

Introduction the DNMS

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About the Presenter



Shirley Jean Schmidt, MA is a Licensed Professional Counselor in private practice in San Antonio, TX specializing in the treatment of adults with trauma and attachment wounds. She's the founder of the DNMS Institute and the author of *The Developmental Needs Meeting Strategy: An Ego State Therapy for Healing Adults with Childhood Trauma and Attachment Wounds*. She has trained hundreds of clinicians in the DNMS model at regional, national, and international workshops and conferences since 2002. She moderates a 600-member DNMS professional listserv. She is a past president of the San Antonio Trauma & Dissociation Professional Study Group. For six years she was an EMDRIA-Approved EMDR Consultant. She has published many articles about EMDR, ego state therapy, pain management, and the DNMS. (See references.) This includes case-study publications in *The Journal of Trauma and Dissociation* and *Traumatology*. She holds the patent on the TheraTapper™, a bilateral tactile stimulation device that has been sold world-wide to DNMS and EMDR therapists.

About the Presentation

This presentation provides a very brief introduction to the DNMS model. For more information, go to the DNMS Institute web site: www.dnmsinstitute.com. The web site provides a 25-minute narrated slide show, a seven-page, illustrated description, two published case-study articles, comments about the DNMS from therapists who use it, and information about the DNMS book and Home Study Course.

Background

When I first began practicing as a psychotherapist I was taught that many of the unwanted behaviors, beliefs, and emotions that clients seek to change, originate with unresolved trauma, often from childhood; and that resolving these traumas would lead to the growth and change clients desire. Consequently I learned to apply the traditional trauma-treatment model – the (roughly) three-stage approach which includes a rapport-building/stabilization stage, a trauma-desensitization stage, and an integration/resolution stage.¹ In the trauma-desensitization stage clients are guided to relive and abreact their traumas with emotionally taxing interventions such as EMDR,² flooding,³ hypnotherapy,⁴ and Prolonged Exposure.⁵

After some years practicing therapy with this approach I observed it was not always helpful. For example, clients who grew up feeling unhappy and insecure did not always have specific childhood “traumas” to desensitize; and some who had actual childhood traumas to target experienced little to no benefit once they were desensitized.

In 2000 I had an interesting conversation with my colleague Merle Yost, a therapist from Oakland. He was working with a very difficult client named Jim – an unemployed diabetic who hoarded. His apartment was filled with junk, which he would not clean or organize. He was not eating properly, which was making him sick, making it hard for him to look for work. Yost told me he had begun experimenting with a needs meeting protocol. He said he invited Jim to think of an internal resource, a nanny, who was able to nurture a young ego state he called Baby Jim; then guided him, starting with infancy, to picture the nanny meeting Baby Jim's needs. They proceeded, developmental stage by stage, meeting needs. By the time they were meeting needs at age three, Jim was cleaning his apartment, working, and eating properly.

His story inspired a significant shift in my view of psychopathology. I suddenly understood how many unwanted behaviors, beliefs, and emotions could originate with unmet developmental needs. I could see that childhood *trauma* was just one of many potential unmet developmental needs – for example, the unmet need for *safety*. So I began experimenting with protocols that might meet clients' unmet childhood needs. The result of these experiments is the DNMS as I teach it today.

In developing the DNMS I've drawn from many sources, including ego state theory, attachment theory, developmental psychology, inner-child therapy, self-reparenting therapy, EMDR therapy, Sensorimotor Psychotherapy, and recent developments in neuroscience. It's been used to treat a wide range of adult clients, including those with *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.

I've published two case study articles in peer-review journals.⁶ The first was 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. Both are posted on the DNMS Institute web site: www.dnmsinstitute.com

Underlying Assumptions

The DNMS is based on the assumption that children have physical, emotional, social, and intellectual needs at each stage of development.⁷ 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.⁸ For example, I may feel like an adult one minute – then something upsetting happens and I suddenly 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, or emotions.

Parts of Self

The DNMS is an ego state therapy based on the idea that different personality parts, alters, or ego states can have different views of reality. *Healthy parts of self* form in response to positive, affirming relationships with caregivers 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 parts of self* form in response to traumas, and to negative, wounding relationships with caregivers 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.

Parts of self that are stuck in the past can have competing agendas, which lead to internal conflicts. These conflicts can generate unwanted behaviors, beliefs, and emotions. The DNMS aims to calm such internal conflicts by getting wounded parts of self unstuck.

Introjection

Introjection is the unconscious internalization of another person's behaviors, ideas, values, or points of view. Historically it has been considered a process intended to reduce anxiety, or protect the mind from thoughts, feelings, and conflicts too difficult to cope with consciously. While it has long been considered a "coping" strategy, the DNMS model looks at introjection a little differently.

New research in the area of mirror neurons appears to provide a possible alternative explanation for introjection. Neurophysiologist Vittorio Gallese and colleagues from the University of Parma (Italy) observed that when one monkey performed an action with his hand, specific neurons fire in association with that action. Another monkey, observing that action, involuntarily fired the same neurons (mirror neurons) that he would need to perform that same task.⁹ 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.¹⁰

For example, certain neural circuits will be activated in my brain when I happily wash the dishes. The same neural circuits will become activated in my child as she observes me happily washing the dishes. Likewise the neural circuits that will be activated in me while I'm cursing at my husband will be activated in my child while she observes me cursing my husband. This is called *shared activation*. Gallese believes that the shared activation that arises as mirror neurons fire leads to embodied simulation. This means that *internal representations* of the body states associated with the actions, emotions, and sensations of the observed are evoked in the observer, 'as if' he or she were doing a similar action or experiencing a similar emotion or sensation.

The internal representation evoked by the firing of mirror neurons will be temporary when an event is not significant. However, when a single event is significant (e.g. a rape), or when an important event is repeated, an internal representation can become engrained – leading to the formation of a part of self.

If the repeated event is positive, like a loving, attuned parent providing supportive guidance over time, the internal representation becomes an adaptive introject. But if the repeated event is negative, like a rejecting, hostile parent creating conflict over time, the internal representation becomes a maladaptive introject.

It may help to think of the introjection process as starting with a blank slate. A blank slate would be a collection of mirror neurons before mirroring begins or simply the brain's potential to mirror someone. For the purposes of understanding introjection, a blank slate can be considered a part of self with a point of view. In a developing brain, that point of view embodies a child's good true nature: a natural curiosity, an eagerness to observe and learn from others, and a desire to be in respectful harmony with self and others.

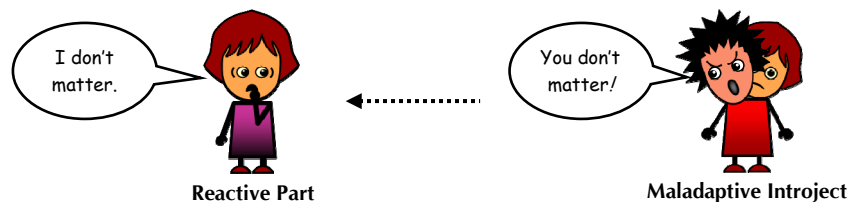
Because a wounding role model's message does not match a child's good true nature it will integrate superficially. The child part becomes like an actor playing a role that he/she does not like, but cannot stop playing, or wearing a costume or mask that he/she does not like, but cannot take off.



Maladaptive Introject

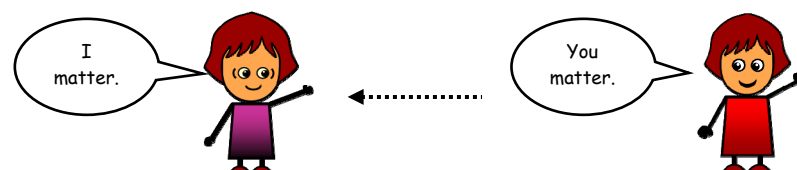
Two Types of Wounded Parts of Self

In the DNMS model there are two types of wounded parts of self – maladaptive introjects and reactive parts. Maladaptive introjects, which form with the firing of mirror neurons, mimic a significant wounding person, such as a rejecting mother or a hostile father. Reactive parts form in reaction to a wounding person, such as a rejecting mother or a hostile father. Reactive parts hold irrational negative beliefs and are stuck in painful emotions. While they formed in reaction to a wounding person, they stay stuck in the past reacting to the introject that mimics that person.



So the DNMS is based on the assumption that all present-day issues that originated in unmet childhood needs are perpetuated by maladaptive introjects who generate internal threats that reactive parts react to with unwanted behaviors, beliefs, and emotions. Therefore, maladaptive introjects are the most important wounded parts to select for healing work.

The DNMS healing interventions are focused primarily on helping the introjects heal. As introjects heal, all the reactive parts that had been affected by the wounding messages experience great relief.



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 I apply this protocol I'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.

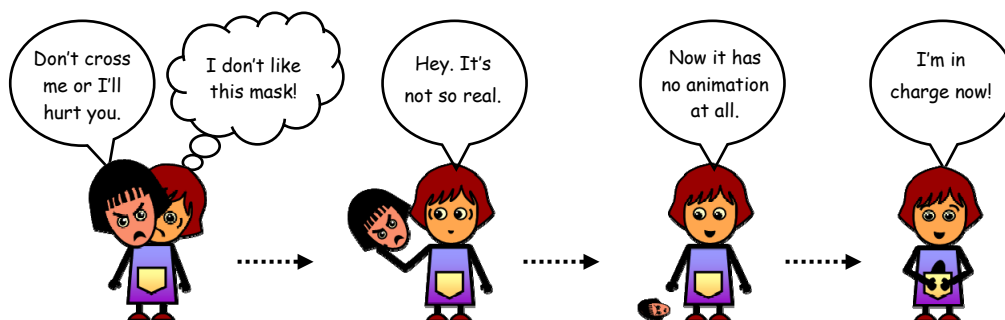
Once a client has connected to each Resource, I'll invite her to bring all three to together – to form a *Healing Circle*. In later protocols, these Resources will work together as a team to help wounded parts of self get unstuck from the past.



The Switching the Dominance Protocol

This is a multipurpose intervention – effective at calming and quieting the wounding messages delivered by maladaptive introjects. 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.

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 I 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, I'll be able to help her understand that the mask is just a recording of a wounding person, 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 healing process. The Needs Meeting Protocol is usually needed to finish the job.

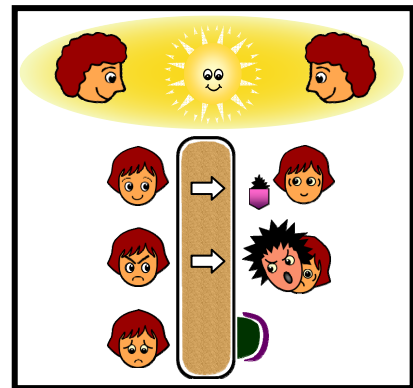
The Attachment Needs Ladder Questionnaire

In the DNMS model, attachment wounds are considered so important they are systematically identified and addressed. *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 are less about bad things that happened, and more about good things that did not happen, such as an absence of attention, loving attunement, or good boundaries.

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. I'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.

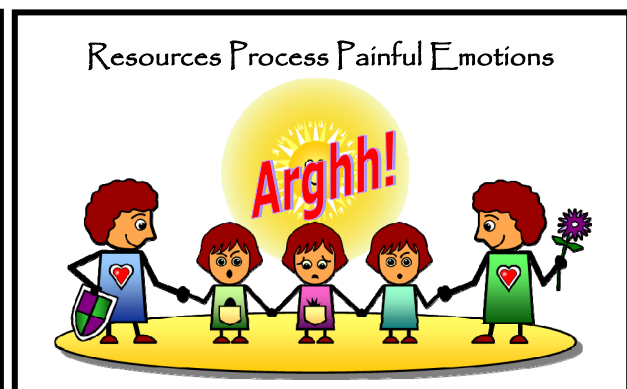
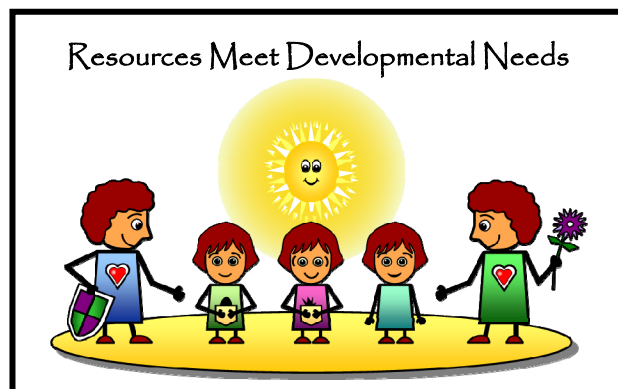
The Conference Room Protocol

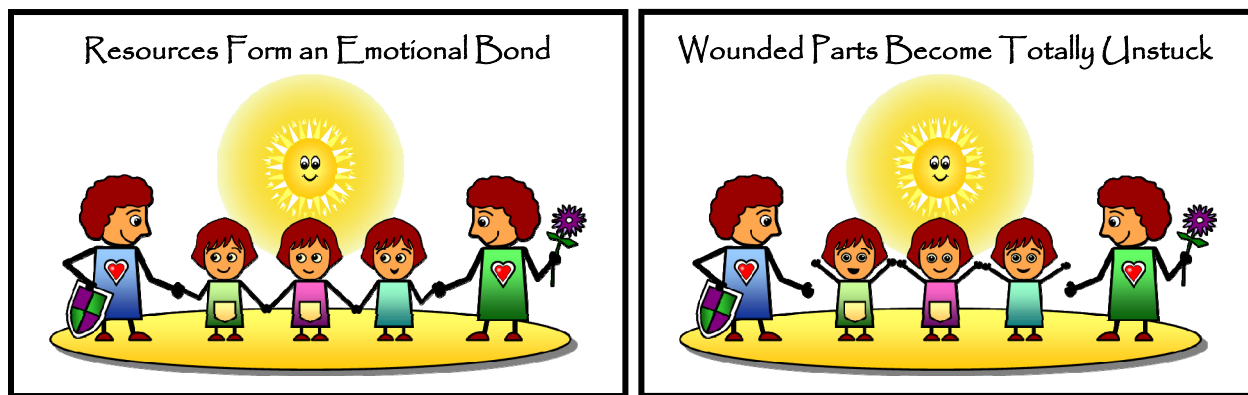
I'll begin the Conference Room Protocol by inviting my client to get a mental picture of her Resources in a conference room, with a conference table and chairs. Next I'll invite into the conference room, to sit on one side of the table, all the reactive parts that believe the negative statements endorsed on a single Rung of the Attachment Needs Ladder. When the wounded parts appear I'll then ask the most upset part to look across the table to see the maladaptive introject she is reacting to. When an introject appears, I'll switch the dominance. Then I'll ask the next most upset reactive part to look across the table. When the next maladaptive introject appears, I'll switch the dominance. I'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. Introjects and reactive parts from the conference room are selected to begin the Needs Meeting Protocol.



The Needs Meeting Protocol

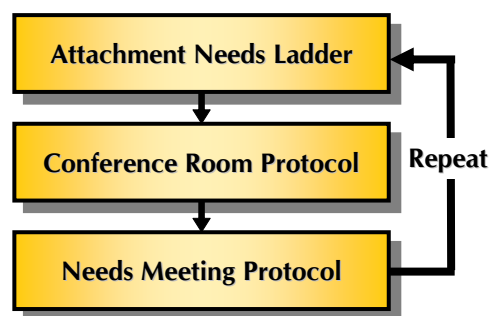
I begin the Needs Meeting Protocol by inviting wounded parts of self into the Healing Circle. Once inside the circle I'll guide the Resources to meet their developmental needs, such as safety, love, attunement, nurturing, validation, respect; help them process through painful emotions, like anger and 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. I'll ask the client follow-up questions to verify a healing shift has occurred. For example, I'll ask if the wounding messages that were delivered by the introject masks are still disturbing. The typical answer is "no." I'll ask if the Attachment Needs Ladder statements that felt true in the beginning still feel true. The typical answer is "no." I'll ask if the targeted issue still feels like a problem. The typical answer is "no." When one issue is resolved, I'll invite the client to focus on another. I'll address each problem this way until all therapy goals have been met.



When I was first developing the DNMS I assumed that a good needs meeting intervention would serve to stabilize clients, and prepare them well for the arduous task of trauma desensitization. To my surprise, I eventually observed that meeting developmental needs could gently desensitize traumas – as a side effect of the needs meeting processing. This eliminated the need to guide clients through a separate desensitization process.

Processing Blocks

Processing blocks can arise during any psychotherapy intervention. The DNMS model includes discrete steps for identifying and working through blocks. Some will come from simple misunderstandings about the protocol process or outcome. Some will come from maladaptive introjects conveying wounding messages that interfere with the work. The DNMS model provides steps for handling both types of blocks.

Alternating Bilateral Stimulation (ABS)

Alternating bilateral stimulation was made popular by EMDR therapy as a means for helping process traumatic memories.¹¹ It involves strategically adding to a treatment protocol rapid back and forth eye movements, alternating bilateral tactile stimulation, or alternating bilateral auditory stimulation. Harvard sleep expert, Robert Stickgold, postulated that ABS applied in therapy allows isolated neural networks to more easily connect to positive, adaptive neural networks.¹²

During the DNMS, ABS is used at key points in the protocols to strengthen the connections between wounded child parts and the Resources, and to facilitate emotional repair. ABS appears to help the DNMS unfold more quickly and thoroughly, but DNMS sessions without ABS have also been successful. Most DNMS clients choose tactile or auditory ABS, so they can process with eyes open or closed.

DNMS Limitations

The DNMS is a helpful approach for presenting problems that originated in unmet developmental needs and/or are perpetuated by maladaptive introjects. The DNMS is not short-term therapy per se, but clients tell me it works much faster than talk therapy. How long it takes will depend on a client's initial ego strength and therapy goals. It can be applied to a wide range of adult clients, from high to low functioning. Dissociative clients and low functioning clients can be more complicated and typically take longer to work with.

The DNMS cannot treat symptoms that come from nutritional deficiencies, hormone imbalance, medical conditions, and inherent temperament. But symptoms associated with such conditions can be exacerbated when wounding messages from a maladaptive introject compound 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.

DNMS Training

If you're interested in learning more about the DNMS the book and 16-hour narrated Home Study Course can help. For information about the Course and live workshops offered, go to www.dnmsinstitute.com.

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