The Developmental Needs Meeting Strategy: Eight Case Studies

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Abstract

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.

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The Developmental Needs Meeting Strategy (DNMS; Schmidt, 2005) is a relatively new psychotherapy. Its development has been informed by a number of well-known therapies and disciplines, including ego state therapy, inner-child work, Eye Movement Desensitization and Reprocessing (EMDR), neuroscience, attachment theory, and developmental psychology. The DNMS is grounded in the premise that children grow and develop in stages and that each developmental stage involves specific needs that must be met by parents or caregivers. It assumes that the degree to which childhood needs were not adequately met at a given developmental stage is the degree to which the adult client is "stuck" in that stage (Erikson, 1950; Illsley-Clarke & Dawson, 1998; Maslow, 1968). Being stuck means that behaviors, beliefs, or emotions connected to unresolved childhood wounds can get triggered today. For example, a person may feel like an adult one minute – then something upsetting happens and the person suddenly sees the world through the eyes of a sad, angry, or fearful child. The DNMS aims to remediate the developmental deficits at the root of such reactions.

Ego State Therapy

The notion that we are composed of ego states, subpersonalities, or parts of self has been around since Freud (1923/1961) proposed the id, ego, and superego. Many therapy approaches use ego state theory principles, including Psychosynthesis (Assagioli, 1975), Transactional Analysis (Berne, 1961), the SARI Model (Phillips & Frederick, 1995), Internal Family Systems Therapy (Schwartz, 1995), Voice Dialogue (Stone & Stone, 1993), Ego State Therapy (Watkins & Watkins, 1997), and Inner Child Psychotherapy (Bradshaw, 1990; Capacchione, 1988; Napier, 1990). These models share the premise that different ego states can have different views of reality. Each approach aims to help individual ego states heal and to increase healthy communication and cooperation between ego states.

The DNMS is also an ego state therapy. It differentiates two classes of wounded ego states: *reactive parts* and *maladaptive introjects*. Reactive parts are wounded child ego states that evolve in reaction to significant childhood role models who are physically or emotionally wounding. For example, a fearful reactive part may evolve in reaction to a violent father, or a sad reactive part may evolve in reaction to a rejecting mother. Some reactive parts hold painful emotions such as fear, sadness, shame, or anger. Some clients cope with these emotions with pain-avoidant behaviors such as withdrawing, drinking, or overeating. Some clients try to manage hurtful people with strategic behaviors such as pleasing, complying, or overachieving. Typical reactive part descriptions include angry, ashamed, bossy, compliant, controlling, drinker, fearful, frozen, helpless, invisible, lonely, numb, overeater, perfectionist, protector, pleaser, powerless, rebel, sad, self-critical, self-punishing, stoic, traumatized, vigilant, and withdrawn. Clients often seek therapy to address the problems that stem from the unwanted behaviors, beliefs, and emotions of reactive parts (see Figure 1).

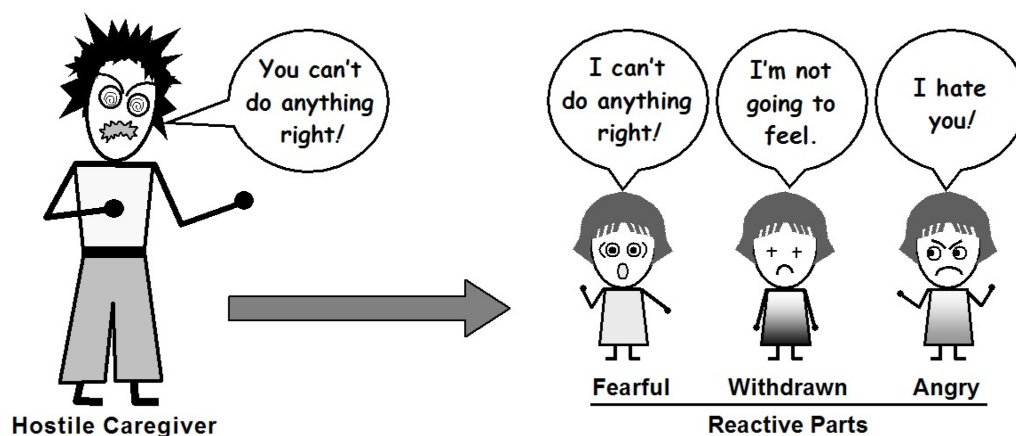

Figure 1. In childhood, reactive parts form in reaction to wounding caregivers.

Internal representations of significant role models, such as primary caregivers, are called *introjects* (Watkins & Watkins, 1997). These are the parts of self that act like or mimic those role models. This can be adaptive and healthy when a role model is supportive, loving, and kind, or it can be problematic when a role model is unkind, neglectful, abusive, or enmeshing (Siegel, 2003). The child parts that mimic role models (e.g., parents) who are physically or emotionally wounding are called *maladaptive introjects*.

The DNMS model conceives of introjection a little differently from other ego state models. Children naturally evolve internal representations of their caregivers. The development of these internal representations is not a decision, it simply happens. It appears to be biologically driven by mirror neurons (Ramachandran, 2000; Rizzolatti & Gallese, 2002). In DNMS language, the creation of an internal representation in a developing brain starts with a *blank slate neural network*.[1] This neural network is a collection of mirror neurons before mirroring begins. It is the brain's potential to mimic someone. In a young person, this blank slate could be considered a child ego state with a point of view – to be curious, engaged, and eager to learn from role models and whose true nature is to be in respectful harmony with self and others (Montessori, 1936). The internal representation of a neglectful, abusive, or enmeshing caregiver will not integrate well because it does not match the child's true nature. Instead it will integrate superficially, like a child reluctantly wearing a (metaphorical) mask that mimics the dysfunctional caregiver's behaviors and words. The child part wearing the mask does not like the mask's behavior or words, and if given a choice, would not choose that behavior (see Figure 2).

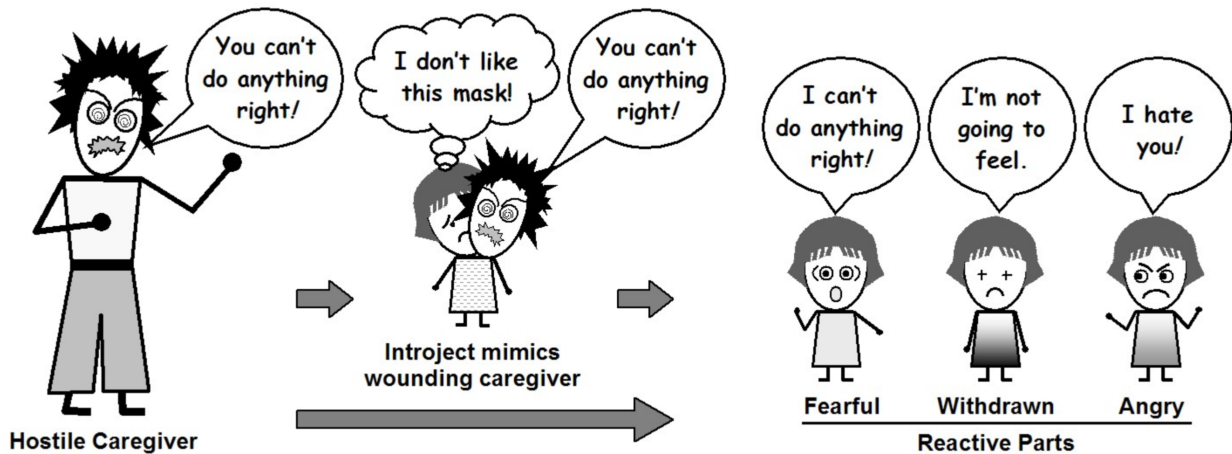

Figure 2. In childhood, maladaptive introjects reluctantly mimic wounding caregivers.

When an adult is under stress, maladaptive introjects can convey to reactive parts the same wounding messages the caregivers conveyed in childhood. Maladaptive introjects keep the reactive parts stuck in childhood and the adult client stuck in unwanted behaviors, beliefs, and emotions (see Figure 3).

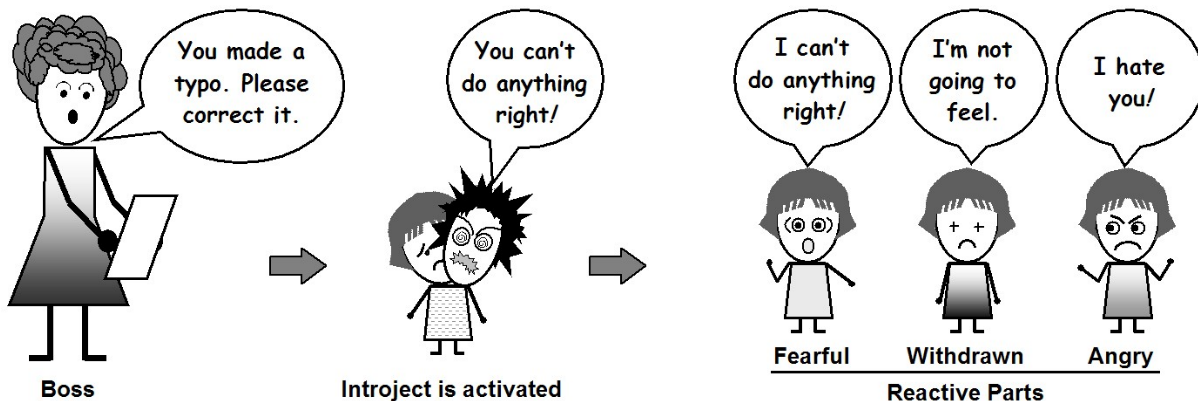

Figure 3. In adulthood, maladaptive introjects under stress can convey wounding messages to reactive parts.

[1] A "blank slate neural network" includes a child's temperament and genetic predispositions.

The DNMS protocols help find and liberate the innocent child from under the mask. As the child part gets unstuck from the past, the mask disappears along with the wounding messages the mask was conveying. Once unstuck, this child part can finally live authentically, from a natural inclination to be in respectful harmony with self and others. The cessation of the wounding message is a great relief to the associated reactive parts, who no longer need to react with the usual unwanted behaviors, beliefs, and emotions. The client can then handle the stress with adult skills and strengths (see Figure 4).

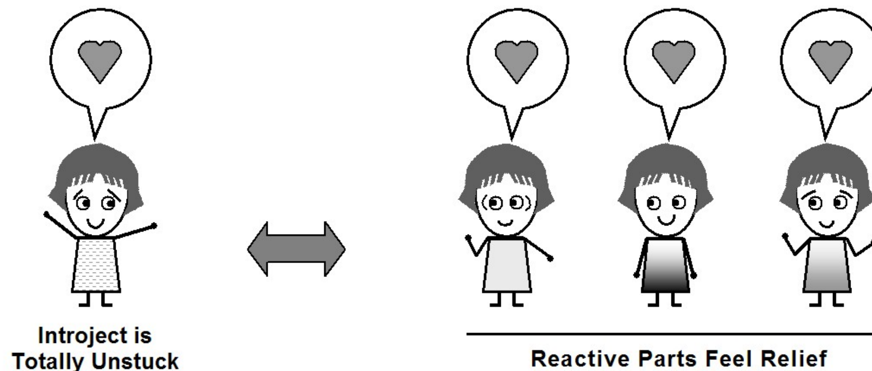

Figure 4. After the DNMS protocols get maladaptive introject unstuck, the associated reactive parts experience relief.

The Treatment Protocols

There are three main DNMS protocols: a *Resource Development Protocol*, an *Ego State Mapping Protocol*, and a *Needs Meeting Protocol*. These protocols are described in detail elsewhere (Schmidt, 2005). The Resource Development Protocol provides a set of special DNMS meditations, used systematically to help clients connect to and strengthen three internal "resource" ego states: a Nurturing Adult Self, a Protective Adult Self, and a Spiritual Core Self. These Resources, which join together to form a Healing Circle, assume competent caregiver roles.

The Ego State Mapping Protocol is used to identify (a) the messages conveyed by childhood caregivers that inspired a current problem, (b) the reactive parts that formed in reaction to the caregiver message(s), (c) the maladaptive introject(s) that mimicked the caregiver message(s), and (d) how stuck each reactive part is, 0 to 10, with respect to the introject message (see the Results section for a sample map).

The Needs Meeting Protocol has 20 steps. Throughout this structured protocol, the client holds a mental picture of the Resources in proximity to a maladaptive introject (the source of a current problem). While holding this mental picture, the therapist facilitates reparative communications between these ego states. The Needs Meeting Protocol begins when the maladaptive introject is invited into the Healing Circle. Once there, the child under the mask is prompted to name her unmet needs. The therapist invites the child to notice that the Resources can meet those needs for her now. The Resources meet many needs, one at a time – simple needs, such as love, attention, connection, validation, and protection, and more advanced needs, such as guidance, age-appropriate responsibility, and information about the world. In the next step, the Resources meet needs specifically connected to anger and sadness to help the child part work through those strong emotions. Next, the child part is invited to notice an emotional bond with each Resource, individually and as a group, to help the child part feel securely attached. Over the course of a typical Needs Meeting Protocol, between 15 and 30 needs are met by the Resources. Collectively, these steps and others provide the needed "corrective emotional experiences" (Alexander & French, 1946). As the protocol proceeds, clients report that the introject mask becomes incrementally smaller and less important, until it eventually disappears. At the same time, the child appears calmer and happier – incrementally more like a carefree child who is securely attached to competent caregivers. By the end of the protocol, a child part is totally unstuck from the mask and the message that had been delivered by the mask, and likewise totally unstuck from childhood. When this is complete, clients typically report significant improvement in the original problem. (For a more detailed description of this protocol, see the Results section, Case #1.)

Alternating Bilateral Stimulation

Alternating bilateral stimulation (ABS) is used throughout the DNMS to strengthen all positive experiences (including enhancing internal resources and positive beliefs about self). Shapiro (1989) discovered that rapid side-to-side eye

movements could be used to facilitate trauma desensitization. Eye movements became a cornerstone of the EMDR 8-Phase Protocol. Shapiro also observed that rapid eye movements could also help strengthen positive beliefs about self. In clinical practice, both alternating bilateral tactile and auditory stimulation were found to be effective alternatives to eye movements (Shapiro, 2001). All three modalities are considered forms of ABS.

Greenwald (1993) and Leeds (1998) have explored the use of ABS to strengthen positive personality traits. Greenwald proposed using ABS to strengthen a client-generated image representing the psychological resource necessary for successful EMDR processing. Leeds introduced the term *Resource Development and Installation* (RDI) to describe his EMDR-related protocol for using ABS to strengthen positive images, memories, and symbols. In two single case design studies, Leeds's RDI protocol was found to be an effective intervention for clients with complex posttraumatic stress disorder in the preparation phase of EMDR (Korn & Leeds, 2002). In the study, ABS was used to enhance a positive felt sense of internal resources and to strengthen the probability clients would use their resources to manage future stressors. Schmidt (1999) developed an ABS protocol for integrating ego state therapy and art therapy. 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.

The application of ABS in a therapeutic intervention does not make that intervention an "EMDR therapy." Therefore, even though DNMS uses ABS, it is not EMDR, and it is not a variation of EMDR. These approaches are distinctly different. DNMS protocols are focused primarily on repairing developmental deficits, whereas 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. Clinical observation suggests that DNMS clients may process more deeply or quickly when ABS is present, but 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.

What the DNMS Treats

Many clients report present-day problems that clearly link to wounds inflicted in childhood. Unresolved childhood abuse (verbal, physical, or sexual), neglect (physical or emotional), enmeshment, and unskillful/ inadequate parenting are all indicators of unmet developmental needs. But not all presenting problems are linked to unmet childhood needs. Unwanted symptoms can come from organic brain dysfunction (e.g., schizophrenia), acute trauma (e.g., stranger rape), chronic physical stress (e.g., chemotherapy), and inherent temperament (e.g., hypersensitivity). These conditions can be exacerbated when unmet developmental needs are also a source of problems. The DNMS appears to relieve symptoms only to the degree the symptoms are linked to unmet developmental needs. Whereas many clients are drawn to the DNMS, some are not. For example, some clients reject the idea of parts of self, some are dead-set on a particular intervention (e.g., EMDR, hypnosis, CBT) and refuse to discuss DNMS, and some need basic help (e.g., personal safety interventions) more than DNMS.

DNMS can treat motivated clients regardless of initial diagnosis or ego strength. Clients with a lot of ego strength and few unmet developmental needs will generally progress more quickly with the DNMS than clients with little ego strength and many unmet needs. Nevertheless, the same DNMS protocols can be used for a wide range of cases – from simple to complex. Clinicians have reported finding the DNMS helpful for treating depression, anxiety, panic disorder, social phobias, substance abuse, complex PTSD, relationship problems, obsessions/compulsions, sexual abuse, eating disorders, dissociative disorders, borderline personality disorder, sexual addiction, self-injurious behavior, and complicated grief.

DNMS DID Case Study Report

Schmidt (2004) described the use of the DNMS for the treatment of dissociative identity disorder (DID). The client, Lisa, had a childhood history of chronic neglect and abuse, including sexual abuse. She began DNMS therapy a few days after being released from a psychiatric ward, where she had been admitted for a deep depression with significant suicidal ideation. Symptoms of severe anxiety, depression, and alcohol and cocaine abuse had been present for years prior to DNMS treatment. None of her prior hospitalizations, drug therapies, or psychotherapies had alleviated her symptoms. The DNMS treatment initially focused on meeting the developmental needs of ego states stuck in childhood – both introjects and reactive parts.[2] Nine months into DNMS treatment, it became apparent that Lisa suffered from DID. Then DNMS treatment shifted to meeting the developmental needs of the alters who were creating the most problems, internally and externally. As each wounded ego state and alter became unstuck, Lisa made tremendous progress. Seventeen months into her treatment, she reported a near total elimination in frequency and

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[2] As the DNMS has evolved, it has become clear that getting reactive parts unstuck is not nearly as beneficial as getting introjects unstuck. Now DNMS protocols are focused exclusively on targeting introjects.

severity of symptoms of depression and anxiety. Her Trauma Symptom Inventory (TSI; Briere, 1995) scores were in the non-clinical range. Her scores on the Multidimensional Inventory of Dissociation (MID; Dell, 2003), an instrument designed for diagnosing dissociative disorders, indicated she no longer met the diagnostic criteria for DID. At the start of therapy, she was taking drugs for depression, anxiety, sleeplessness, and psychosis, and by 18 months after the start of DNMS treatment, she was off all medications and functioning well without them. A follow-up examination revealed that the original gains have been maintained (Schmidt, 2006b).

Hypothesis Tested in This Study

This study investigated the hypothesis that using the DNMS to treat problem behaviors and emotions that originated in unmet developmental needs would lead to a significant reduction in those behaviors or emotions and in the associated negative beliefs.

METHODS

Three experienced DNMS therapists, all in private practice, provided the treatments for the 8 participants in this study. In preparation for this study, the first author held a special research/certification workshop to (a) provide training on the research protocol and (b) test knowledge of and fidelity to the DNMS protocols. These therapists met or exceeded the minimum criteria for becoming a certified DNMS therapist (competent practitioner) at the conclusion of the workshop (Schmidt, 2006c).

Research Participants

Although the DNMS can be effective with unstable, low-functioning clients (Schmidt, 2004), they usually need longer term therapy. Because we planned to collect outcome data within a 12-month period, participants were limited to those considered “stable and reasonably high-functioning.” Clients who met any of nine exclusionary criteria were not eligible for the study. Participants who met any one of the exclusionary criteria after enrolling in the study were dropped from the project (but not from treatment). Clients were excluded from the study if:

1. They were overwhelmed by neutral stimuli or small triggers.
2. They could not self-soothe after being triggered.
3. They needed more than 300 minutes to get one ego state unstuck (cumulative over the course of many sessions).
4. Their emotional instability made working through processing blocks especially time-consuming.
5. They did not attend sessions consistently or regularly.
6. They needed substantial session time for debriefing about current events/crises, leaving little time for DNMS.
7. They routinely scheduled sessions more than 4 weeks apart.
8. They had one or more significant experiences during the data collection period, which made it difficult to attribute psychological and physiological changes to the DNMS (e.g., radical change in drug therapy, sudden debilitating illness, acute trauma, etc.).
9. Their presenting problems were unrelated to unmet developmental needs.

Criteria 1 to 4 were used to screen for clients who were not sufficiently “stable and reasonably high-functioning” to complete the study within 12 months. Criteria 5 to 7 were used to ensure that the participant’s DNMS experiences were frequent enough, or intensely focused enough, to account for any positive changes reported. Criterion 8 was used to screen out obvious confounding variables. Criterion 9 was used to ensure that the DNMS was an appropriate intervention for treating the presenting problem.

Except for exclusion #9, these restrictions are not at all relevant to the application of the DNMS in normal clinical practice. These limitations were only applied to ensure a sampling of participants who could complete their work within the 12-month time frame of this study.

Participants were recruited from the private practice caseloads of the three DNMS therapists – the first author (in Texas), Joan Bacon (in Pennsylvania), and Richard Holcomb (in New Zealand). Clients who were not ruled out by the exclusionary criteria were invited to participate in the study if they had completed the Resource Development Protocol and were planning to do DNMS needs-meeting work anyway. Participants were not recruited to engage in DNMS treatment per se; rather, they were recruited to take part in data-collection activities that would systematically track their progress with the DNMS treatment they elected to get.

Human Participants Protection

All methods, protocols, and instruments were reviewed and approved by the Institutional Review Board of the University of Texas at San Antonio. Clients invited to participate were given an informed-consent form to read and initial. The consent form explained that if they chose to participate, they would be receiving the same therapy whether they participated in the study or not and would be able to continue with therapy after participation in the study concluded.

Study Design

In an initial interview, participants were asked the following four questions:

1. What problem or symptom are you most bothered by?
2. On a 0-10 scale, where 0 is "not at all" and 10 is the "worst possible," how much does this problem/ symptom bother you? (Greenwald, 1996)
3. What negative belief(s) are associated with this problem/symptom?
4. On a 0-10 scale, where 0 is "not at all true" and 10 is "totally true," how true does each negative belief feel?

Then these four questions were asked again for two more problems (or one more if participant could not name two more). Responses were handwritten on the *Initial Assessment Interview Worksheet*. These answers were later typed onto a *Treatment Progress Report* form, which included a preprinted Likert-type scale for each problem and negative belief listed. At the start of each subsequent session, participants were given the preprinted Treatment Progress Report form and asked to circle the number, from 0 to 10, that best described the current significance of each problem and negative belief listed.

One at a time, each problem named in the initial assessment interview was addressed, in order of importance, with the DNMS Ego State Mapping and Needs Meeting Protocols. (Standard DNMS protocol calls for processing a client's most important issue first.) Once all the targeted problems were resolved, and the significance of each problem and each associated negative belief was rated 0, the treatment portion of the collection process was complete. The DNMS treatment data were collected over a 12-month period. Follow-up data were collected 15 months after the project began. Follow-up intervals varied from case to case (from 3 months to 1 year), as each of the 8 participants started and finished at different times over the course of this study. Those who finished treatment closer to the start date provided longer range follow-up than those who completed treatment later.

RESULTS

Of the 8 cases, the first is described in detail and the remaining 7 are summarized. (All participant names have been changed to protect their identity.) A brief summary of childhood history relevant to the targeted problems is provided for each participant. Pre-treatment, post-treatment, and follow-up ratings are shown for each case. For the problem ratings, 0 refers to "not at all a problem" and 10 refers to "worst possible problem." For the negative belief ratings, 0 refers to "not at all true" and 10 refers to "totally true."

Case #1: Annie

Annie was a middle-aged, married (but separated) unemployed female. She reported that by age 7 her mother had put her in charge of raising her four younger siblings. She had no control over her siblings but would be punished when one of them upset mother. Annie recalled her parents neglected her needs and told her to meet her own needs. Her father conveyed that a woman's job was to make men happy. She had developed her Resources and successfully completed several needs-meeting sessions before enrolling in this study (see Table 1).

Problem 1, "I panic when I perceive I might be controlled by another person," was addressed first. The therapist began with the Ego State Mapping Protocol. He wrote the problem statement on the top of a blank ego state map page and wrote below it the two associated negative beliefs. Annie recalled coming to believe these statements in childhood while listening to her dad convey, "You're powerless to get away. You should be a real woman who wants to do what men tell you to do or else you're a failure. You should make me happy. You can only go when I let you go." She named the two child parts that formed in reaction to dad's message: "Frozen" and "Panic." The therapist drew this on the ego state map. He also drew an introjected dad and explained how a blank slate neural network (innocent child part) had taken on dad's persona as a mask. They discussed how his message had generalized internally to "You're powerless to get away. You should be a real woman who wants to do what men tell you to do or else you're a failure. You should make *others* happy. You can only go when *others* let you go." The therapist

explained that the mask creates internal distress by delivering dad's wounding message to reactive parts now. He asked how stuck each reactive part was, 0 to 10 where 10 equaled totally stuck. Annie reported each reactive part was stuck at 10. She was told that the DNMS could help the child part wearing the mask get free from the mask and the message delivered by the mask, by getting all her needs met by the Resources, and that both reactive parts (frozen and panic) would feel a little or a lot of relief once the child behind the mask was healed. (Figure 5 shows Annie's Problem #1 ego state map.)

Table 1. Annie's Progress Report ratings of problems and negative beliefs

		0-10 Ratings		
		Pre-treatment	Post-treatment	6-Mo Follow-up
Problem #1:	I panic when I perceive I might be controlled by another person.	10	0	0
Neg Beliefs:	1. If I allow myself to be controlled, it will be worse than being dead because I can't stop it.	10	0	0
	2. I'm powerless once I've agreed to be in a situation, because I can't get out.	10	0	0
Problem #2:	Excessive need to control and organize others.	9	0	0
Neg Beliefs:	1. I have to control everything or else something bad will happen and it will be my fault.	10	0	0
Problem #3:	Can't recognize my own needs.	8	0	0
Neg Belief:	1. I don't deserve care and attention.	8	0	0

Problem #1: I panic when I perceive I might be controlled by another person.

Negative beliefs: If I allow myself to be controlled, it will be worse than being dead because I can't stop it.
I'm powerless once I've agreed to be in a situation, because I can't get out.

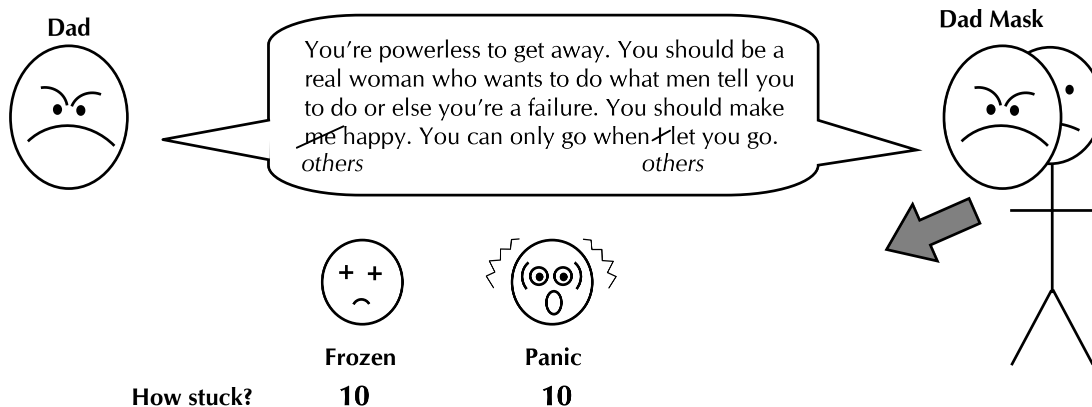

Figure 5. Annie's Problem #1 ego state map.

When the map was completed, the therapist began the Needs Meeting Protocol. He said, "I'd like to invite, to approach the Resources, the part of you that mimics dad and conveys his message: 'You're powerless to get away. You should be a real woman who wants to do what men tell you to do or else you're a failure. You should make others happy. You can only go when others let you go.'" When Annie indicated the dad introject was approaching the Resources, the therapist asked the child under the introject mask about her age and mood. She reported she was 9 years old and scared. He invited the 9-year-old to come into the Healing Circle and to bring the angry dad mask along. Once there, the child's sense of connection and safety in the Resources' care was strengthened with ABS. The child was informed that the Resources could help her get unstuck by meeting her needs now. She was asked, "What do you need most right now?" The child said, "To be nurtured." She was then asked, "Can the Resources nurture you now?" When she said "yes," the therapist said, "Good, notice that. Take as long as you need to let it strengthen. Tell me when it's strengthened all the way." ABS was applied to help it strengthen. Once fully strengthened, the child part was asked, "And what else do you need?" The child identified a second need, "acceptance," and the experience of

the Resources accepting her was strengthened all the way. This process was repeated with additional needs met, including "kindness," "freedom to be myself," "someone on my side," "safety," "security," and "love." The therapist then asked Annie to report on the appearance and mood of the 9-year-old. Annie reported that the mask was getting smaller and less important and the 9-year-old was no longer scared.

Next, the 9-year-old was invited to work through anger and grief. The therapist asked, "If you could feel anger about your dad's message, completely and fully in your body now, how intense would it be, 0-10?" She answered "8," and he asked, "Of your dad's behaviors, which is most connected to that 8?" She answered, "His disrespect." The therapist asked, "Can you count on the Resources to treat you with respect now?" When she said "yes," the therapist said, "Good. Notice that. Tell me when it's strengthened all the way." ABS was applied to help it strengthen. Once fully strengthened, the child part was again asked to rate the level of anger. This time it was a 6. Again this rating was linked to an unmet need – a need that was met by the Resources. These steps were repeated. Each time a need was met, the anger intensity diminished a little more. After a few minutes of meeting anger-related needs, the anger rating had diminished to 0 – gently, easily, and without lengthy, painful abreactions. This procedure was repeated for sadness. Once the emotion processing was complete, Annie was asked to report again on the appearance of the 9-year-old. The mask was completely gone, and the child appeared very happy. Next, the therapist invited the 9-year-old to notice and strengthen (with ABS) her emotional bond with each Resource, one at a time, and as a group (Napier, 1990; Paulsen, 2000; Steele, 2001). Once the bonds were strengthened, he asked the 9-yearold if she felt "somewhat unstuck, mostly unstuck, or totally unstuck." She replied, "Mostly unstuck."

She was then asked to disconnect from the Resources for a moment, in order to (mentally) revisit being in her parents' care, especially her dad's care, just like it was in childhood, without Resources there to support her, and to rate any disturbance that came up, on a 0 to 10 scale (10 = *worst possible disturbance*). The 9-year-old rated the disturbance a 10. He then asked which of her parents' behaviors were most connected to the 10. She said, "I can't get away from them, I'm trapped and powerless." The therapist asked, "Are you trapped and powerless in the care of the Resources now?" She answered "no." "Can the Resources grant you age-appropriate power and freedom now?" When she said "yes," with ABS on, he said, "Good. Notice that. Tell me when it's strengthened all the way." This routine was repeated. Each time the Resources met another need, the disturbance rating decreased. This step was complete when the 9-year-old reported that she could revisit her dad's care, without the Resources present for support, without any disturbing body sensations arising. This step is important because it ensures that the gains reported are due to more than a temporary feel-good connection to the Resources. It is similar to Peter Levine's technique of "pendulating" between comfort and trauma when processing through disturbing memories (Poole Heller, 2001).

Next, the therapist asked the 9-year-old, "Do you know you're in an adult body now?" The child was invited to fully recognize the benefits of being in an adult body, in contrast to the perils of being age 9 (Paulsen, 2000; Twombly, 2000). That awareness was strengthened with ABS. Again the therapist asked the child part how stuck she felt now, "mostly unstuck or totally unstuck." She replied, "Totally unstuck." Annie reported her body felt clear and relaxed, and she pictured the child doing cartwheels – a free and happy 9-year-old. The therapist asked the child, "When you think about what we have done today, what you've learned and how you've grown, what's a positive belief you know to be true about you now?" The 9-year-old replied, "I am strong (even when others try to control me). I can leave bad situations. I can change my mind (even after I've agreed to something). It's okay to do what I want." She reported that each of these beliefs felt totally true. These statements were strengthened with ABS. The therapist then thanked her for her hard work and invited her to "tuck in" (Paulsen, 2000) with the Resources. Returning to the Ego State Map, she reported each reactive part was totally unstuck with respect to dad's message. She re-rated Problem 1 a 0 (*not at all a problem*), down from 10 (*worst possible problem*), and both negative beliefs a 0 (*not at all true*), down from 10 (*totally true*). This work was completed in one 115-minute session.

Problem 2, "Excessive need to control and organize others," was addressed next. As the therapist constructed the ego state map, Annie recalled her parents conveying the message "You must control your brothers and sisters so we don't have to. You must set a good example for your brothers and sisters. You're in charge. You have to be good, or else you're in trouble." She named five reactive parts that evolved in reaction to this message: "I'm a failure," "Stressed out," "Logical/Analytical," "Black & White," and "Anxious." When the map was complete, the therapist invited into the Healing Circle the part of her that mimicked mom and dad conveying the generalized message "You must control *(uncontrollable) others*, so *others* don't have to. You must set a good example for *others*. You're in charge. You have to be good, or else you're in trouble." The therapist guided the 7-year-old wearing the mom/dad mask through the steps of the Needs Meeting Protocol. By the end of the session, Annie reported the dad/mom mask was gone and the 7-year-old child part and all five reactive parts were totally unstuck. The Problem 2 rating was down to 0. The associated negative belief rating was also down to 0. This work was completed in one 100-minute session.

Problem 3, "Can't recognize my own needs," was addressed next. As the therapist constructed the ego state map, Annie recalled her parents delivering the message "You're a nuisance, and a pain in the ass. Your needs are an

inconvenience, and a trial for us. You shouldn't be here – you shouldn't exist. You don't have any needs. If you are here, then don't want anything." She named six reactive parts that evolved in reaction to this message: "Unimportant," "Hindrance," "Rejected," "Bewildered," "Distressed," and "Pleaser." When the map was complete, the therapist invited into the Healing Circle the part of her that mimicked mom and dad conveying the generalized message "You're a nuisance, and a pain in the ass. Your needs are an inconvenience, and a trial for *others*. You shouldn't be here – you shouldn't exist. You don't have any needs. If you are here, then don't want anything." The therapist guided the 5-year-old child wearing the mom/dad mask through the steps of the Needs Meeting Protocol. By the end of the session, Annie reported the dad/mom mask was gone and the 5-year-old child part and all six reactive parts were totally unstuck. The Problem 3 rating was down to 0. The associated negative belief rating was also down to 0. This work was completed in one 90-minute session.

Once the research data were collected, Annie chose to continue therapy to work on additional issues. Follow-up data were collected 6 months after her last DNMS research session – all ratings were still 0 (see Table 1). Shortly after completing these sessions, she reported to her therapist that she was no longer feeling intimidated by controlling people. She proceeded to divorce her estranged, controlling husband. She began to set and maintain firm boundaries with her controlling and verbally abusive mother and overly needy sister. She had a longstanding pattern of over-focusing on others' needs while ignoring her own. This was evident by the way she over-controlled and overprotected her teenage children at a time they needed to become more independent. She was able, for the first time, to give her children age-appropriate responsibilities and freedoms. This significantly reduced family conflicts. She found that, when she stopped over-focusing on her children, she could start listening to and responding kindly to her body. She began to take care of herself by appropriately managing activity/ rest cycles and by setting boundaries when her needs were being compromised. She commented, "Since starting the DNMS, I noticed it's much more peaceful in my head. The part that used to react to any idea with 'you can't make me' or 'you can't stop me,' appears to be gone. What a relief. Once I address an issue, not only does it no longer bother me, but I can't remember what it was. I can remember incidents clearly, but the negative emotional response doesn't exist anymore. This seems to be permanent."

Summary of Annie's DNMS treatment

Problem #1	Problem #2	Problem #3
I panic when I perceive I might be controlled by another person.	Excessive need to control and organize others.	Can't recognize my own needs.
Introject message: *Dad:* You're powerless to get away. You should be a real woman who wants to do what men tell you to do or else you're a failure. You should make me happy. You can only go when I let you go.	*Introject message:* *Dad:* You must control your brothers and sisters so we don't have to. You must set a good example for your brothers and sisters. You're in charge. You have to be good, or else you're in trouble.	*Introject message:* *Dad/Mom:* You're a nuisance, and a pain in the ass. Your needs are an inconvenience, and a trial for us. You shouldn't be here - you shouldn't exist. You don't have any needs. If you are here, then don't want anything.
Number of reactive parts on map: 2	*Number of reactive parts on map:* 5	*Number of reactive parts on map:* 6
Child part under mask: Nine-year-old under dad mask.	*Child part under mask:* Seven-year-old under dad mask.	*Child part under mask:* Five-year-old under dad/mom mask.
Once nine-year-old was totally unstuck: – Both reactive parts totally unstuck. – Problem #1 rated 0. – Problem #1 negative beliefs rated 0.	*Once seven-year-old was totally unstuck:* – All 5 reactive parts totally unstuck. – Problem #2 rated 0. – Problem #2 negative beliefs rated 0.	*Once five-year-old was totally unstuck:* – All 6 reactive parts totally unstuck. – Problem #3 rated 0. – Problem #3 negative beliefs rated 0.
Completion time: One 115-minute session.	*Completion time:* One 100-minute session.	*Completion time:* One 90-minute session.

Case #2: Betty

Betty was a married, middle-aged, female graduate student. She recalled that while growing up, her father was constantly verbally abusive to all family members. Her parents attended a fundamentalist church that valued boys over girls. She reported that her 3-year-old brother died in a hospital when she was 5 years old. Her parents did not tell her about his death until after the funeral, and then only one sentence was spoken. They never talked about it again. She recalled being treated as though she should have died instead. Her parents discouraged her from excelling at school. Betty understood that if she succeeded too much, they would exclude her from the family. She enrolled in the study shortly after beginning DNMS therapy (see Tables 2 and 3).

Once the research data were collected, Betty reported she had met her goals and chose to terminate therapy. Follow-up data were collected 1 year after her last DNMS session (see Table 2). She reported to her therapist shortly after the work ended that she had attended a large professional meeting that she had been dreading before the DNMS and had felt completely comfortable. She reported that before the DNMS, she had felt like a child around a particular controlling professor at school, who reminded her of her father. After the DNMS, he no longer felt like a threat. She

reported that she had met with a suicidal client without panicking, and she could now talk about her deceased brother without panicking. At follow-up, she commented that as a result of the DNMS she had experienced "dramatic changes in affect, both to the stimuli that previously bothered me and to my general level of tension. I have noticed that I no longer go around malls with my hands clenched, my breathing is normal in places when there are a lot of new people, I feel relaxed and also have noticed somatic relief from eczema and irritable bowel syndrome. I have more confidence."

Table 2. Betty's Progress Report ratings of problems and negative beliefs

		0-10 Ratings		
		Pre-treatment	Post-treatment	12-Mo Follow-up
Problem #1:	Feels anxious in professional meetings.	7	0	0
Neg Beliefs:	1. I'm inadequate.	8	0	0
	2. I'm not good enough.	9	0	0
Problem #2:	Feels like a child when talking to controlling people.	7	0	0
Neg Beliefs:	1. I'm powerless.	9	0	0
	2. I can't give a logical response	7	0	0
Problem #3:	Panics when with suicidal client or talking about death of brother.	9	0	0
Neg Belief:	1. I must be in control	8	0	0

Table 3. Summary of Betty's DNMS treatment

Problem #1	Problem #2	Problem #3
Problem: Feels anxious in professional meetings.	*Problem:* Feels like a child when talking to controlling people.	*Problem:* Panics when with suicidal client or talking about death of brother.
Introject messages: *Mom:* You can't please me no matter what you do. *Dad:* You're an inconvenience. You're not important. Your ideas are flawed.	*Introject message:* *Dad:* I'm right, you're wrong. You're stupid. You should be seen, not heard. Your needs are not important. You should be a boy (not a girl). You should be an adult.	*Introject message:* *Dad/Mom/Sister:* You mustn't talk about death. It's morbid - just get on with the job. You can't cope with death. You must be protected from knowing about death. You can't attend to death because you can't cope. You shouldn't have to deal with death.
Number of reactive parts on map: 5	*Number of reactive parts on map:* 6	*Number of reactive parts on map:* 7
Child parts under masks: 4-year-old under mom mask, and 4-year-old under dad mask.	*Child part under mask:* 6-year-old under dad mask.	*Child part under mask:* 12-year-old under dad/mom/sister mask.
Once four-year-olds were totally unstuck: – All 5 reactive parts totally unstuck. – Problem #1 rated 0. – Problem #1 negative beliefs rated 0.	*Once six-year-old was totally unstuck:* – All 6 reactive parts totally unstuck. – Problem #2 rated 0. – Problem #2 negative beliefs rated 0.	*Once twelve-year-old was totally unstuck:* – All 7 reactive parts totally unstuck. – Problem #3 rated 0. – Problem #3 negative beliefs rated 0.
Completion time: One 90-minute session.	*Completion time:* One 90-minute session.	*Completion time:* One 90-minute session.

Case #3: Cathy

Cathy was in her 30s – a married mother and housewife. She reported her father had been very abusive toward her, her mother, and her siblings. Cathy recalled her father and two brothers physically and sexually abused her. Her father would eat lavish meals while his children went hungry. He was eventually jailed for murder. She recalled being actively and persistently discouraged from getting an education. Cathy learned to manage the trauma of the sexual abuse with a pattern of "forgetting." As an adult, she had great difficultly remembering even everyday things. Cathy had been in treatment intermittently for 2 years with her therapist prior to enrolling in this study. (See Discussion section for more about the earlier treatment.) (See Tables 4 and 5.)

After the research data were collected, Cathy continued with therapy intermittently to work on other issues. Follow-up data were collected 5 months after her last DNMS session (see Table 4). Shortly after the research sessions, she reported a dramatic improvement in memory and gave several accounts of successfully asserting herself with intimidating superiors. Months later she reported her memory and assertiveness skills continue to improve, as she gained confidence from doing these activities repeatedly, without internal conflict. At follow-up, she commented, "The quality of my life has improved. I really enjoyed the DNMS. This is definitely a good tool to help me to break through the barriers."

Table 4. Cathy's Progress Report ratings of problems and negative beliefs

		0-10 Ratings		
		Pre-treatment	Post-treatment	5-Mo Follow-up
Problem #1:	Panics when required to remember things.	10	0	0
Neg Beliefs:	1. I'll get it wrong.	10	0	2
	2. I must not know too much, or else I'll get rejected.	10	0	2
Problem #2:	Feels intimidated by authority figures..	10	0	1
Neg Beliefs:	1. I'm wrong.	10	0	1
	2. I'm guilty.	10	0	4
	3. I'm a victim.	10	0	0
	4. I'm nothing.	10	0	0
Problem #3:	Can't assert herself without getting upset.	10	0	3
Neg Belief:	1. I'm worthless.	10	0	1
	2. I'm not good enough.	10	0	1
	3. I'm nobody.	10	0	0

Table 5. Summary of Cathy's DNMS treatment

Problem #1	Problem #2	Problem #3
Problem: Panics when required to remember things. *Introject message:* *Mom/Dad:* What others do is okay, but what you do isn't. You're wrong. You don't know what you're talking about. Don't be smarter than others. You're a smart alec. Don't learn. You're stupid. *Number of reactive parts on map:* 8 *Child part under mask:* Seven-year-old under mom/dad mask. *Once seven-year-old was totally unstuck:* – Four reactive parts were mostly unstuck and four were totally unstuck. – Problem #1 rated 0. – Problem #1 negative beliefs rated 0. *Completion time:* One 150-minute session.	*Problem:* Feels intimidated by authority figures. *Introject message:* *Dad:* It doesn't matter what you do, feel, think or say, others are going to do what they like with you. You will be punished if you speak out for yourself. You have no control over others. You're powerless. *Number of reactive parts on map:* 8 *Child part under mask:* Three-year-old under dad mask. *Once three-year-old was totally unstuck:* – All 8 reactive parts totally unstuck. – Problem #2 rated 0. – Problem #2 negative beliefs rated 0. *Completion time:* One 180-minute session.	*Problem:* Can't assert herself without getting upset. *Introject message:* *Dad:* You're worthless. You're not good enough. You're nobody. Whatever you say doesn't count. *Number of reactive parts on map:* 7 *Child part under mask:* Five-year-old under dad mask. *Once five-year-old was totally unstuck:* – All 7 reactive parts totally unstuck. – Problem #3 rated 0. – Problem #3 negative beliefs rated 0. *Completion time:* One 120-minute session.

Case #4: Debbie

Debbie was a single, middle-aged, female graduate student. Her father was a successful professional, and her mother was a stay-at-home mother. Debbie was the eldest of three children. She remembered her mother as cold and rejecting. They often had power struggles over food. Her only emotional connection was to her father, so she was desperate to please him. Debbie recalled her father was attentive and approving of her as long as she kept her mother happy. If her mother became upset, he would leave the house. As an adult, she has believed that having sexual intimacy with a man would betray her father. Debbie enrolled in the study shortly after beginning DNMS therapy (see Tables 6 and 7).

Once all the research data were collected, Debbie reported she was satisfied her goals had been met and chose to terminate therapy. Follow-up data were collected 3 months after her last DNMS session (see Table 6). At follow-up, she commented to her therapist that she had completed graduate school and was about to begin a new job, that she was taking good care of her body now, and that she was open to finding a romantic partner. Debbie was the only research participant on a psychotropic medication (bupropion hydrochloride) at the start of the study. A few weeks after beginning the DNMS, she stopped taking it, stating she no longer needed it.

Table 6. Debbie's Progress Report ratings of problems and negative beliefs

		0-10 Ratings		
		Pre-treatment	Post-treatment	3-Mo Follow-up
Problem #1:	I avoid romantic relationships with available men.	9	0	0
Neg Beliefs:	1. I would lose myself in a romantic relationship.	9	0	0
	2. If I have intercourse I'll disappear.	10	0	0
	3. Unless I sacrifice myself for my partner, I will be left.	10	0	0
Problem #2:	I am unable to lose weight.	9	0	0
Neg Beliefs:	1. I need the weight to keep me safe from men.	8	0	0
	2. I need food to nurture myself.	9	0	0
	3. Overeating is a way to assert my independence.	10	0	0
	4. I need to eat now before I run out of money for food.	10	0	0
Problem #3:	I have to make career choices now and I get too overwhelmed to think about them.	9	0	0
Neg Belief:	1. I am afraid I'm not good enough.	8	0	0
	2. I must have done something wrong because no one loves me and I have to do this all by myself.	9	0	0

Table 7. Summary of Debbie's DNMS treatment

Problem #1	Problem #2	Problem #3
Problem: I avoid romantic relationships with available men.	*Problem:* I am unable to lose weight.	*Problem:* I have to make career choices now and I get too overwhelmed to think about them.
Introject messages: *Mom:* It is your fault if others leave because you will never be enough. *Dad:* Others will leave because you aren't making them happy. *Number of reactive parts on map:* 8 *Child parts under masks:* Four-year-old child under mom mask, and four-year-old child under dad mask *Once four-year-olds were totally unstuck:* – All 8 reactive parts were totally unstuck. – Problems #1, 2, & 3 rated 0. – Problems #1, 2, & 3 beliefs rated 0. *Completion time:* Six 90-minute sessions.	*Problem #2 resolved automatically once the problem #1 introjects were totally unstuck.*	*Problem #3 resolved automatically once the problem #1 introjects were totally unstuck.*

Case #5: Ellen

Ellen was a married, middle-aged female paraprofessional. Her parents were high school students when she was conceived. They married young and had two more children. Ellen reported that while her father stayed in the background, her mother was a physically abusive alcoholic and rageaholic. She remembered her mother telling her that she had "ruined her life." After her parents divorced, her mother remarried. She recalled her stepfather sexually molesting her and her siblings. Ellen became a rebellious alcoholic adult. Her three children were taken from her by the courts and given to her ex-husband. Prior counseling had addressed the addictions. She was in recovery when she began the DNMS. Ellen enrolled in the study shortly after beginning DNMS therapy (see Tables 8 and 9).

Once the research data were collected, Ellen chose to stay in therapy to work on other issues. Follow-up data were collected 8 months after her last DNMS research session (see Table 8). After this work, she could finally initiate projects. She reported to her therapist that she was starting to write a children's book, enrolling in knitting lessons, and forming a creativity study group. She reported she had stopped working long hours to prove herself. At follow-up, she commented, "I can see that troubles are temporary now and get through them knowing they will pass. I am not worried about what my coworkers or family members think of me anymore. I do not feel like a failure or a phony. I feel GREAT about myself!"

Table 8. Ellen's Progress Report ratings of problems and negative beliefs

		0-10 Ratings		
		Pre-treatment	Post-treatment	8-Mo Follow-up
Problem #1:	I don't start new things because I never finish anything. I have a genius IQ and a GED. I feel stuck. I can't move forward.	10	0	0
Neg Beliefs:	1. I am a bad person and I don't deserve anything good.	9	0	0
	2. I fail at everything.	9	0	0
Problem #2:	I work long, hard hours, so no one knows I'm not qualified (not college degree) for my job.	10	0	0
Neg Belief:	1. If people really know the truth they would think I'm not good enough.	10	0	0
	2. I don't know what I am doing.	8	0	0
	3. I must fight constantly for everything or I'll drown.	10	0	0
	4. I am a phony.	8	0	0

Table 9. Summary of Ellen's DNMS treatment

Problem #1	Problem #2
Problem: I don't start new things because I never finish anything. I have a genius IQ and a GED. I feel stuck. I can't move forward. *Introject message:* *Mom:* Others lives are ruined because you were born. You are not allowed to have emotions or needs. You are so bad you deserve to be destroyed. *Number of reactive parts on map:* 7 *Child parts under masks:* Four-year-old child under mom mask. *Once four-year-old was totally unstuck:* – All 7 reactive parts were totally unstuck. – Problems #1 and 2 rated 0. – Problems #1 and 2 negative beliefs rated 0. *Completion time:* Four 50-minute sessions and one 90-minute session.	*Problem:* I work long, hard hours, so no one knows I'm not qualified (not college degree) for my job. *Problem #2 resolved automatically once the Problem #1 introjects were totally unstuck.*

Case #6: Frank

Frank was a middle-aged, married, educated, self-employed professional male. He recalled that, while his parents for the most part were caring and kind to their children, they completely failed to meet certain important needs. He reported his father shamed him whenever he expressed pride or joy for his outstanding sports achievements. That shame held him back from being a star player. He explained that if he went to his mother with an upset, she would try to comfort him with an unsatisfactory, "There, there – it will be okay." Frank felt unable to discuss with his parents the challenges of growing up. During a visit with his grandparents, he watched his enraged grandmother threaten to kill his grandfather. This reinforced the stoicism that was modeled and rewarded by his parents. Frank enrolled in the study shortly after beginning DNMS therapy (see Tables 10 and 11).

Once the research data were collected, Frank reported he had met his immediate goals and chose to terminate therapy. Follow-up data were collected 5 months after his last DNMS session (see Table 10). At follow-up, he reported to his therapist that he was able to discuss his angry feelings to resolve whatever issue caused those feelings. He said he was no longer taking every job he was offered, so consequently he was much less likely to take on too many jobs. He reported he was open and present much more of the time. In times of work stress, he would notice an impulse to fall into old patterns but would succeed in choosing more effective behaviors.

Table 10. Frank's Progress Report ratings of problems and negative beliefs

		0-10 Ratings		
		Pre-treatment	Post-treatment	5-Mo Follow-up
Problem #1:	Whenever I feel angry I completely shut down.	8	0	1
Neg Beliefs:	1. If I feel anger, there is something deficit in me, so I have to shut it down.	8	0	0
	2. Anger can be lethal, so I have to suppress it.	9	0	0
	3. There is no good anger (i.e., it feels as if there is something shameful about that emotion).	7	0	0
Problem #2:	I have trouble setting appropriate boundaries, especially with client workloads and deadlines. As a result I take on too much work, which stresses me out.	7	0	3
Neg Beliefs:	1. I can't tolerate the stresses of setting boundaries (e.g., saying "no" to someone asking for my help or confronting someone who has trespassed my boundaries in some way).	8	0	0
	2. If I set boundaries, people won't like me and they'll leave me.	7	0	1
Problem #3:	I am a little shutdown emotionally all the time. The more personal or interpersonal pleasure or pain I feel that is outside my "safe zone," the more I shut down.	7	0	1
Neg Belief:	1. I should not feel a lot of deep personal pleasure (e.g. proud of self for accomplishments), because if I do I'm being too egocentric (arrogant, self-centered, selfish, not humble).	8	0	0
	2. I should not feel a lot of interpersonal pleasure (e.g. giving and receiving affection), because if I do and then lose their love I will be devastated.	8	0	1
	3. I cannot tolerate deep personal or interpersonal pain.	9	0	1

Table 11. Summary of Frank's DNMS treatment

Problem #1	Problem #2	Problem #3
Problem: Whenever I feel angry I completely shut down.	*Problem:* I have trouble setting appropriate boundaries, especially with client work-loads and deadlines. As a result I take on too much work, which stresses me out.	*Problem:* I'm a little shutdown emotionally all the time. The more personal or interpersonal pleasure or pain I feel that is outside my "safe zone," the more I shut down.
Introject message: *Grandmother/Mom/Dad:* In spite of a capacity to be extremely loving, you have the capacity to extinguish life, if you get angry enough. You must keep your self-shame self talk to keep your anger in check.	*Introject messages:* *Mom/Dad:* If you can't grin and bear it, you're not a man. *Dad:* Shame on you for bragging about yourself.	*Problem #3 resolved automatically once the problem #1and 2 introjects were totally unstuck.*
Number of reactive parts on map: 8	*Number of reactive parts on map:* 5	
Child part under mask: Seven-year-old child under grandmother/mom/dad mask.	*Child parts under masks:* Ten-year-old child under mom/dad mask, and eight-year-old child under dad mask.	
Once seven-year-old was totally unstuck: – All 8 reactive parts were totally unstuck. – Problem #1 rated 0. – Problem #1 negative beliefs rated 0.	*Once 8 & 10-year-olds were totally unstuck:* – All 5 reactive parts were totally unstuck. – Problem #2 rated 0. – Problem #2 negative beliefs rated 0.	
Completion time: Three 90-minute sessions.	*Completion time:* One 90-minute session.	

Case #7: Gail

Gail was a married, middle-aged, female doctorate-level professional. She reported growing up in a chaotic family. She recalled her father was an alcoholic who spent little time with the family and that when he was home he was often intoxicated and frightening. Her mother was a full-time professional who worked a night shift. The five children were often left at home unattended. She recalled her mother attempting to manage her children with threats of abandonment and fits of rage. Gail learned to keep quiet, have no needs, feel no body sensations, and avoid conflict at all cost. She recalled watching her mother enmesh with other siblings and hoping that one day she would get some of mother's attention too. When Gail was in junior high, her mother told her father to stop drinking or leave. He chose to leave. She never saw him again. Gail enrolled in the study shortly after beginning DNMS therapy (see Tables 12 and 13).

Once the research data were collected, Gail chose to continue therapy to work on other issues. Follow-up data were collected 1 year after her last DNMS research session (see Table 12). She reported an end to her usual pattern of reacting to a controlling supervisor from a needy child ego state. After this work, she began reacting to him

as an adult, which included setting boundaries. She stopped making sacrifices for him, just to win his approval. She reported she had stopped using food to manage her emotions. Furthermore, she joined a gym and hired a trainer. At follow-up, she commented, "As a result of working with DNMS, today I live with a stronger sense of reality. I no longer feel like a child trying to figure out the adult world. As a result of this therapy, I am more often in my authentic adult self more of the time."

Table 12. Gail's Progress Report ratings of problems and negative beliefs

		0-10 Ratings		
		Pre-treatment	Post-treatment	12-Mo Follow-up
Problem #1:	Feeling too needy.	10	0	0
Neg Beliefs:	1. It's not okay for me to have needs or ask for things	8	0	0
	2. I can't depend on others – I must meet my own needs.	10	0	0
	3. If I ask for things I'll be rejected.	9	0	0
Problem #2:	Eating to numb out negative feelings.	10	0	0
Neg Beliefs:	1. I have no control.	10	0	0
	2. I am not safe.	9	0	0
Problem #3:	Fear of setting boundaries in personal relationships (friends, family, spouse).	10	0	0
Neg Belief:	1. If I set a boundary I will anger others and they will reject me.	10	0	0
	2. I don't have a right to set boundaries.	9	0	0
	3. If I set a boundary I'll lose options.	10	0	0

Table 13. Summary of Gail's DNMS treatment

Problem #1	Problem #2	Problem #3	
Problem: Feeling too needy.	*Problem:* Eating to numb out negative feelings.	*Problem:* Fear of setting boundaries in personal relationships (friends, family, spouse).	
Introject message: *Mom:* You won't get your needs met, so don't ask.	*Introject message:* Mom: You should be grateful for the sacrifices others make, otherwise they won't care for you, and they'll give up and leave.	*Introject messages:* *Dad:* I'll stay if you accept my abusive behavior. *Mom:* I won't love you if you have your own life.	*Introject message:* *Mom:* Better be who others need you to be. If others reject you, you won't matter and no one will care about you.
Reactive parts on map: 6	*Reactive parts on map: 7*	*Reactive parts on map:* 10	*Reactive parts on map:* 8
Child part under mask: Eight-year-old child under mom mask.	*Child part under mask:* Six-year-old child under mom mask.	*Child parts under masks:* Twelve-year-old under dad mask, and ten-year-old under mom mask.	*Child part under mask:* Two-to-twelve-year-old child under mom mask.
Once eight-year-old was totally unstuck: – All 6 reactive parts were totally unstuck. – Problem #1 rated 0. – Problem #1 beliefs rated 0.	*Once six-year-old was totally unstuck:* – All 7 reactive parts were totally unstuck. – Problem #2 rated 0. – Problem #2 beliefs rated 0.	*Once ten and twelve-year-olds were totally unstuck:* – All but 2 reactive parts were totally unstuck. – Problem #3 rated 4. – Problem #3 beliefs rated 5.	*Once two-to-twelve-year-old was totally unstuck:* – All 8 reactive parts were totally unstuck. – Problem #3 rated 0. – Problem #3 beliefs rated 0.
Completion time: One 90-minute session.	*Completion time:* One 90-minute session.	*Completion time:* Three 90-minute sessions.	*Completion time:* Two 90-minute sessions.

Case #8: Holly

Holly was a single, middle-aged professional female with a graduate degree. She described her father as a critical, rigid, and rageful man who believed he was always right and who expected his four children to take care of their mother. Holly reported her mother was frequently overwhelmed and turned to her for guidance. She and her siblings were often left in the care of an aunt and uncle. Although the uncle seductively molested her during most of her grade school years, it was not possible for her to discuss this with her parents. As she got older, she was rewarded for maintaining her role as the "good child" in the family, while her siblings rebelled. She enrolled in the study shortly after beginning DNMS therapy (see Tables 14 and 15).

Once the research data were collected, Holly chose to continue therapy to work on other issues. Follow-up data were collected 4 months after her last DNMS research session (see Table 14). Before DNMS therapy, Holly had a long history of avoiding unpleasant confrontations. After the work, she reported to her therapist that she was no longer tolerating the bad work habits of a subordinate. She began actively confronting the situation and took definitive

steps to solve the personnel problem. At follow-up, she commented, "My quality of life has improved as a result of DNMS. What held me captive and made me depressed, my low self-esteem and my fear are totally gone. My issues with feeling unworthy to express my feelings are also gone. I feel and know that I am strong, that I am good, that I am worth being taken care of and worth being able to speak up for myself."

Table 14. Holly's Progress Report ratings of problems and negative beliefs

		0-10 Ratings		
		Pre-treatment	Post-treatment	4-Mo Follow-up
Problem #1:	I put everyone else's needs before my own.	9	0	0
Neg Beliefs:	1. I'm selfish if I voice my needs.	10	0	0
	2. I'm a failure if I don't meet others' needs.	9	0	0
	3. I'm bad if others are upset or angry with me.	10	0	0
Problem #2:	I act cheerful and competent at all times, regardless of how I really feel.	9	0	0
Neg Beliefs:	1. It's not ok to ask for help.	10	0	0
	2. I won't be loved if I express anger.	10	0	0

Table 15. Summary of Holly's DNMS treatment

Problem #1	Problem #2	
I put everyone else's needs before my own.	I act cheerful and competent at all times, regardless of how I really feel.	
Note: Over the course of the processing it became clear that Problem #2 was a subset of Problem #1. It took addressing both problems, in a total of six Ego State Maps, for both to fully resolve.		
Mapping & Needs Meeting #1	Mapping & Needs Meeting #2	Mapping & Needs Meeting #3
Introject messages: *Mom:* You are a failure unless you put other's needs first. You are selfish to have needs/feelings of your own. *Dad:* You are bad if others are upset. It's your job to figure out what to do. *Number of reactive parts on map:* 6 *Child parts under masks:* Six-year-old child under mom mask, and six-year-old child under dad mask. *Once six-year-olds were totally unstuck:* – All 6 reactive parts were totally unstuck. – Problems #1 & 2 rated 4-5. – Problems #1 & 2 beliefs rated 1-2. *Completion time:* Four 50-minute sessions and one 90-minute session.	*Introject messages:* *Mom:* Everything is fine. *Dad:* Family is first! Be cheerful and pleasant at all times. How we look is more important than how you feel or what you need. *Number of reactive parts on map:* 6 *Child parts under masks:* Seven-year-old child under mom mask, and seven-year-old child under dad mask. *Once seven-year-olds were totally unstuck:* – All 6 reactive parts were totally unstuck. – Problems #1 & 2 rated 6. – Problems #1 & 2 beliefs rated 2-6. *Completion time:* One 50-minute and one 90-minute session.	*Introject messages:* *Dad:* You'll never be perfect enough to get others' love. *Mom:* Your job is to figure out what makes others happy. It's all about everyone else. *Number of reactive parts on map:* 5 *Child parts under masks:* Six-year-old child under mom mask, and six-year-old child under dad mask. *Once six-year-olds were totally unstuck:* – All 5 reactive parts were totally unstuck. – Problems #1 & 2 rated 1-2. – Problems #1 & 2 beliefs rated 1-2. *Completion time:* Three 50-minute sessions.
Mapping & Needs Meeting #4	Mapping & Needs Meeting #5	Mapping & Needs Meeting #6
Introject messages: *Uncle:* Others will only love you if you do what they say. *Mom/Dad:* I have no idea how to do anything, you need to figure it out. You're on your own. *Number of reactive parts on map:* 4 *Child parts under masks:* Five-year-old child under uncle mask, and five-year-old child under mom/dad mask. *Once five-year-olds were totally unstuck:* – All 4 reactive parts were totally unstuck. – Problems #1 & 2 rated 1. – Problems #1 & 2 beliefs rated 1-3. *Completion time:* Five 50-minute sessions and one 90-minute session.	*Introject messages:* *Mom:* If you give others upsetting information, they'll think you're crazy and will be mad at you. *Dad:* Don't be so stupid. You're overreacting if you have emotions. *Number of reactive parts on map:* 6 *Child parts under masks:* Eight-year-old child under mom mask, and eight-year-old child under dad mask. *Once eight-year-olds were totally unstuck:* – All 6 reactive parts were totally unstuck. – Problems #1 & 2 rated 1. – Problems #1 & 2 beliefs rated 1-2. *Completion time:* Two 90-minute sessions.	*Introject messages:* *Mom:* You'd better not make others angry or they will hate you and totally reject you. Keep others happy. *Mom:* Go away don't bother others with your problems. *Number of reactive parts on map:* 5 *Child parts under masks:* Eight-year-old child under mom mask, and eight-year-old child under dad mask. *Once eight-year-olds were totally unstuck:* – All 5 reactive parts were totally unstuck. – Problems #1 & 2 rated 0. – Problems #1 & 2 beliefs rated 0. *Completion time:* Two 50-minute and two 90-minute sessions.

DISCUSSION

This study investigated the hypothesis that using the DNMS to treat problem behaviors and emotions that originated in unmet developmental needs would lead to a significant reduction in those behaviors or emotions and in the associated negative beliefs. These findings provide preliminary support for this hypothesis. Each participant's targeted problem behaviors and emotions were clearly linked (by the participant) to unmet developmental needs. Pre-treatment "Problem" ratings ranged from 7 to 10 (10 = *worst possible problem*), whereas post-treatment ratings were all 0 (*not at all a problem*). Pre-treatment "negative belief" ratings ranged from 7 to 10 (10 = *totally true*), whereas post-treatment ratings were all 0 (*not at all true*). At follow-up, 6 of the 8 participants re-rated all problems and all negative beliefs a 0. Although Cathy and Frank provided slightly elevated ratings at 5-month follow-up, they also reported substantial improvements following DNMS treatment. This was especially evident when Cathy disclosed to her therapist that her memory and assertiveness skills had improved dramatically right after treatment, with continued improvement over time. Likewise, at follow-up, Frank gave specific examples of how he was managing emotions, stress, and boundaries with much greater skill.

As these 8 cases demonstrated, it can take one or many sessions to resolve a single problem with DNMS protocols. The protocols are very structured – one step follows the next step, in a logical sequence. All the steps must be completed to get an introject totally unstuck. As a general rule, the processing steps will be completed in less time when (a) a protocol can be completed in one session (sometimes a long session), (b) most of the session time is used for the DNMS, (c) a client naturally processes quickly, and/or (d) there are few processing blocks to clear, and those that do arise clear easily. Likewise, it may take many sessions to complete the steps when (a) sessions are only 50 minutes long, (b) a small portion of session time is used for the DNMS, (c) a client naturally processes slowly, and/or (d) there are many processing blocks that are not easily resolved. Three of the 8 participants, Debbie, Ellen, and Holly, fell into the latter category.

This study demonstrates that DNMS has the flexibility to handle both simple and complex cases. Annie, Betty, and Cathy illustrated that sometimes just a single DNMS session is needed to resolve a single problem. Gail and Holly illustrated that sometimes a single problem is associated with multiple maladaptive introjects and that to resolve the problem, all the introjects must be named and treated. Debbie, Ellen, and Frank illustrated that sometimes DNMS work addressing one problem will generalize to resolve other problems too.

It is unlikely that the changes observed between pre- and post-treatment were merely the result of a good therapeutic alliance. For example, Cathy had a very good working relationship with her therapist long before beginning DNMS therapy. Early on they recognized a link between the physical and sexual abuse from her father and her difficulty remembering things and asserting herself. When they tried to desensitize the terrifying abuse memories with an intense trauma-focused treatment, she became paralyzed with fear (from reactive parts), making it impossible to deal with the trauma that way. So they resorted to talk therapy and behavioral interventions, such as memorization practice and assertiveness training, neither of which resulted in much improvement. Once they began DNMS therapy, the Healing Circle of Resources provided the safe "container" the reactive parts needed to even consider addressing the abuse trauma. The mapping helped the fearful reactive parts understand that the intimidating abusive dad introject was not really "dad" but was instead a "dad mask" unwillingly worn by a child part with a fundamentally good nature. With that understanding, and with a safe/loving connection to the Resources, processing could proceed to a successful outcome. The therapist described the difference between the previous work and the DNMS as "the difference between using a chain saw and a scalpel. The precision of the DNMS made all the difference." In Cathy's case, it took much more than a good therapeutic alliance to resolve her issues.

It is unlikely that the changes observed between pre- and post-treatment were due to the personality or clinical skill of the DNMS developer. The first author provided the treatment for just two of the eight cases presented. The other two therapists, who contributed three cases each, applied the DNMS in their own offices, in their usual way, with minimal input from the developer.

Limitations

There are some limitations to this study. (a) Because this was a preliminary study, intended only to investigate the efficacy of the DNMS, the study design did not include a control group or alternate treatment group. (b) Several participants exercised their option to continue with therapy (to address additional issues) between the post-treatment and follow-up assessment. This could make it difficult to discern to what extent the gains maintained at follow-up were due to the additional therapy. Nonetheless, all participants, including those who had not received additional therapy, reported gains maintained at follow-up. (c) This study was intended for "stable and reasonably high functioning" clients only. Therefore, unstable clients, who encountered complex processing blocks during their initial experiences with

the DNMS, were excluded from the study. In theory, this selection criterion could have resulted in a bias toward highly responsive participants. Although DNMS has been reported to be effective with complex, challenging clients (e.g., Schmidt, 2004), such a conclusion cannot be drawn from this study.

SUMMARY

Ego state therapies have been around since the 1960s (Assagioli, 1975; Berne, 1961; Schwartz, 1995; Watkins & Watkins, 1997). Inner-child psychotherapies (Bradshaw, 1990; Capacchione, 1988; Napier, 1990) have been around since the 1980s. Although the DNMS shares much in common with these approaches, the DNMS differs in important ways by (a) systematically developing multiple internal resources (competent internalized caregivers) to facilitate the healing; (b) differentiating child parts who reacted to wounding childhood messages (reactive parts) from those who now deliver wounding childhood messages (maladaptive introjects); (c) focusing exclusively on healing maladaptive introjects; (d) systematically and thoroughly focusing on remediating unmet developmental needs with a variety of protocol steps, which collectively results in a corrective emotional experience; and (e) providing a stepwise protocol that ensures maladaptive introjects will get completely and totally unstuck. The DNMS approach stands apart because it postulates that by strategically healing a single maladaptive introject, substantial improvements can occur, because that one change can benefit many wounded child parts throughout the self-system.

Future DNMS research studies might include (a) a wait group, (b) an alternate treatment group, (c) unstable participants, and/or (d) a focus on a particular diagnosis (e.g., eating disorder, panic disorder, borderline personality disorder). The daily challenges of applying the DNMS in clinical practice have led to ongoing refinements to the protocols. With each change, the needs-meeting work appears to become more effective and efficient. Several significant refinements, which were not part of this study, were recently incorporated into the model (Schmidt, 2006a). One major change involves systematically addressing unmet *attachment needs* in order of importance. Another change involves finding and processing *all* the maladaptive introjects associated with a problem/issue, *at the same time*. Research on these new DNMS protocols will begin soon. In conclusion, the results of this study suggest that the DNMS is a promising new intervention, effective in resolving the unwanted behaviors, beliefs, and emotions that originated in unmet developmental needs.

REFERENCES

Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy: Principles and application*. New York: Ronald Press.

Assagioli, R. (1975). *Psychosynthesis: A manual of principles and techniques*. London: Turnstone.

Berne, E. (1961). *Transactional analysis in psychotherapy, a systematic individual and social psychiatry*. New York: Grove.

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

Briere, J. (1995). *Trauma symptom inventory*. Lutz, FL: Psychological Assessment Resources.

Capacchione, L. (1988). *The power of your other hand: A course in channeling the inner wisdom of the right brain*. Newcastle upon Tyne, UK: Newcastle Publishing.

Dell, P. (2003). *Multidimensional Inventory of Dissociation (MID): A comprehensive self-report instrument for pathological dissociation*. Unpublished manuscript.

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

Freud, S. (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, pp. 11-36). London: Hogarth. (Original work published 1923)

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

Greenwald, R. (1996). Psychometric review of the Problem Rating Scale. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 242-243). Lutherville, MD: Sidran.

Illsley-Clarke, J., & Dawson, C. (1998). *Growing up again: Parenting ourselves, parenting our children*. Center City, MN: Hazelden Information Education.

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

Leeds, A. (1998). Lifting the burden of shame: Using EMDR resource installation to resolve a therapeutic impasse. In P. Manfield (Ed.), *Extending EMDR*. New York: Norton.

Maslow, A. H. (1968). *Toward a psychology of being*. New York: D. Van Nostrand.

Montessori, M. (1936). *The secret of childhood*. New York: Frederick A. Stokes.

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

Paulsen, S. (2000, April). *EMDR and the divided self: EMDR and ego state therapy for non-dissociative and dissociative clients*. Workshop in San Antonio, TX.

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

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

Ramachandran, V. S. (2000). *Mirror neurons and imitation learning as the driving force behind "the great leap forward" in human evolution*. Retrieved June 1, 2006, from www.edge.org/documents/archive/edge69.html

Rizzolatti, G., & Gallese, V. (2002). From mirror neurons to imitation: Facts and speculations. In A. Meltzoff & W. Prinz (Eds.), *The imitative mind: Development, evolution, and brain bases*. Cambridge, UK: Cambridge University Press.

Schmidt, S. J. (1999). Resource-focused EMDR: Integration of ego state therapy, alternating bilateral stimulation, and art therapy. *EMDRIA Newsletter*, *4*(1), 8-26.

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. (2005). *The Developmental Needs Meeting Strategy: An ego state therapy for healing childhood wounds*. San Antonio, TX: DNMS Institute.

Schmidt, S. J. (2006a, May 5-8). *Developmental Needs Meeting Strategy training*. Four-day DNMS training, Baltimore, MD.

Schmidt, S. J. (2006b). *Developmental Needs Meeting Strategy: A dissociative identity disorder case study follow-up report.* Unpublished manuscript.

Schmidt, S. J. (2006c). *DNMS certification for professionals*. Retrieved Jan 1, 2006, from http://www.dnmsinstitute.com/certification.html

Schwartz, R. C. (1995). *Internal family systems therapy*. New York: Guilford.

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

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). New York: Guilford.

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.

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

Stone, H., & Stone, S. (1993). *Embracing our selves: The voice dialogue manual*. Mill Valley, CA: Nataraj.

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

Watkins, J. G., & Watkins, H. H. (1997) *Ego states: Theory and therapy*. New York: Norton.