

Chapter 1

Overview and Background

The DNMS is an ego state therapy – a psychotherapeutic approach for healing wounded adults, based on what is known about how a child’s brain develops within a healthy family. It borrows from ego state theory, inner-child therapy, self-reparenting therapy, developmental psychology, attachment theory, Eye Movement Desensitization and Reprocessing (EMDR) therapy, and recent developments in neuroscience.

This model is based on the assumption that children have physical, emotional, social, and intellectual needs at each stage of development.¹ When caregivers meet those needs well, children thrive. When caregivers fail to meet needs well enough, they suffer. The degree to which developmental needs were not adequately met is the degree to which a part of self can become stuck in childhood. *Being stuck* means that behaviors, beliefs, or emotions connected to unresolved wounds from the past can get triggered today.² For example, you may feel like an adult one minute – then something upsetting happens and suddenly you see the world through the eyes of a sad, angry, or fearful child. The more stuck we are in childhood, the more we have unwanted behaviors, beliefs, and emotions.

The DNMS is designed to treat a wide range of motivated³ clients, regardless of initial diagnosis or ego strength. This includes clients with complex *trauma wounds* such as those inflicted by verbal, physical, and sexual abuse; and *attachment wounds*, such as those inflicted by parental rejection, neglect, and enmeshment. Clinicians have used the DNMS to treat a wide range of symptoms and issues, including depression, anxiety, panic disorder, social phobia, substance abuse, complex PTSD, relationship trouble, sexual abuse trauma, obsessions/compulsions, eating disorders, dissociative disorders, borderline personality disorder, sexual addiction, self-injurious behaviors, and complicated grief.

Preliminary research supports the efficacy of the DNMS protocols. Two journal articles describe case study data.⁴ The first is a single case study report about a client with dissociative identity disorder. The second describes eight case studies from the caseloads of three different DNMS therapists. The two article abstracts are provided in Appendix B, page 197.

Overview of the Key DNMS Protocols & Procedures

This will give you an overview of the model, so as you begin to learn the individual protocols, you’ll understand where each fits in the big picture. In the chapters to come, each protocol is explained in detail with many case examples and sample interventions.

Taking a History

Psychotherapy usually begins with getting a history. Before starting the DNMS you'll especially want to find out about a client's most significant relationships – especially those from the developing years. The history-taking should include questions about:

- How family members related to the client (e.g. loving, abusive, neglectful, rejecting, enmeshing).
- How family members related to themselves (e.g. self-critical, self-sabotaging, self-soothing).
- How family members related to each other (e.g. mutually supportive, mutually destructive).
- How family members related to people outside the family (e.g. supportive or destructive).
- How people outside the family related to the client (e.g. supportive or destructive).

Answers to these questions should provide you a pretty good idea of where a client's current strengths and weaknesses have come from. See Appendix D for more information about taking a history and orienting clients for DNMS processing.

The Resource Development Protocol

The DNMS assumes that most adult clients already have within them the skills and abilities to meet a loved one's developmental needs. Such skills might be expressed often or rarely, but if they are present at all clients should be able to access and strengthen them. The Resource Development Protocol is structured to strengthen a client's connection to three Resource parts of self – a Nurturing Adult Self, a Protective Adult Self, and a Spiritual Core Self. When you apply this protocol you'll invite clients to recall real moments of nurturing and protecting a loved one, and peak spiritual experiences – times they experienced the distinct qualities of each Resource. These real experiences anchor three brief, guided meditations that help clients connect to these Resources. For example, during the Nurturing Adult Self meditation a client might recall nurturing her grandson through an illness. During the Protective Adult Self meditation she might recall protecting him by rushing him to the hospital. During the Spiritual Core Self meditation she might recall a peak spiritual experience during a church retreat. By anchoring each meditation with a familiar experience, clients understand their Resources are real parts of self, not just imaginary helpers.

Once a client has connected to each Resource, you'll invite her to bring all three to together – to form a *Healing Circle*. In later protocols, these Resources will work together as a team to help wounded parts of self get unstuck from the past.



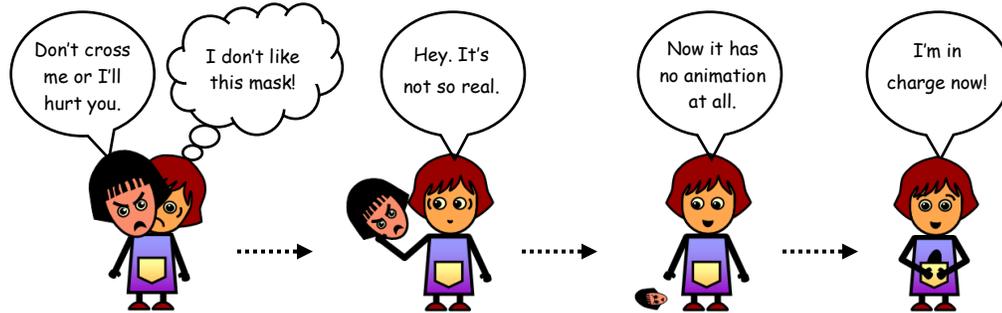
The Switching the Dominance Protocol

The Switching the Dominance Protocol is a multipurpose intervention – effective at calming and quieting internal conflicts. It can provide immediate relief for certain emotional overreactions and it can help in overcoming processing blocks. It is also an integral part of the DNMS Conference Room Protocol.

The DNMS model posits several types of wounded child parts. The most damaging type, *maladaptive introjects*, mirror the wounding actions and messages of abusers, neglecters, rejecters, or betrayers. Their wounding messages are directed towards other parts of self. This perpetuates the internal conflicts that fuel many unwanted behaviors, beliefs, and emotions.

A maladaptive introject is made up of two components: (1) a mask or costume that mimics a wounding caregiver, and (2) an innocent child self underneath, reluctantly wearing it. When you start this protocol, the introject mask will be dominant. By speaking to the child part under the mask and applying a series of mini-interventions, you will be able to help her understand that the mask is just a recording of the wounding person the mask is mirroring, and not a real threat at all. As the child part begins to understand this, the mask will

appear smaller and less important. Eventually the mask will appear so small and so unimportant that the child part can put the remains of it in her pocket, and feel control over it for the first time. When this occurs the dominance has switched from the mask to the child part that was wearing it.



The Switching the Dominance Protocol often results in an immediate reduction of the associated unwanted targeted behaviors, beliefs, or emotions. Clients typically report less internal conflict. The positive effects may last a long time, a few weeks, or until the next time the client is stressed. While it *helps* introjects to heal, it does not usually complete the process. The Needs Meeting Protocol is usually needed to finish the job.

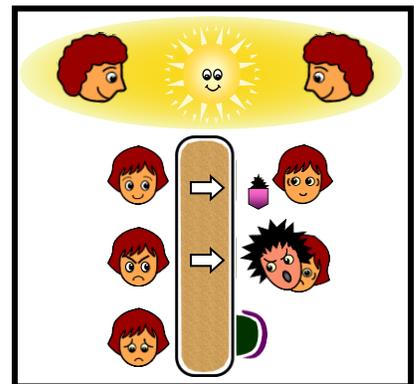
The Attachment Needs Ladder Questionnaire

In the DNMS model, attachment wounds are considered so important they are systematically identified, addressed, and healed. Attachment wounds are defined as the emotional wounds sustained in childhood with caregivers' day-to-day failures to meet attachment needs by being chronically rejecting, neglectful, enmeshing, invalidating, or unsupportive. They often form in the absence of good things happening, such as a lack of positive attention, loving attunement, or good boundaries. Clients who cannot readily recognize the good things they missed often have difficulty talking about the harm these experiences inflicted.

The DNMS Attachment Needs Ladder questionnaire helps clients articulate the very important negative beliefs associated with attachment wounds. It consists of a list of negative beliefs a client might acquire in childhood if attachment needs were not met well. The beliefs are organized in four categories – listed on the questionnaire in order of importance. The categories include: Rung 1 - Existence, Rung 2 - Basic Safety, Rung 3 - Sense of Self, and Rung 4 - Relationship to Others. You'll ask clients to rate, from 0-10, how true each negative belief on a single Rung feels, at moments they've felt especially vulnerable. Those beliefs that are rated above zero will be addressed by the Conference Room and Needs Meeting Protocols, one Rung at a time.

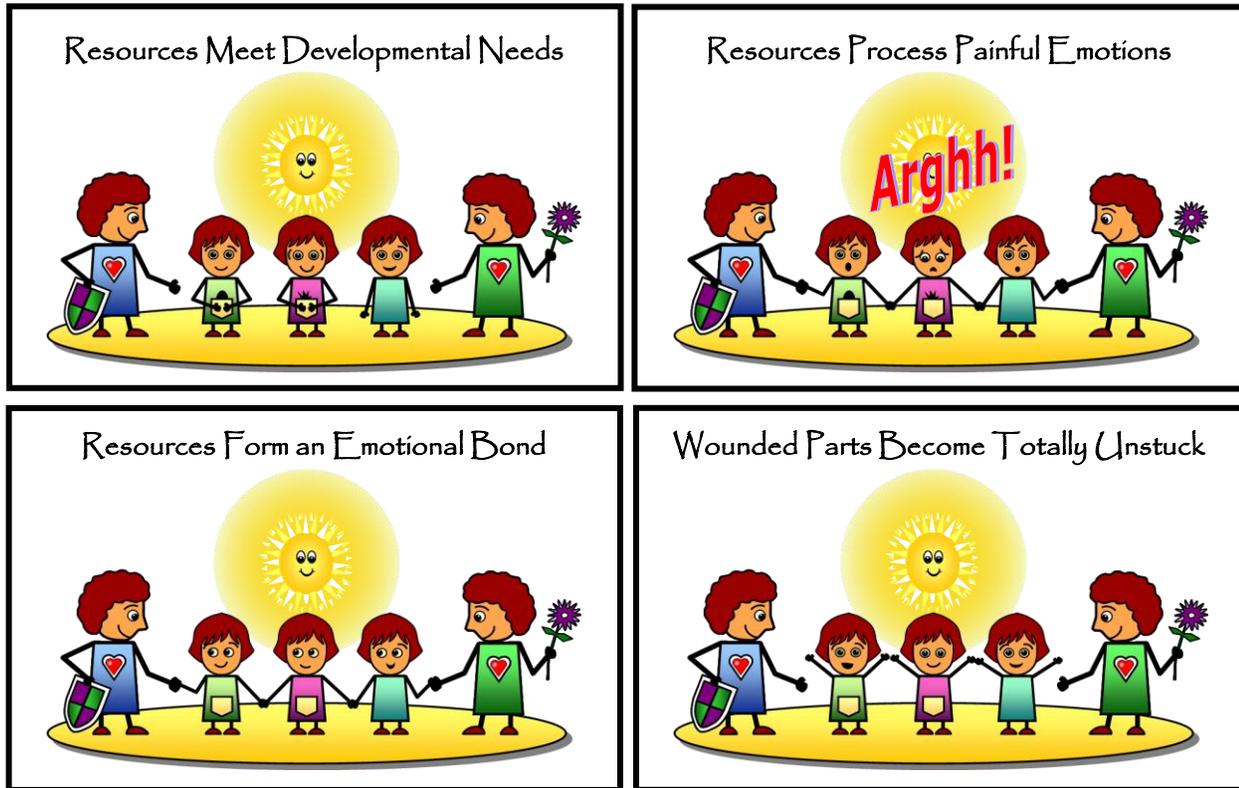
The Conference Room Protocol

You'll begin the Conference Room Protocol by inviting your client to get a mental picture of the Resources in a conference room, with a conference table and chairs. Next you'll invite into the conference room, to sit on one side of the table, all the parts of self that believe the negative statements that the client rated above zero. These are called *reactive parts*. You'll then ask the most upset reactive part to look across the table to see the maladaptive introject that is mirroring the person at the root of the upset. When an introject appears, you'll switch the dominance. Then you'll ask the next most upset reactive part to look across the table. When the next maladaptive introject appears, you'll switch the dominance. You'll repeat these steps until every reactive part at the table has identified each associated introject, and the dominance of each has been switched. Once this protocol is complete, all parts at the table will feel a sense of relief and the internal disturbance around the targeted issue will be substantially calmed. You'll then invite the client to select one or more introjects and reactive parts from the conference room to begin the Needs Meeting Protocol.



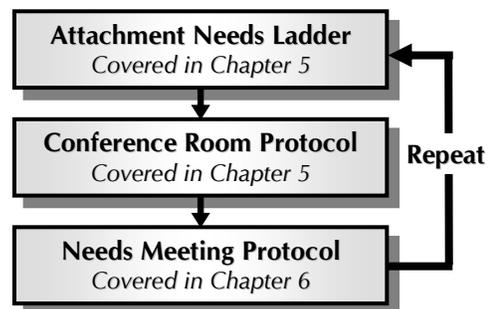
The Needs Meeting Protocol

The Needs Meeting Protocol begins when you invite the introjects and reactive parts, selected from the conference room, into the Healing Circle. Once inside the circle you'll guide the Resources to meet their developmental needs (e.g. safety, love, attunement, nurturing, validation, respect), help them process through painful emotions (e.g. anger and grief), and establish an emotional bond. As the wounded parts make a loving connection to the Resources, they become totally unstuck from the past.



Follow-up and Repeat the Process

Once the Needs Meeting Protocol is complete the unwanted behaviors, beliefs, and emotions associated with a targeted issue typically abate. You'll ask the client follow-up questions to verify a healing shift has occurred. For example, you'll ask if the wounding messages that were delivered by the introject masks are still disturbing. The typical answer is "no." You'll ask if the negative belief that felt true in the beginning still feels true. The typical answer is "no." You'll ask if the targeted issue still feels like a problem. The typical answer is "no." When one issue is resolved, you'll invite the client to focus on another. You'll address each problem this way until all therapy goals have been met.



DNMS Limitations

Some presenting problems are related to unmet developmental needs and perpetuated by maladaptive introjects, and some are not. For example, unwanted symptoms can come from organic brain dysfunction (e.g. head

injury), chronic physical stress (e.g. chemotherapy), and inherent temperament (e.g. hypersensitivity). The symptoms associated with such conditions can be exacerbated when wounding messages from a maladaptive introject is compounding a problem. The DNMS can help relieve the portion of unwanted symptoms generated by maladaptive introjects. For example, a person who is inherently hypersensitive may feel driven to anxiety and shame about that by a critical mother introject. If the DNMS heals the mother introject, the anxiety and shame can be eliminated, but the DNMS is not likely to diminish the inherent hypersensitivity.

While many clients are drawn to the DNMS, some are not. Some clients reject the idea of parts of self, some are dead-set on a particular therapy (e.g. EMDR, hypnosis, CBT) and refuse to discuss DNMS, and some need basic help (e.g. personal safety coaching, career counseling) more than DNMS.

Background Material

Developmental Stages

The idea of developmental stages has been around a long time. Sigmund Freud theorized about stages of psychosexual development,⁵ Jean Piaget about stages of physical and intellectual development,⁶ and John Bowlby about stages of attachment to the caregiver.⁷ For the purposes of the DNMS, a developmental stage is defined as a span of time relevant to a baby's, child's, or adolescent's physical, intellectual, social, and emotional maturation.

Erik Erikson theorized that human development unfolds in eight predetermined stages, from infancy to late adulthood, and that each stage involves specific psychosocial developmental tasks.⁸ He asserted that progress through each stage was in part determined by the degree of success or failure in all the previous stages. He understood that a person who got their early needs met well, and who successfully mastered developmental tasks, would have certain virtues and psychosocial strengths which would help him lifelong. In contrast, if one's developmental needs were not met well, the person would fail in these tasks and might develop too much of the negative aspect of the task (e.g. too mistrusting), or too much of the positive (e.g. too trusting).

Jean Illsley-Clarke and Connie Dawson⁹ wrote *Growing Up Again: Parenting Ourselves, Parenting Our Children* with the dual purpose of teaching parents how to raise their children and of teaching adults how to grow up again. They describe how caregiver behaviors make it more or less possible for children to master the full spectrum of their developmental tasks, needs, and challenges, in order to meet their full potential. They propose nine developmental stages, from pre-birth to old age. The table on the following two pages lists their first seven stages, with corresponding developmental tasks, needs, and clues that needs were not met well. (The table was adapted from Chapter 25 of *Growing up Again*, with permission from the publisher.)

Hierarchy of Needs

Abraham Maslow is best known for his study of human needs. He believed that if a person's developmental needs were not met well enough it could cause one to "fixate" on those unmet needs for the remainder of life. He considered this fixation to be the basis of neurosis. He theorized a hierarchy of basic human needs¹⁰ His hierarchy included:

- Physiological needs – Need for food, water, air, sleep, activity, rest, etc.
- Safety and security needs – Need to be protected from danger.
- Belongingness needs – Need for love, secure attachment, attunement, and connection to others.
- Lower esteem needs – Need to be respected and appreciated by others.
- Higher esteem needs – Need for self-respect, confidence, competence, achievement, and independence.
- Aesthetic needs – Need for symmetry, order, and beauty.

See Appendix B, page 198 for Maslow's Hierarchy of Needs pyramid, and for a table that integrates Maslow's needs with Erikson's stages of development.

Illsley-Clarke and Dawson: Developmental Stages, Tasks, and Needs

| | Developmental Tasks | Developmental Needs | Clues Needs Were Not Met Well |
|--|--|---|---|
| Prenatal Stage: Conception to Birth | <ul style="list-style-type: none"> To grow To experience being separate and connected to mom To accept nourishment, love To move around To get familiar with mom To make decisions about trust To initiate and complete the birth process | <ul style="list-style-type: none"> Mother gets proper nutrition, exercise, rest, medical care Mother's basic needs are met Parents resolve their own prenatal traumas or grief from earlier miscarriages Parents prepare to welcome the child for who she is Parents lovingly talk, sing to baby Parents joyful about baby coming Family prepared to welcome baby Parents prepare place for baby Mother arranges for a safe birth Parents plan good care for baby Parents plan how to meet their own needs after baby is born | <ul style="list-style-type: none"> An unaccounted-for incompleteness of self Lack of joyfulness not otherwise accounted for Unable to start things Addictions or compulsions Strong desire to be in or avoid water Struggle to get food or wanting to be served food Need to sleep all curled up Reacting against someone wanting to get too close Excessive independence Starting things and not finishing Feeling grandiose or worthless |
| Stage 1: Birth to 6 Months | <ul style="list-style-type: none"> To call for care To cry or signal to get needs met To accept touch To accept nurturance To bond emotionally To learn to trust caring adults and self To decide to live, to be | <ul style="list-style-type: none"> Developmental achievements affirmed Loving, consistent care Appropriate response to needs Parents thinking of baby Holding and looking at baby while feeding Talking to and echoing baby Nurturing touch, gaze, talk, song Parents who seek help as needed Reliable and trustworthy caregivers Parents who can meet their own needs | <ul style="list-style-type: none"> Not trusting others Wanting others to anticipate needs Not aware of needs Not needing anything Feeling numb Others needs are more important Not wanting to be touched Compulsive, joyless sexual touching Unwilling to self-disclose, especially negative information |
| Stage 2: 6 to 18 Months | <ul style="list-style-type: none"> To explore and experience the environment To develop sensory awareness To signal needs To trust others and self To continue forming secure attachments with parents To get help when distressed To learn there are options, not all problems are easily solved To develop initiative To continue tasks from Stage 1 | <ul style="list-style-type: none"> Developmental achievements affirmed Loving, consistent care Safe environment Protection from harm Food, nurturing, touch Two yeses for every no Many sensory experiences Uninterrupted expression Validation of experience Lots of conversation and eye contact Response to child-initiated play Parents who can meet their own needs | <ul style="list-style-type: none"> Boredom Reluctance to initiate Being overactive or too quiet Perfectionism or avoidance Compulsively neat Doubting familiar knowledge Believing it's okay not to be safe, supported, protected |
| Stage 3: 18 Months to 3 Years | <ul style="list-style-type: none"> To establish an ability to think for self To test reality, to push against boundaries and other people To learn to solve problems with cause-and-effect logic To learn words like: stop, go there, come here, stay here To express emotions like anger To separate from parents without losing their love To develop initiative To begin ending ego-centricity To continue tasks from earlier stages | <ul style="list-style-type: none"> Developmental achievements affirmed Love, safety, and protection Help transitioning between activities Clear, simple instructions Encouragement and praise Words like: stop, come, stay, go there Reasonable limits enforced well Celebration of ability to think Time and space to organize thinking Permission to express positive and negative feelings Reasons and information Help naming things Harmony, not conflict Even-tempered caregivers Parents who can meet their own needs | <ul style="list-style-type: none"> Inappropriate rebellion Preference to be right over successful Fear and sadness covered with anger or bullying Egocentric Fear of anger in self or others Saying no or yes without thinking Trouble setting boundaries Letting others dominate Expression of anger indirectly |

Illsley-Clarke and Dawson: Developmental Stages, Tasks, and Needs

| | Developmental Tasks | Developmental Needs | Clues Needs Were Not Met Well |
|------------------------------|---|---|--|
| Stage 4: 3 Years to 6 Years | <ul style="list-style-type: none"> To assert an identity separate from others To acquire information about world, self, body, and gender To learn that behaviors have consequences To discover one's effect on others and one's place in groups To learn to exert power to affect relationships To practice socially appropriate behavior To separate fantasy from reality To learn extent of personal power To continue learning earlier developmental tasks | <ul style="list-style-type: none"> Developmental achievements affirmed Love, safety, and protection Support for exploring the world of things, people, ideas, feelings Encouragement to express feelings and connect feelings and thinking Information about the environment Answers to questions Appropriate (loving) positive or negative consequences for actions Age-appropriate responsibility Encouragement of fantasy and separation of fantasy from reality Praise for appropriate behavior Age-appropriate information about world, self, body, and gender | <ul style="list-style-type: none"> Having to be in a position of power Afraid of or reluctant to use power Unsure of personal adequacy Identity confusion – needing to define self by a job or relationship Feeling driven to achieve Overuse of outlandish dress or behavior Frequently comparing self to others and needing to come off better Wanting or expecting magical solutions or effects |
| Stage 5: 6 Years to 12 Years | <ul style="list-style-type: none"> To learn skills, learn from mistakes, and decide to be adequate To learn to listen, collect information and think To practice thinking and doing To reason about wants and needs To check out family rules and learn about structures outside the family To learn the relevancy of rules To learn consequences of breaking rules To disagree with others and still feel loved To test ideas and values To develop internal controls To learn age-appropriate responsibility To learn when to flee, when to flow, and when to stand firm To learn to cooperate To test abilities against others To identify with one's own gender To continue to learn from earlier tasks | <ul style="list-style-type: none"> Developmental achievements affirmed Love, safety, and protection Affirmation for learning in own style Love and praise for developing skills Reliable sources and accurate information about people, world, sex Challenges to negative behavior/thinking Encouragement for cause-and-effect thinking Clearly defined, age-appropriate responsibilities Affirmations for logical/creative thinking Problem solving help/tools Help discerning when to flee, flow, or fight Appropriate negotiable and non-negotiable rules Experience of natural consequences Sense of connection in spite of disagreement Encouragement of accurate reporting Encouragement of age-appropriate behaviors Encouragement and help being responsible for own decisions, thinking, and feelings Teachers to develop skills of interest | <ul style="list-style-type: none"> Having to be part of a gang or only functioning well as a loner Not understanding the relevance of rules Not understanding the freedom rules can give Unwillingness to examine own values or morals. Needing to be king or queen of the hill Trusting the thinking of others more than trusting own intuition Expecting one has to know how to do things without learning how, finding out, or being taught how Reluctance to learn new things or be productive |
| Stage 6: 12 to 19 Years | <ul style="list-style-type: none"> To take more steps towards independence To achieve a clearer emotional separation from family To emerge gradually as a separate, independent person with own identity and values To be competent and responsible for own needs, feelings, and behaviors To integrate sexuality into earlier developmental tasks | <ul style="list-style-type: none"> Developmental achievements affirmed Love, safety, and protection Acceptance of feelings Discussion about sexuality Unacceptable behavior confronted Clear boundaries about drug use and sexual activity Support for moves towards independence Help reworking tasks from earlier developmental stages Encouragement of the development of true-to-self unique identity based on socially acceptable behaviors | <ul style="list-style-type: none"> Preoccupation with sex, body, clothes, appearance, friends, or sex role Unsure of own values; vulnerable to peer pressure Problems with starting and ending jobs, roles, and relationships Over-dependence on or alienation from family or others Irresponsibility Trouble making /keeping commitments Looking to others to define self Confusing sex with nurturing Unsure of sexual identity Unsure of lovability |

Well-Intentioned Caregivers Can Fail to Meet Needs

Unmet developmental needs are not limited to incidents of outright child abuse and neglect. It is possible for well-intentioned, reasonably educated, highly motivated, loving caregivers to fail to meet all the needs of a child. This can happen when a child's needs are particularly complex or obscure; caregivers are ill-informed about the specific needs of the child at a given developmental stage, and unknowingly make poor choices in feeding, limit setting, discipline, child care, managing sibling rivalries, etc.; caregivers have unresolved emotional issues; caregivers are under extreme stress or suffering hardships, such as financial problems, health problems, natural disasters, or war, which make it impossible for them to meet needs they would otherwise be able to meet.

Ego State Theory

The DNMS is an ego state therapy based on ego state theory. This section provides you an overview of ego state theory. Chapter 2 will discuss the application of ego state therapy. Ego state theory posits that we all have different sub-personalities, parts of self, or ego states. To understand ego states, you must first understand states of mind.

A state of mind consists of behaviors, beliefs, emotions, and body sensations evoked by the environment at a given moment in time.¹¹ You're always in a state of mind. You're in a state of mind right now. Hopefully it's relaxed, alert, and curious. States of mind are temporary, and constantly changing. For example, you may wake up one morning in a calm and rested state of mind, then shift into a vigilant state of mind when a suicidal client calls in crisis. Later you may shift back into a calm state of mind when your client is admitted to a hospital.

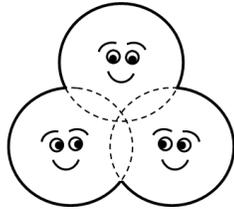
According to Daniel Siegel, a state of mind can become *engrained* when a positive event is experienced repeatedly (e.g. when a parent consistently supports and encourages a child's self-expression); when a negative event is experienced repeatedly (e.g. when a parent consistently punishes a child's self-expression); or when the mind cannot make sense of a traumatic event (e.g. when a child is assaulted by a parent and cannot understand why).¹² An engrained state of mind can become an ego state, or a part of self with a point of view. An ego state is more enduring than a temporary state of mind. When a person is in a particular ego state, all the emotions, beliefs, and/or body sensations that were present when that state of mind became engrained are present again.

Healthy ego states form in response to positive, affirming relationships with role models who are loving and attuned. They live in the present; feel and manage the full range of emotions; hold positive beliefs about self and world; engage in appropriate/desirable behaviors; and have an adaptive point of view.

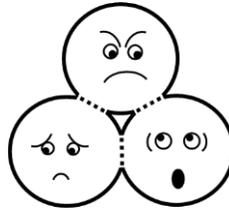
Wounded ego states form in response to traumas; and to negative, wounding relationships with role models who are abusive, neglectful, rejecting, and enmeshing. They live in the past; are stuck in painful emotions; hold negative, irrational beliefs about self and world; engage in unwanted or inappropriate behaviors; and have a maladaptive point of view.

Ego states can change over time – usually becoming more engrained as new events are interpreted based on past experience and bias. Healthy ego states typically adapt well to new experiences, while wounded ego states do not. In fact, wounded parts of self may feel more powerless as their poor decisions lead to more problems. But wounded ego states can heal and grow if they can get nurturing from adult parts of self, and process through their traumas and losses.

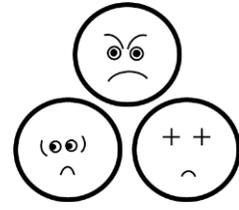
An individual can have many ego states – both healthy and wounded. The term self-system refers to the “family” of ego states within an individual.¹³ Ego states, just like family members, may communicate with each other effectively or ineffectively, or interact cooperatively or uncooperatively.¹⁴ The nature of ego state interactions within the self-system is influenced by the nature of *ego state boundaries* – which may be permeable, semi-permeable, or rigid. These boundaries affect the way ego states communicate with each other.¹⁵



When boundaries are *permeable*, communication between ego states is open, and cooperative.

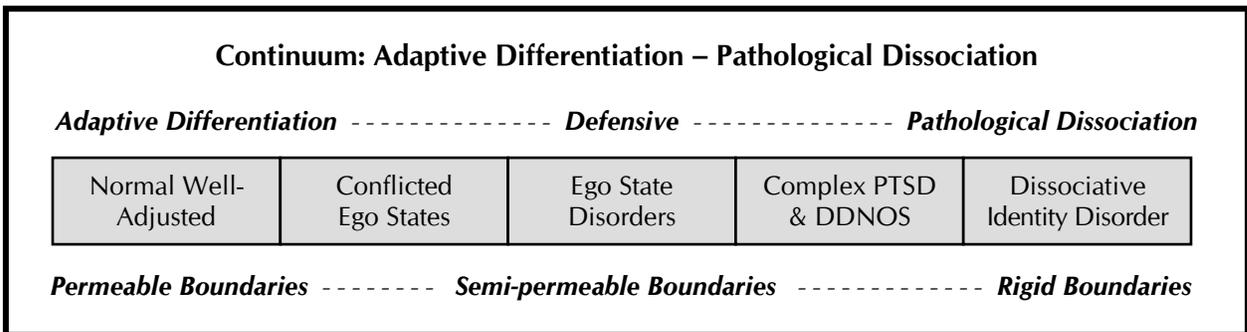


When boundaries are *semi-permeable* communication between ego states is problematic, and marked by a lack of internal cooperation, and difficulty resolving internal conflicts.

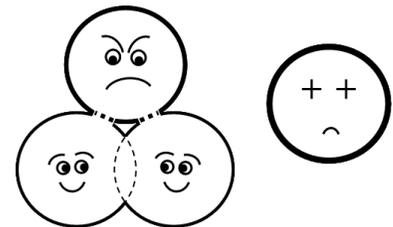


When boundaries are *rigid*, communication between ego states is minimal or non-existent, and marked by unresolvable internal conflicts.

The degree of ego state permeability is a reflection of ego state integration. Ego states are more or less *integrated* or *dissociated*. This occurs on a continuum – from *adaptive differentiation* to *pathological dissociation*.¹⁶ At the left of the continuum fall the well-adjusted individuals experiencing healthy integration or the *adaptive differentiation* of ego states. For example the drill sergeant who has one state of mind for training soldiers, another state of mind for playing with his infant son, and another state of mind for romancing his wife. These ego state boundaries are permeable. At the center of the continuum fall clients with *defensive* dissociation. They have internal conflicts that are difficult to manage. They present with problems, such as PTSD, eating disorders, panic disorder, depression, obsessive-compulsive disorder, and so forth.¹⁷ These ego state boundaries are semi-permeable. At the right of the continuum fall the clients with pathological dissociation. They have ego states, or alters, that may not know of each other’s existence. These clients present with dissociative identity disorder. These ego state boundaries are rigid.



An individual’s ego state boundary permeability will not necessarily be uniform across the self-system, as this continuum might suggest. An individual may have ego states with permeable boundaries, semi-permeable boundaries, and/or rigid boundaries – all at the same time. An individual may have some ego states that co-exist in harmony, while others exist in hostile conflict.



Wounded Ego States Formed by the Firing of Mirror Neurons

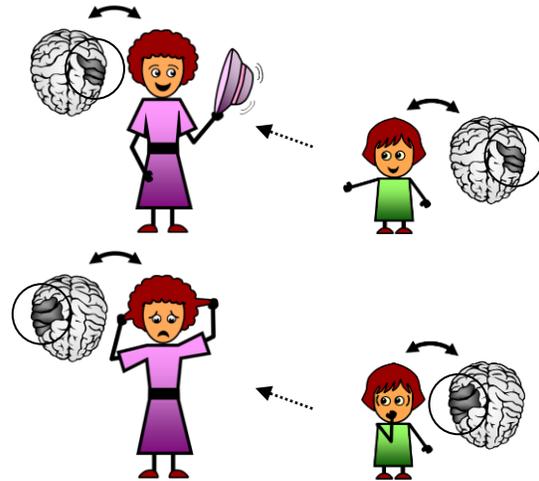
The DNMS focuses a lot of attention on healing the most damaging wounded ego states – maladaptive introjects. To really understand the nature of introjects, it helps to understand how they form. New research in the area of *mirror neurons* appears to provide a possible explanation for introjection. Neurophysiologist Vittorio Gallese and colleagues from the University of Parma observed that when one monkey performs a specific action with his hand, specific neurons fire in association with that action. A second monkey, observing that action, will involuntarily fire the same neurons (mirror neurons) that he would need to perform that same task.¹⁸ This discovery, made in the mid 1990s, has spurred a flood of research into the nature and role of a mirror neuron system in humans.

Neuroimaging studies have demonstrated that certain neural circuits get activated in a person who is carrying out an action, expressing an emotion, or experiencing a sensation, and in a person who is observing that person's action, emotion, or sensation.¹⁹

For example, certain neural circuits are activated in the brain of this happy woman (to right) waving her hat. The same neural circuits become activated in the brain of this child observing the happy woman waving her hat.

Likewise, certain neural circuits are activated in the brain of this unhappy woman pulling her hair (below). The same neural circuits become activated in the brain of this child observing the unhappy woman pulling her hair. This is called *shared activation*.

Mirror neurons appear to get activated when we observe characters in a movie. We feel fear when a character is in danger. We feel sad when a character loses a loved one. We feel aroused when a character is aroused. We feel happy when the boy wins the girl. Of course mirror neurons can get activated in real life dramas as well.



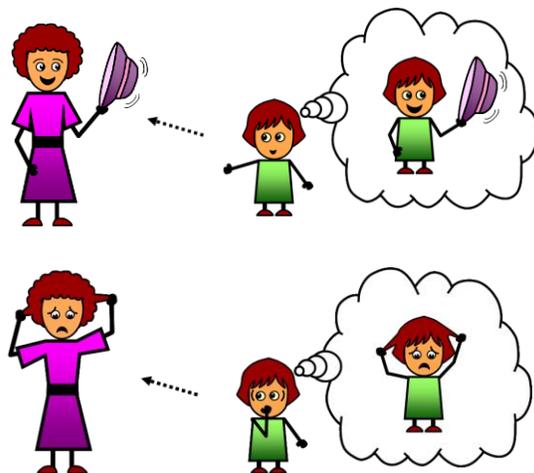
Two Examples of *Shared Activation*

UCLA professor Marco Iacoboni's studies suggest that mirror neurons can send messages to the limbic system making it possible for humans to read each other's feelings.²⁰ That appears to account for empathy. Studies suggest that the mirror neurons activated while observing others' actions, emotions, or sensations, also respond to their intentions.²¹

Mirror neurons may help us make predictions about others' behavior and emotions. They may help us learn from each other how best to survive. Neuroscientist V.S. Ramachandran suggests that mirror neurons in primitive clans may have enabled innovations such as language and tool use to spread quickly, because they were hardwired to mimic each other.²²

Gallese believes that the shared activation that arises as mirror neurons fire leads to *embodied simulation*.²³ He writes: "By means of embodied simulation we do not just 'see' an action, an emotion, or a sensation (of another). Side by side with the sensory description of the observed social stimuli, internal representations of the body states associated with these actions, emotions, and sensations are evoked in the observer, 'as if' he or she were doing a similar action or experiencing a similar emotion or sensation."

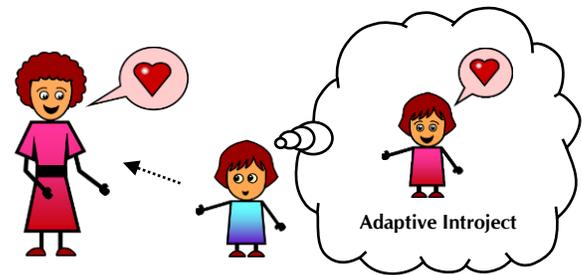
So this child (to right) is not just observing the happy woman waving a hat, she is also creating an internal representation of being in a happy mood waving a hat. Likewise, the child (below) is not just observing the unhappy woman pulling her hair; she is also creating an internal representation of being in an unhappy mood pulling hair.



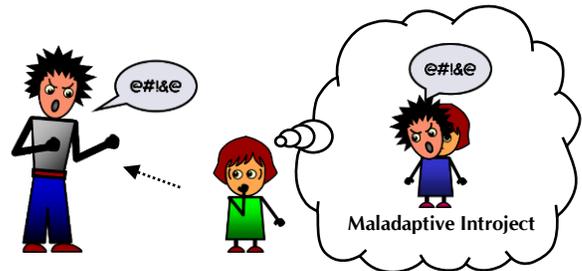
As discussed above, we are always in a state of mind. A state of mind can be temporary or engrained. A state of mind can become engrained when a significant event is experienced repeatedly, or when a person cannot make sense of a trauma. The DNMS model presumes that a state of mind associated with the firing of mirror neurons can likewise be temporary or engrained.

A temporary state of mind evoked by the firing of mirror neurons might feel comfortable or uncomfortable. For example, the joy a person feels when a movie has a happy ending will dissipate soon after the movie is over. Likewise, the fear a person feels while watching a scary movie will dissipate after the movie is over.

An engrained state of mind evoked by the firing of mirror neurons in response to repeated interactions with a loving, supportive role model over time will be positive, healthy, and enduring. For example, the security a child feels during years of being cared for by a loving, attuned parent, can last a lifetime. The child's sense of security can become engrained along with an embodied simulation of the loving, attuned parent – an *adaptive introject*.



Likewise, an engrained state of mind evoked by the firing of mirror neurons in response to a single or repeated interactions with an abusive, neglectful, rejecting, or enmeshing role model will be negative, wounded, and enduring. For example, the horror a child feels while being assaulted by a parent can linger for years after the event. The child's fear can become engrained – along with an embodied simulation of the wounding parent – a *maladaptive introject*.



Gallese understands *embodied simulation* to be a basic functional mechanism of the brain, which engages automatically and unconsciously, not the result of a willed or conscious cognitive effort, not aimed at interpreting the intentions of others.²⁴ This is in contrast to *standard simulation*, which relies on explicitly simulating another's internal state, explicitly taking on another's perspective, and introspection.

In the DNMS model, introjection is presumed to be part of a basic neurological mechanism that operates indiscriminately, without a strategic intention, mirroring healthy and unhealthy role models alike – just because they are there. So whether an introjection is adaptive or maladaptive depends entirely on who has been introjected. When we mirror positive, supportive role models we thrive. When we mirror abusive, neglectful, rejecting, or enmeshing role models we suffer.

The mirror neuron system may help us survive as a species, but under certain conditions, it can hurt us as individuals. This is like our immune system, which is generally good for us, but which can wreak havoc in a single individual with an autoimmune disorder. Clients often feel some shame when they face the reality that they mirror the behaviors of wounding role models. But if introjection is truly just a biological reflex – that happens completely outside of our control – there is no basis for shame. Clients deeply appreciate learning they've been mimicking undesirable people because of biology, not bad intentions.

Healing by Neural Integration

According to neuropsychologist Allan Schore, loving, attuned caregivers stimulate and encourage a child's sense of well being, calm and soothe a child's upset feelings, and provide appropriate safety and protection. A child will form a secure attachment to such caregivers.²⁵ Securely attached children develop the neural networks²⁶ and pathways²⁷ needed for the optimal self-regulation of emotion. These *neural networks* are the internal representations of the loving, attuned caregivers. These *neural pathways* link these internal representations to other neural networks in a way that facilitates self-soothing. These children grow to become well-adjusted adults with the ability to form secure attachments, and regulate their own emotions.

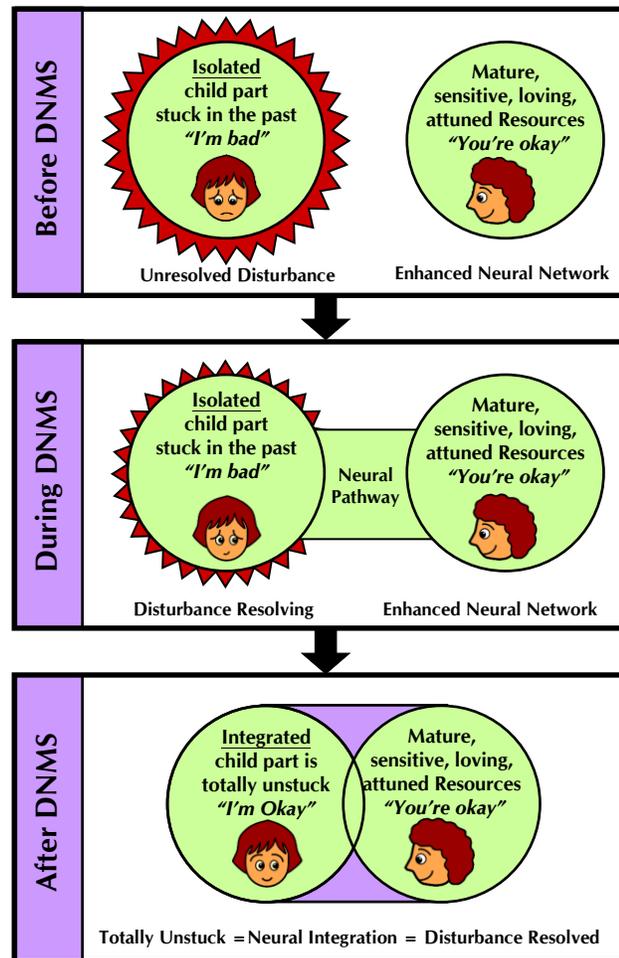
Poorly attuned caregivers have an impaired ability to encourage a child's sense of well being, calm and soothe a child's upset feelings, and provide needed safety and protection. A child will form an anxious or insecure attachment to such caregivers. Anxiously-attached children fail to optimally develop the neural networks and pathways needed for the self-regulation of emotion. Children who are anxiously attached to poorly attuned caregivers may become adults with an impaired ability to self-soothe, an impaired ability to recover from loss or trauma, and an increased risk of psychopathology. (Appendix B, page 199, provides a detailed write up of attachment theory and the neurobiology of attachment.)

Many psychotherapy clients lack the neural architecture needed to regulate emotions well. The DNMS endeavors to raise their emotion-regulation skill to the level it would have been, if they'd been securely attached to loving, attuned caregivers from the beginning. It appears to accomplish this by positively impacting the neural networks and neural pathways needed for the regulation of emotion. This has not yet been proven with brain scan technology. For the moment the ideas proposed here are theoretical.

I believe that the Resource Development Protocol can enhance the neural networks containing skills and resources for regulating emotions, and that the Needs Meeting Protocol strengthens the neural pathways that can connect those skills and resources to the neural networks holding unresolved wounds. DNMS therapists have observed that loving, attuned Resources can stimulate and encourage a wounded child part's sense of well being, calm and soothe a child part's upset feelings, and provide appropriate safety and protection, just like loving, attuned parents would. This appears to provide the emotional repair needed to help child parts heal.

The graphic on the right illustrates progress through the DNMS protocols. Before beginning the DNMS, an isolated child part that is stuck in the past holds an unresolved disturbance. (The halo indicates emotional charge.) The part is disconnected from mature Resource parts of self. During the DNMS, a neural pathway connecting the isolated child parts to the Resources is strengthened. This loving, attuned connection helps to resolve the childhood disturbance. By the end of the DNMS process, a solid connection has been established. The child part that had been stuck in the past is now fully integrated with the Resources and is living in present time. All emotional disturbance related to that child part is resolved.

According to Daniel Siegel, self-regulation is accomplished with the process of neural integration, as functional linkages are made between disparate regions of the brain.²⁸ He suggests that the therapeutic interpersonal experience may actually enable integrative fibers to grow, leading to the attainment of new abilities. Within the DNMS the primary agent for change is the therapeutic intrapersonal relationship between the Resources and wounded child parts.²⁹ This is akin to what Siegel refers to as *intrapersonal attunement*.³⁰ This relationship helps child parts of self integrate with adult parts of self, get unstuck from the past, come fully into the present moment, and let go of counterproductive "coping" behaviors, negative beliefs, and painful emotions.



Alternating Bilateral Stimulation (ABS)

Alternating bilateral stimulation (ABS) is used throughout the DNMS to strengthen all positive experiences (e.g. enhancing internal Resources and positive beliefs about self). Francine Shapiro discovered that rapid side-to-side eye movements could be used to facilitate trauma desensitization.³¹ Eye movements became a cornerstone of her Eye Movement Desensitization and Reprocessing (EMDR) eight-phase trauma-processing Protocol. Shapiro observed that rapid eye movements could also help strengthen positive beliefs about self.³² In clinical practice, both alternating bilateral tactile and auditory stimulation were found to be effective alternatives to eye movements. All three modalities are considered forms of ABS.

ABS appears able to strengthen positive traits. Andrew Leeds introduced an EMDR-related protocol, called *Resource Development and Installation (RDI)*, which uses ABS to strengthen positive images, memories, and symbols, to prepare clients for EMDR.³³ His RDI protocol was tested in two single-case-design studies with clients with complex PTSD.³⁴ In the study, ABS was used to enhance a positive felt sense of internal resources and to strengthen the probability clients would use their resources to manage future stressors. Ricky Greenwald proposed using ABS to strengthen a client-generated image representing a psychological resource necessary for successful EMDR processing.³⁵ In 1999 I developed an ABS protocol for integrating ego state therapy and art therapy.³⁶ Clients were directed to shift their eyes back and forth between artistic representations of resource ego states and wounded child ego states, to facilitate healing.

Laurel Parnell's book, *Tapping In: A Step-by-Step Guide to Activating Your Healing Resources Through Bilateral Stimulation*, describes a number of ways one can use imagery to *tap into resources*, then strengthen and integrate the resources by *tapping* (applying tactile ABS).³⁷ She writes about the many ways *resource tapping* can be of benefit, for example by reducing anxiety, coping with trauma and illnesses, improving sleep, and increasing confidence – to name a few.

The Benefits of ABS

Harvard University sleep researcher Robert Stickgold proposed that ABS applied during EMDR therapy may facilitate the memory consolidation that occurs during rapid eye movement (REM) sleep.³⁸ During REM sleep, associations between neural networks can become activated and strengthened. He postulated that isolated or weakly-associated neural networks can more easily connect to positive adaptive neural networks when ABS is applied. The use of ABS during the DNMS appears to help facilitate communication between wounded ego states and the Resources, and to strengthen positive feelings and beliefs.

ABS Cautions

ABS can suddenly weaken tenuous dissociative barriers, so it should never be used indiscriminately. Sandra Paulsen first wrote about this in 1995 after several EMDR therapists had observed dissociative clients could become overwhelmed during EMDR when ABS was applied.³⁹ EMDR therapists have observed that: (1) some clients tap into more negative emotions than they can manage, (2) some clients have few internal resources for managing and processing through their negative emotions, and/or (3) ABS does not always process through emotions that get stirred up. To lessen the risk of these things occurring, therapists trained in EMDR now are wisely cautioned to screen for dissociative disorders and to prepare clients well for the intensity of the trauma-processing experience.

ABS is applied during the DNMS almost exclusively to strengthen positives, and to enhance a positive relationship between wounded ego states and the Resources. If a wounded part temporarily loses a supportive connection to the Resources, ABS is stopped until the connection is restored. For this reason, DNMS clients rarely report unfavorable or adverse reactions to ABS. While these above cautions may apply more to EMDR than DNMS, a client's ability to tolerate positive or negative affect should always be considered before applying ABS.

Applying ABS during the DNMS

ABS can be applied as side-to-side eye movements, alternating bilateral auditory stimulation, or alternating bilateral tactile stimulation. The DNMS involves a lot of mental imagery, which most clients prefer to do with eyes closed. Tactile and auditory ABS are popular options. Tactile ABS can be applied manually, by tapping on the client's knees, hands, or feet in an alternating fashion, or with an electronic device called a TheraTapper™. The TheraTapper™ consists of a small control box attached by six-foot wires to two handheld pulsers which vibrate in an alternating fashion. From a six-foot distance, the therapist can change the intensity, length, and speed of the vibrations. (For more information, go to page 255 or www.theratapper.com.) Auditory ABS is best applied with headphones. *BioLateral™* produces a collection of tapes and compact discs with a variety of sounds and music with alternating bilateral tones. (For more information, go to www.biolateral.com.)

ABS Does Not Make the DNMS a Variation of EMDR

The addition of ABS to a therapeutic intervention does not make the intervention an "EMDR therapy." So even though the DNMS uses ABS, it is not EMDR or a variation of EMDR. These approaches are distinctly different.

DNMS protocols are focused primarily on repairing developmental deficits, while EMDR protocols are focused primarily on resolving trauma memories. Other than the use of ABS, the DNMS and EMDR protocol steps share little in common. While clinical observation suggests DNMS clients may process more deeply or quickly when ABS is present, it is not an essential component of the protocols. DNMS sessions without ABS have also been successful. ABS does not appear to be as important to the DNMS protocols as it is to the EMDR and RDI protocols.

How Long Does DNMS Therapy Take?

While the DNMS does appear to resolve symptoms with far greater efficiency than traditional talk therapy, it is not always “brief” therapy. Generally speaking, the more ego strength and fewer unmet developmental needs a client has the more quickly she will progress through the DNMS. Those with a history of chronic *attachment wounds* tend to proceed more slowly than those with *trauma wounds* alone. Clients with attachment wounds and trauma wounds usually proceed the most slowly.

Several personal factors can affect the length of the therapy including a client’s level of motivation, ability to get and stay focused on DNMS protocols, natural inclination to process quickly versus slowly, eagerness to disclose processing blocks, and ease with resolving processing blocks. Several logistical factors can play a role, such as the frequency of sessions (sessions spaced weeks apart are usually less efficient), and the length of sessions (90-minute sessions are usually more efficient than 50-minute sessions).

Some clients can establish Resources in a single session while others take many months. Those who generally accomplish this quickly and easily had at least one positive childhood role model, and/or have now, or had in the past, a personal experience of being a competent caregiver. Clients with ambivalence about growth and change, no positive childhood role models, and/or no competent caregiver experiences, will take the longest to develop Resources. Some clients need a lot of time to fully access their caregiver skills and/or spiritual core. Some have many basic fears and blocks to change to overcome. But even when it takes a long time to work through processing fears and blocks, the steps to mobilizing Resources can be very ego strengthening, especially for fragile clients. It can be an important part of the overall healing process.

Chapter Summary

This chapter provided an introduction to the DNMS model, including a brief description of each key protocol and procedure. It also provided background information about developmental stages and needs, ego state theory, and mirror neurons. It explained the theoretical foundation and provided a detailed discussion about alternating bilateral stimulation.

Chapter 1 Notes and References

1. Erikson, E.H. (1950). *Childhood and Society*. New York: Norton.
 Illsley-Clarke, J. & Dawson, C. (1998). *Growing up again: Parenting ourselves, parenting our children*. Hazelden Information Education.
 Maslow, A.H. (1968). *Toward a Psychology of Being*. D. Van Nostrand Company.
2. Bowlby, J. (1988). *A secure base*. New York: Basic Books.
3. A motivated client is defined as someone who is prepared to seriously work towards insight and change. A motivated client may have processing blocks and complications arise, but is determined to work through them. An unmotivated client does not intend to seriously work towards change. This includes clients who want the therapist to be “mommy” or simply “take all the pain away.” It includes clients who have been unwillingly sent to therapy by a spouse or parole officer, clients who are not ready to open up, and clients who refuse to work through processing blocks. Unmotivated clients do not respond well to any psychodynamic therapy.
4. Schmidt, S.J. (2004) Developmental Needs Meeting Strategy: A new treatment approach applied to dissociative identity disorder. *Journal of Trauma and Dissociation*, 5(4), 55-78.

- Schmidt, S.J., & Hernandez, A. (2007). The Developmental Needs Meeting Strategy: Eight case studies. *Traumatology*, 13:27-48.
5. Freud, S. (1923/1961). The ego and the id. In J Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol.19). London: Hogarth Press. (Original work published in 1923)
 6. Piaget, J. & Inhelder, B (1969). *The Psychology of the Child*, New York: Basic Books.
 7. Bowlby, J. (1988). *A secure base*. New York: Basic Books.
 8. Erikson, E.H. (1950). *Childhood and Society*. New York: Norton.
 9. Illsley-Clarke, J. & Dawson, C. (1998). *Growing up again: Parenting ourselves, parenting our children*. Hazelden Information Education.
 10. Maslow, A.H. (1968). *Toward a Psychology of Being*. D. Van Nostrand Company
 11. Siegel, D.J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford Press.
 12. Siegel, D.J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford Press.
 13. Paulsen, S. (2000). *EMDR and the Divided Self: EMDR and ego state therapy for non-dissociative and dissociative clients*. All-day workshop in San Antonio, Texas, April, 2000.
 14. 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.
 - Schwartz, R. C. (1995). *Internal family systems therapy*. New York: Guilford Press.
 15. Watkins, J.G., & Watkins, H.H. (1997). *Ego states: Theory and therapy*. New York: Norton.
 16. Braun, B. (1988). The BASK model of dissociation. *DISSOCIATION*, 1, 4-23
 17. Watkins, J.G., & Watkins, H.H. (1997). *Ego states: Theory and therapy*. New York: Norton.
 18. 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.
 19. Gallese V., Eagle M.E., and Migone P. (2007). Intentional attunement: Mirror neurons and the neural underpinnings of interpersonal relations. *Journal of the American Psychoanalytic Association*, 55: 131-176
 20. Gallese V., Fadiga L., Fogassi L., and Rizzolatti G. (1996). Action recognition in the premotor cortex. *Brain* 119: 593-609.
 21. Iacoboni, M., (2005). Understanding others: Imitation, language, empathy. In: *Perspectives on imitation: from cognitive neuroscience to social science*, Hurley, S., and Chater, N. (Eds), Cambridge, MA: MIT Press.
 22. Iacoboni, M., Molnar-Szakacs, I., Gallese, V., Buccino, G., Mazziotta, J.C., and, Rizzolatti, G. (2005). Grasping the intentions of others with one's own mirror neuron system. *PLoS Biology* Vol. 3, No. 3.
 23. Ramachandran, V.S. (2000) Mirror neurons and imitation learning as the driving force behind "the great leap forward" in human evolution. www.edge.org/documents/archive/edge69.html.
 24. Gallese V., Eagle M.E., and Migone P. (2007). Intentional attunement: Mirror neurons and the neural underpinnings of interpersonal relations. *Journal of the American Psychoanalytic Association*, 55: 131-176.
 25. Gallese V., Eagle M.E., and Migone P. (2007). Intentional attunement: Mirror neurons and the neural underpinnings of interpersonal relations. *Journal of the American Psychoanalytic Association*, 55: 131-176.
 26. Schore, A. (1994). *Affect regulation and the origin of self: The neurobiology of emotional development*. Hillsdale, NJ: Erlbaum.
 27. Definition of *neural network* from Wikipedia, January 2009: http://en.wikipedia.org/wiki/Biological_neural_network "In neuroscience, a neural network describes a population of physically interconnected neurons or a group of disparate neurons whose inputs or signaling targets define a recognizable circuit. Communication between neurons often involves an electrochemical process. The interface through which they interact with surrounding neurons usually consists of several dendrites (input connections), which are connected via synapses to other neurons, and one axon (output connection). If the sum of the input signals surpasses a certain threshold, the neuron sends an action potential (AP) at the axon hillock and transmits this electrical signal along the axon."
 28. Definition of *neural pathway* from Wikipedia, January 2009: http://en.wikipedia.org/wiki/Neural_pathway "A neural pathway is a neural tract connecting one part of the nervous system with another, usually consisting of bundles of elongated, myelin-insulated neurons, known collectively as white matter. Neural pathways serve to connect relatively distant areas of the brain or nervous system."
 29. Siegel, D.J. (2003). An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In M. F. Solomon & D. J. Siegel (Eds.), *Healing trauma: attachment, mind, body and brain* (pp. 1-56). New York: Norton.
 30. Because the relationship wounded child parts have with the Resources is the primary agent for change, transference issues tend to be less important in the DNMS. Child parts learn to look to the Resources to meet needs, rather than looking to the therapist.
 31. Siegel, D.J. (2007). *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being*. New York: Norton.
 32. Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. Second edition. New York: Guilford Press.
 33. Only the use of eye movements in EMDR has been well researched. Parker and Davidson, the authors of a 2001 meta-analysis, concluded that EMDR-with-eye movements was no different than EMDR-without-eye movements. Davidson, P.R., & Parker, K.C.H. (2001). Eye movement desensitization and reprocessing (EMDR): A meta-analysis. *Journal of Consulting and Clinical Psychology*, 69(2), 305-316.

However, many other studies have come to the opposite conclusion, such as:

Barrowcliff, A.L., Gray, N.S., MacCulloch, S. Freeman, T.C.A., & MacCulloch, M.J. (2003). Horizontal rhythmical eye-movements consistently diminish the arousal provoked by auditory stimuli. *British Journal of Clinical Psychology*, 42 (3), pp. 289-302.

Christman, S.D., Garvey, K.J., Propper, R.E. & Phaneuf, K.A. (2003). Bilateral eye movements enhance the retrieval of episodic memories. *Neuropsychology*, 17(2):221-9.

While these studies are very relevant to the trauma-focused EMDR protocols, they likely have little bearing on the application of ABS during the DNMS. That is because the DNMS and EMDR protocols are very different. Research to test the effectiveness of ABS during the DNMS has not yet been conducted.

33. 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.
34. 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.
35. Greenwald, R. (1993). Magical installations can help clients to slay their dragons. *EMDR Network Newsletter*, 3(2),16-17.
36. Schmidt, S.J. (1999) Resource-Focused EMDR: Integration of Ego State Therapy, Alternating Bilateral Stimulation, and Art Therapy. *EMDRIA Newsletter*, 4(1), 8-26.
37. Parnell, L. (2008). *Tapping In: A Step-by-Step Guide to Activating Your Healing Resources Through Bilateral Stimulation*. Louisville, Colorado: Sounds True.
38. Stickgold, (2002). EMDR: A putative neurobiological mechanism of action. *Journal of Clinical Psychology*, 58, 61-75.
39. Paulsen, S. (1995). Eye movement desensitization and reprocessing: Its cautious use in the dissociative disorders. *DISSOCIATION*, 8(1), 32-44.