Enhancing Self-Belief with EMDR:

Developing a Sense of Mastery in the Early Phase of Treatment

SHANTI SHAPIRO, M.S.W.*

Deep inside each of us is a seed that holds our vision of truth, peace, and happiness. Our early childhood attachments, societal influences, and innate capacity determine how well that seed is nurtured and the deepest inner vision is set free. This article is about the ways that vision becomes clouded by attachment deficits, trauma, and subsequent symptoms. The deep inner wish to heal allows for transformation, and approaches like Eye Movement Desensitization and Reprocessing, and hypnotherapy can assist in creating a more rapid acceleration of trauma resolution and transformation of self.

INTRODUCTION

Early traumatic experiences potentiate the development of regulatory dysfunction and subsequent persisting negative sequelae. Attachment deficits within relational bonding of the infant to the primary caretaker (1), or traumatic interruptions in later stages of childhood development, can create a change in affect regulation and physiological reactivity. For example, research now illustrates that approximately 80% of children who experience some type of child abuse show insecure attachment behavior in adulthood (2). The correlation between symptoms of posttraumatic stress, early attachment disturbances, and the development of psychopathology is growing more evident as trauma treatment research unfolds (3, 4). The profile that emerges may become one of negative self-image, shame, dissociation, panic disorder, depression, immature defensive structure (4, 5), and, in many cases, extreme difficulty with basic trust and the formation of healthy relationships.

The total violation of boundaries that occurs whenever there is a childhood history of sexual, physical, or early characterological abuse (damaging one's basic sense of self-belief) also intensifies the affect of shame. For purposes of this paper, like Morrison (6), in addition to shame,

*Private practice, EMDRIA Approved Consultant, EMDR facilitator. ***Mailing address:*** 16 Center Street, Suite 323, Northampton, MA 01060-3031.

I shall incorporate "humiliation, remorse, apathy, and lowered self-esteem." The development of shame, as it relates to the dynamics of attachment, is manifested on both a conscious and unconscious level and is not always observed behaviorally (4).

Often in order to escape the psychological and emotional pain that develops from early-childhood trauma and attachment deficits, a creative part of the self emerges. For example, young children cannot physically flee from an abusive situation, but in the richness of their fantasy world will often learn to dissociate as an escape from the intolerable. I view dissociation as a creative process, and have found that many traumatized children who have to survive in a toxic atmosphere appear to kindle a substantial creative ability. This creative self-component can often be observed behaviorally or accessed through the use of ego-state therapy (7).

Occasionally, it is the creative part of the self that can open the door to restructure ego functions and the shattered ego ideal. The ego ideal is an important construct because it is a repository by which attributes of healthy adults and mentors may be introjected, and/or further enhanced in the initial and subsequent phases of treatment. The development of inner resources creates a greater safety net for the containment of powerful affect connected to the painful memories that emerge as past experiences are processed in the context of psychotherapy.

When patients enter treatment, flooded and overwhelmed by painful memories, nightmares, anxiety, and intense emotions, the application of specific interventions designed to enhance self-belief and self-efficacy will offer comfort and stabilization. A brief definition of terms used in this paper regarding the importance of enhancement and efficacy are as follows: *Self-belief*: a deep inner sense of confidence and trust in one's own inner ability to move ahead and take risks toward personal growth. Basically, I view self-belief as the establishment of healthy narcissism. *Self-enhancement*: an ability to experience and trust in the self as having an appealing sense of value and meaning. *Self-efficacy*: the belief in one's own capacity to experience positive results from desired goals. *Mastery*: this term is used in the context of this paper as an ability to overcome challenges and fears that prohibit one from obtaining desired results. Minor experiences of mastery in the early phase of treatment will often lead to deeper and more extensive experiences of mastery as treatment progresses. Experiences of mastery provide a sense of motivation and hope for transformation from the deleterious effects of trauma.

I have found that the treatment process for healing from traumatic experiences can be enhanced with the use of hypnotherapy and Eye

Movement Desensitization and Reprocessing (EMDR)(8). Since the inception of EMDR as developed by Dr. Francine Shapiro, other methods of bilateral stimulation with sound or tapping (used to stimulate both sides of the brain), along with a variety of protocols that have emerged in the EMDR field, also prove to be effective in treatment. Regardless of all the technical aspects related to the use of EMDR (too extensive to describe in the context of this paper) proper training is essential for effective treatment. A comprehensive knowledge of hypnotherapy is extremely helpful and complements the clinical work that can be accomplished with the use of EMDR. In single-incident trauma, or when it is felt to be appropriate, teaching self-hypnotic techniques early in treatment can also help reduce anxiety and allow the patient to develop a sense of mastery.

THE THERAPY

For purposes of this paper, the focus will remain on the development of self-belief with a process that stems from Dr. Francine Shapiro's (5) work and the training she developed known as Eye Movement Desensitization Reprocessing (EMDR). A brief description of the setup for the EMDR process is as follows: While setting up the protocol for EMDR, the therapist asks the patient: 1. To name the major issue that he/she wants to work on in the session; 2. to provide a picture that is most representative of the earliest memory related to the issue or the worst part of the patient's memory; 3. to develop both a negative and positive self-referencing statement (cognition); 4. to identify the emotion related to the picture and the negative self-referencing belief, and where it is felt in his/her body.

The therapist takes a validity measurement of the positive cognition, the level of disturbance as it relates to the issue or picture, and the negative cognition. The patient's awareness of body sensation is also a focus in the initial and subsequent places in the processing. A more detailed analysis can be found in Dr. Francine Shapiro's book, *Eye Movement Desensitization Reprocessing.*

This model of treatment allows for rapid change from previously maladaptive thoughts and behaviors to adaptive resolution. The use of bilateral stimulation and appropriate protocols plays an integral part in this process. Prior to initiating EMDR, proper training is essential. I recommend careful assessment, and work at a pace that will not flood or create a decompensative neurosis in the patient. As in all sound clinical practice, one must respect the patient's need for established mechanisms of defense, while developing and maintaining the therapeutic alliance throughout the treatment. Most of my clinical work with survivors of trauma is generally

done in a phase- (9-11) or stage-oriented method (3). The length of time it will take to conclude treatment is contingent on the patient's ability to transform the past traumatic memories sufficiently to eliminate pathological sequelae and the extent of resolution that the patient ultimately wishes to achieve.

THE PHASES OF THERAPY

The early phase is forming a therapeutic alliance, taking a comprehensive history, creating a sense of safety, stabilization, and the rudimentary beginnings of establishing enhanced self-belief. For example, if there is past trauma, after documenting a sufficient history, consider the following: 1. Educating the patient about the psychological consequences of trauma; 2. working with the patient to identify resources to be used for support; 3. providing information about how EMDR and hypnotherapy can be integrated in the healing of trauma and the enhancement of self-efficacy and self-belief.

The middle phase is meant to metabolize and transform the negative schemas that develop as an outcome of childhood trauma and attachment deficits. It is at this phase of treatment that the therapeutic work of affect regulation, integration, and disclosure of painful memories related to history of trauma are processed with a greater emphasis on the deepest and most painful memories. It is in this phase that I find it most important to support or help create statements related to positive self-belief or self-enhancement; this creates a balance between the pain of the past and tolerance to contain related affect, and move beyond the mind/body affects of the traumatic experiences.

I consider the final phase as the renewed entry to life with a more established sense of self-belief, self-efficacy, and a shift to a higher level of integration. By this point in the treatment, the patient may experience an ability to succeed in the world and within the context of social and most intimate relationships. Ultimately, this would also allow for higher defense mechanisms to emerge, like altruism and compassion. If treatment is effective, negative symptoms and trauma-related phobias should no longer impact on or affect the patient's ability to function. The capacity for love and relatedness will hopefully be enhanced as the self continues to mature.

In the initial phase of the treatment, hypnotherapy can help to strengthen resources, self-belief, and the ability to gain some sense of mastery. In cases where there is sufficient ego strength and a less severe history of trauma, the use of EMDR and hypnotherapy can help allow for a more rapid recovery. With high-functioning patients, I have found that

feared situations and achievement goals and aspirations may be experienced early in the treatment process.

The very first step in the process is to take a comprehensive family and developmental history, and to create a working genogram. The use of a life line in which the patient and therapist detail important life events, both positive and negative, can help to identify: specific patterns, time of traumatic events, rites of passage and important developmental issues in the patient's life. When patients present with chronic and repeated trauma, it is important to assess their ego strengths and weaknesses in formulating a treatment plan.

When I have a sense that the treatment may be long term, I request that the patient maintain a journal that includes: sections for dreams, memories, life and treatment goals, and a general section for creative writing or art. I ask the patient to think about and include any additional sections that would help with identifying issues for personal growth and individual treatment. I find that less direction often leads to greater creativity.

In many cases of repeated trauma, once the patient's history is complete, the use of self-enhancement interventions can provide a safety net that allows the ego to tolerate the emotionally painful memories that will often emerge in later phases of treatment. In addition, early integration of self-enhancement work can help titrate the previous traumatic memories and reduce the repetition compulsion often experienced in adulthood. The enhancement of self-efficacy, self-belief, and mastery may be integrated in all phases of treatment.

Central to the role of healing is the development of self-belief. Belief in one's self is an important step toward internalizing experiences of mastery and achievement. I ask my patients in session to develop an image, as clearly as possible, by visualizing themselves in situations that they would like to master. When a clear image is created, they are then asked to become aware of their body sensations, i.e., what it feels like to be successful in the situation. This is then elaborated upon in further detail as I continue to use words and phrases previously created by the patients for self-enhancement. When the image becomes more powerful, I begin the work of integrating therapeutic techniques for self-enhancement and ego-strengthening by using bilateral stimulation (eye movements), or sound tapes developed by David Grand, Ph.D., etc. Although there are many new methods for bilateral stimulation, they will not be discussed in the context of this paper. One protocol for Resource Development is designed by Andrew Leeds, Ph.D. (12), to be used with bilateral stimulation. I find it helpful to design the self-enhancing techniques with the

patient in a way that allows it to be woven into the fabric of the clinical work as the therapy evolves throughout the treatment process.

Advanced training in EMDR-related techniques of resource development, self-enhancement, and the development of strengthening self-belief is extremely helpful for the clinician. Ego-strengthening self-enhancement techniques have been used with hypnotherapy for many years (13). Resource development can be integrated as appropriate within the various sessions and is particularly important to begin in the initial phase of treatment. Hypnosis can also be applied to help identify the positive aspects of self that the patient may wish to develop further in the treatment process.

A deeper sense of mastery and enhancement of self-belief can begin to develop when the patient brings out the creative and affirming part of the self. The application of brief sets of rapid eye movements, or other bilateral forms of stimulation, appears to deepen and accelerate this process. As the therapy relationship unfolds over time, shifts begin to occur and the patient will often report positive changes through the course of the treatment. It is important to note that these shifts are often rapid and differ from the traditional psychoanalytic treatment in the time it may take for treatment to be completed.

It is the rapidity of this process that makes it helpful in the initial phase of treatment for the patient to develop a sense of hope regarding his/her treatment and ability to heal. Ego-strengthening in this fashion allows the patient to become familiar with my own style of working with the patient to enhance self-belief and the newer intervention of bilateral stimulation. The time utilized for the initial phase of treatment is contingent upon the patient's progress and ego capacity to move into the deeper levels of his or her childhood experiences. In cases where there are significant early attachment deficits, longer-term treatment may need to be considered. For example, if Jane is self-mutilating or suicidal, and has a history of poor object relations, I would continue the process of stabilization and safety prior to any deeper exploratory clinical work. For Jane, the initial phase of treatment may need to be extended while the therapeutic alliance and her sense of self-efficacy is strengthened.

If the patient has considerable ego strength or there is no history of repeated trauma or extreme attachment deficits, the initial phase of treatment may move more quickly. In one case where a patient was referred exclusively for EMDR, after experiencing a traumatic car accident, which resulted in 30 surgical procedures post accident, she was able to overcome her fear of driving in approximately six sessions. Of most

interest was the fact that this patient was also able to separate from an abusive marriage during those sessions, as a result of ego-strengthening applications. In some cases and situations, however, I have noticed that without ongoing psychotherapy, a return to familiar patterns may occur.

There are times when the phases of treatment will overlap. The most important aspect of any treatment is the quality of the therapeutic relationship and the process of healing that is unique to each individual patient. That is why sound clinical judgment always needs to prevail before using any model of treatment. For example, a patient who has had a prior treatment failure may arrive flooded with memories. Stabilization of that patient may need to include a processing of the traumatic event which is beneath the surface and pushing its way into the conscious mind and creating intolerable symptoms of anxiety. How this initial crisis is resolved can prove to be critical to the treatment process. This resolution will often allow for a healthy beginning with effective boundary setting and a return to a more stabilizing alliance for the initial phase of treatment.

The cases listed below will be used to demonstrate how this work establishes the goals of self-enhancement and ego-strengthening in the initial phases of treatment.

VIGNETTE 1

John, a 50-year-old erudite man, works as a defense attorney. He is devoted to his wife and children. He entered treatment because he was not feeling in control of his life and his weight was beginning to have a dramatic effect on his health. John is a compulsive overeater who is mildly obese. John was aware that there was a myriad of psychological issues beneath his eating disorder and he was concerned about the declining state of his physical health. He spoke with me about his deep feelings of shame and humiliation and the role that played in his depression.

John was troubled by a growing awareness from several prior treatments that he was not maintaining a healthy lifestyle. He was not exercising, did not wish to go on any further diets, and was feeling unmotivated toward good self-care. John had been sexually molested during latency by a rabbi from the Synagogue. He never disclosed this experience to his parents. John described his father as a perfectionist who was emotionally abusive. John suffered from a pervasive sense of rejection and a haunting feeling of never being good enough. He believed that the conflict in his relationship with his father also led to a sense of "sadness so deep, I can't get out of it." John stated that the sadness pervaded his whole life.

The dyadic relationship with his mother was quite complex; she was

described as cold and strong-willed. When John was two years of age, his sister was born and he experienced further detachment from his mother. John's father was a heavy drinker and eventually his parents divorced. Shortly after John began treatment, he expressed concern about his father's planned visit with himself and his family. Prior visits were often laden with tension and conflict.

As an adult, John believed his father's behavior toward him caused him to regress and feel humiliated. Listening to John's concerns, I suggested that we use EMDR for self-enhancement and ego-strengthening, as discussed in this article. After only a few sessions, John's father arrived for an extended visit. John indicated that he was able to engage in a new and different relationship with his father and was no longer pulled into the old frustrating patterns of interaction.

DISCUSSION OF VIGNETTE 1

My initial sessions with John were used to build a foundation for treatment. This included: establishing a genogram, formulating a comprehensive family history, and developing a working alliance. The frame for treatment included the issues John wanted to address, as well as creating a flexible focus for his process of healing. Two important issues for John initially were his conflict-laden relationship with his father and his deep sense of loneliness.

Self-hypnosis was taught to help John trust his mind's ability to relax his body, thus initiating a sense of self-control and efficacy. EMDR sessions were designed to reduce the negative and regressive triggers he experienced when in his father's presence. The clinical work of ego-enhancement and the strengthening of his self-belief focused on his compassion for others, his intelligence, fairness, and broad range of interests in life. This was accomplished with the use of hypnotherapy and EMDR.

As John's therapy with me continues, it is this weaving of ego-strengthening and building of self-belief that allows for the more painful and deeper work to be pursued without regression or a flooding of negative experiences from childhood. By the end of John's middle phase of treatment, he was able to process his experience of sexual abuse in several sessions, with significant resolution. It should be noted that John did not demonstrate the full spectrum of posttraumatic stress symptoms. The early antecedents related to John's depression, his feelings of betrayal about his relationship with his father and his rabbi, and his sense of isolation proved to be the most important aspects to address in the initial phase of his treatment. Despite the emotional pain discharged in the sessions, John

continues to feel a greater sense of hope and empowerment in his life. As his painful childhood memories continue to heal, John's spiritual insights and journey become more available to him.

VIGNETTE 2

Maria, a 28-year-old married college professor, is an extremely attractive woman who presents to the external world as extroverted, intelligent, and highly competent. She discussed her story when she entered treatment, disclosing a history of panic attacks and struggle with agoraphobia. Maria's mother has an untreated history of anxiety and compulsive behavior.

Maria was an unplanned child, something her mother reminds her of each year on her birthday. Maria's relationship with her mother was one of endless dependency. Issues of separation/individuation were paramount in her treatment. It appears that her mother's emotional availability was not sufficient to stabilize an inner state of constancy or self-soothing (14). One example of this lack of internalization was demonstrated by Maria's difficulty in holding an inner image of her husband when he went off on a business trip. To Maria, it was as though he was totally gone and this was terrifying to her.

Other considerations raised in early treatment included an early-childhood memory of a tumultuous period in third grade when she experienced many nightmares, and was afraid to attend school because she was teased by other children about being bright. Maria recalled another experience at school at age 12, regarding a teacher who taught a class on the Holocaust. The teacher focused on her and said that she, too, might be taken away some day. She later became fearful that others would see her as "weird." Maria often felt herself to blame for the problems she experienced at home and this was reinforced by the incident with the teacher. Maria feared returning to the classroom. She proceeded to have temper tantrums and had to be taken to school by her father. Maria did not disclose this incident to her parents until she was taken to a therapist for a single session. In that meeting, Maria recalled her parents saying, "You are the cause of all our problems."

In a hypnotherapy session, Maria said, "I believe that my parents wished I had never been born," and focused on how often she felt she let them down. At 19 years of age, she was raped by a boyfriend and told no one of this experience for many years. As intense and overwhelming as these memories seem, they are just a few of the issues that impacted on Maria's life. During graduate school, Maria struggled with anorexia nervosa, which she managed to overcome on her own.

As her therapy progressed, she gained insight into her parents' own limitations and personal problems. Through these reflections, Maria's knowledge grew, as did her ability to individuate. Maria's strengths are many; she is a talented, highly respected professor, insightful and motivated, providing a rich soil for effective psychotherapy. In treatment, we concentrated on enhancing her innermost attributes, mourning the loss of what she had not received, and continuing to move on in a healthier way in her life. The aspects of her treatment discussed here took one year. As therapy with Maria continues, she is now able to move into the middle phase of her treatment. My role is to be there for her and to continue to apply various appropriate methodologies, while gradually assisting with the process leading to a greater ability for internalization and the eventual establishment of object constancy.

DISCUSSION OF VIGNETTE 2

My approach to Maria's treatment was primarily a psychodynamic one, supplemented with hypnotherapy and EMDR. Maria was asked to think about what she needed in order to feel comfortable while engaging in hypnotherapy. She wrote the following:

I will go as deep as I feel comfortable.
I can have my feelings and still remain in control.
No one will judge me.
This is important work and I can do this.
I am safe.
There is no "right way." However I do this is right for me.
If I feel a fear, I can relax into it. It's okay. I'm okay.

Each of the concerns that Maria expressed about feeling comfortable during hypnotherapy were repeated during the induction and later integrated as suggestion. My EMDR work with her began with an attempt to find an image of a comfortable place. This led to Maria's voicing of feelings of sadness and isolation. Similar to my work with John, experiences of shame, fear, and humiliation began to emerge for Maria. Eventually, she was able to create an image of a safe and comfortable place in her mind. Maria was taught to use this image as an anchor and to employ a rapid induction for a light trance state to reduce her level of anxiety when needed. We also made audio tapes during our sessions to strengthen Maria's ability to use trance and establish an ongoing repertoire of ego-enhancement and sense of mastery. As the therapeutic alliance deepened, so did the focus of the clinical work. EMDR sessions became more intense and focused with a greater emphasis on early developmental

relationships and how they affected Maria in her present life situations. EMDR was also woven into the fabric of the treatment with self-chosen phrases like "I'm strong and I can trust myself." Eventually, Maria began taking trips with her husband and later invited friends on several of these excursions. As Maria explored the deeper issues and conflicts with her parents, the quality of her relationships with them and others began to change. She became more assertive and more open about her panic attacks and agoraphobia. These conversations in treatment reduced her level of shame and allowed for a greater intimacy with her friends. As she began to discuss her situation with others, she also learned that her symptoms were not so uncommon. Each of her disclosures continued to reduce her feelings of shame. Her husband's brief trips away from home, which were previously intolerable, over time became manageable and her panic attacks diminished.

CONCLUSION

Enhancing self-belief with EMDR creates a shift toward change and personal growth that allows traumatic memories to be metabolized with greater expediency and less abreaction. EMDR and the use of ego-strengthening techniques seriously enhance the clinical work. EMDR and hypnotherapy are not a substitute for a strong therapeutic alliance and sound clinical skills and judgment, nor do they help us avoid the frustrating and painful places to which therapy often leads us. The empathy and compassion of the therapist helps to create a safe and nurturing environment for treatment.

In many cases, the use of EMDR and hypnotherapy in fostering self-belief will prove to create a faster road to recovery. It is an important clinical task to apply the use of ego-enhancement techniques and interventions beginning in the initial phase of treatment. In a number of cases, a deeper sense of happiness and spiritual awareness emerged as the path of hope and a vision of an enhanced future became clearer.

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