some of the difficult experiences she had been through. This caused her to feel frustrated and to nearly give up on trying to retrieve positive feelings at times. Furthermore, N perceived that the safe place technique did not work for her to achieve a calm and unbothered feeling. That was a result of needing to be able focus for a long time in a quiet situation in order to be successful, but a lot of the unwanted thoughts often presented themselves at school, where it was always crowded and noisy.

The RDI *Point of Power* and *Absorption* sessions provided in this study successfully strengthened positive resources and decreased negative feelings in a 16-year-old female adolescent diagnosed with NSSI. In general, there was a positive change in her thoughts, feelings, and behavior after the intervention session was provided. She reported that RDI improved her ability to gain control over negative thoughts and regulate negative feelings by shifting it into positive thoughts and memories. Her parents also observed that she was more open and interacted more easily with family members. For example, she shared her feelings and problems openly with her sister. Her NSSI thoughts also decreased as the impact of her ability to regulate negative emotions and use positive resources to face problems increased.

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