Appendix B:
Additional Background Material

Section 1: DNMS Journal Article Abstracts

Both articles are available on-line at www.dnmsinstitute.com.

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

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Published in the *Journal of Trauma & Dissociation*
December 2004, Volume 5, Issue 4, pages 55-78.
The *Journal of Trauma & Dissociation* is published by Haworth Press, Inc.
10 Alice St., Binghamton, NY 13904 www.HaworthPress.com

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-related symptoms, and her Multidimensional Inventory of Dissociation scores indicated she no longer met the diagnostic criteria for DID. She was functioning well without any medication. Further research concerning this treatment strategy is warranted.

The Developmental Needs Meeting Strategy: Eight Case Studies

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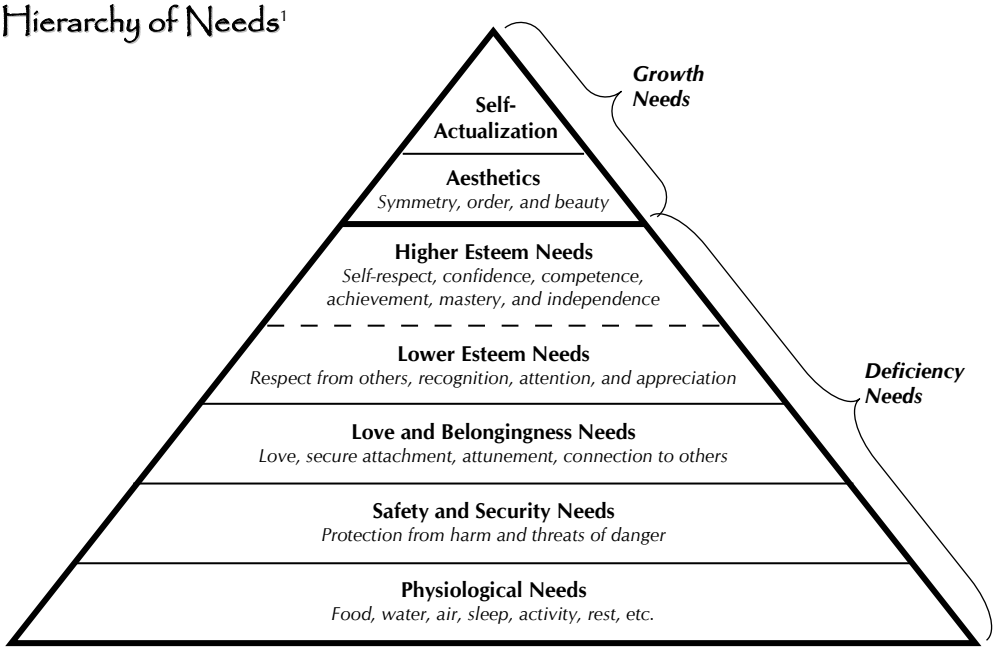
Published in the March 2007 issue of *Traumatology*, Volume 13, Issue 1, pages 27-48
Traumatology is an on-line journal published by Sage Publications
2455 Teller Road, Thousand Oaks, CA 91320 http://www.sagepub.com/

This study investigates the merits of the Developmental Needs Meeting Strategy (DNMS), a relatively new ego state therapy. The DNMS is based on the assumption that many presenting problems are due to wounded ego states stuck in childhood because of unmet developmental needs. DNMS protocols endeavor to identify and heal the wounded child parts most responsible for a presenting problem. When internal Resource ego states, which serve as competent caregivers, meet the wounded ego states' developmental needs, the wounded ego states become unstuck and heal. Eight participants were recruited from the private practice caseloads of 3 DNMS therapists. All participants reported significant improvement in the targeted problems, with gains maintained at follow-up. These findings suggest that the DNMS has therapeutic potential.

Section 2: Maslow Pyramid & Maslow/Erikson Chart

Maslow's Hierarchy of Needs[1]



Integration of Erikson's[2] Developmental Stages with Maslow's Needs

Erikson's First 5 Developmental Stages	Key Features	Maslow's Needs *A developmental perspective*	Virtues Achieved When Needs are Met
Stage 1: **Trust vs Mistrust** Infant, Ages 0-1	Baby ready to trust that mom will feed, protect comfort & bond	Physiological needs Safety needs Belongingness needs	Trust, hope, faith, an ability to mistrust
Stage 2: **Autonomy vs Shame & Self Doubt** Toddler, Ages 2-3	Child ready to develop a sense of self control, safe differentiation, and independence	Physiological needs Safety needs Belongingness needs Lower Esteem needs	Determination, willpower, sense of self control & of being separate from mom
Stage 3: **Initiative vs Guilt** Preschool, Ages 3-6	Child ready to take initiative, make things, and compete.	Physiological needs Safety needs Belongingness needs Lower Esteem needs	Purpose, initiative, courage, capacity for action while knowing limits
Stage 4: **Industry vs Inferiority** School-age, Ages 7-12 or so	Child ready to learn, master new things, & develop competencies	Physiological needs Safety needs Belongingness needs Lower Esteem needs Higher Esteem needs	Sense of industry, mastery and competence
Stage 5: **Ego-identity vs Role-confusion** Adolescent, Ages 12-18 or so	Adolescent ready to find a sense of identity & begin making educational & occupational decisions	Physiological needs Safety needs Belongingness needs Lower/Higher Esteem needs Aesthetic needs	Identity, fidelity, loyalty, willing to accept and contribute to society despite its imperfections

1. Maslow, A.H. (1968). *Toward a Psychology of Being.* D. Van Nostrand Company
2. Erikson, E.H. (1950). *Childhood and Society*. New York: Norton.

Section 3: Background Material on Attachment

Attachment Theory

The DNMS is designed to heal attachment wounds. This section provides an overview of some attachment theory basics and the neurobiology of attachment. It is intended to give DNMS therapists a fuller appreciation of what the DNMS endeavors to accomplish in healing clients with who suffer with attachment wounds.

The Attachment System

According to John Bowlby,[1] an inborn *attachment system* has emerged in humans over the course of evolution. This system provides the instinctive motivation for a child to *seek proximity* to a caregiver who will provide a safe, *secure base* from which to learn and grow. A child naturally anticipates that a caregiver will provide a *safe haven* and a source of comfort in times of distress. This attachment system increases the likelihood that young children, who cannot care for themselves, will survive and eventually reproduce.

The attachment system motivates a child to bid for a caregiver's attention, reassurance, comfort, and protection with *attachment behaviors*. For example, a baby may cry, reach out, or cling to her mother; a toddler may follow mother or climb on her lap; a five-year-old may make contact with mother by catching her eye or calling out for a vocal response. These behaviors are designed to elicit a caregiver response that reassures the child she is loved and safe. An appropriate caregiver answer to such bids might include holding, rocking, or stroking the child; or making vocal or eye contact. The child will return to sleep, play, or exploration once she feels sufficiently reassured.[2] This helps the child develop an enduring emotional bond with the caregiver.[3]

Attunement

According to Allan Schore,[4] caregiver *attunement* conveys to an infant that she is loved, seen, heard, and understood. It occurs during intense moments of non-verbal communication between an infant and caregiver when their states of mind are aligned (e.g. gazing, smiling, and laughing together). They communicate their affect to each other, via facial expression, vocalizations, body gestures, and eye contact. An attuned caregiver will sense what the infant wants and needs from behavioral cues – whether obvious (crying, clinging, reaching) or subtle (looking away, becoming numb), and will respond appropriately to those cues. This includes engaging when the infant wants connection, and disengaging when the infant wants distance. During affect attunement the infant and caregiver communicate their internal emotional states externally. For example, they smile and laugh at each other. *Alignment*, a component of attunement, occurs when one person alters her state of mind to approximate the state of mind of the other. This can be a one-way or two-way process. For example, a mother preparing an excited child for bed calms the child down more easily if she first aligns with the child's excited state, then brings the child down to a calmer state.[5]

Mental Models

Mental models are summations or generalized representations of repeated experiences.[6] They guide a person to unconsciously interpret present experiences and anticipate future ones. The mental models a child creates over the first two years of life are significant, because they form the basis for assumptions about self, relationships, and the world that can last a lifetime. A baby who is skillfully cared for and comforted by loving, attuned caregivers will learn to expect care and comfort in the future. As the baby gets what she expects, over time the mental model of a predictable world with safety and connection is strengthened.[7]

Within an intimate, attuned, interpersonal relationship, a young *child's immature brain uses the mature functions of a caretaker's brain to organize its own processes.*[8] Loving, sensitive caregivers will amplify a child's positive states and modulate the negative states. When this is experienced repeatedly, the child can construct a mental model for managing her own emotions. As a child's needs for love, safety, comfort, and connection are consistently met throughout childhood, she will grow into an adult who can feel secure in herself and securely attach to others.

In contrast, a baby who is subjected to abuse, rejection, neglect, or enmeshment in the care of unskillful caregivers will learn to anticipate more of the same. As this baby continues to get what she expects (e.g. abuse or neglect), her mental model of an unsafe or insecure world is strengthened. Even if this child is later moved to a loving home, those mental models formed in the early years will continue to contribute to her assumptions about self, relationships, and the world and to her interpretations of new experiences. If a child is consistently led to expect mistreatment or rejection throughout childhood, she will grow into an adult who will not be able to feel secure in herself, or to securely attach to others.

Internalized Representations of Caregivers and Self-Regulation

Children develop internalized representations of their significant caregivers.[9] This works to a child's advantage when *skillful caregivers* are able to manage and regulate her emotions well. By providing an internalized sense of a *secure base* and a *safe haven*, these internalized caregivers can *facilitate the self-regulation of emotions*. For example: Each time a young girl suffers minor injuries playing in the yard, her mother comforts her with a smile, a hug, and a band-aid. Mother tells her, "It may hurt for a while, but you're going to be okay." At age 15, she suffers her first romantic loss when her boyfriend breaks up with her. As she grieves the loss, her internalized mother reassures her with, "It's going to hurt for a while, but you're going to be okay." As children learn to manage their emotions they are able to individuate and mature in healthy ways. (In the DNMS model, internalized representations of skillful caregivers are referred to as *Adaptive Introjects*.)

In contrast, internalization of caregivers works to a child's disadvantage when *unskillful caregivers* are unable to manage and regulate emotions well. Such internalized caregivers can *perpetuate the dysregulation of emotions* by either generating, or failing to soothe, insecurity and anxiety. This dysregulation will impair a child's development of normal behaviors, such as play, exploration, and social interactions. (In the DNMS model, internalized representations of unskillful caregivers are referred to as *Maladaptive Introjects*.)

Attachment Styles

Individuals can form secure or insecure styles of attachment depending on their interactions with their primary caregivers.

- ***Secure Attachment***

  Children develop secure attachments to caregivers who rate high in maternal sensitivity[10], respond promptly to distress,[11] provide moderate stimulation,[12] are non-intrusive,[13] interact with synchrony,[14] and are warm, involved, and responsive.[15] Caregivers of secure infants interact positively, are rarely over-arousing, and are able to stabilize a child's disorganized emotional responses. These caregivers remain calm and secure in stressful situations, and regard their child's negative emotions as meaningful and not threatening.[16]

  The benefits of a secure attachment last a lifetime. Securely attached infants trust they will be soothed when upset, so they readily engage in play and exploration. Securely attached preschool children have been observed to be more ego-resilient and independent, demonstrating higher self-esteem than insecure children. They have friends, social skills, and empathy for peers in distress.[17] Securely attached adults are able to understand themselves and others; recognize their own internal conflicts; and realize why their parents behaved as they did.[18] Mary Main observed that securely attached adults, when asked to discuss childhood experiences (including painful interactions with parents), were able to discuss their experiences coherently, accept their parents' failings, show compassion, value attachment, demonstrate a strong personal identity, display ease with their personal imperfections, accept personal responsibility, and see reality clearly.[19]

  A secure attachment to loving, attuned caregivers is the most important of all childhood needs. Children who grow up feeling securely attached to consistently loving, attuned caregivers become well-adjusted adults with the ability to form secure attachments and regulate their own emotions, and hold a positive outlook on self and world.[20]

- ***Insecure Attachment***

  A child will form an *insecure or anxious attachment* to caregivers who are not able to provide a secure base or a safe haven. Ainsworth *et al*. observed two types of insecure attachments in children: *avoidant* and *ambivalent*.[21] Avoidantly attached children tend to enter adulthood with a *dismissing* state of mind

with respect to attachment, while ambivalently attached children tend to enter adulthood with a *preoccupied* state of mind with respect to attachment.[22]

- Avoidant/Dismissing Attachment

  A child will develop an avoidant attachment to *rejecting caregivers*. Caregiver behaviors that predict an avoidant attachment include withdrawing, hesitating, wincing, and arching away from the child. These caregivers actively block awareness of a child's attachment behaviors (e.g. crying, reaching). They are averse to physical and emotional interactions with the child. Children will experience such withdrawals as an assault on their safe haven. These caregivers are reluctant to organize the child's attention or behavior, or modulate her emotions. They are unwilling to provide comfort, whether the child's distress is aroused by environmental upsets or by the caregiver's behavior.[23]

  The avoidant toddlers exhibit little interest in adults attempting to attract their attention or little motivation to maintain contact. They appear undisturbed by a caregiver's departure, and indifferent about the caregiver's return. While avoidant children feel angry that proximity to the caregiver is restricted or blocked, they will not openly express their distress. Children may respond with rejecting behaviors, such as not looking at the caregiver, or avoiding the caregiver entirely. They have learned to expect the caregiver will not provide comfort. Main and Stadtman believe that avoidance is a mechanism to "modulate the painful and vacillating emotion aroused by the historically rejecting mother."[24] Alan Sroufe observed three types of avoidant preschoolers: (1) the lying bullies who blame others; (2) the shy, spacey, loners who appear emotionally flat; and (3) the obviously disturbed daydreamers with repetitive tics, who show little interest in their environment. The avoidant children were observed to be sullen and oppositional, often preying on other children.[25] They were disliked by their peers and described by preschool teachers as dishonest and mean. While they normally exhibited negative, attention-seeking, dependent behaviors, they would withdraw if injured or disappointed. Adults who had an avoidant attachment style in childhood are said to have a *dismissing state of mind with respect to attachment* in adulthood.[26] Main observed that these adults, when asked to discuss childhood experiences (including painful interactions with parents), tend to idealize one or both parents, fail to support idealized characterizations with meaningful examples, show contempt for attachment figures or attachment related experiences, and describe themselves positively, as strong, independent, and normal. They minimize their negative childhood attachment experiences by reporting they had little or no negative impact; by insisting they were character-building experiences; by suggesting everyone has these experiences; and/or by summarizing a negative story with a positive spin. They are not able to talk about or express feelings of vulnerability. Many are unable or unwilling to answer questions about attachment experiences from childhood.

  Children who grow up with an avoidant attachment to caregivers become adults who are dismissive of emotional connections and attachments, and who manage distress by ignoring painful realities and repressing unpleasant emotions.

- Ambivalent/Preoccupied Attachment

  A child will develop an ambivalent attachment to *intrusive/engulfing caregivers*. Caregiver behaviors that predict an ambivalent attachment (sometimes called *resistant* attachment) include routinely subjecting the child to high-intensity emotional stimulation, while ignoring the child's bids for stimulation reduction (e.g. crying, looking away). These caregivers are emotionally insensitive, haphazard, and unpredictable – emotionally available sometimes but not always. Even when they are present, the child cannot be sure her signals and communications will be handled by the caregiver appropriately. Because these caregivers are not attuned or sensitive to a child's cues, they overwhelm the child with stimulation. This interferes with the child's ability to assimilate new experiences. These caregivers are ineffective at setting boundaries and limits, at reducing feelings of shame, and at managing the child's aggressions.[27]

  Ambivalent children alternate proximity-seeking behaviors with angry, rejecting behaviors – perhaps punishing the caregiver for being unavailable. Because these caregivers do not function as a reliable, secure base, the children can become preoccupied with the caregiver's emotional states to the point of not feeling free to play and explore independently. As this child displays heightened emotionality and dependence, she succeeds in drawing the caregiver's attention.[28] The child becomes addicted to

the caregiver, and addicted to strategies to influence the caregiver to change. The ambivalent child learns that fear will bring attention, so she looks for things to be afraid of.[29] Sroufe observed two types of ambivalent preschoolers: (1) those who were fidgety, impulsive, tense, with poor concentration, and easily upset by failures; and (2) those who were fearful, hypersensitive, clingy, lacking in initiative, and prone to give up easily.[30] These children were too preoccupied with their own needs to have any feelings for the children around them. They were highly dependent, exhibiting a weak sense of self. Their disruptive behavior often angered other children. Aggressive encounters evoked a panic response, which made them easy targets for future bullying. The preschool teachers described the ambivalent children as ineffective, emotionally immature, and incapable of following rules. Ambivalent children worry about themselves and their intrusive caregiver, often becoming the *parentified child*. The child may be afraid of going to school, not because something at the school is frightening, but because she fears losing her caregiver, or worries that her caregiver will become unbearably lonely while she is away.[31] Adults who had an ambivalent attachment style in childhood are said to have a *preoccupied state of mind with respect to attachment* in adulthood.[32] Main observed that these adults, when asked to discuss childhood experiences (including painful interactions with parents), would discuss disturbing attachment experiences to excess. They would go on and on about parents' failings, taking far more than the usual conversational turn, demonstrating their preoccupation with anger. They exhibited a lack of coherence by not answering the questions asked; by wandering off topic; or by oscillating between positive and negative evaluations of a caregiver, in rapid succession. They appeared incapable of objectivity, insight, or genuine understanding about their attachment wounds, and were consequently unable to discuss them fruitfully or skillfully. They resorted to blame of self or others. Their sense of self appeared closely linked to unresolvable disturbing experiences with their parents.

Children who grow up with an ambivalent attachment to caregivers become adults who are preoccupied with problematic emotional connections and attachments – both past and present, who are overly dependent on others, and who lack the ability to manage their own emotions and impulses.

- ***Disorganized/Unresolved Attachment***

In addition to the three childhood attachment styles listed above (secure, ambivalent, or avoidant) a child may have a *disorganized attachment* to caregivers.[33] The disorganized attachment status is a secondary classification, applied in addition to the child's primary attachment status. For example, a child may be secure-disorganized, ambivalent-disorganized, or avoidant-disorganized. Caregivers who have unresolved traumas and losses can slip into an unresolved, anxious, dissociated state of mind. In this *unresolved state of mind*, the *dissociated caregiver* cannot provide a child with a secure base or safe haven. Infants identified as disorganized demonstrated unusual behaviors upon reunion with their mother following a brief separation. Examples of these unusual behaviors include sequential or simultaneous contradictory behaviors (e.g. avoidance and contact-seeking gestures); incomplete approaches to the caregiver; unusual body movements or posturing; fearful or dazed facial expressions; and rapid changes in affect.[34] Main and Hesse attributed this disorganization to unresolved caregiver behaviors that frighten the child. They reasoned that, if a caregiver arouses a child's fear, it places the child in an unresolvable paradox, because the caregiver to go to for safety is the also the source of the fear.[35] Karlen Lyons-Ruth *et al*. advanced two alternative hypotheses. First, that unresolved caregivers might display competing or contradictory strategies for caring for the child, much as disorganized children display competing or contradictory attachment strategies. Second, that any caregiver behaviors (e.g. rejection, neglect, intrusion) that were unable to calm a child's fear, would also be potentially disorganizing, whether or not those caregivers behaviors actually elicited the fear. Unresolved adults become disoriented, illogical, and incoherent during discussions of abuse or loss.[36]

Children who are not offered a safe haven from fearful arousal often become dissociated adults. As they experience traumas and losses in adulthood they are unable to resolve them, because their disorganized mental models and internal representations lack the means to do so.[37]

- ***Earned/Autonomous Secure Attachment***

Bowlby writes, "Fortunately the human psyche, like human bones, is strongly inclined towards self-healing. The psychotherapist's job, like that of the orthopedic surgeon's, is to provide the conditions in which self-

healing can best take place."[38] Individuals with any of the insecure attachment categories listed above can achieve "earned" secure/autonomous attachment status. Individuals who have earned secure/autonomous attachment status have finally made sense of their childhood wounds with the help of one or more supportive relationships and/or psychotherapy.[39] They are able to understand, organize, and discuss painful childhood attachment relationships in a coherent way. (The term "earned" does not refer to "deserving.")

Caveat about Attachment Styles

Each attachment style described above reflects a relationship with a single caregiver. For example, an infant could be securely attached to her nanny, avoidantly attached to her father, and ambivalently attached to her mother. The attachment styles outlined above describe these classifications in their purest form. While they are helpful categories for attachment researchers, in reality, many people do not fit these classifications exactly as described. A given individual may exhibit behavior patterns from more than one attachment classification.[40] This is understandable considering that different ego states can have different mental models, formed by the internalized representations of different significant caregivers.

Rupture and Repair

Relationships between children and caregivers will naturally involve times of disconnection. These small traumas may or may not be followed by reconnection and repair. Loving, attuned caregivers recognize and respond to these disconnections with soothing and comfort, which leads to the necessary repair. Avoidantly attached children have rejecting caregivers who lack the willingness or ability to provide the needed reassurance to effect a repair. Ambivalently attached children have intrusive caregivers who persist in making reparative contact, but who do so without sufficient sensitivity or attunement. Because the caregiver is misattuned, the child becomes overwhelmed, and attempts to initiate a repair fail. Disorganized children may have frightening caregivers who are unable to affect a repair because they are the source of the fear. This leaves the child over-aroused, in a state of despair.[41]

Neurobiology of Attachment and Attunement

Two branches of the autonomic nervous system (ANS) help control the body's state of arousal. The *sympathetic branch* is associated with excitatory, arousing affect. It induces physiological responses that increase heart rate, respiration, sweating, and states of alertness. The *parasympathetic branch* is associated with inhibitory, de-arousing, energy-conserving affect. It induces physiological responses that decrease heart rate, respiration, sweating, and states of alertness.

Excited states of mind (sympathetic branch) predominate in the first year of life, during moments of intense non-verbal attunement between a child and her loving, attuned caregiver. Inhibited states of mind (parasympathetic branch) predominate in the second year, when a child becomes more mobile, and caregivers prohibit risky exploration. For example, when the child reaches for a hot stove, mother will yell "No!" For a child to learn self-regulation, caregivers must balance the child's need for excitatory mental-state alignment with the need for inhibitory prohibitions.

The *orbitofrontal cortex* (OFC) is the part of the brain just behind the eyes. It is the only cortical structure with direct connections to the cingulate gyrus, hypothalamus, the amygdala and brainstem nuclei; thereby constituting the rostral (extended) limbic system. The lower limbic structures (hypothalamus, amygdala and brainstem) provide automatic, primitive, survival reflexes (e.g. fight or flight) while the higher rostral limbic structures (OFC and cingulate gyrus) allow for fine-tuned adjustments in emotional perception and affect management.[42] Because of its strategic anatomic location, the OFC is able to integrate these higher and lower limbic processes into a functional whole. The OFC is especially sensitive to face-to-face communication and eye contact. Because it serves as an important center of appraisal, it has a direct influence on the elaboration of states of arousal into various types of emotional experience. Understanding the OFC is crucial to understanding emotional self-regulation and neural integration.[43]

Caregiver attunement appears to have a direct impact upon a child's OFC.[44] When a happy excited toddler is about to touch a hot stove, and the caregiver yells "No!", the OFC puts on the brakes. The toddler contracts in

shame. Shame can be understood as a sudden shift from sympathetic system activation (the accelerator) by an *internal* "Go!", to parasympathetic system activation (the brakes) by an *external* "Stop!"[45] The attuned caregiver comforts the upset child, and lovingly explains that hot stoves can cause painful burns. This helps restore the child-caregiver alignment, which leads to a release of the brakes (the parasympathetic system is deactivated). Once the emotional repair with the caregiver has been completed, the child feels free to return to exciting play and exploration (the sympathetic system is reactivated). There is a healthy balance between the activation of the accelerator and the application of the brakes – which is the essence of affect regulation. The child successfully integrates this upsetting experience by concluding that, while her caregivers might not always like what she does, they always like her. As this child becomes an adult her OFC will be able to regulate the sympathetic "accelerator" and the parasympathetic "brakes," without an attuned caregiver present to guide the process.

When a caregiver responds with disgust or displeasure to a child's bid for attunement, the child shifts into an escalating state of shame. This is a serious relationship break, and if unrepaired, will lead to mental models that cannot self-regulate shame, and that inhibit the spontaneous expression of "true self." [46]

The OFC plays an important role in many brain functions.[47] When developing in the care of loving, attuned parents, it functions very differently than when developing in the care of misattuned, rejecting, or intrusive parents. This point is illustrated in the table below.

An optimally-developed OFC plays a role in the following benefits:	**A non-optimally-developed OFC may play a role in the following problems:**
▪ The regulation of emotion;	▪ Impaired regulation of emotion;
▪ The appraisal of stimulus to make meaning of events; [48]	▪ Impaired appraisal of stimulus. Problems making meaning of events;
▪ Engagement in emotionally attuned communications;	▪ Difficulty engaging in emotionally attuned communications;
▪ Sensitivity to others' subjective experience;	▪ Difficulty sensing others' subjective experience;
▪ Moral reasoning; and	▪ Poor moral reasoning; and
▪ *Response flexibility*, the ability to adapt to the internal and external environment with appropriate behavioral and/or cognitive responses. [49]	▪ Inflexible responses resulting in a failure to adapt to internal and external environments.

An optimal-functioning emotion-regulating OFC develops as child-caregiver psychobiological states are attuned.[50] There can be neurobiological consequences when this does not happen. Excessive, unregulated arousal (whether from the sympathetic or parasympathetic branch) will interfere with the maturation of the child's right hemispheric structural systems that mediate socioaffective self-regulation. Reductions in the levels of neurotrophic catecholamines during critical periods (first two years) of corticolimbic maturation produce alterations in the structural development of the OFC. Extreme hormonal alterations induce "developmental overpruning" of the sympathetic ventral tegmental and/or parasympathetic lateral tegmental limbic circuits that it dominates. The release of stress hormones leads to excessive death of neurons in the crucial pathways involving the cortico-limbic structures – the areas responsible for emotional regulation.

The orbitofrontal region plays an important role in response flexibility. This refers to the brain's ability to adapt to the internal and external environment with appropriate behavioral and/or affective responses. This appears to require the integrative capacities of the orbitofrontal region in order to functionally link the associational cortex, limbic circuits, and brainstem areas. In this manner, the orbitofrontal region enables the more complex "higher order" processing of the left dorsolateral prefrontal cortex to be integrated with the "lower order" functions of the deeper structures. The region functions as a neural pathway that links a wide array of perceptual regulatory and abstract representational regions of the brain.[51]

Siegel defines integration as the "functional coupling of distinct and differentiated elements into a coherent process or functional whole."[52] Adaptive and flexible ego states can be both highly differentiated *and* functionally united. He describes ego states that are stuck in unresolved trauma as "…functionally independent, an isolation

that may have preserved the ability of the individual to function in the face of traumatic experiences."[53] If trauma leads to the isolation of ego states, it follows that the neural integration of those ego states should lead to healing. Siegel favors psychotherapies that encourage the bilateral integration of information across the right and left hemispheres of the brain, as well as integration of here-and-now with past-present-future awareness.[54]

The orbitofrontal region plays a key role in facilitating neural integration. It makes sense that a psychotherapy that helps it to function optimally should increase the probability of adaptive neural integration occurring. The OFC thrives in the care of loving, attuned caregivers in childhood. It appears to respond well to nurturing in adulthood too – whether the loving, attuned caregivers are internal or external.

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Section 4: Background Material on Prenatal Introjection

Prenatal Introjection

According to Siegel, *explicit memory* can be verbal, episodic and/or semantic. It requires conscious awareness for encoding.[1] It involves a subjective sense of self, of time, and of "recalling." It includes factual memories (e.g. names of each state) and autobiographical memory (e.g. 1980 trip to Paris). In contrast, *implicit memory* is nonverbal and procedural. It includes behavioral, emotional, perceptual, and perhaps somatosensory memory. It lacks a subjective experience of self, of time, or of "recalling." Focused attention is not required for encoding. While children begin to collect and recall explicit memories about age two, implicit memories begin forming in the womb. Both types of memories contribute to the formation of mental models of the world. The explicit memories contribute consciously, while the implicit memories contribute unconsciously.

In his book, *The Secret Life of the Unborn Child*, Thomas Verny writes that an unborn baby is capable of learning, hearing, responding to voices and sounds, and responding to love.[2] The baby is an active, feeling human being, sensitive to parents' feelings about him. He cites several research projects relevant to the DNMS. Monika Lukesch, at Constantine University in Frankfurt, followed 2000 women through pregnancy and birth. The mothers came from the same economic background, had the same intelligence level, and received the same degree and quality of prenatal care. Lukesch observed that the mothers who had wanted a family had children who were physically and emotionally healthier, at birth and afterwards, than the children of rejecting mothers. Gerhard Rottmann, at the University of Salzburg, placed each of 141 pregnant mothers in one of four emotional attitude categories based on psychological testing that measured the mother's conscious and unconscious desire to have the baby. The *Ideal Mothers* who wanted their babies both consciously and unconsciously had the easiest pregnancies, the most trouble-free births, and the healthiest offspring – physically and emotionally. The *Ambivalent Mothers* appeared to others to want their babies, but were privately ambivalent. An unusually large number of their babies had both behavioral and gastrointestinal problems. The *Cool Mothers* reported they were not ready to become mothers (e.g. due to financial problems or career plans), but actually wanted their babies. An unusually large number of their babies were apathetic and lethargic. The *Catastrophic Mothers* did not want to be pregnant. Their babies had the most devastating medical problems during pregnancy, and bore the highest rate of premature, low birth weight, and emotionally disturbed infants.

The *Avon Longitudinal Study of Parents and Children*, is a prospective, community-based study that has followed a cohort of 7144 women since pregnancy. The women delivered their baby between April 1, 1991, and December 31, 1992. The women were asked to self-report levels of anxiety and depression at repeated intervals during and pregnancy. Then parents assessed their children's behavioral/emotional problems at age 4. After statistically accounting for a number of confounding effects, such as smoking, alcohol abuse, birth weight, maternal age, and socioeconomic factors, the researchers, O'Conner, Heron, and Glover, found that the women who reported feeling highly anxious during pregnancy were twice as likely as non-anxious women, to have children with behavioral difficulties, depression, and anxiety.[3]

Prenatal Introjection References

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Section 5: Popular Ego State Psychotherapies

Psychosynthesis

Psychosynthesis, developed by Roberto Assagioli, is an approach focused on the integration of previously separate elements into a more unified whole.[1] Those separate elements range from the lower unconscious subpersonalities (pre-programmed, contradictory aspects of self) to the superconscious (inspiration, guidance, comfort, strength, peace, hope, wisdom). Much of Psychosynthesis is aimed at recognizing and harmonizing subpersonalities. Methods commonly used include honoring parts of self, acknowledging and meeting subpersonality's needs, guided imagery, body awareness and movement, symbolic art work, journal-keeping, training of the will, goal-setting, dreamwork, development of the imagination and intuition, gestalt, ideal models, and meditation.

Transactional Analysis

Transactional Analysis, developed by Eric Berne, is based on the idea that human personality is made up of three distinct ego states (Parent, Adult, and Child).[2] Each ego state is a set of related thoughts, feelings, and behaviors from which we can understand interpersonal and intrapsychic dynamics. Berne believed decisions made in childhood in the interest of survival could become self-limiting and result in dysfunctional behavior. The Parent ego state has two parts, the Nurturing and the Controlling Parent, and the Child ego state has two parts, the Adapted and the Free Child. The Nurturing Parent is comparable to the DNMS *adaptive introject*; the Controlling Parent is comparable to the DNMS *maladaptive introject*, the Adapted Child is comparable to the DNMS *reactive part*; and the Free Child is comparable to a reactive part that's become totally unstuck.

Gestalt Therapy

Gestalt Therapy, developed by Fritz Perls, invites clients to integrate and accept parts of their personality they have disowned or denied.[3] Perls believed a *top dog* (controlling, blamer part of self) and an *underdog* (victim, complainer part of self) are in constant internal conflict. His top dog is considered an introject of societal authority figures and parents conveying "should" and "shouldn't" messages. The underdog resists the top dog's messages. The empty chair technique is a role-play used to reduce the internal conflict. The client engages these conflicted parts of self in dialogue by playing the top dog in one chair, talking to the underdog in another chair. The internal conflict resolves as both parts come to understand and accept each other.

The SARI Model

The SARI Model, developed by Maggie Phillips and Claire Frederick, is a four-stage approach for the treatment of clients with ego state conflicts and dissociative disorders.[4] SARI is an acronym for each stage, starting with stage one, *safety* and *stabilization*; stage two, *accessing* the trauma and related resources; stage three, *resolving* traumatic experiences and *restabilization*; and stage four, personality *integration* and the creation of a new *identity*. Phillips & Frederick advocate the use of clinical and Ericksonian hypnotherapy at each stage of treatment.

Internal Family Systems Therapy

Internal Family Systems Therapy, developed by Richard Schwartz, evolved out of the observation that patients had an internal system of parts of self that interacted just like members of a family. 5 This approach is based on the idea that each person has a core Self that contains crucial leadership qualities (e.g. curiosity, competence, clarity, confidence, compassion, acceptance), and other parts of self which fall into three categories. These categories include Exiles (young traumatized parts which embody pain, terror, and fear, which are isolated from the rest of the system), Managers (parts that control situations and relationships in an effort to protect exiles from feeling hurt or rejection), and Firefighters (parts that engage when Exiles are activated in an effort to control and extinguish their feelings). Therapy is designed to unburden parts so a client can be effectively led by the Self.[6]

Voice Dialogue

Voice Dialogue, developed by Hal and Sidra Stone, aims to expand a client's ability to act consciously.[7] The therapy is designed to help a client develop an "Aware Ego" that is able to make choices by taking the views of opposing selves into consideration. Those contrasting views come from Primary Selves (responsible for executive functioning and decision-making) and Disowned Selves (repressed vulnerable parts of self), that are often in direct conflict. The goal of Voice Dialogue is not to change parts of self, but to bring sufficient awareness to internal dynamics that harmony can replace conflict. One aspect of this work involves honoring the parts, acknowledging and meeting their needs.

Ego State Therapy

Ego State Therapy, developed by Jack and Helen Watkins, is based on the belief that ego states constitute a "family of self" within an individual.[8] Hypnosis and family/group therapy techniques are used to resolve conflicts between ego states. Internal negotiations may use directive, behavioral, abreactive, or analytic or humanistic techniques of treatment, usually under hypnosis. Dependent ego states are helped to find internally the nurturing needed to heal. According to Watkins & Watkins, as internal needs are satisfied and conflicts are resolved, the internal family becomes happy and the whole person is well adjusted.

Inner Child Psychotherapy

Inner Child Psychotherapy is based on the idea that adults who suffered neglect, abuse, or unmet needs from childhood can heal past hurts by nurturing their child ego states. In his book *Homecoming,*[9] John Bradshaw outlines methods for using a "wise and gentle old wizard" self to adopt and nurture an infant self, a toddler self, a pre-school self, a school-age self, and an adolescent self. Nancy Napier's books *Recreating Yourself*[10] and *Getting Through the Day*[11] suggest ways to connect to an optimal future self and to identify and embrace disowned child parts of self. Lucia Capacchione wrote several books proposing non-dominant hand drawing and writing to connect to and heal the inner child.[12] Some others who have promoted inner child healing work include Bishop & Grunte,[13] Chopich,[14] Hay,[15] Levin,[16] Missildine,[17] Paul,[18] Taylor,[19] and Whitfield.[20]

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Section 6: Typical Developmental Needs Table

Some Typical Developmental Needs

Conception to Birth

- Parents want the baby
- Parents prepared to bond with baby
- Parents lovingly talk, sing to baby
- Parents happy about baby coming
- Mother eating well
- Mother exercising enough
- Mother refrains from unhealthy acts
- Mother supported by father
- Parents emotionally prepared for baby
- Parents financially prepared for baby
- Parents who can meet their own needs and manage own emotions

Birth to 1 Year

- Good food
- Safety
- Attunement
- Warmth and closeness
- Appropriate response to cries
- Consistent nurturing
- Loving eye contact
- Respectful caregivers
- Positive attention

1 Year to 3 Years *Plus all birth to 1 year needs*

- Reassurance
- Supervised play
- Unconditional acceptance
- Loving correction
- Conversation
- Praise
- Stimulating exploration
- Freedom of expression
- Structure
- Consistency
- Freedom to develop self control
- Repair of relationship breaks

3 Years to 6 Years *Plus all birth to 3 year needs*

- Encouragement and praise
- Approval for accomplishments
- Validation of perceptions
- Opportunities to make things
- Opportunities to master motor skills
- Freedom to express emotions
- Help processing through emotions
- Age-appropriate limits
- Patient caregivers

6 Years to 12 Years *Plus all birth to 6 years needs*

- Support for exploring the world
- Encouragement to develop opinions
- Encouragement to express ideas
- Help solving problems
- Help developing social skills
- Age-appropriate responsibility
- Learning opportunities
- Intellectual challenges
- Physical challenges

12 to 18 Years *Plus all birth to 12 years needs*

- Age-appropriate independence
- Age-appropriate limits and rules
- Support for finding sense of identity
- Permission to separate from parents
- Support for making education and occupational decisions

Section 7: Typical Misunderstandings That Block Processing and Suggestions for Correcting Them

Misunderstandings Unique to the Resource Development Protocol

Client has confused the words "protective" and "overprotective."
Show client the difference with her own experiences of being appropriately protective.

Client has confused the notion of "being nurturing to others" with "being exploited by others."
Show client the difference with her own experiences of being appropriately nurturing.

Client has assumed a skill must be applicable all the time, with everyone, to be endorsable.
Explain to client that a skill can be endorsed if it is ever applied with a loved one, from the most adult self, even for short periods of time. It does not matter that the skill is not applied at other times.

"I wasn't very good at protecting my kids. I don't think I have a Protective Self."
Explain to client that if she has ever been appropriately protective of a loved one, while in her most adult self, even for short periods of time, then she has the potential to be protective again in the future. So for the purposes of connecting to a PAS, it does not matter that there were also times she was not protective. What matters is that she can recall times she was protective.

"There's no point in developing Resources because they won't be real."
Explain that the Resources are about real skills contained in real neural networks. If a client's love and affection for her cherished loved one is real, then the Resources are real as well.

"I prefer to experience my Resources as fictional beings because they'd be better caregivers than I am."
Ask the client if her cherished loved one believes she is an adequate caregiver when she is in her most adult self. If so, her Resources should be as good as or better than fictional Resources.

"If I admit to having adult skills, I'm bragging. Bragging is bad and should be punished."
Explain the difference between bragging, self-absorption, and conceit, versus self-confidence, self-esteem, and self-assurance. (There may also be an introject involved, threatening to punish bragging.)

Misunderstandings Unique to the Conference Room Protocol

"Inviting an introject forward puts child parts at risk."
Reactive parts often fear that the introjects who are going to be invited to the conference table, are a threat. Offer to separate the reactive parts and introjects with a protective "glass wall" across the table. In addition, reactive parts can be informed that, while an introject costume may appear threatening, the danger is just an illusion. The child wearing the costume is not a threat at all.

Misunderstandings Unique to the Needs Meeting Protocol

"There's no point in doing the needs meeting work because it won't be real."
Explain that the Resources are real neural networks that can be nurturing and protective of wounded child parts in the same real way the most adult self can be nurturing and protective of her cherished loved one.

"I can't process my anger or grief without being overwhelmed." (Step 8)
Explain the *Processing Emotions by Needs Meeting* routine.

"Anger is a bad emotion." (Step 8)
Some clients believe that bad emotions, like anger, must be avoided. Explain that emotions are not good or bad, they are comfortable and uncomfortable, pleasant and unpleasant. When managed appropriately, every emotion can serve a valuable purpose – even anger. (This may be a message from a maladaptive introject.)

"Only bad people express anger." (Step 8)
Validate that mean people can hurt others in anger. Then explain that healthy people can express anger in healthy ways – with skill and respect for others. (This may be coming from a maladaptive introject.)

"I'd be just like my (*wounding role model*) **if I show my anger."** (Step 8)
Explain that there is a difference between expressing anger skillfully versus unskillfully. Her wounding role model expressed anger unskillfully and destructively. In contrast, skillful expression of anger is not disrespectful. It can be constructive and healing. Furthermore, the loving compassion of the Resources can help the anger process through.

"If I express my anger I'll be disloyal." (Step 8)
Some children grow up being told that any negative emotions they expressed towards or about parents is a sign of being ungrateful or disloyal. These clients may have trouble acknowledging unexpressed and unresolved anger or grief about unmet childhood needs. Explain that the expression of anger about wounding parental behaviors is natural and appropriate – whether or not the parents agree. (There may also be an introject threatening to punish child parts for being disloyal.)

"Bonding with a caregiver will inevitably lead to betrayal or abandonment." (Step 9)
Remind the child parts that the Resources would not betray or abandon their cherished loved one. (There may also be an introject threatening to betray or abandon child parts if they get too close.)

"If I bond with the Resources I'll be smothered or engulfed." (Step 9)
Explain that bonding to loving, attuned Resources is not smothering or engulfment. Invite the child parts to notice that the Resources totally understand her aversion, and grant her explicit permission to feel it as long as she needs to. Explain they want her to express whatever emotion comes up, without pressure to feel any other way. (There may also be an introject threatening to smother or engulf child parts.)

"It's not okay for the Resources to hurt when I hurt." (Step 9)
Have the child parts ask the Resources if they are okay with hurting when they hurt. When the Resources say "yes," the aversion may soften. Ask the child parts if they would feel distressed seeing their favorite kitten or puppy hurt, and if so, would that be okay? The child parts may then see it is a normal appropriate reaction. Help the child parts understand that the hurt experienced in empathy for a loved one is a good hurt. Tell the child parts that parents who cannot manage emotions well are more likely to shame or punish a child for "making them hurt." In contrast, the Resources can manage emotions quite well.

Misunderstandings Common to all the Protocols

"I'm afraid I'll lose a familiar sense of identity."
Say something like: "You'll never be without a sense of identity. While you maintain your old familiar negative identity, based on (*feeling lonely, depressed, etc.)* the Resources will help create a new one, based on self-esteem and self-confidence. Anything of value from your old sense of identity will be integrated into your new identity. Once your new identity is strong enough, everything about your old identity that no longer helps you will be naturally and automatically discarded. How does that sound?" This usually resolves the fear.

"I had to meet my own needs in childhood. Doing the DNMS means I'll have to meet my own needs again. I don't want to do that. It's time for someone else to meet my needs."
When child parts voice this concern they need to know that they will not be expected to meet their own needs, the Resources will do that for them.
When adult clients voice this concern they need to know that when a young child gets connection, soothing, and nurturing needs met by parents, in the brain ***special neural networks*** form (which mimic the loving parents) and ***special neural pathways*** form (which communicate that mimicked love to other parts of the brain). As parents meet these needs over time, these neural networks and pathways become stronger and better developed, and eventually facilitate self-soothing. When this child is an adult, these neural pathways help in the management of painful emotions, especially at times of crisis or loss. A child who does not get these needs met well, may not develop these neural networks and pathways well enough for self-soothing, and may have great difficulty as an adult, managing even mildly painful emotions. The DNMS appears to help establish these pathways in adulthood. That means that, even if they were not formed well in childhood, they can be formed and strengthened now. The result is an adult brain capable of managing emotions well – the same brain the client would have had if those needs had been met in childhood.

"If I get unstuck from childhood, my abusive parents are off the hook."
Tell the child parts that adults' abusive behavior towards children is never excusable. In a perfect world parents would be held accountable for abusive behavior, but that does not always happen. Fortunately the child parts can get unstuck whether parents pay for their crimes or not.

"The Resources would (or will) eventually abandon me like everyone else has."
The client is probably projecting a wounding role model onto the Resources. Ask client if she is going to abandon her cherished loved one eventually. (There may also be an introject threatening abandonment.)

"Authority figures cannot be fully trusted – not even my Resources."
The client is probably projecting a wounding authority figure onto the Resources. Ask client if she is trustworthy with her cherished loved one. (There may also be an introject who cannot be fully trusted.)

"The Resources would (or will) act just like my wounding parents."
The client is probably projecting wounding parents onto the Resources. Ask client if she wounds her cherished loved one while in her most adult self. (There may also be an introject mimicking dysfunctional parents.)

"The Resources would (or will) expect me to meet their needs."
The client is probably projecting a needy caregiver onto the Resources. Ask client if she expects her cherished loved one to meet her needs. (There may also be a needy parental introject involved.)

"The Resources would (or will) be perpetrators, and I'll be their victim."
The client is probably projecting a perpetrator onto the Resources. Some child parts may only know of two roles in a relationship – perpetrator and victim. Ask client if she victimizes her cherished loved one. (There may also be a perpetrator introject involved.)

"The Resources would (or will) impose their agenda on me."
The client is probably projecting a wounding caregiver onto the Resources. Ask client if she imposes an agenda on her cherished loved one. (There may also be an introject threatening to impose an agenda.)

"If I feel closely connected to the Resources, the intimacy will inevitably lead to betrayal."
The client is probably projecting an earlier betrayal onto the Resources. Ask client if she would ever betray her cherished loved one because of an intimate connection. (There may also be an introject associated with a betrayal.)

"If I connect to Resources or get unstuck, I'll have to be perfect all the time."
Ask client if she would ever expect her cherished loved one to be perfect all the time. Explain client has the freedom to be imperfect after connecting to Resources or getting needs met. (There may also be an introject insisting on perfection.)

"If I connect to Resources or get unstuck, I'll have to meet other's needs at the expense of my own."
Explain that healing involves learning to set good boundaries. Ask client if she would allow her special loved one to meet others' needs at the expense of her own? (There may also be an introject threatening to harm parts that assert themselves.)

"If I connect to Resources or get unstuck, I'll have to disconnect from my family."
Explain that the level of connection to family members will always be the client's choice. There is no fixed, predictable outcome. All options are open and each option gets evaluated on a case-by-case, moment-to-moment basis.

"If I connect to Resources or get unstuck, I'll have to be to be responsible for everything."
Ask the client if she would ever expect her cherished loved one to be responsible for everything. Explain that with the Resources' help, she can learn appropriate responsibility. (There may also be an introject involved insisting on over-responsibility.)

"If I connect to Resources or get unstuck, I'll have to assert myself all the time."
Explain that is not wise to be assertive all the time. Sometimes it is smart to keep quiet. Part of being appropriately protective is knowing when to do which. Ask client if she would expect her cherished loved one to be assertive all the time. (There may also be an introject threatening to harm parts that assert themselves.)

"If I connect to Resources or get unstuck, I'll be more vulnerable. People will take unfair advantage of me."
Explain that being appropriately nurturing is also about setting good boundaries. (There may also be a introject involved that takes unfair advantage of vulnerable people.)

"If I connect to Resources or get unstuck, I'll stop meeting my parents' needs and lose my connection to them."
Explain that while the relationship to parents may change, it is not certain that the connection will be lost. It is more likely that the relationship will improve as she is better able to stay in her most adult self around them. (There may also be an introject threatening rejection.)

"If I connect to Resources or get unstuck, I'll start setting boundaries and people will reject me."
Explain that setting good boundaries can improve relationships. Those who cannot tolerate boundaries do not make good company. (There may also be an introject threatening rejection.)

"If I connect to Resources or get unstuck, I'll come out of hiding. Then people will see how inadequate I am and reject me."
Ask client if she considers herself inadequate caring for her cherished loved one, or if her special loved one sees her as inadequate. (There may also be a rejecting introject involved.)