Developmental Needs Meeting Strategy: A New Treatment Approach Applied to Dissociative Identity Disorder

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Abstract

This article describes the use of the Developmental Needs Meeting Strategy (DNMS) for the treatment of dissociative identity disorder (DID). The DNMS is an ego state therapy which guides a client's own internal resources to meet developmental needs that were not met in childhood. After 17 months of DNMS treatment a client with DID reported a near total elimination in frequency and severity of symptoms of depression, anxiety and suicidal thoughts, her Trauma Symptom Inventory scores indicated no trauma symptoms, and her Multidimensional Inventory of Dissociation scores indicated she no longer meets the diagnostic criteria for DID. She was functioning well without any medication. Further research is warranted.

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Dissociation can be understood as mentally compartmentalizing a traumatic experience to escape from it (Bliss, 1986; Putnam, 1991, 1997; van der Kolk, van der Hart, & Marmar, 1994). Children who repeatedly cope with trauma by dissociating can develop a maladaptive dependence on dissociation - they become triggered to dissociate with even small stressors (Putnam, 1991; Ludwig, 1983; Bloch, 1991).

Mental compartmentalization can occur, not only with trauma, but when significant developmental needs are not met. Barach (1991) argues that, what Bowlby (1980) calls detachment from the neglectful caretaker, may actually be dissociation. He suggests that a parent's failure to protect the child from abuse, or a parent's emotional detachment from the child, can profoundly influence the development of dissociative psychopathology. Gold, et al (2001) observed that pathological dissociation is not exclusively attributable to discrete traumas. Dysfunctional interpersonal relationships within the family of origin environment can also contribute significantly to the symptoms developed in victims of prolonged childhood abuse (Alexander, 1993; Fromuth, 1986; Mullen, et al, 1996; Nash, et al 1993; Widom, 1999). When parents are cold, distant, neglectful or inconsistent, and when they fail to teach skillful management of emotions or resolution of interpersonal conflicts, their child can develop an unstable sense of self, tenuous attachments, dissociative absorption, amnesia, and identity disintegration commonly associated with trauma (Alexander, 1992; Barach, 1991; Gold, 2000).

In the treatment of dissociation much emphasis is placed on helping clients process through the memories of traumatic events that were mentally compartmentalized in childhood. The processing often occurs with painful abreactions as the client is asked to relive or reexperience their trauma. Some authorities have recommended that this processing of traumatic material be preceded by a period of preparation and stabilization (Herman 1992; Phillips & Frederick, 1995; Putnam 1989). Some experts in the field (Barach, 1999; Courtois, 1999; Gold, et al, 1999; van der Kolk, 1999) have suggested that trauma-focused treatment approaches may even be contraindicated for some victims of prolonged childhood abuse.

Cognitive-behavioral therapies, such as Linehan's (1993) Dialectical Behavioral Therapy, Meichenbaum's narrative constructivist therapy (Hoyt, 1996), and contextual therapy (Gold, et al, 2001) facilitate remediation of deficits which originated in the dysfunctional family of origin. Therapies such as these put considerable emphasis on teaching clients affect management skills, on understanding and reframing their past, and having a healthy relationship with the therapist.

The Developmental Needs Meeting Protocols

Foundations of the Protocols

The Developmental Needs Meeting Strategy (DNMS) is also focused on remediating developmental deficits. The DNMS protocols work from the assumption that the degree to which childhood needs were not adequately met at a given developmental stage, correlates with the degree to which the adult client is stuck in that stage. In other words, when a client has endured overwhelming childhood abuse, neglect, or dysfunctional parenting sufficient to warrant the mental compartmentalization of experiences, one or more neural networks or ego states become stuck in the past. This idea is supported by Maslow (1968), who believed that significant unmet needs during developmental stages could cause one to "fixate" on those needs for the remainder of life, and Erikson (1950), who believed if a person's childhood needs were inadequately met he could develop enduring counterproductive thinking, affect, and behaviors.

The DNMS has much in common with inner child psychotherapy, which is based on the idea that adults who suffered neglect, abuse, or unmet needs from childhood can heal past hurts by inviting competent adult parts of self to nurture wounded child parts (Bradshaw, 1990; Napier, 1990). The DNMS endeavors to get child ego states unstuck from the past by directing the client's own internal resources to meet needs now that were not met in childhood. These internal resources are developed in a systematic and structured way. They are referred to throughout treatment as the "Resources". The protocols guide the Resources to provide the child ego states (child parts) the needed "corrective emotional experiences." Getting an ego state totally unstuck appears to be the same thing as integration, as defined by Phillips and Frederick (1995), when ego states have achieved "sufficient maturity, are communicating with one another and working together empathically and cooperatively, and are experiencing the consciousness of one another" (p.160). Positive changes in emotions, cognition, and behavior follow when a child part gets totally unstuck.

The DNMS evolved under the influence of the Adaptive Information Processing (AIP) model, which was conceived by Francine Shapiro to provide a theoretical basis for the efficacy of EMDR therapy (Shapiro, 2001). EMDR incorporates the use of alternating bilateral stimulation (ABS), applied as side-to-side eye movements, alternating bilateral auditory stimulation, or alternating bilateral tactile stimulation within an eight-phase treatment approach. The eight phases include (1) taking a history, (2) patient preparation, (3) assessment, (4) desensitization of a traumatic memory, (5) installation of a positive cognition, (6) body scan, (7) closure, and (8) reevaluation. EMDR therapy appears to diminish negative imagery, affects, sensations, and beliefs while strengthening positive imagery, affects, sensations, and beliefs (Shapiro, 1989). In the AIP model information is understood to be stored in a system of neural networks containing related memories, thoughts, images, emotions, and sensations. The model proposes that under ideal conditions a person can experience a disturbing event, assimilate it and process it through. The disturbing material naturally connects to positive adaptive information. This helps the person to make sense of the traumatic experience. According to Shapiro, psychopathology results when a highly negative experience is not adequately processed through and/or not linked to positive adaptive information. Instead it gets dysfunctionally stored in a neural network which becomes effectively isolated. (In DNMS language: a part of self becomes stuck in the past.) This can happen whether the negative experience is a single large trauma or small traumas frequently repeated. The AIP model proposes that a treatment which connects the positive adaptive information (in the DNMS: the Resources) with the isolated neural network (a part of self that is stuck) should successfully process through the trauma and achieve adaptive resolution. The model assumes that when a person's inherent information processing system is fully engaged the dysfunctionally stored memory will process through. The result will be a positive resolution, as evidenced by affective, cognitive, and behavioral changes. Consistent with this model, the structured DNMS protocols appear to fully engage a patient's inherent information processing system with the systematic and structured use of internal Resources.

The DNMS shares the same AIP theoretical base as EMDR, evolved within an EMDR practice, and is enhanced by the use of ABS, but the DNMS is not EMDR, nor is it a variation of EMDR. It is a stand-alone approach. EMDR assumes that adaptive resolution of many problems comes through trauma processing with the eight-phase protocol. The DNMS assumes adaptive resolution for many disorders is accomplished by meeting unmet childhood needs. Consequently these protocols are very different.

The use of ABS to strengthen positive personality traits was explored by Greenwald (1993), Leeds (1998), Martinez (1991), and Wildwind (1992). Leeds introduced the term Resource Development and Installation (RDI) to describe his EMDR-related protocol for using ABS to strengthen positive images, memories, and symbols. In two single case design studies Leeds' RDI protocol was found to be an effective intervention for clients with Complex Posttraumatic Stress

Disorder in the preparation phase of EMDR (Korn & Leeds, 2002). In the study, ABS was used to enhance a positive felt sense of internal resources and to strengthen the probability the client would use their resources to manage future stressors. Twombly (2000) proposed using ABS to strengthen a DID client's orientation to present time and body height, and to diminish negative transference some alters might have to the therapist and/or the therapist's office. She asserts these interventions are helpful for preparing a client for EMDR.

ABS is used during the DNMS to reinforce all ego strengthening experiences. It appears to help connect Resource neural networks to child part neural networks. While clients may process more deeply and resolve more quickly when ABS is present, DNMS sessions without ABS have also been successful. ABS may not be as critical with DNMS as it is with EMDR and RDI treatments. Research is needed to better understand the benefits of including it in the DNMS protocols.

DNMS Preparation: Accessing Internal Resources and the Healing Circle

The protocols are described only briefly here. A thorough description can be found in ***Developmental Needs Meeting Strategy for EMDR Therapists*** (Schmidt, 2002). Several chapters in the book detail how to work through processing blocks.

The work begins with the use of structured protocols (not described here) to help the client develop three internal Resources, a Spiritual Core Self, a Protective Adult Self, and a Nurturing Adult Self. This step could take as little as 20 minutes, or as long as a year. Most clients take 1-2 sessions for this. Once developed, the Resources are invited to come together to form a "Healing Circle", which is the centerpiece of the DNMS protocols. A 20-step DNMS protocol is used to get ego states unstuck from general experiences of neglect, abuse, or poor parenting. A 12-Step DNMS trauma protocol is used to get ego states unstuck from specific events or traumas, where unmet developmental needs were significant.

DNMS 20-Step Protocol: Getting Child Ego States Unstuck

The 20-step protocol starts with (1) a discussion about which child part to work with in the Healing Circle. For example, one may choose to work with a child part associated with a current conflict or problem (e.g. the child part upset at work this week). Some child parts are internalized representations of significant, harmful childhood role models (e.g. abusive or neglectful parent, sibling, or nanny). In the DNMS they are referred to as ***maladaptive introjects***. A maladaptive introject is conceptualized as an innocent child part wearing a mask or costume, acting out the script of a hurtful role model on other parts of self. By encouraging the child part under the mask into the Healing Circle and getting her needs met, she is eventually able to shed the mask and costume, thereby ending a piece of the internal conflict.

Once the client has decided which child part to process, (2) the therapist invites the client to connect to her Resources and the Healing Circle. (3) The identified troubled child part is invited to approach the Resources. The therapist greets the child part, learns more about who she is and what kind of mood she is in. If the Resources seem safe to the child part, (4) she is invited inside the Healing Circle, and (5) the sense of safety she feels in the Resource's presence is allowed to strengthen all the way. (i.e. ABS is applied until the good feeling does not get any stronger.) (6) Then the child is asked if she believes she is stuck in the past, and if so, if she wants to get unstuck. When she says "yes" the therapist says, "Notice the Resources... notice they're real, notice they're here for you, and notice they can help you get unstuck because they can meet needs for you now that were not met well in the past. Think back to the past... think about needs that were met well and needs that were not met well, and when you're ready, tell me what you need most right now."

(7) When the child part names a need (e.g. safety, protection, validation, connection, praise, nurturing, warmth, etc.) the therapist asks if the Resources are able to meet that need. When she says "yes" she is asked to notice the Resources meeting that need now and the experience is strengthened all the way. Once fully strengthened the child part is asked, "And what else do you

need?" The experience of having another need met is strengthened all the way. This process is repeated for some time. At some point the client may report strong emotions coming up (e.g. anger or grief). (8) The child part is asked to notice that the Resources can encourage and support her while she works the emotions all the way through – a process enhanced by sensorimotor psychotherapy (Ogden & Minton, 2000). (This step is similar to the abreaction phase of exposure therapies, but is experienced as more tolerable. The presence and support of Resources appears to shorten processing time considerably. It usually takes between 2-10 minutes to complete.)

Once the child part reports all strong emotions are processed through and all needs have been met (9) the therapist asks the child part to notice and strengthen the bond with each Resource, both individually and as a group. This is similar to techniques described by Napier (1990), Paulsen (2000), and Steele (2001). (10) The therapist checks in to see how stuck/unstuck the child part is. Usually the child part is mostly unstuck at this point.

(11) Next the child part is asked to think back to being in her parent's care, and to rate on Wolpe's (1969) 0-10 Subjective Units of Disturbance (SUD) scale, how disturbed she feels by it. If the SUD level is more than 0, she is asked, "What is the worst part of it?" From that answer the therapist deduces the associated unmet need. (12) The therapist asks the child part if the Resources can meet that need. When she says "yes" she is asked to notice the Resources meeting that need now and the experience is strengthened all the way. (13) Steps 11 and 12 are repeated, bringing the SUD level down incrementally, eventually to 0. This is similar to Peter Levine's technique of "pendulating" between comfort and trauma when processing through disturbing memories (Poole Heller, 2001). (14) Next the therapist asks the child part to rapidly shift attention back and forth between her parent's care then and her Resource's care now. (If there is a small bit of disturbance remaining it shows up here in sharp contrast to the Resource's care.) This step is complete once the scene of being in her parent's care feels neutral in the body.

(15) Then the therapist asks the child part "Do you know you're in an adult body now?" (Paulsen, 2000; Twombly, 2000). If she does not know this, she is told that as an adult she can make choices about her life and protect herself from bad people. She is invited to let this new information strengthen all the way. (16) Again the therapist checks in to see how unstuck the child part is. The typical answer at this point is "totally unstuck". When the client is asked to describe the child part's appearance and mood, she reports a significant change. Sometimes a child part is seen as older but always happy, relaxed, and often engaged in some age-appropriate behavior such as play. She will report the body feels clear and relaxed. (17) The child part is then asked for a positive belief about herself that feels true now. She is asked to think about that belief and let it strengthen all the way. (18) The child part is thanked for her hard work and invited to tuck in with the Resources until the next time she is needed (Paulsen, 2000). "Tucking in" means inviting a child part to retreat into a non-active state, usually in the company of the Resources. (19) If the client has gone into a light trance she is reoriented to the present by counting up. (20) In the last step the client is asked to revisit her current issue or dilemma. Most of the time clients report a significant shift in perspective about the problem as a result of getting the associated child part totally unstuck. ABS is used each time a need is getting met, a strong emotion is processed through, and during all other ego strengthening moments.

The DNMS 12-Step Protocol: Processing Childhood Trauma by Meeting Needs

The 12-Step trauma protocol starts with (1) the identification of a specific trauma or event. (2) The client is then invited to connect to her Resources and the Healing Circle. (3) The troubled child part associated with that trauma is invited to approach the Resources. The therapist greets the child part and learns more about who she is and what kind of mood she is in. If the Resources seem safe to the child part, she is invited inside the Healing Circle, and the sense of safety she feels in the Resource's presence is allowed to strengthen all the way. Then the child is asked if she believes she

is stuck in the past, and if so, if she wants to get unstuck. When she says "yes" the therapist informs her the Resources are real and here for her and can help her get unstuck by meeting needs now that were not met well in the past.

(4) The therapist asks the child part to direct her attention to the traumatic event, then asks for a SUD level and for the worst part of the trauma. From that answer the therapist deduces what unmet need (e.g. safety, validation, comforting) is associated with the trauma. The therapist asks the child part if the Resources can meet that need. When she says "yes" she is asked to notice the Resources meeting that need now and the experience is strengthened all the way. The child part is asked again to think about the trauma and report a SUD level and the worst part of it. Again the therapist deduces the associated unmet need and asks the child part if the Resources can meet that need. The experience of having another need met is strengthened all the way. As this process is repeated, the SUD level comes down. (5) When strong emotions come up, usually anger, grief, or both, the therapist encourages the child part to feel her feelings and let them process through, while experiencing the support of the Resources.

(6) Once all needs are met, all emotions have processed through, and the SUD level has dropped to 0, the therapist checks on changes in the appearance of the child part and body sensations. The client typically describes a significant change in the child part's appearance and mood and reports the body feels more relaxed. (7) The therapist asks the child part to shift her attention rapidly back and forth between the trauma and the Resource's care now. This step is complete when the client's body feels neutral when thinking of the trauma. (8) The therapist then asks the child part if she knows she is in an adult body now. If she does not know this, it is explained to her. She is allowed to let this new information strengthen all the way. (9) At this point the child part is asked how stuck she feels. Most child parts are totally unstuck here. If she is still a little stuck, the therapist can find out what other needs were not met and strengthen the Resources meeting those additional needs. (10) The child part is then asked for a positive belief about herself that feels true now. She is asked to think about that belief and let it strengthen all the way. (11) The child part is thanked for her hard work and invited to tuck in with the Resources until the next time she's needed. (12) If the client has gone into a light trance she is reoriented to the present by counting up. ABS is used each time a need is getting met, a strong emotion is being processed through, and during all other ego strengthening moments.

A Single Subject Design Case Report

The Subject

Lisa was born in the early 60s, the second of four children, to an alcoholic father and an angry, abusive mother. She experienced repeated sexual abuse by a family friend as a toddler, and by an older boy in grade school. The abuse was kept secret until adulthood. She began abusing drugs, alcohol, and tobacco in high school – a trend which continued into adulthood. She was able to establish a successful career throughout the 90s, becoming an executive at a large company. When a five-year romantic relationship ended in the late 90s, her substance abuse escalated out of control.

Baseline Presentation

Ten months before starting DNMS therapy she was admitted to a psychiatric hospital for treatment of cocaine and alcohol abuse, cutting, hallucinations, and chronic suicidal thoughts. She was diagnosed with Major Depressive Disorder and Borderline Personality Disorder and started on antidepressants and mood stabilizing drugs. After 12 days she was released. Three weeks later she was readmitted for the same symptoms. She was discharged three weeks later. For the following eight months she met regularly with a cognitive-behavioral psychotherapist, and a psychiatrist. She

was disappointed they did not address her underlying issues. She told them she was drug and alcohol free, but confided to me recently she doubted she had been drug-free. She was able to work and function fairly normally during this time, after she was demoted to a position of less responsibility and pay. Eight months after her release from the hospital her mood began to deteriorate. She stopped her therapy and medications. A family member found her home from work, wasting on the couch, crying, cutting herself, and wracked with suicidal thoughts. She was not eating or showering. After watching her deteriorate for a week, her family admitted her to the hospital. Hospital records indicated she had used cocaine three days before her admission. She was released after one week with prescriptions for venlafaxine, lorazepam, nortriptyline, oxcarbazepine, and zolpidem. She began therapy with me three days after she was released. She said the hospital did not help much. She was still crying constantly and suffering from constant thoughts of suicide. She was unable to function in almost all areas of her life.

Treatment Experience

Shortly after Lisa began therapy she quit her job so she could focus on healing. She returned to work a year later. I had 79 therapy encounters (most 90 minute sessions, some phone calls) with Lisa over the 17-month period. Neither she nor I suspected she was DID when we started therapy. Nine months after we began, the DID diagnosis was made when I met many distinct alters with their own names, their own flavor of personality, each believing they lived in a body separate from Lisa's. My initial conversations with the alters were not heard by Lisa. This diagnosis was confirmed by Lisa's psychiatrist, Helen Pankowsky (2003). Over this time period 27 ego states were invited into the Healing Circle to get their needs met. All got unstuck within one to four sessions with the 20-step and/or 12-step protocol. Of the 27 ego states, 20 were partially dissociated ego states (five of which were parental introjects) and seven were fully dissociated alters. ABS was used during all DNMS processing. (For a supplemental document with a brief summary of each session contact the author.)

Measures

The following measures were used to track Lisa's response to the DNMS: the Symptom Frequency Scale or SFS (Schmidt, 1996), Trauma Symptom Inventory or TSI (Briere, 1995) and the Multidimensional Inventory of Dissociation or MID (Dell, 2003). Before starting DNMS therapy, the client filled out the SFS, and TSI. After six months of treatment she filled out the TSI, and after 17 months she filled out the SFS, TSI, and MID.

The SFS records a client's self-report of frequency of 31 depression and anxiety symptoms. The client is asked to indicate how often those symptoms were present over the previous two weeks, on a 10-point scale, from "not at all" to "all the time". The TSI evaluates various types of posttraumatic stress, including the lasting sequelae of childhood abuse. The questionnaire contains 100 items which pertain to 10 Clinical scales, 3 Summary scales, and 3 Validity scales. Clients are asked to indicate on a four-point scale, from "never" to "often," how frequently in the prior 6 months they have had each of the experiences listed. The MID is a comprehensive self-report instrument for pathological dissociation. Clients are asked to indicate how often they experience each of 218 dissociative symptoms on a 0-10 scale, from "never" to "always".

The client gave informed consent to have her history, treatment, test scores, and other treatment results written up as a clinical case study.

Results

Figure 1 shows the client's report of crucial symptoms of depression and anxiety before and after 17 months of treatment, on the SFS. She reported a significant reduction in the frequency in

most every symptom, with a total elimination of key symptoms, such as worthlessness, hopelessness, thoughts of death, thoughts of suicide, fear of losing control, and fear of dying.

FIGURE 1. Symptom Frequency Scale (SFS) results

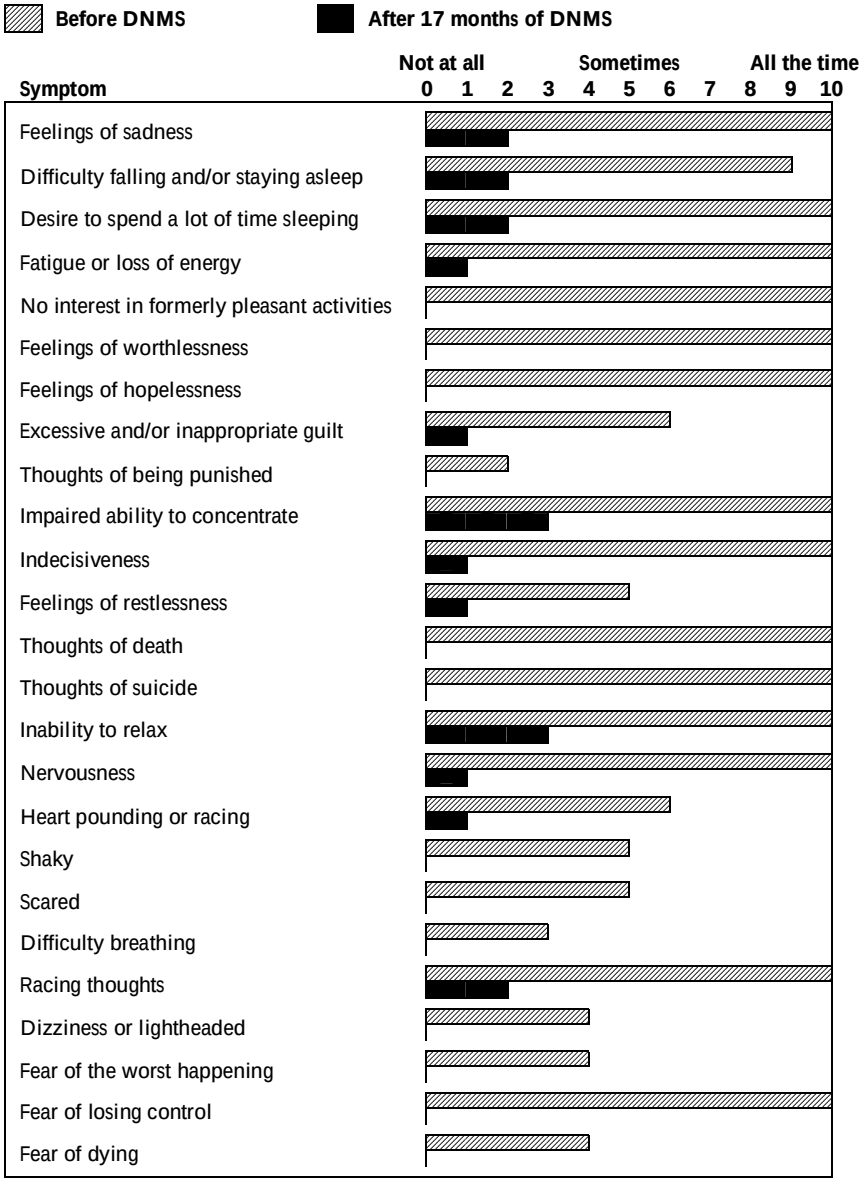
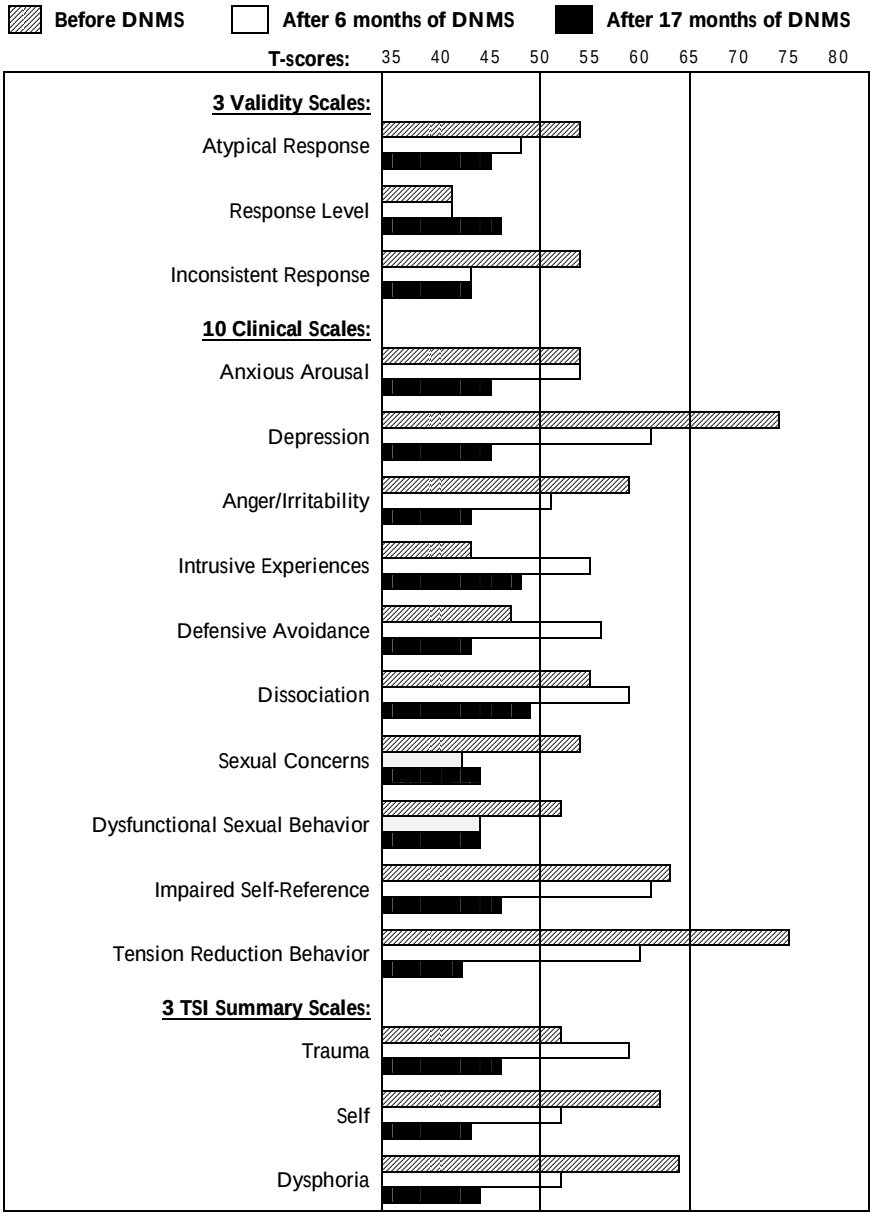


Figure 2 summarizes the client's TSI scores on all scales. Her t-scores after 17 months of treatment were 17-79% lower on all 10 clinical scales. The most significant score drops occurred in the Depression and Tension Reduction Behavior scales, with reductions of 64% and 79% respectively. All post-treatment TSI scores are below the normal range, suggesting significant resolution of traumatic memories. Her initial t-score of 43 on the Intrusive Experiences scale was lower than her score of 55 after six months of treatment. Since she had reported managing incessant intrusive thoughts of sexual abuse with alcohol and cocaine, it is quite plausible that, when she first took the TSI, her usual intrusive thoughts were masked by the psychotropic medications she had been taking over the prior year. The client's validity scale scores suggest she answered all questions honestly.

FIGURE 2. Trauma Symptom Inventory (TSI) responses.



MID test results are summarized in three MID graphs, a Dissociation Scales graph (Figure 3), a Clinical Summary graph, (Figure 4) and a Diagnostic graph (Figure 5). Lisa's scores are graphed with normative data from 220 known DID patients and 183 normal patients (non-dissociative individuals).

Figure 3 summarizes Lisa's scores on the MID dissociative symptom scales. These scores reflect how often these symptoms are experienced. Lisa's scores on all the 23 scales were comparable to non-dissociative individuals with three exceptions. She scored high on Memory Problems and Being Told of Recent Actions scales. Before taking the MID Lisa complained oxcarbazepine and zolpidem tartrate were interfering with her short-term memory. Since taking the MID Lisa has come off both drugs and now reports her short-term memory and concentration are no longer impaired. That suggests these two scores may be artificially high. Her Persecutory Voices scale was also slightly elevated. This suggests the presence of one or more consciously experienced ego states.

FIGURE 3. MID Dissociation Scales

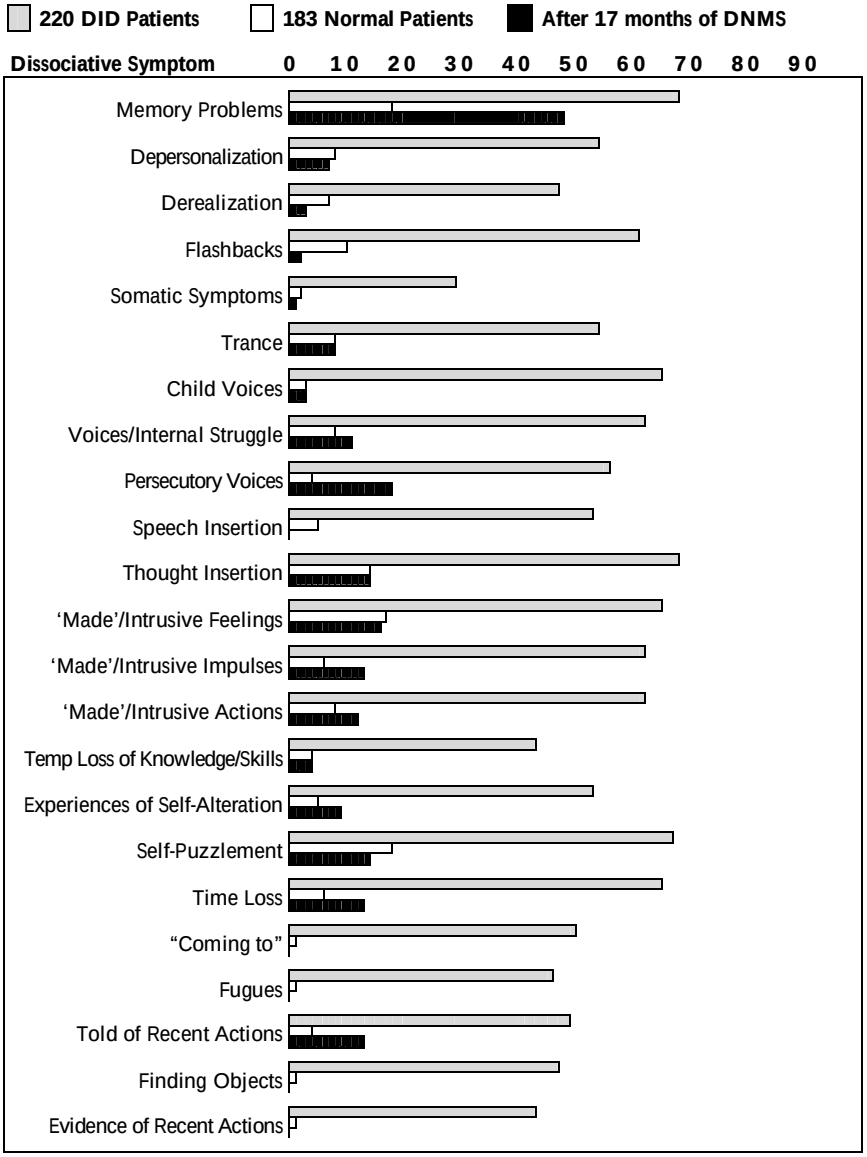


Figure 4 summarizes her scores in the five Clinical Summary categories. In the Dissociation Scales category, Lisa's Mean MID score of 10.5 indicates a low frequency of dissociative symptoms. Her Mean Severe Dissociation Score of 20 (based on her answers to 168 items) indicates a narrow range of dissociative symptoms. These two low mean scores correspond to individuals with few dissociative experiences and are common in therapy patients who do not have a dissociative disorder. Scores in all other scales in this category were below normal. In the Self-States and Alters Scales category Lisa scored slightly higher than normal on the "I Have DID", "I Have Parts", Child Part, Angry Part, and Persecutor scales. Again this suggests the presence of consciously experienced ego states. Her Helper Part scale was much higher than normal. This is predictable, since DNMS clients learn to use their team of Resources throughout the day for comfort and support. Her scores in all scales in the other three categories, Validity Scales, Characterological Scales, and Cognitive and Behavioral Functionality Scales were close to or below normal.

FIGURE 4. MID Clinical Summary Graph

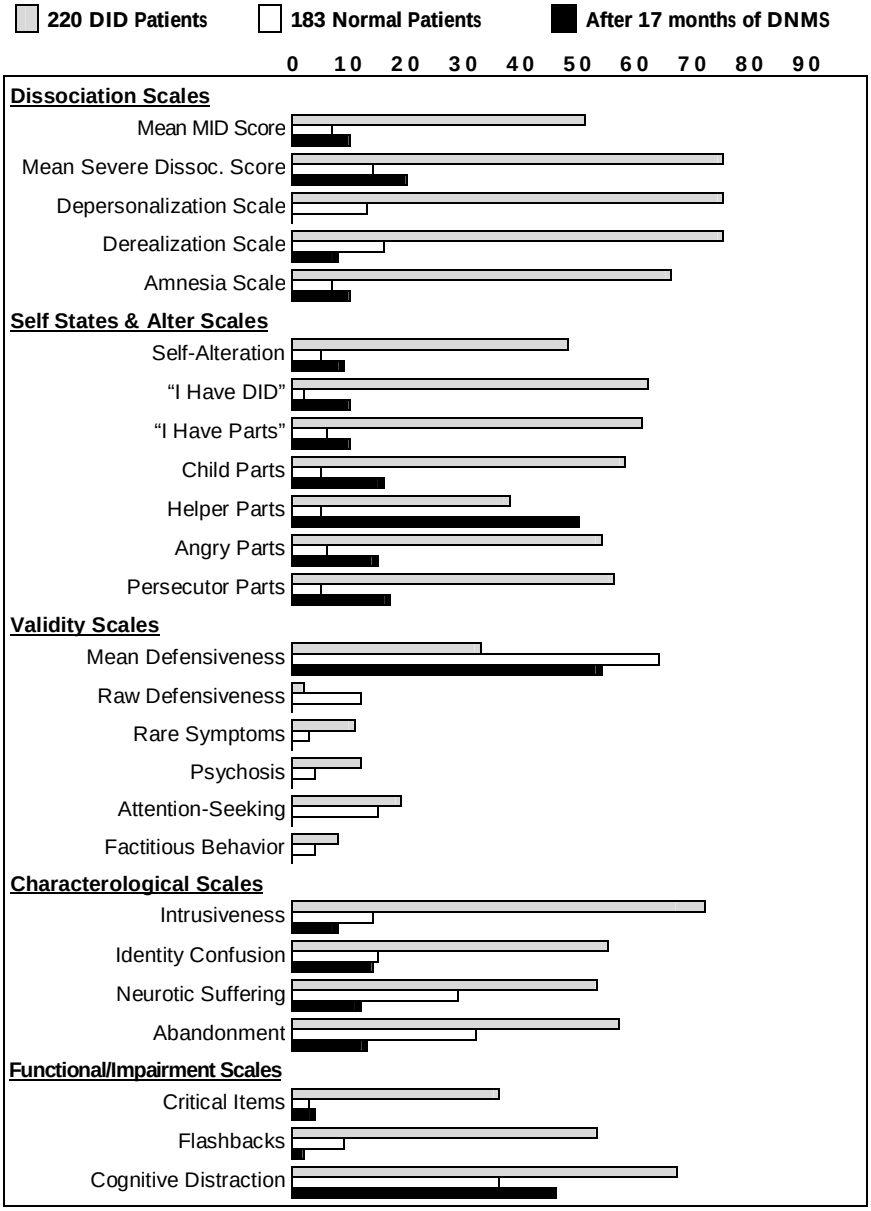


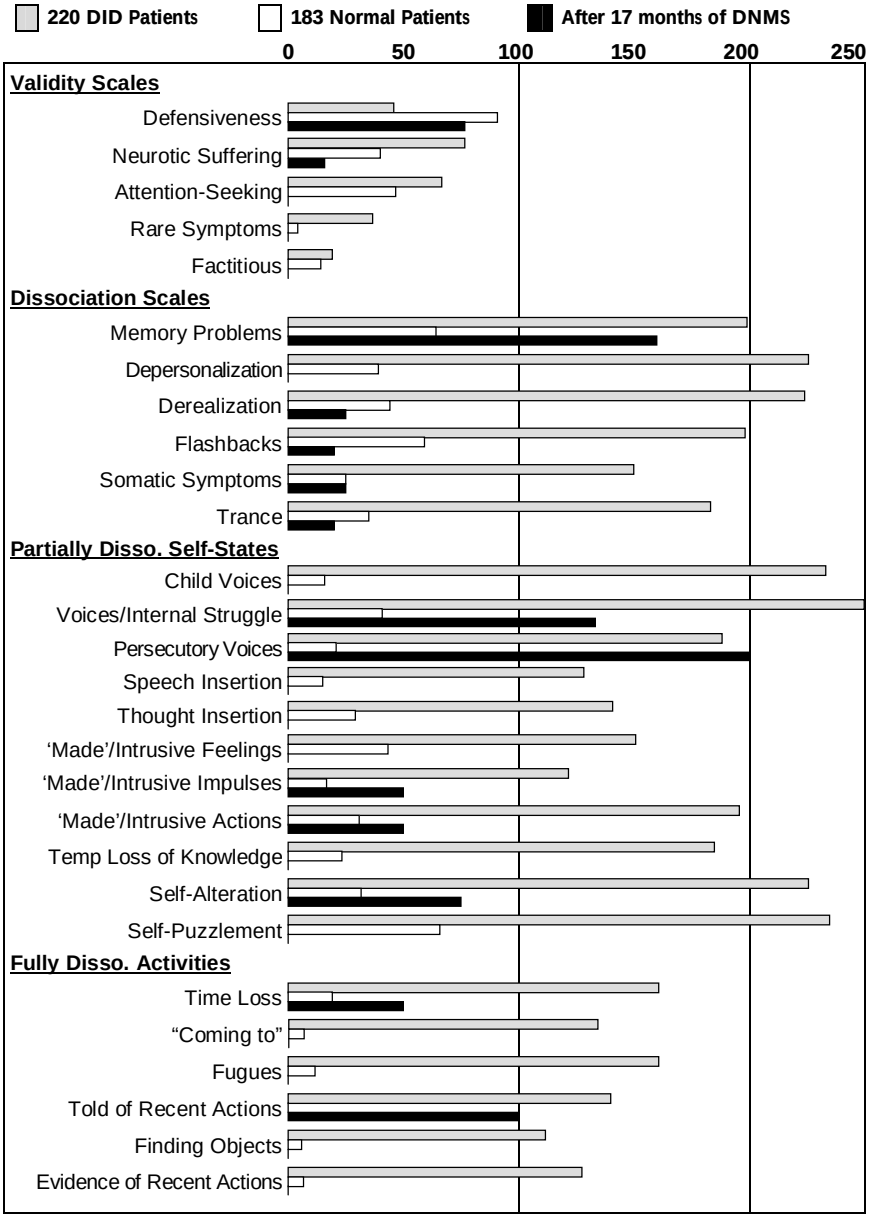
Figure 5 summarizes Lisa's scores in the Validity Scales and Diagnostic Criteria portion of the MID. The Diagnostic Criteria section of the MID organizes the dissociative scales into three categories, General Dissociative Symptoms (criterion A), Consciously Experienced Intrusions from a Dissociated Self-State (criterion B), and Fully-Dissociated Activities (criterion C). These scores reflect the number of symptoms endorsed in a scale, above a minimum cutoff point. A score of 100 means that the person 'passed' enough items on that scale to show that he or she is clearly experiencing that symptom. A high score on this scale validates that a symptom is present, but does not reflect how often it is experienced.

The number of scales at or above a score of 100 in each of these categories determines the MID diagnosis. For example, to be diagnosed with DID the client must have four or more symptoms from criterion A, six or more from criterion B, and two or more from criterion C (plus Loss of Knowledge). To be diagnosed with an ego state disorder, the client must have no more than two symptoms from criterion A, no more than nine from criterion B, and no more than one

from criterion C. According to this system, Lisa meets the diagnostic criteria for ego state disorder. That means that parts of self that are known to her occasionally intrude or create conflicts.

In the General Dissociative Symptoms category Lisa's scores were below normal on every scale but Memory Problems. Of the 11 scales in the Consciously Experienced Intrusions from a Dissociated Self-State category, she scored high in two scales - Voices/Internal Struggle and Persecutory Voices. These scores suggest Lisa has a conscious awareness of one or more dissociated self-states. Of the six scales in the Fully-Dissociated Activities category, one score, Being Told of Recent Actions, was especially high, primarily due to an answer on one item. Again this is likely related to transient memory disturbances created by oxcarbazepine and zolpidem tartrate.

FIGURE 5. MID Diagnostic Graph



Other Observations

At our 14-month milestone Lisa looked confident and radiant. She announced applying for a corporate sales job. Earlier she had been nervous about returning to work (after a year off), but she expressed total confidence in her ability to get the job, hold it, and perform well. She did get the job and she has held it for five months as of this writing. She has performed well and successfully managed stressors. She also reported beginning a romantic relationship – her first in years. She took great care determining if this person would make an appropriate partner - a total change from her previous partner selections. Over the last five months she has navigated the ups and downs of the relationship with notable skill and self-confidence.

Treatment Success in Lisa's Own Words

Many significant changes have occurred since I first began my DNMS journey. Overall, I just feel different. I feel better than I have felt in my entire life. Almost daily I learn something new about myself. It's a great feeling to look in the mirror and I see the difference in my face, my countenance. People who know me note it and tell me and it just further validates the healing that has taken place.

- For most of my life I had felt "dark", "heavy" or sad. I always had difficulty waking up to face the day. I rarely looked forward to anything. Now, I wake up feeling generally good and I look forward to most every day.
- My self-image had always been poor. I hated myself. I was disgusted with my body and my face. I always dressed down and did not care about how I looked. Now, while I know there is room for improvement, I don't feel disgusted when I look at myself. I enjoy shopping for new clothes and care about how I look.
- As a child, I never wanted to go to friends' parties and would become upset because my mother would "make" me go. I found it very difficult to engage in social activities and would suffer great anxiety as a result. The problem persisted as I grew older. Then, I learned it became easy to be around people when I was intoxicated. Now, I can be around people, be myself, without alcohol and the anxiety is almost completely gone.
- I was 15 years old when I discovered that alcohol "could" ease anxiety, make me more fun to be around, help me forget my problems, help me make friends, etc. It became a huge "tool" for me. A few times throughout my adult life, I attempted to quit drinking, but it was the most difficult thing to do and I always ended up drinking again. With drinking came the use and abuse of other drugs. I was always looking for a better way to feel better. I used cocaine whenever I drank so that I could keep drinking longer. Today, I am alcohol free and it is 100% effortless. I do not think about alcohol and I feel absolutely sure that I will not ever drink alcohol again.
- I began smoking because I though it was cool. Many times I attempted to quit and would always go back to smoking. Now, I live every day without cigarettes and with not one urge to smoke.
- I never felt comfortable being alone. I always had to have someone with me, someone who loved me and cared about me. When, the relationship would inevitably fall apart, I would fall apart and become very depressed, very angry. I'd usually go running into another relationship in order to avoid being alone. Now, while I enjoy the company, affection and warmth (and everything else) one gets from being close to someone, I do not feel incomplete without it. I do not feel ***desperate*** for affection and love. I do not want to be "taken care of". I am now looking for a partner, who fits a list of very specific traits and characteristics.
- I had always bitten my fingernails. Now, I don't and I have to trim them with nail clippers.
- I used to feel a very strong need to please my parents – even as an adult. Now, I do what I know is best for me, what I feel strongly about and don't care if it pleases or displeases them.

- If I was angry with someone, I would become quiet, distant and mean towards the other person. I wouldn't just say what was bothering me. I wouldn't try to figure out why I was so angry with the person in the first place. If I was "pushed" into talking about it, I was hurtful and would communicate with no control over my thoughts and words. Now, I know how to communicate my feelings and I do. Before I begin the conversation I look inside myself and try to figure out what exactly is at the bottom of the emotion and then I communicate it in a controlled and respectful manner.
- I can remember being very young and wanting to die. Thoughts of suicide were frequent and were not always tied into any major emotional event. Now, I want to live every day and I have not had a suicidal thought in some time.
- People were really never drawn to me. Recently, at a family reunion, many cousins and family members approached me and engaged in conversations with me. It was a very nice, wonderful feeling. I have even noticed that strangers engage me more if just with a smile or a conversation while waiting in line at the grocery store.
- I used to regularly show up late for work and other appointments. Now I am almost always early or on time.

Discussion

Lisa showed marked clinical changes from baseline after 17 months of DNMS treatment, with substantial reductions in symptoms of depression, anxiety, dissociation, and urges to smoke, drink, use drugs, and self injure. She also reported improvements in confidence, her ability to manage emotions and to interact skillfully with others. This may to be the direct result of getting 27 ego states totally unstuck using DNMS protocols. Getting an ego state unstuck appears to be the same thing as achieving ego state integration. Two of Lisa's alters, Nicki and Reba, had been very hostile, angry, and injurious. Before getting their needs met each believed they were in a body separate from Lisa's. They believed they could exert power and control over Lisa that did not harm them. After Nicki got totally unstuck, Reba was worried. She reported in the following session that Nicki had disappeared and was feared dead. I invited Reba, Nicki, and Lisa into a metaphorical conference room (Fraser, 1991) where Nicki explained to Reba that she was now happier than she had ever been, thinking the same thoughts as Lisa, on the same wavelength - in total harmony. Reba found that appealing, and after she got unstuck, reported the same positive experience.

Another alter, Sue, exemplifies the integration power of the DNMS. As we worked through the 20 steps she described her appearance changing. The closer she got to totally unstuck, the more she reported looking like Lisa. She reported looking exactly like Lisa when we finished - a change she readily embraced.

Many ego states and alters reported specific identifying ideas or beliefs, such as "intimate relationships are not safe" or "drinking is a good way to cope with stress." Once totally unstuck, these negative or harmful beliefs were effortlessly replaced with positive, self-supportive beliefs. Behavior change followed the change in beliefs. For example, Sue, the alter who believed intimate relationships were not safe, ceased sabotaging a new romantic relationship. Louise, the alter who used alcohol to cope, reported her urges to drink and smoke were gone and alcohol consumption ceased. Louise explained that she used to secretly sneak alcohol without Lisa's knowledge. After she was totally unstuck she confessed she could no longer keep secrets from Lisa – which was just fine with her.

The above examples are consistent with Shapiro's (2001) AIP model which proposes that treatment which connects an isolated neural network holding dysfunctionally stored information (an ego state or alter stuck in the past), to positive adaptive information (DNMS Resources), should result in a positive resolution, as evidenced by emotional, cognitive, and behavioral changes.

The extent of Lisa's healing potential was concealed when she presented for therapy immersed in hopelessness and suicidal thoughts. The DNMS appears to have made excellent use of all her latent skills and abilities. Lisa's positive experience with the DNMS may be attributable to her relationship with a nurturing nanny who cared for her during her grade school years. The bond they formed may have created a point of reference that made trusting a therapist, and connecting to and strengthening inner Resources, easy for her. Other DID clients, with minimal positive childhood experiences and few latent skills and abilities, may require much more time to establish rapport with the therapist and develop their internal Resources. Given Lisa's innate capacity to heal and grow, she might have had similar success if another treatment approach had been used.

While Lisa's MID scores suggest a change in diagnosis from DID to ego state disorder, it is conceivable that she still has one or more alters that are dormant at the moment - which could appear under special conditions later. Even so, she has progressed remarkably from a low level of functioning to a high level of functioning, with or without all alters integrated.

Since March of 2002 several hundred clinicians have begun using the DNMS. Many of them communicate regularly on a DNMS e-mail discussion list. List members have reported finding the DNMS helpful for treating depression, anxiety, social phobias, panic disorder, obsessions, compulsions, relationship problems, eating disorders, addictions, complicated grief, and dissociative disorders. It appears to be a helpful treatment for many clients suffering with symptoms that originated in unmet developmental needs.

In conclusion, the results of this practice-based study do not permit definitive conclusions about the use of the DNMS to treat dissociative disorders. However, together with anecdotal clinical data from DNMS clinicians, the results suggest that meeting the unmet developmental needs of child parts stuck in the past may be a useful approach in resolving trauma symptoms, in reducing symptoms of depression, anxiety, substance abuse, and dissociation, and in developing self-esteem. This appears to apply whether stuck child parts present as ego states who are consciously known to the client or as totally dissociated alters. Further research is warranted on this highly promising intervention. Lisa is still in treatment. A follow-up case study report will be submitted for publication in the future.

References

Alexander, P.C. (1992). Application of attachment theory to the study of sexual abuse. ***Journal of Consulting and Clinical Psychology, 60,*** 185-195.

Alexander, P.C. (1993). The differential effects of abuse characteristics and attachment in the prediction of long-term effects of sexual abuse. ***Journal of Interpersonal Violence, 8,*** 346-362.

Barach. P.M. (1991). Multiple personality disorder as an attachment disorder. ***Dissociation 4.*** 117-123.

Barach. P.M. (1999). A threshold-of-vulnerability model for dissociation; Etiological and treatment considerations. Plenary paper presented at the Sixteenth International Fall Conference of the International Society for the Study of Dissociation. Miami, FL.

Bliss. E.L. (1986). ***Multiple personality, allied disorders, and hypnosis.*** Oxford: Oxford University Press.

Bloch, J.P. (1991). ***Assessment and treatment of multiple personality and dissociative disorders.*** Sarasota, FL: Professional Resource Press.

Bowlby, J. (1980). ***Attachment and loss: Vol. 3: Loss: Sadness and depression***. Middlesex, England: Penguin Books.

Bradshaw, J. (1990). ***Homecoming: Reclaiming and championing you inner child***. Bantam Books

Briere, J. (1995). ***Trauma Symptom Inventory***. Florida: Psychological Assessment Resources, Inc.

Courtois. CA. (1999). The scientifically-based treatment of memories of trauma. Plenary paper presented at the Sixteenth International Fall Conference of the International Society for the Study of Dissociation, Miami. FL.

Dell, P. (2003). ***Multidimensional Inventory of Dissociation (MID): A Comprehensive Self-Report Instrument for Pathological Dissociation***. Unpublished.

Erikson, E.H. (1950). ***Childhood and Society***. New York: Norton.

Fraser, G. A. (1991). The dissociative table technique: A strategy for working with ego states in dissociative disorders and ego state therapy. ***DISSOCIATION, 4***(4), 205-213

Fromuth, M.E. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. ***Child Abuse & Neglect. 10.*** 5-15.

Gold, S.N., Silberg, J., Beere, D.B., & Rivera, M. (1999). Clinicians' update: New approaches to the treatment of dissociation. Workshop conducted at the Sixteenth International Fall Conference of the International Society for the Study of Dissociation. Miami, FL.

Gold, S.N. (2000). ***Not trauma alone: Therapy for child abuse survivors in family and social context***. Philadelphia, PA: Brunner/Routledge.

Gold, S.N., Elhai, J.D., Rea, B.D., Weiss, D., Masino, T., Morris, S.L., McInich, M. (2001). Contextual treatment of dissociative identity disorder: Three case studies. ***Journal of Trauma and Dissociation,*** Vol. 2(4), 5-36.

Greenwald, R. (1993). Magical installations can empower clients to slay their dragons. ***EMDR Network Newsletter, 3*** (2), 16-17.

Herman, J.L. (1992). ***Trauma and recovery: The aftermath of violence from domestic abuse to political terror.*** New York: Basic Books.

Hoyt, M.F. (1996). Cognitive-behavioral treatment of posttraumatic stress disorder from a narrative constructivist perspective: A conversation with Donald Meichenbaum. In M.F. Hoyt. (Ed.), ***Constructive therapies: Vol. 2***. (pp. 124-147). New York: Guilford Press.

Korn, D. L., & Leeds, A. M. (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. ***Journal of Clinical Psychology***, 58, (12), 1465-1487.

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.

Linehan, M. (1993). ***Cognitive-behavioral treatment of borderline personality disorder***. New York: Guilford Press.

Ludwig, A.M. (1983). The psychobiological functions of dissociation. ***American Journal of Clinical Hypnosis. 26***, 93-99.

Martinez, R. (1991). EMDR: Innovative uses. ***EMDR Network Newsletter, 1*** (2), 7.

Maslow, A.H. (1968). ***Toward a Psychology of Being.*** D. Van Nostrand Company.

Mullen, P.E., Martin. J.L., Anderson, J.C., Romans, S.E., & Herbison, G.P. (1996). The long term impact of physical, emotional, and sexual abuse of children: A community study. ***Child Abuse & Neglect. 20***, 7-21.

Napier, N. (1990). ***Recreating your self: Building self-esteem through imaging and self-hypnosis***. W.W. Norton & Company.

Nash, M.R., Hulsey, T.L., Sexton, M.C., Harralson, T.L., & Lambert, W. (1993). Longterm sequelae of childhood sexual abuse: Perceived family environment, psychopathology, and dissociation. ***Journal of Consulting and Clinical Psychology***, 61, 276-283.

Ogden, P. & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. ***Traumatology***, 6(3), article 3.

Pankowsky. H. (2003) ***Personal communication.***

Paulsen, S. (2000). ***EMDR and the Divided Self: EMDR and ego state therapy for non-dissociative and dissociative cleints***. All-day workshop in San Antonio, Texas, April, 2000.

Poole Heller, D. (2001). ***Crash course: A self-healing guide to auto accident trauma and recovery***. North Atlantic Books.

Phillips, M., & Frederick, C. (1995). ***Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions***. New York: W.W. Norton & Company.

Putnam, F.W. (1989). ***Diagnosis and treatment of multiple personality disorder***. New York: The Guilford Press.

Putnam, F.W. (1991). Dissociative phenomena. In A. Tasman & S.M. Goldfinger (Eds.), ***Review of psychiatry*** (pp. 145-160), Vol. 10, Washington. DC: American Psychiatric Press.

Putnam, F.W. (1997). ***Dissociation in children and adolescents: A developmental perspective***. New York: The Guilford Press.

Schmidt, S.J. (1996) ***Symptom frequency Scale.*** Unpublished.

Schmidt, S.J. (2002) ***Developmental Needs Meeting Strategy for EMDR Therapists,*** Third Edition DNMS Institute: San Antonio.

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. ***Journal of Traumatic Stress, 2,*** 199-223.

Shapiro, F. (2001). ***Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures***. Second edition. New York: Guilford Press.

Steele, A. (2001). ***Introduction to imaginal nurturing with EMDR in the treatment of adult clients with insecure attachment.*** Presentation at the 2001 EMDRAC Conference in Vancouver, BC.

Twombly, J. (2000). Incorporating EMDR and EMDR adaptations into the treatment of clients with dissociative identity disorder. ***Journal of Trauma and Dissociation,*** Vol. 1(2), 61-81.

van der Kolk, B., van der Hart, O,. & Marmar, C.R. (1994). Dissociation and information processing in posttraumatic stress disorder. In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds), ***Traumatic Stress: The effects of overwhelming experience on mind, body, and society*** (pp. 303-327). New York: Guilford Press.

van der Kolk, B.A. (1999). Trust in the treatment of PTSD, complex PTSD, dissociative disorders: A debate. With S. Bloom (Chair), L. Tinnin, O. van der Hart, & J. Shay. Symposium conducted at the Fifteenth Annual Meeting of the International Society for Traumatic Stress Studies. Miami. FL.

Widom, C.S. (1999). Posttraumatic stress disorder in abused and neglected children grown up. ***American Journal of Psychiatry, 156***, 1223-1229.

Wildwind, L. (1992). ***Treating chronic depression.*** Paper presented at the First Annual EMDR Conference, San Jose, CA

Wolpe, J. (1969). ***The practice of behavior therapy***. New York: Pergamon Press.