A BIBLICAL ANALYSIS OF EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) THERAPY AND ITS USE IN BIBLICAL COUNSELING

A Thesis

Presented to

the Faculty of

The Southern Baptist Theological Seminary

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Ministry

---

by

Matthew Claude Higgins

May 2024

APPROVAL SHEET

A BIBLICAL ANALYSIS OF EYE MOVEMENT
DESENSITIZATION AND REPROCESSING
(EMDR) THERAPY AND ITS USE
IN BIBLICAL COUNSELING

Matthew Claude Higgins

Read and Approved by:

_____
John M. Henderson (Chair)

_____
Curtis W. Solomon

Defense Date: March 11, 2024

To my bride, Dana

The gift of a godly wife is unparalleled. Thank you for your sacrifices and support.

To my daughter, Gwen

When you run, may you feel God's pleasure. He loves you dearly.

To my church, NorthWoods Church

I am thankful for your heart for discipleship. Let's keep making disciples who make disciples.

My prayer is this research thesis edifies his church and honors Christ alone.

TABLE OF CONTENTS

PREFACE

About five years ago, a counselee came into my office for a session and asked, "How do I know if my memories are real?" I wasn't sure how to answer that question, so I asked the counselee for some context. This counselee, who struggled with long-term addiction issues, had also been seeing a secular psychologist for treatment. To uncover the sources of his addiction, the counselee consented to take part in a new form of therapy called eye movement desensitization and reprocessing (EMDR). During the first EMDR therapy session (which the counselee described as "hypnosis"), the counselee "recovered" memories of various family members sexually molesting him. While he considered this memory recovery a breakthrough in the moment, my counselee now doubted whether these events took place.

A few years later, a different counselee came to me about struggles in her marriage. In an earlier party-fueled lifestyle, many men had sexually assaulted this counselee, and she now struggled with sexual intimacy in marriage. When I asked what she had done to address her problems, she explained that she had previously received EMDR therapy to overcome her trauma. After several EMDR sessions, the EMDR specialist had told her that the EMDR therapy had "cured" her of her trauma. The counselee then asked me why she didn't like her husband touching her if EMDR had "cured" her.

The two counseling cases were my first interactions with EMDR and, honestly, both cases continue to haunt me. The first case ended with a return to addiction, and the second case ended with a nasty divorce. While I am not saying that EMDR led to their negative outcomes, I am convinced that both of their personal experiences with EMDR

demonstrate the need for research. Specifically, the biblical counseling community needs to understand whether EMDR and Scripture are compatible.

Quite simply, this research thesis is for all my past and future counselees that have experienced the depths of the hurts that this broken world can hold. My prayer is that you know that God weeps with you in your suffering and longs to heal and restore you. May we continue to approach the throne of grace together in our time of need.

Matthew Claude Higgins

Evansville, Indiana

May 2024

CHAPTER 1

INTRODUCTION

Over a short period of time, EMDR therapy has become a popular and trusted psychotherapy technique used to treat persons suffering from post-traumatic stress disorder (PTSD), particularly combat-based trauma. In 1987, Dr. Francine Shapiro developed EMDR therapy by noting that rapid eye movements eased her own feelings of distress. Shapiro began to apply and hone the use of rapid eye movements to treat her trauma patients.

Today, EMDR therapy is an accepted practice of the American Psychological Association, the World Health Organization, and the US Veterans Administration in the treatment of PTSD.[1] Due to this technique's perceived effectiveness in treatment of PTSD, psychotherapists are now beginning to use EMDR therapy to treat other presenting counseling issues, such as anxiety and major depression. In EMDR therapy, a trained therapist uses bilateral stimulation, or rhythmic right-left movement stimuli, on the counselee through various sights (i.e., finger movements or twinkling lights), sensations (i.e., rhythmic tapping) or sounds (i.e., ticking sounds in headphones) to process the counselee's traumatic memories.[2] Unlike exposure therapy, EMDR therapy

[1] "Eye Movement Desensitization and Reprocessing (EMDR) Therapy," American Psychological Association, last modified July 31, 2017, https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing.

[2] Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd ed. (New York: Guilford Press, 2017), 29-30.

seeks to integrate the traumatic experience into the counselee's information processing system, so that the experience "stops having a life of its own."[3]

Despite its increasing prevalence in the treatment of PTSD, no major work has been done from the perspective of biblical counseling on EMDR therapy. To this end, this thesis will ask the following questions: Is EMDR therapy compatible with Scripture and the precepts of biblical counseling in the treatment of PTSD? Can trauma counseling be effective without the examination of core beliefs (or "the heart")?

Two major reasons exist for the study of EMDR therapy. First, no scientific consensus exists about how and why EMDR works.[4] Shapiro's prevailing theory is that the brain often becomes overloaded during traumatic situations, and the brain needs help to process troubling memories. To this end, Shapiro holds that a psychotherapist can use the EMDR process to effectively reprocess trauma. However, other theories exist as to why EMDR therapy works. Despite the lack of understanding why EMDR therapy works, psychotherapists continue to use this form of treatment, since scientific studies have shown the effectiveness of EMDR therapy in the treatment of PTSD.[5]

Second, the literature regarding EMDR, including the works of Shapiro, displays a negative view of other treatments of PTSD, such as talk therapy and exposure-based therapies. In the view of many EMDR practitioners, the problem is not that talk therapy and exposure-based therapies are ineffective; instead, the problem is they are simply inefficient. In *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma*, Francine Shapiro and Margot Forrest demonstrate their position on the inefficiency of traditional therapy: "EMDR accesses the memories of these experiences

---

[3] Bessel van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2014), 258.

[4] Francine Shapiro and Margot Silk Forrest, *EMDR: The Breakthrough "Eye Movement" Therapy for Overcoming Anxiety, Stress, and Trauma* (New York: Basic Books, 2016), 40.

[5] Tal Croitoru, *The EMDR Revolution: Change Your Life One Memory at a Time, The Client's Guide* (New York: Morgan James, 2014), 126.

but does not dwell on them and does not, as traditional therapy can, last for years."[6] In a 2014 interview, Shapiro brags of an "84 to 100% remission of PTSD within about five hours of (EMDR) treatment."[7] By seeking to simply reprocess traumatic events stored by the brain, the psychotherapist can eliminate any confrontation of the counselee's core beliefs and, sometimes, any proper discussion of the traumatic event at all. To this end, the World Health Organization's 2013 report on the treatment of trauma through EMDR therapy touts, "Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework."[8] The circumventing of core beliefs ("the heart") by EMDR therapy would seem to make this therapy at odds with the Bible's view of the heart as well as the primary endeavor of biblical counseling to address the heart.

Familiarity with Literature

This doctoral thesis will review primary sources from Francine Shapiro, who is the originator and developer of EMDR therapy. This thesis will also review secondary sources that both support and critique EMDR.

EMDR therapy is almost singularly associated with the work of psychotherapist Francine Shapiro, who recently passed away of cancer in 2019. Over the course of her lifetime, Shapiro wrote a prolific number of journal articles, books and other works on EMDR therapy. Of particular note, her 1995 book, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures*, and her 1997 book, *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma*, are considered the seminal works on EMDR therapy. In 2012, Shapiro moved

---

[6] Shapiro and Forrest, *EMDR*, 19.

[7] Ruth Wetherford, "Francine Shapiro on the Evolution of EMDR Therapy," Psychotherapy, accessed September 13, 2021, http://www.psychotherapy.net/interview/francine-shapiro-emdr.

[8] World Health Organization, *Guidelines for the Management of Conditions Specifically Related to Stress* (Geneva: World Health Organization, 2013), 1.

EMDR therapy into the self-help genre by writing *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy*. Since Shapiro only recently passed away, numerous first-person interviews, journal articles, and various other writings from Shapiro are readily available in print and online.[9]

Secondary Sources

A number of books and articles have been written from the field of psychology on the efficacy of EMDR therapy. Outside of Shapiro's works, additional works on EMDR therapy include *EMDR Essentials: A Guide for Clients and Therapists* by Barb Maiberger, *EMDR: Transforming Trauma* by Laurel Parnell, and *Every Memory Deserves Respect* by Michael Baldwin and Deborah Korn.[10] In addition, secular works on trauma, such as *Waking the Tiger: Healing Trauma* by Peter Levine, *The Feeling of What Happens* by Antonio Damasio, and *Trauma and Recovery* by Judith Herman, will provide important insights for the thesis project.[11] In addition, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* by Bessel van der Kolk is considered an

---

[9] First person interviews of Shapiro include John D. Lentz, "In the Spirit of Therapy: Interview with Francine Shapiro, Ph.D.," *Milton H. Erickson Foundation Newsletter* 33, no. 2 (2013): 4; Marilyn Luber and Francine Shapiro, "Interview with Francine Shapiro: Historical Overview, Present Issues, and Future Directions of EMDR," *Journal of EMDR Practice and Research* 3, no. 4 (2009): 217-31; and Wetherford, "Francine Shapiro On The Evolution of EMDR Therapy." Academic articles by Shapiro include Francine Shapiro, "Efficacy of the Eye Movement Desensitization Procedure in the Treatment of Traumatic Memories," *Journal of Traumatic Stress* 2, no. 2 (1989): 199-223; Francine Shapiro, "Eye Movement Desensitization: A New Treatment for Post-Traumatic Stress Disorder," *Journal of Behavior Therapy and Experimental Psychiatry* 20, no. 3 (1989): 211-17; Francine Shapiro, "EMDR: In the Eye of a Paradigm Shift," *Behavior Therapist* 17, no. 7 (1994): 153-57; and Francine Shapiro, "EMDR 12 Years after Its Introduction: Past and Future Research," *Journal of Clinical Psychology* 58, no. 1 (2002): 1-22. Shapiro's teaching and training sessions are also available online: Francine Shapiro, "The Past Is Present," Psychology Webinar Group, February 6, 2014, YouTube video, 58:57, https://www.youtube.com/watch?=lsQbzfW9txc.

[10] See Barb Maiberger, *EMDR Essentials: A Guide for Clients and Therapists* (New York: W. W. Norton, 2009); Laurel Parnell, *Transforming Trauma: EMDR, The Revolutionary New Therapy for Freeing the Mind, Clearing the Body, and Opening the Heart* (New York: W. W. Norton, 1998); Michael Baldwin and Deborah Korn, *Every Memory Deserves Respect: EMDR, the Proven Trauma Therapy with the Power to Heal* (New York: Workman, 2021).

[11] See Peter A. Levine and Ann Frederick, *Waking the Tiger: Healing Trauma* (Berkeley, CA: North Atlantic Books, 1997); Antonio Damasio, *The Feeling of What Happens: Body and Emotion in the Making of Consciousness* (London: Harcourt, 2000); Judith Herman, *Trauma and Recovery: The Aftermath of Violence, From Domestic Abuse to Political Terror* (New York: Basic Books, 2015).

authoritative psychological work on trauma, and van der Kolk spends some time addressing the efficacy of EMDR in this work.

While many secondary sources on EMDR therapy have been written from the secular perspective, far fewer works are available from a Christian worldview. Only one book on EMDR therapy has been written from the perspective of the Christian counselor: *Unburdening the Soul at the Speed of Thought: Psychology, Christianity, and the Transforming Power of EMDR* by Andrew Dobo.[12] No major works have been written on EMDR therapy from the biblical counseling perspective. However, biblical counseling works on the traumatic experience include, *Trauma: Caring for Survivors* by Darby Strickland,[13] *Post-Traumatic Stress Disorder: Recovering Hope* by Jeremy Lelek,[14] *PTSD: Healing for Bad Memories* by Timothy Lane,[15] and *I Have PTSD: Reorienting After Trauma* by Curtis Solomon.[16] Several other biblical counseling works, *The Christian Counselor's Medical Desk Reference*[17] and *The Gospel for Disordered Lives*,[18] have chapters specifically dedicated to the traumatic experience. In addition, Diane Langberg's *Suffering and the Heart of God* does address the topic of PTSD from a

---

[12] Andrew J. Dobo, *Unburdening Souls at the Speed of Thought: Psychology, Christianity, and the Transforming Power of EMDR* (Sebastian, FL: Soul Psych, 2015).

[13] Darby Strickland, *Trauma: Caring for Survivors* (Philipsburg, NJ: P & R, 2023).

[14] Jeremy Lelek. *Post-Traumatic Stress Disorder: Recovering Hope*, Gospel for Real Life (Philipsburg, NJ: P & R, 2013).

[15] Timothy S. Lane, *PTSD: Healing for Bad Memories* (Greensboro, NC: New Growth Press, 2012), Kindle.

[16] Curtis Solomon, *I Have PTSD: Reorienting after Trauma* (Greensboro, NC: New Growth Press, 2023).

[17] Mark Buono, "Post-Traumatic Stress Disorder: Rewriting the Narrative to Include Hope," in *The Christian Counselor's Medical Desk Reference*, ed. Charles D. Hodges Jr. (Greensboro, NC: New Growth Press, 2023).

[18] Robert D. Jones, Kristen L. Kellen, and Rob Green, *The Gospel for Disordered Lives: An Introduction to Christ-Centered Biblical Counseling* (Nashville: B & H Academic, 2021).

Christian perspective.[19] Heather Gingrich's *Restoring the Shattered Self* and *Treating Trauma in Christian Counseling* are also notable Christian counsleing books about trauma.[20]

Void in Literature

After Shapiro developed EMDR in 1987, she quickly became EMDR's chief supporter, writing three major books and many scholarly articles on the effectiveness of EMDR. In the 1990s, many psychologists derided Shapiro's "hand waving" technique, which remained largely unproven due to a lack of sound studies on the topic.[21] As studies seemed to bear out the effectiveness of Shapiro's technique, reputable organizations, such as the US Veterans Administration and the World Health Organization, began to accept EMDR in the treatment of trauma. Within the last three decades, psychologists have written extensively on the efficacy and proper practice of EMDR.

The Christian community has voiced a mixed response to EMDR. Some Christian counselors, such as Andrew Dobo, have wholeheartedly incorporated EMDR into the treatment of trauma patients. In 2018, Focus on the Family endorsed EMDR as an acceptable form of treatment to address trauma, saying that EMDR is "not a faddish 'fly-by-night' development."[22] In 2019, Christian apologist J. P. Moreland published his book *Finding Quiet*, which addresses Moreland's struggle with anxiety and depression. In this book, Moreland gives a full-throated endorsement of EMDR: "I highly

---

[19] Diane Mandt Langberg, *Suffering and the Heart of God: How Trauma Destroys and Christ Restores* (Greensboro, NC: New Growth Press, 2015).

[20] Heather Davediuk Gingrich, *Restoring the Shattered Self: A Christian Counselor's Guide to Complex Trauma*, 2nd ed., Christian Association for Psychological Studies Books, (Downers Grove, IL: InterVarsity Press, 2020).

[21] Lynda Liu, "Hand Waving: An Unconventional Treatment for Post-Traumatic Stress Is Put to the Test," *The Sciences* 36, no. 4 (July/August 1996): 13.

[22] "Eye Movement Desensitization and Reprocessing (EMDR)," Focus on the Family, accessed November 7, 2023, https://www.focusonthefamily.com/family-qa/eye-movement-desensitization-and-reprocessing-emdr/.

recommend considering EMDR therapy as an aid in the battle against anxiety and depression."[23] A commonality of these works is a failure to consider the foundations of EMDR in light of the authority of Scripture.

Despite a growing acceptance in many Christian circles, the biblical counseling movement has not produced a major work evaluating EMDR. In December 2021, the Biblical Counseling Coalition became the first biblical counseling organization to produce an evaluation of it.[24] To this end, a significant void in literature exists from the perspective of biblical counseling.

Thesis

This thesis will examine whether EMDR therapy is compatible with Scripture and the precepts of biblical counseling. To this end, the thesis will examine Shapiro's naturalistic worldview and the adaptive information processing (AIP) model, which is Shapiro's "working hypothesis" about how EMDR works. The AIP model holds that mankind's problems are generally physiological in nature, where traumatic events cause the body to improperly process traumatic memories. As such, the AIP model holds that persons afflicted by trauma can solely use physiological means—particularly the reprocessing of memories—to solve mankind's problems. In contrast, Scripture holds to the position of holistic dualism, meaning that human beings are comprised of soul and body, a psychosomatic unity of two substances. The believer needs sanctification of the soul, or "inner man" or "the heart," through the regeneration of Christ to overcome life's problems, including extreme suffering caused by traumatic events. As the AIP model is

---

[23] J. P. Moreland, *Finding Quiet: My Story of Overcoming Anxiety and the Practices That Brought Peace* (Grand Rapids: Zondervan, 2019), 135.

[24] "Statement on EMDR," Biblical Counseling Coalition, accessed November 7, 2023, https://www.biblicalcounselingcoalition.org/wp-content/uploads/2021/12/Statement-on-EMDR-by-the-BCC.pdf.

contrary to a biblical understanding of anthropology, EMDR treatment is incompatible with biblical counseling.

Outline of Chapters

The researcher utilizes the following chapters to examine the thesis presented and to show why additional research is needed in this area.

Chapter 1: Introduction

This first chapter offers an introduction to the subject of EMDR and surveys the prevailing literature regarding EMDR and trauma counseling. Ultimately, this chapter proves that a void in literature exists on the compatibility of EMDR with biblical counseling.

Chapter 2: The Foundations of EMDR

This second chapter focuses on the history of EMDR. The beginning of this chapter focuses on what was occurring in the environment of psychology in the 1980s that led to the development of EMDR. This chapter then shows how Shapiro discovered EMDR treatment and then worked to popularize this psychotherapy technique. Finally, this chapter shows how the psychiatric community went from generally dismissing EMDR as a pseudoscience to accepting EMDR as a practical therapy.

Chapter 3: The Adaptive Information Processing Model

This third chapter principally explores Shapiro's prevailing theory of how EMDR works, which is the AIP model. First, this chapter explores the foundations of EMDR in cognitive behavioral therapy (CBT). Next, this chapter explores what various neuroscientists and psychologists believe about how the body processes traumatic events. This chapter also explores the AIP model, which is Shapiro's working theory about how EMDR works on a neurological level. In addition, this chapter explores alternative

working theories of why EMDR appears to work. Finally, this chapter summarizes Shapiro's eight phases of EMDR therapy.

Chapter 4: Biblical Appraisal of EMDR

This chapter shows how the precepts of the AIP model are incompatible with the biblical anthropology of Scripture. Principally, this chapter explores how the AIP model is incompatible with a biblical understanding of who human beings are. In contrast to the physiologically focused approach of the AIP model, Scripture holds that human beings are comprised of body and spirit, and mankind will face physical and spiritual problems due to the prevalence of human sinfulness. Second, this chapter investigates how the AIP model is incompatible with a biblical view of how humans make choices. While the AIP model holds that human beings are solely a product of genetics and experiences, Scripture holds that people make conscious choices based on the heart. Third, this chapter shows that the AIP model is incompatible with a biblical understanding of how human beings change. While the AIP model holds that people change through humanistic, physiological interventions, Scripture teaches that human beings can only change through the power of the gospel. Finally, this chapter shows that the AIP model is incompatible with a biblical view of how quickly human beings change. While the AIP model boasts that EMDR can cure human beings' problems in an expeditious fashion, Scripture emphasizes patience in suffering and progressive sanctification.

Chapter 5: Implications for Biblical Counseling

Finally, this chapter looks to synthesize the information presented above to present an overall picture of the implications of this research on biblical counseling. In addition, the chapter offers some practical considerations for biblical counselors and suggests some potential areas of further research.

CHAPTER 2

THE FOUNDATIONS OF EMDR

In the 1980s, EMDR emerged from the psychiatric community's attempts to effectively treat a new diagnosis: Post-traumatic stress disorder (PTSD). Many mental health professionals were struggling to find effective treatment options for veterans trying to cope with the aftermath of wartime service. At a time when most PTSD treatment options were considered time-consuming and marginal in help, Francine Shapiro introduced EMDR, which promised to efficiently eliminate the symptoms of PTSD. Though EMDR initially proved controversial to a skeptical psychiatric community, EMDR is now a common and accepted treatment for PTSD.

Post-Traumatic Stress Disorder

While the PSTD diagnosis is pervasive and embedded in our modern culture, the idea that traumas can lead to psychological ailment is a relatively new concept.[1] Post-traumatic stress disorder (PTSD) has been a medical diagnosis since its inclusion in the third edition of the Diagnostic and Statistical Manual (DSM-III) in 1980.[2] Historically, PTSD has been interconnected with the soldier's wartime experience. In the 1860s, the literature of the time period noted that Civil War veterans experienced physical and emotional trauma, but often dismissed such trauma as moral failure and physical weakness.[3] In 1871, surgeon Jacob DaCosta observed symptoms of exhaustion and

---

[1] Allan V. Horwitz, *PTSD: A Short History* (Baltimore: John Hopkins University Press, 2018), 19.

[2] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-III*, 3rd ed. (Washington, DC: American Psychiatric, 1980), 236-39.

[3] Darby Strickland, "Foundations of Trauma Care for Biblical Counselors," *Journal of Biblical Counseling* 36, no. 2 (2022): 27.

cardiovascular distress in Civil War soldiers, leading to a physiological diagnosis known as "soldier's heart" or "DaCosta's Syndrome."[4] After World War I, the experience of the soldier after wartime was classified as "shell shock," since theories often linked the phenomenon to falling artillery shells.[5] The research of the World War I era began to link the horrors of combat to symptoms of amnesia and dissociation, leading to the diagnosis of "combat fatigue."[6] Other researchers and military officials determined that the soldier's anxiety symptoms were merely a demonstration of cowardice.[7]

As the horrors of trench warfare in World War I gave way to the nuclear nightmares of World War II, clinicians and researchers began to the understand the connections between the stressors of wartime and the soldier's anxiety. In the 1960s and early 1970s, the military community coined "Post Vietnam Syndrome" as a term describing the Vietnam veteran's reaction to the horrors of wartime.[8] By the late 1970s, a Vietnam veterans group lobbied the American Psychological Association (APA) to add a diagnosis for war-related trauma to their diagnostic manual.[9] In 1980, the APA added PTSD to the new version of the diagnostic manual (DSM-III) as a new diagnosis, describing a cluster of symptoms related to experiencing traumatic suffering.[10] The new diagnosis of PTSD was supported by extensive research literature regarding the

---

[4] J. Douglas Bremner, *Does Stress Damage the Brain? Understanding Traumas-Related Disorders from a Mind-Body Perspective* (New York: W. W. Norton, 2002), 27.

[5] Nancy C. Andreasen, "Post-Traumatic Stress Disorder: A History and a Critique," *Annals of the New York Academy of Sciences* 1208, no. 1 (October 2010): 67.

[6] Bremner, *Does Stress Damage the Brain?*, 31.

[7] Paul Lerner and Mark Micale, "Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction," in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age*. ed. Paul Lerner and Mark Michale, Cambridge Studies in the History of Medicine (New York: Cambridge University Press, 2001), 2.

[8] Greg Gifford, *Helping Your Family through PTSD* (Eugene, OR: Wipf and Stock, 2017), 19.

[9] Andreasen, "Post-Traumatic Stress Disorder," 69.

[10] APA, *DSM-III*, 236-39.

epidemiology and symptomatology of the traumatic experience.[11] Much of the research on PTSD has been connected to combat veterans due to the significant trauma of combat veterans and research funds available from the U.S. Department of Defense and the U.S. Department of Veterans Affairs.[12]

Although PTSD was originally conceived as a diagnosis related to military combat, the original PTSD diagnosis acknowledged that trauma has the potential to negatively impact persons from any walk of life.[13] The DSM-III authors chose to define stressors as being so severe that they would "evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict."[14] As such, the APA recognized that traumatic events have the potential to negatively impact other populations, such as abuse survivors, sexual assault survivors, first responders and accident survivors.[15] In particular, the women's rights movement of the 1970s served to highlight the trauma that women experience due to sexual violence, child abuse, and domestic abuse.[16]

What is Trauma?

Trauma is a result of living in a world broken by sinfulness. Darby Strickland defines trauma as "the emotional, spiritual, and physical disruptions that occur when a

---

[11] Andreasen, "Post-Traumatic Stress Disorder," 69.

[12] Curtis Solomon, "Evaluating the Legacy Program of the Mighty Oaks Foundation," (PhD diss., The Southern Baptist Theological Seminary, 2020), 9.

[13] Lelek, *Post-Traumatic Stress Disorder*, 4.

[14] APA, *DSM-III*, 236.

[15] Solomon, "Evaluating the Legacy Program of the Mighty Oaks Foundation," 11.

[16] Judith Herman, *Trauma and Recovery: The Aftermath of Violence, From Domestic Abuse to Political Terror* (New York: Basic Books, 2015), 28-32.

person is overwhelmed by extreme suffering."[17] In fact, the etymology of the word "trauma" is rooted in the Greek word for wound or physical injury.[18] Creation's brokenness can generate significant suffering, such as a natural disaster, violent wartime experience, child abuse or sexual assault, which potentially leads to an overwhelming wound in a person's life. Traumatic events can be sudden and unpredictable, such as a violent car accident, but can also be an ongoing violation of trust, such as child abuse.[19] Medical professionals use the term "traumatized" when someone experiences overwhelming emotions, negative cognitions and a disruption in relationships resulting from their traumatic experience.[20]

Epidemiological research has showed that 70.4 percent of the world's population will experience a traumatic event (as defined by the DSM-V) during their lifetime.[21] However, not all persons that experience extreme suffering will experience traumatization.[22] Some persons who experience trauma have negative responses for a limited period and then can resume a healthy and normal life, where the trauma is not recurring or re-experienced.[23] Other persons will overcome their suffering through God's grace and will go on to experience an extremely functional life, where past suffering does not impact their present life experiences. However, some survivors will become traumatized, experiencing adverse, ongoing negative effects to the traumatic event, such

---

[17] Strickland, "Foundations of Trauma Care for Biblical Counselors," 26.

[18] Diane Mandt Langberg, *On the Threshold of Hope: Opening the Door to Healing for Survivors of Sexual Abuse*, AACC Counseling Library (Carol Stream, IL: Tyndale House, 1999), 53.

[19] Darby Strickland, *Trauma: Caring for Survivors* (Philipsburg, NJ: P & R, 2023), 3.

[20] Strickland, *Trauma: Caring for Survivors*, 3.

[21] Corinas Benjet, et al., "The Epidemiology of Traumatic Event Exposure Worldwide: Results from the World Mental Health Survey Consortium," *Psychological Medicine* 46, no. 2 (2016): 332.

[22] Strickland, *Trauma: Caring for Survivors*, 3.

[23] US Department of Veterans Affairs, "PTSD History and Overview," accessed March 17, 2024, https://www.ptsd.va.gov/professional/treat/essentials/history_ptsd.asp.

as nightmares, flashbacks, and sleep disturbances.[24] In 1995, the National Comorbidity Survey found that 60.7 percent of men and 51.2 percent of women had experienced a traumatic event intense enough to develop the symptoms of post-traumatic stress disorder (PTSD); however, only 8.2 percent of men and 20.4 percent of women developed a PTSD diagnosis.[25] Similarly, the 2012-2013 National Epidemiologic Survey on Alcohol and Related Conditions-III similarly found that 68.6 percent of respondents reported one or more potential traumatic event (PTE) in their lifetime; however, 6.1 percent of respondents developed a PTSD diagnosis.[26]

The psychiatric community has struggled to explain why some persons are traumatized by certain events and others are not. In the nineteenth and early twentieth century, psychologists often believed that people who struggled with trauma simply had "weak constitutions."[27] Today, the DSM-V-TR outlines various risk factors for the development of PTSD, delineating them into pretraumatic, peritraumatic and posttraumatic factors.[28] Potential pretraumatic risk factors, occurring prior to the experiencing the traumatic event, include temperamental factors (i.e., childhood emotional problems), environmental factors (i.e., lower socioeconomic or education status), and genetic issues.[29] Peritraumatic factors, occurring during the traumatic event, generally revolve around the severity or duration of the traumatic event.[30] Posttraumatic

---

[24] Robert D. Jones, Kristen L. Kellen, and Rob Green, *The Gospel for Disordered Lives: An Introduction to Christ-Centered Biblical Counseling* (Nashville: B & H Academic, 2021), 376.

[25] Ronald C. Kessler, et al., "Posttraumatic Stress Disorder in the National Comorbidity Survey," Archives of General Psychiatry 52 (1995): 1049-1050.

[26] Rise B. Goldstein, et al., "The Epidemiology of DSM-5 Posttraumatic Stress Disorder in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions-III," *Social Psychiatry and Psychiatric Epidemiology* 51 (2016): 1140.

[27] Horwitz, *PTSD: A Short History*, 9.

[28] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-V-TR*, 5th ed. (Washington, DC: American Psychiatric, 2023), 309-10.

[29] APA, *DSM-V-TR*, 309-10.

[30] APA, *DSM-V-TR*, 310.

factors, occurring after the traumatic event, center around temperamental issues (i.e., coping strategies) and environmental factors (i.e., repeated upsetting reminders and social support).[31] However, the greatest factor in the development of PTSD is previous exposure to traumatic events.[32] This perspective is called "stress sensitization," which holds that "repeated stress increases the risk for development of abnormalities in both neurobiology and behavior following reexposure to stress."[33]

What is PTSD?

The current version of the Diagnostic and Statistical Manual (DSM-V-TR) defines the medical diagnosis of PTSD as "exposure to actual or threatened death, serious injury, or sexual violence."[34] Similarly, Biblical counselor Jeremy Lelek describes PTSD as a "profoundly intense response to a profoundly intense, danger-provoking experience."[35] In essence, PTSD occurs when a period of unwanted extreme suffering invades someone's life and a person experiences prolonged and severe negative emotions and beliefs as a direct result. The DSM-V-TR gives examples of persons who might experience PTSD, including combat veterans, prisoners of war, sexual assault survivors, child abuse survivors, persons who have experienced an automobile accident and kidnapping victims.[36] These descriptions of PTSD—as well as the examples of PTSD—remind that trauma is not just restricted to combat situations; instead, trauma can negatively impact anyone from any walk of life.

The DSM-V-TR strictly defines the type of traumatic events that can lead to a

---

[31] APA, *DSM-V-TR*, 310.

[32] Bremner, *Does Stress Damage the Brain?*, 151.

[33] Bremner, *Does Stress Damage the Brain?*, 150.

[34] APA, *DSM-V-TR*, 301.

[35] Jeremy Lelek, *Post-Traumatic Stress Disorder: Recovering Hope*, Gospel for Real Life (Philipsburg, NJ: P & R, 2013), 8.

[36] APA, *DSM-V-TR*, 301-303.

PTSD diagnosis, and these traumatic events are outlined as Criterion A of the PTSD diagnosis.[37] While a person might experience a variety of events that they might describe as stressful or traumatic, only the traumatic events as listed in Criterion A can lead to an official PTSD diagnosis.[38] Based on the definitions of Criterion A, a person is exposed to a traumatic event under one of four circumstances. First, a person is exposed to a traumatic event when they directly experience actual or threatened death, serious injury or sexual violence.[39] The DSM-V-TR may consider bullying, life-threatening illnesses and debilitating medical conditions as traumatic events if certain conditions are met.[40] Second, a person is exposed to a traumatic event when a person witnesses actual or threatened death, serious injury or sexual violence in person.[41] Third, a traumatic event can occur when a person learns that a close family member or friend has experienced actual or threatened death, serious injury or sexual violence.[42] Finally, a traumatic event can occur when a person experiences "repeated of extreme exposure" to the details of a traumatic event.[43] Examples of persons that typically have repeated exposure to traumatic events include first responders who collect human remains and police officers exposed to details of child abuse.[44] Of importance, someone with a PTSD does not necessarily have to directly experience a traumatic event; PTSD sufferers can witness traumatic events in person, learn about the actual or threatened death of family or friends, or repeatedly

---

[37] APA, *DSM-V-TR*, 301.

[38] Anushka Pai, Alina Suris, and Carol S. Norris, "Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations," *Behavioral Sciences* 13, no. 7 (2017): 2.

[39] APA, *DSM-V-TR*, 301.

[40] APA, *DSM-V-TR*, 305.

[41] APA, *DSM-V-TR*, 301.

[42] APA, *DSM-V-TR*, 301.

[43] APA, *DSM-V-TR*, 301.

[44] APA, *DSM-V-TR*, 301.

experience negative details about traumatic events.[45]

In addition to experiencing a traumatic event as defined by Criterion A, the DSM-V-TR outlines someone with a PTSD diagnosis must develop four clusters of behavioral symptoms associated with the traumatic event: intrusion, avoidance, negative cognitions and mood, and hyper-arousal and reactivity.[46] The DSM-V-TR lists these symptoms as Criterion B-E.[47]

First, someone affected by PTSD must have symptoms of intrusion (Criterion B), meaning that the trauma survivor relives or re-experiences the traumatic event.[48] These intrusion symptoms may take the form of unwanted upsetting memories, nightmares, flashbacks, emotional distress after exposure to upsetting reminders, and physical reactivity after exposure to upsetting reminders.[49] For PTSD sufferers, anthropologist Allan Young argues that "time runs in the wrong direction, that is, from the present back to the past."[50] Past traumatic events can intrude into the survivor's life while dreaming or while fully awake.[51] Various sights and sounds can trigger a vivid reliving or reexperiencing of a traumatic event, which can be just as uncomfortable, painful, or disturbing as the original experience.[52] For example, a backfire of an engine or a loud bang can incite realistic memories of a combat veteran's wartime experiences. To this end, the survivor can often feel "stuck" in past events, unable to deal with present

---

[45] APA, *DSM-V-TR*, 301.

[46] APA, *DSM-V-TR*, 301.

[47] APA, *DSM-V-TR*, 301-303.

[48] APA, *DSM-V-TR*, 301; Henry Beaulieu, *PTSD Biblical Perspective for Hope and Help*, (Bemidji, MN: Focus, 2018), 6.

[49] APA, *DSM-V-TR*, 302; US Department of Veterans Affairs, "PTSD and *DSM-V*," accessed March 17, 2024, https://www.ptsd.va.gov/professional/treat/essentials/dsm5_ptsd.asp.

[50] Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton, NJ: Princeton University Press, 1995), 7.

[51] Gifford, *Helping Your Family Through PTSD*, 9.

[52] Gifford, *Helping Your Family Through PTSD*, 9.

events due to their overwhelming experience with the past.[53] To qualify for a PTSD diagnosis, the DSM-V-TR states that a person must experience one (or more) of the symptoms of intrusion listed in Criterion B in association with the traumatic event, beginning after the traumatic event.[54]

Second, someone affected by PTSD must have symptoms of persistent avoidance (Criterion C), meaning that a person avoids thinking about or discussing the traumatic event.[55] These avoidance symptoms may be demonstrated through avoidance of trauma related thoughts or feelings and/or avoidance of trauma related reminders.[56] Due to the continual intrusion of past traumatic events into present life, the survivor will seek to avoid situations that could potentially bring back negative memories and emotions.[57] As traumatic memories continue to intrude into the PTSD sufferer's life, the survivor will tend to withdraw from everyday life to avoid potentially negative scenarios.[58] As such, the experience of trauma can often be bewildering since the trauma survivor experiences two opposing forces concurrently: Intrusive symptoms and avoidance behavior. Simultaneously, the trauma survivor insulates themselves from their suffering but feels like they cannot escape their experience.[59] To qualify for a PTSD diagnosis, the DSM-V-TR states that a person must experience one (or both) of the symptoms of persistent

---

[53] Bessel Van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2014), 18.

[54] APA, *DSM-V-TR*, 301.

[55] APA, *DSM-V-TR*, 301.

[56] US Department of Veterans Affairs, "PTSD and *DSM-V*."

[57] Gifford, *Helping Your Family Through PTSD*, 9.

[58] Mark Buono, "Post-Traumatic Stress Disorder: Rewriting the Narrative to Include Hope," in *The Christian Counselor's Medical Desk Reference*, ed. Charles D. Hodges Jr. (Greensboro, NC: New Growth Press, 2023), 267.

[59] Buono, "Post-Traumatic Stress Disorder," 267.

avoidance listed in Criterion C in association with the traumatic event, beginning after the traumatic event.[60]

Third, someone affected by PTSD must have symptoms of negative alterations in cognitions and mood associated with the traumatic event (Criterion D), meaning the trauma sufferer experiences negative changes to their thinking and emotions.[61] These symptoms may be demonstrated as inability to recall key features of the trauma, overly negative thoughts and assumptions about oneself or the world, exaggerated blame of self or others for causing the trauma, negative affect, decreased interest in activities, feeling isolated, and/or difficulty experiencing positive affect.[62] As a result of the traumatic event, the trauma survivor's beliefs about themselves and their environment might change (i.e. "Bad things will always happen to me;" "I can't trust anyone ever again;" "My life is permanently ruined.").[63] Those impacted by PTSD might believe that they are irreparably broken and beyond healing due to the traumatic event.[64] In addition, the trauma survivor might blame themselves for the cause or circumstances of the traumatic event.[65] The survivor might experience a negative mood, including feelings of guilt, anger, shame and anxiety, which will cause them to distance themselves from family and friends.[66] To qualify for a PTSD diagnosis, the DSM-V-TR states that a person must experience two (or more) of the symptoms of negative alterations of cognitions and mood

---

[60] APA, *DSM-V-TR*, 302.

[61] APA, *DSM-V-TR*, 301.

[62] US Department of Veterans Affairs, "PTSD and *DSM-V*."

[63] APA, *DSM-V-TR*, 307.

[64] Buono, "Post-Traumatic Stress Disorder," 266.

[65] Buono, "Post-Traumatic Stress Disorder," 266.

[66] APA, *DSM-V-TR*, 307.

listed in Criterion D in association with the traumatic event, beginning after the traumatic event.[67]

Finally, someone affected by PTSD must have symptoms of "marked alterations in arousal and reactivity associated with the traumatic event" (Criterion E), meaning a person displays a keen hyper-awareness of the surrounding world.[68] These hyperarousal and hyperreactivity symptoms might be evidenced as irritable behavior and angry outbursts, reckless or self-destructive behavior, hypervigilance, heightened startle response, concentration difficulties and sleep disturbances.[69] In *Trauma and Recovery*, Judith Herman states that trauma can cause the body to go into a state of "permanent alert," where people believe and live like their trauma could potentially return at any moment.[70] To this end, the trauma survivor "superimpose" their trauma on their world, interpreting ordinary things in life as a potential threat.[71] Hyper-arousal symptoms are principally incited by some form of trigger.[72] For example, the female rape victim might perceive aggressive men as potential rapists, and the child abuse survivor might see an authoritarian figure like an abusive father. The survivor's physiological responses to their triggers might seem uncontrollable, seeming "as if the switch is turned on and there is no de-escalation or calming down."[73] As a result, PTSD sufferers often experience sleep disturbances and nightmares, which lead to the person receiving little restorative sleep.[74] To qualify for a PTSD diagnosis, the DSM-V-TR states that a person must experience

---

[67] APA, *DSM-V-TR*, 301.

[68] APA, *DSM-V-TR*, 302.

[69] US Department of Veterans Affairs, "PTSD and *DSM-V*."

[70] Herman, *Trauma and Recovery*, 35.

[71] Van der Kolk, *The Body Keeps the Score*, 17.

[72] Gifford, *Helping Your Family Through PTSD*, 9.

[73] Gifford, *Helping Your Family Through PTSD*, 9.

[74] Buono, "Post-Traumatic Stress Disorder," 267.

two (or more) of the symptoms of marked alterations in arousal and reactivity listed in Criterion E in association with the traumatic event, beginning after the traumatic event.[75]

The DSM-V-TR has three more criteria that must be met for a person to receive a PTSD diagnosis. First, Criterion F states the PTSD symptoms (as defined by Criteria B-E) must persist for more than one month. Next, Criterion G states these symptoms must cause "significant distress or impairment in social, occupational, or other important areas of functioning."[76] Finally, Criterion H states the disturbance must not be related to substances, such as alcohol or medications, or another underlying medical condition.[77]

What is A Traumatic Event?

When introduced in the DSM-III in 1980, the PTSD diagnosis was unique in the history of the DSM, as the post-traumatic diagnosis asserted a causal linkage between a traumatic event and its consecutive symptoms.[78] As such, the definition of what the APA constitutes as a "traumatic event" would become controversial amongst the psychiatric community, as the broadness or narrowness of the definition of a "traumatic event" would either expand or contract the number of PTSD diagnoses. [79] The definition of a "traumatic event" has been found in Criterion A of the PTSD diagnosis, which has been the source of "heated drama." [80] In fact, the APA admits in *Clinical Practice Guidelines for the Treatment of PTSD* that "the definition of psychological trauma has

---

[75] APA, *DSM-V-TR*, 301.

[76] APA, *DSM-V-TR*, 302.

[77] APA, *DSM-V-TR*, 303.

[78] Thomas Maier, "Post-Traumatic Stress Disorder Revisited: Deconstructing the A-Criterion," *Medical Hypothesis* 66 (2006): 104.

[79] Frank Weathers and Terence Keane, "The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma," *Journal of Traumatic Stress* 20, no. 2 (2007): 107.

[80] Weathers and Keane, "The Criterion A Problem Revisited," 107.

been widely debated and the delineation of a traumatic event in DSM (known as Criterion A) has gone through numerous revisions."[81]

The DSM-III defined PTSD as "the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience."[82] This definition of traumatic events proved controversial as the DSM-III described traumatic events as infrequent and aberrant on the world stage.[83] To the contrary, epidemiological studies have demonstrated exposure to traumatic events occurs frequently and, in the case of military combat or abusive relationships, can occur on a constant basis.[84] According to the National Center for PTSD, approximately 5 out of 100 persons in the U.S. struggles with a PTSD diagnosis every year, and, as of 2020, approximately 13 million Americans have had a PTSD diagnosis.[85] Wars, sexual assaults and other traumatic events have been common throughout the annals of history. In this vein, Judith Herman makes the following argument about traumatic events: "Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life."[86]

Subsequent revisions of the DSM did not quell the debate regarding the definition of a traumatic event. In 1987, a revision to the DSM-III (known as the DSM-III-R) emerged which clarified the definition of a traumatic event; however, the DSM-III-R added new controversy by allowing for the possibility that learning of threats or harm

---

[81] American Psychological Association, *Clinical Practice Guideline for the Treatment of PTSD*, February 24, 2017, https://www.apa.org/ptsd-guideline/ptsd.pdf.

[82] APA, *DSM-III*, 236.

[83] Weathers and Keane, "The Criterion A Problem Revisited," 107.

[84] Weathers and Keane, "The Criterion A Problem Revisited," 109.

[85] US Department of Veterans Affairs, "How Common Is PTSD In Adults?," accessed March 17, 2024, https://www.ptsd.va.gov/understand/common/common_adults.asp.

[86] Herman, *Trauma and Recovery*, 33.

to family or friends could qualify as a traumatic event.[87] Despite clarifications and changes to Criterion A in DSM-IV (1994), the issue of subjectivity and broadness of the PTSD diagnosis continued to trouble many in the psychiatric community, including Harvard professor Richard McNally and University of Washington professor Gerald Rosen.[88] In particular, McNally was concerned that the pressures upon medical professionals to provide "reimbursable treatment" of PTSD could lead to "conceptual bracket creep" or over-diagnosis of PTSD.[89] Similarly, Gerald Rosen pushed against subjectivity in the DSM's definition of a traumatic event:

> Without a clear basis for delineating traumatic events, and without brakes on the social forces that press for expansion, Posttraumatic Stress Disorder runs the risk of becoming a cultural narrative for significant human suffering after any type of event. If this happens, the study of PTSD will have turned on itself, engulfing the broader stress of human stress responses from which it emerged.[90]

Further editions of the DSM would highlight the uniqueness of the PTSD diagnosis based on its relationship to a traumatic event. In the DSM-V (2013), the APA shifted PTSD out of the spectrum of anxiety disorders and created a new category of "Trauma and Stressor-Related Disorders," which included PTSD, Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, Acute Stress Disorder and other specified trauma- and stressor-related disorders[91] While the PTSD diagnosis still involves anxiety, this shift acknowledged that trauma- and stressor-related disorders uniquely emanate from a traumatic event.[92] As a result, J. Douglas Bremner noted that an "odd

---

[87] Weathers and Keane, "The Criterion A Problem Revisited," 108.

[88] Richard J. McNally, "Can We Fix PTSD in DSM-V?," *Depression Anxiety* 26, no. 7 (2009): 597-600; Gerald Rosen, "Malingering and the PTSD Database," in *Post-Traumatic Stress Disorder: Issues and Controversies*, ed. Gerald M. Rosen (West Sussex, England: John Wiley and Sons, 2004).

[89] NcNally, "Can We Fix PTSD?," 597.

[90] Rosen, "Malingering and the PTSD Database," 88.

[91] APA, *DSM-V-TR*, 265-90.

[92] Curtis Solomon, "Evaluating the Legacy Program of the Mighty Oaks Foundation," (PhD diss., The Southern Baptist Theological Seminary, 2020), 14.

dichotomy" has historically existed between the PTSD diagnosis and other psychiatric disorders, as the DSM defined other disorders associated with trauma, such as depressive and anxiety disorders, solely by their symptoms instead of precipitating traumatic events.[93] While psychologists assume that most psychological diagnosis stem from internal sources, the diagnosis of PTSD uniquely asserts a person's cognitions and behaviors can emanate from exposure to extreme suffering, which is outside of the person.[94] Biblical counselor Curtis Solomon notes, "The connection to an event or events leads some to argue that it should be treated as an injury rather than an illness, which is the way most disorders in the DSM are addressed."[95]

This matter of the definition of traumatic events proves important to the discussion of EMDR. Francine Shapiro, the originator of EMDR, has expressed a broad view of traumatic events, defining trauma as "any event that has a lasting negative effect on the self or psyche."[96] Similarly, Shapiro has stated, "The Criterion A events . . . officially required to diagnose the (PTSD) condition were too limiting a conceptualization."[97] Instead, Shapiro argues for the existence of "small-T" and "large-T" traumas.[98] Shapiro describes large-T traumas as the large-scale life events that are dangerous, life-threatening and meet Criterion A of the DSM, such as natural disasters, sexual assault, terrorist events, or even automobile accidents. Conversely, small-T

---

[93] Bremner, *Does Stress Damage the Brain?*, 34.

[94] Horwitz, *PTSD: A Short History*, 3.

[95] Solomon, "Evaluating the Legacy Program of the Mighty Oaks Foundation," 14-15.

[96] Francine Shapiro, "Introduction: Paradigms, Processing, and Personality Development," In *EMDR as an Integrative Psychotherapy Approach*, ed. Francine Shapiro. 3rd ed. (Washington, DC: American Psychological Association, 2007), 14.

[97] Francine Shapiro, "EMDR. And Case Conceptualization from an Adaptive Information Processing Perspective," in *Handbooks of EMDR and Family Therapy Processes*, ed. Francine Shapiro, Florence Kaslow, and Louise Maxfield (Hoboken, NJ: John Wiley and Sons, 2007), 5.

[98] Francine Shapiro and Louise Maxfield, "EMDR and Information Processing in Psychotherapy Treatment: Personal Development and Global Implications," in *Healing Trauma: Attachment, Mind, Body and Brain*, ed. Marion Solomon and Daniel Siegel, Norton Series on Interpersonal Neurobiology (New York: W. W. Norton, 2003), 200-201.

traumas (also called "adverse life experiences") are more subtle and innocuous, but still negatively impacts how a person perceives themselves, others, and their world.[99] Shapiro argues that both small-T and large-T traumas work in the same manner: "Information from that experience has not been processed adequately, and that this recollection has within it some of the perceptions, emotions and cognitions from the actual event."[100] As any level of traumatic events can cause stubborn physiological and psychological problems, Shapiro argues that the discussion of PTSD should not be limited to the large-T traumas outlined by the DSM.[101] Ultimately, Shapiro offers a view of trauma different from the DSM's strict conception: "Any event can be a trauma."[102]

Prevalence of the PTSD Diagnosis

The DSM-V-TR reports that "the national lifetime prevalence estimate of PTSD using DSM-IV criteria 6.8% for U.S. adults."[103] However, the Institute of Medicine (IOM) suggests that PTSD is likely underreported as people often have PTSD symptoms for years without seeking professional treatment.[104] One of the groups with a high prevalence of PTSD diagnoses is military combatants. The lifetime incidence of PTSD is slightly higher in military veterans (7 percent) than the general population (6 percent).[105] In addition, lifetime prevalence of PTSD is higher amongst female combat

---

[99] Barbara J. Hensley, *An EMDR Therapy Primer: From Practicum to Practice*, 2nd ed. (New York: Springer, 2016), 3.

[100] Shapiro and Maxfield, "EMDR and Information Processing," 201.

[101] Francine Shapiro and Margot Silk Forrest, *EMDR: The Breakthrough "Eye Movement" Therapy for Overcoming Anxiety, Stress, and Trauma* (New York: Basic Books, 2016), 26-27.

[102] Shapiro, "Introduction: Paradigms, Processing, and Personality Development," 14.

[103] APA, *DSM-V-TR*, 308.

[104] Institute of Medicine of the National Academies, *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment* (Washington D.C.: National Academies Press, 2014), 35.

[105] US Department of Veterans Affairs, "How Common Is PTSD In Veterans?," accessed March 17, 2024, https://www.ptsd.va.gov/understand/common/common_veterans.asp.

veterans (13 percent) than male combat veterans (6 percent).[106] In addition, the lifetime incidence of PTSD varies by the service timeframe of the combat veteran: WWII/Korean War (3 percent), Vietnam War (10 percent), Persian Gulf War (Desert Storm) (21 percent) or Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF) (29 percent).[107]

Another group with a high prevalence of PTSD diagnoses is sexual assault survivors. The women's rights movement of the 1970s brought to light the medical and legal consequences of sexual assault, particularly in relationship to the PTSD diagnosis.[108] The Rape Abuse and Incest National Network reports, "1 out of every 6 American women has been the victim of an attempted or completed rape in her lifetime (14.8% completed, 2.8% attempted)."[109] Similarly, 3 percent of American men have experienced attempted or completed rape in their lifetime.[110] Over 12 million women in the U.S. have a lifetime history of PTSD resulting from rape, and rape sufferers represent the highest number of PTSD sufferers in the U.S.[111] In addition, the National Center for PTSD comments: "The experience of sexual assault may be more likely to lead to PTSD (assessed with DSM-IV criteria) than other types of traumatic events."[112] In fact, the National Comorbidity Survey found that "sixty-five percent of men and 45.9 percent of

---

[106] US Department of Veterans Affairs, "Epidemiology and Impact of PTSD," accessed March 17, 2024, https://www.ptsd.va.gov/professional/treat/essentials/epidemiology.asp.

[107] US Department of Veterans Affairs, "How Common is PTSD in Veterans?"

[108] Herman, *Trauma and Recovery*, 28-32.

[109] RAINN (Rape, Abuse and Incest National Network), "Scope of the Problem: Statistics," accessed March 17, 2024, https://www.rainn.org/statistics/scope-problem.

[110] RAINN, "Scope of the Problem: Statistics."

[111] Barbara O. Rothbaum, Millie C. Astin, and Fred Marsteller, "Prolonged Exposure Versus Eye Movement Desensitization and Reprocessing (EMDR) for PTSD Rape Victims," *Journal of Traumatic Stress* 18, no. 6 (2005): 607.

[112] US Department of Veterans Affairs, "Sexual Assault Experienced as an Adult," accessed March 17, 2024, https://www.ptsd.va.gov/professional/treat/type/sexual_assault_adult.asp.

women who reported (rape) as their most upsetting trauma developed PTSD."[113]

A PTSD diagnosis is closely associated with other physiological and psychological problems.[114] According to the National Comorbidity Survey, Kessler et al. found a higher incidence of alcohol and drug abuse amongst those diagnosed with PTSD than those with no PTSD diagnosis.[115] Persons with a PTSD diagnosis have a higher risk for forms of cardiovascular disease, such as coronary heart disease, hypertension and possibly stroke.[116] In addition, chronic cases of PTSD can lead to depression, suicidal behavior and other high risk behaviors, such as excessive alcohol use and engagement in dangerous activities.[117] Without intervention, untreated symptoms can prove to the be highly dangerous for PTSD sufferers on both physiological and psychological levels.

PTSD Treatment Options

When Francine Shapiro began her work on EMDR in the 1980s, the landscape of research into PTSD treatment was still gestating, and mental health professionals had a limited number of treatment options. Howard Lipke, who worked at the Chicago Veterans Affairs Medical Center, described the milieu of PTSD treatment in the 1980s: "Lots of clinicians shied away from treating PTSD. It brought up too many negative feelings . . . There was not much we could do with intrusive memories, especially combat-related."[118] During the 1980s, the most common treatment options were

---

[113] Kessler et al., "Posttraumatic Stress Disorder," 1053.

[114] Institute of Medicine of the National Academies, *Treatment for Posttraumatic Stress Disorder*, 34.

[115] Kessler et al., "Posttraumatic Stress Disorder," 1056.

[116] Steven S. Coughlin, "Post-traumatic Stress Disorder and Cardiovascular Disease," *The Open Cardiovascular Medicine Journal* 5 (2011): 168.

[117] Institute of Medicine of the National Academies, *Treatment for Posttraumatic Stress Disorder*, 34.

[118] Hara Estroff Marano, "Wave of the Future," Psychology Today, last modified June 9, 2016, https://www.psychologytoday.com/us/articles/199407/wave-the-future.

variations of exposure therapy, where psychologists exposed their clients to memories and images of their fears in a safe environment. Common forms of exposure therapy that psychologists used to treat PTSD during this time, included flooding (exposing clients to their most extreme fears first) and systematic desensitization (combining relaxation techniques with exposure to fears).[119] In 1987, researchers had only completed one published randomized study on PTSD treatment, which explored the impacts of exposure therapy on combat veterans.[120] During this time, pharma-psychology was still in its infancy, and clinicians did not commonly treat PTSD through pharmaceuticals.[121] During the 1980s, many clinicians—particularly at the VA—found veterans with a PTSD diagnosis to be intractable, and were frustrated that many available treatment options were painfully slow in helping suffering veterans.[122]

As the number of PTSD treatment options have grown, multiple organizations, including the American Psychological Association (APA), the Veterans Health Administration and Department of Defense (VA/DoD), and the Institute of Medicine (IOM), have developed clinical practice guidelines for the treatment of PTSD.[123] Clinical practice guidelines "are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."[124]

---

[119] Judith Lyons and Terence M. Keane, "Implosive Therapy for the Treatment of Combat-Related PTSD," *Journal of Traumatic Stress* 2, no. 2 (1989): 137-38.

[120] Marilyn Luber and Francine Shapiro, "Interview with Francine Shapiro: Historical Overview, Present Issues, and Future Directions of EMDR," *Journal of EMDR Practice and Research* 3, no. 4 (2009): 219.

[121] Luber and Shapiro, "Interview with Francine Shapiro," 219.

[122] Francine Shapiro, *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (New York: Rodale, 2012), 26.

[123] American Psychological Association, *Clinical Practice Guideline for the Treatment of PTSD*; Department of Veterans Affairs, *VA/DOD Clinical Practice Guideline for the Management of Post-Traumatic Stress Disorder and Acute Stress Disorder*, June 2017, https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf; Institute of Medicine of the National Academies, *Treatment of Post-Traumatic Stress Disorder: An Assessment of the Evidence* (Washington DC: National Academies Press, 2008).

[124] Department of Veterans Affairs, *VA/DOD Clinical Practice Guideline*, 8.

These clinical practice guidelines, which are based on systematic literature reviews of treatment options, represent treatment recommendations to the medical community and are not any form of mandatory treatment requirements.[125]

Due to different methodological considerations, each set of clinical practice guidelines has a different analysis of the effective, evidence-based forms of treatment of PTSD. The APA defines an "evidence-based" practice (EBP) as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."[126] The IOM's *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence* (2008) only recommends prolonged exposure (PE) therapy as a psychotherapeutic treatment option for PTSD.[127] In contrast, the APA's *Clinical Practice Guidelines for the Treatment of PTSD* (2017) strongly recommends cognitive-behavior therapy (CBT), cognitive processing theory (CPT), prolonged exposure (PE) and cognitive therapy (CT) as effective psychotherapies for the treatment of PTSD.[128] In terms of EMDR, the APA's guidelines state "EMDR received a conditional recommendation because of low strength of evidence for the critical outcome of PTSD symptom reduction."[129] Finally, the VA/DoD's *Clinical Practice Guideline for the Management of PTSD* (2023) guidelines strongly recommends cognitive processing theory (CPT), prolonged exposure (PE) and EMDR as valid psychotherapies for the

---

[125] Laura Watkins, Kelsey R. Spring, and Barbara O. Rothbaum, "Treating PTSD: A Review of Evidence-Based Psychotherapy Interventions," *Frontiers in Behavioral Neuroscience* 12 (2018): 2.

[126] American Psychological Association, "Policy Statement on Evidence-Based Practice in Psychology," Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder, last modified July 31, 2017, https://www.apa.org/practice/guidelines/evidence-based-statement.

[127] Institute of Medicine of the National Academies, *Treatment of Post-Traumatic Stress Disorder*, 8-9.

[128] American Psychological Association. *Clinical Practice Guideline for the Treatment of PTSD*.

[129] American Psychological Association. *Clinical Practice Guideline for the Treatment of PTSD*.

treatment of EMDR.[130]

As it would prove difficult to evaluate all the treatment options for PTSD, this study will supply a brief overview of the strongly recommended PTSD treatment options from the VA/DoD's clinical practice guidelines, which represents one of the most current professional clinical practice guidelines for PTSD. The rest of this section will discuss cognitive-processing theory (CPT) and prolonged exposure (PE) as methods of treatment for PTSD, and EMDR will subsequently be discussed throughout the course of the rest of this study.

Cognitive Processing Theory

Cognitive processing theory (CPT) is a short-term cognitive behavior therapy developed in the 1980s by Patricia Resick to treat PTSD symptoms.[131] The goal of CPT is to change how a trauma survivor thinks about the traumatic event.[132] Traumatic events can often make survivors distort their cognitions about themselves, others and the world as survivors work to make sense of these events.[133] CPT is based on the social-cognitive theories of PTSD, which "focus more on the content of cognitions and the effect that distorted cognitions have on emotional response and behavior"[134]

CPT holds that survivors of traumatic events generally do one of three things with new information regarding the event: Assimilate, accommodate or over-

---

[130] Department of Veterans Affairs, *VA/DOD Clinical Practice Guideline*.

[131] Patricia A. Resick, Shannon W. Stirman, and Stefanie T. LosSavio, *Getting Unstuck from PTSD: Using Cognitive Processing Therapy to Guide Your Recovery* (New York: Guilford Press, 2023), 5.

[132] Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 9.

[133] Watkins, Spring, and Rothbaum, "Treating PTSD: A Review of Evidence-Based Psychotherapy Interventions," 4.

[134] American Psychological Association, *Cognitive Processing Theory Military/Veteran Version: Therapist and Patient Material Manual*, May 2014, https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-patient.pdf.

accommodate.[135] On one end of the spectrum, trauma survivors often "assimilate" the traumatic event by making it fit into their previous belief systems.[136] In essence, the survivor changes their interpretation or memory of the event instead of changing their beliefs (i.e. "If only I hadn't done such-and-such, this wouldn't have happened.").[137] On the other end of the spectrum, trauma survivors can over-accommodate, meaning that survivors "go overboard" by modifying their belief systems to extreme levels to integrate information regarding the event.[138] For example, a trauma survivor might believe that they have control over their life's events prior to the traumatic event, and then believes that they have no control over life's events after the traumatic event. As a result of assimilation or over-accommodation, the trauma survivor might develop new emotions that are solely based on the cognitions manufactured by the traumatic event.[139] In short, the traumatic event creates "stuck points" in the survivor's life, where negative cognitions created by traumatic events ultimately lead to manufactured emotions.[140] The goal of CPT is for the survivor to move beyond "stuck points" to accommodation, which is "balanced thinking that takes into account the reality of the traumatic event without going overboard."[141]

---

[135] Amy Williams, Tara E. Galovski, and Patricia Resick, "Cognitive Processing Theory," in *Treating PTSD in Military Personnel*, ed. Bret A. Moore and Walter E. Penck. 2nd ed. (New York: Guilford Press, 2019), 64.

[136] Williams, Galovski, and Resick, "Cognitive Processing Theory," 65; Resick, Stirman, and LosSavio, *Getting Unstuck from PTSD*, 41.

[137] Resick, Stirman, and LosSavio, *Getting Unstuck from PTSD*, 41.

[138] Resick, Stirman, and LosSavio, *Getting Unstuck from PTSD*, 41.

[139] Williams, Galovski and Resick, "Cognitive Processing Theory," 64-63.

[140] Resick, Stirman, and LosSavio, *Getting Unstuck from PTSD*, 44.

[141] Williams, Galovski, and Resick, "Cognitive Processing Theory," 65; Watkins, Spring, and Rothbaum, "Treating PTSD," 4.

The VA/DoD clinical treatment guidelines currently states that CPT normally requires 10-12 weekly sessions lasting 60 to 90 minutes in length.[142] The three phases of CPT treatment start with education of the client regarding trauma and identification of "stuck points."[143] Next, CPT moves into a challenge phase where the clinician uses the Socratic Method to logically challenge the trauma survivor's "stuck points."[144] Finally, the clinician works with their clients to change their maladaptive cognitions and to re-evaluate their emotional responses to trauma.[145] The limitations of CPT are connected to the PTSD sufferer's avoidance of traumatic situations and memories, as trauma survivors may look to avoid the probing and time-consuming homework assignments associated with CPT.[146]

Prolonged Exposure Therapy

Prolonged exposure (PE) therapy is a form of cognitive behavior therapy (CBT) designed to help people face the fears and control the responses associated with their traumatic experiences.[147] PE is one of the most researched PTSD interventions, where medical researchers have conducted 65 randomized clinical trials (RCTs) on the treatment of PTSD.[148]

---

[142] Department of Veterans Affairs, *VA/DOD Clinical Practice Guideline*.

[143] Williams, Galovski, and Resick, "Cognitive Processing Theory," 66.

[144] American Psychological Association, *Cognitive Processing Theory Military/Veteran Version.*

[145] Williams, Galovski, and Resick, "Cognitive Processing Theory," 66.

[146] Williams, Galovski, and Resick, "Cognitive Processing Theory," 71-72.

[147] Buono, "Post-Traumatic Stress Disorder," 273; Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 9; Alan L. Peterson, Edna B. Foa, and David S. Riggs, "Prolonged Exposure Therapy," in Moore and Penck, *Treating PTSD in Military Personnel*, 46.

[148] US Department of Veterans Affairs, "Prolonged Exposure for PTSD," accessed March 17, 2024, https://www.ptsd.va.gov/professional/treat/txessentials/prolonged_exposure_pro.asp.

The theoretical model behind PE is emotional processing theory (EPT), which was developed by Edna Foa and Michael Kozak in 1989.[149] Persons with anxiety disorders often associate a stimulus most would consider safe (i.e. going to the grocery store) with physiological distress (i.e. increased heart rate) and negative cognitions ("I'm not safe here").[150] Therefore, EPT holds that people with anxiety disorders engage in heightened avoidance behavior when exposed to fear stimuli, and the solution is to stay in fearful situations long enough to "habituate"—or create new responses—to the stimuli.[151] The core of PE is teaching people to confront instead of avoiding fears.[152]

The VA/DoD clinical treatment guidelines currently states that PE normally requires 10-12 weekly sessions lasting 60 to 90 minutes in length.[153] The four principal components of PE are psychoeducation, imaginal exposure, in vivo exposure and breathing retraining.[154] PE sessions begin with psychoeducation, which is educational teaching about the body's traumatic responses, and breathing training, which is training on responding to traumatic events with slow and relaxed breathing.[155] Next, the treatment continues into imaginal exposure, where the client interacts with memories of the traumatic event to "change inaccurate, trauma-related cognitions."[156] Finally, the treatment moves into in-vivo exposure to traumatic event, where the client interacts with

---

[149] Dean Lauterbach and Sarah Reiland, "Exposure Therapy and Post-Traumatic Stress Disorder," in *Handbook of Exposure Therapies*, ed. David C. S. Richard and Dean Lauterbach (Burlington, MA: Academic Press, 2007), 129-30.

[150] US Department of Veterans Affairs, "Prolonged Exposure for PTSD."

[151] Lauterbach and Reiland, "Exposure Therapy and Post-Traumatic Stress Disorder," 129-30.

[152] Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 47.

[153] US Department of Veterans Affairs, "Prolonged Exposure for PTSD;" Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 46.

[154] Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 46.

[155] Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 48.

[156] Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 47; Watkins, Spring, and Rothbaum, "Treating PTSD," 3.

people, situations or objects that they have been avoiding.[157] Prolonged exposure holds that the treatment has been successful when traumatic events or memories no longer elicit "extreme negative responses or meanings."[158]

In terms of strengths and limitations, proponents of exposure therapy hold that exposure to traumatic memories in a controlled and safe environment aids the healing process.[159] The principal limitation of exposure therapy is the concern that exposure to traumatic memories could lead to heightened stress levels, high dropout rates and exacerbation of PTSD symptoms.[160] While the APA and VA/DoD consider PE to be effective form of PTSD treatment, Lauterbach and Reiland note, "A substantial percentage (30% to 40%) would be classified as treatment failures, by virtue of either premature termination or nonresponsiveness."[161]

The Development of EMDR

Francine Shapiro's interest in the field of trauma begins with her own personal journey with cancer. In the 1970s, Shapiro was pursuing a PhD in English literature in New York City. In 1978-1979, Shapiro experienced surgery and radiation as treatment for cancer, and left the experience pondering the connections between mind and body in healing.[162] During this same timeframe, Shapiro learned that her sister, who died at age nine, suffered from a form of colitis.[163] Shapiro came to believe that her cancer and her sister's colitis were both stress-induced, and began searching for "ways to use the mind

---

[157] Watkins, Spring, and Rothbaum, "Treating PTSD," 3.

[158] US Department of Veterans Affairs, "Prolonged Exposure for PTSD."

[159] Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 10.

[160] Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 54.

[161] Lauterbach and Reiland, "Exposure Therapy and Post-Traumatic Stress Disorder," 147.

[162] Shapiro and Forrest, *EMDR*, 20.

[163] Shapiro and Forrest, *EMDR*, 20.

or the body to cope with stress so we wouldn't damage our health in the first place."[164] Shapiro's belief about the mind's impact on the body was influenced the popular work of Norman Cousins, a reporter for the *Saturday Review* who experienced a second career in researching the connection between positive thinking and recovery from illnesses. Along with researchers at UCLA, Cousins's research demonstrated that laughter and positive thinking had a positive impact on the body's immune system.[165] Shapiro's new interest in mind-body connections created a massive shift in her life, where she moved to California and enrolled in alternative workshops in meditation, hypnosis and other New Age forms of therapy.[166] Shapiro often states that she would use her own body to "experiment" on the mind-body connection, attempting to figure out what forms of alternative treatment worked.[167] Ultimately, Shapiro would switch career paths to pursue a doctorate in clinical psychology at the Professional School for Psychological Studies, a non-accredited San Diego university.

In the early 1980s, Shapiro formed the Human Development Institute (HDI), which conducted seminars in the neuro-linguistic programming (NLP) technique.[168] NLP is a "set of procedures developed to influence and change the behaviors and beliefs of a target person."[169] Linguistics professor John Grinder and hypnotherapist Richard Bandler developed NLP by researching why various psychologists and businessmen were

---

[164] Shapiro and Forrest, *EMDR*, 20; Dan McLean, "Aiming at Superachievers: NLP, Influencing Anybody to Do Just About Anything," *Los Angeles Times*, February 13, 1985.

[165] John D. Lentz, "In the Spirit of Therapy: Interview with Francine Shapiro, Ph.D." *Milton H. Erickson Foundation Newsletter* 33, no. 2 (2013): 1.

[166] Nancy Wartik, "The Amazingly Simple, Inexplicable Therapy That Just Might Work: Is EMDR Psychology's Magic Wand or Just Some Hocus Pocus?," *Los Angeles Times*, August 7, 1994.

[167] Luber and Shapiro, "Interview with Francine Shapiro," 218.

[168] Dan McLean, "Aiming at Superachievers."

[169] David Druckman and John Swets, *Enhancing Human Performance: Issues, Theories and Techniques* (Washington, DC: National Academy of Science, 1988), 6.

successful.[170] NLP practices involve the tracking of eye movements to determine the thought processes of people.[171] In 1988, the *Los Angeles Times* summarized NLP,

> NLP, an amalgam of linguistics and hypnosis, studied how people influence each other in subconscious ways. Bandler and Grinder claimed that therapists could use NLP techniques—scanning a patient's eye movements, speech pattern, body language, changes in skin tone or breathing—for a quick fix on the patient's problem. Then hypnotic techniques could be used to reprogram behavior.[172]

Since Grinder and Brandler published their initial NLP work, *The Structure of Magic Vol. 1*, in 1975, NLP proponents have offered little scientific research to support the NLP technique.[173] In 1988, the US Army Research Institute investigated NLP and determined that there is "no scientific evidence to support the claim that neurolinguistic programming is an effective strategy for exerting influence."[174] While most accounts of Shapiro's personal biography and EMDR's development have omitted a connection to NLP, Gerald Rosen has recently unearthed contributions by Shapiro in the 1980s to NLP literature.[175] In 1995, psychologist Bruce Grimley was the first to accuse Shapiro of using the eye movement aspects of NLP as the true foundation of EMDR.[176] Subsequently, various NLP advocates have come forward to accuse Shapiro of borrowing EMDR's eye

---

[170] Gareth Roderique-Davis, "Neuro-Linguistic Programming: Cargo Cult Psychology?," *Journal of Applied Research in Higher Education* 1, no. 2 (2009): 59.

[171] Francine Shapiro, "Neuro-Linguistic Programming: The New Success Technology," *Holistic Life Magazine* (Summer 1995): 41-43.

[172] Miles Corwin, "Bizarre Case Shows Flaky Underside of Santa Cruz," *Los Angeles Times*, January 28, 1988.

[173] Gerald Rosen, "Revisiting the Origin of EMDR," *Journal of Contemporary Psychotherapy* 53, no. 4 (2023): 291-92.

[174] Druckman and Swets, *Enhancing Human Performance*, 21.

[175] Dan McLean, "Aiming at Superachievers;" Francine Shapiro, "Neuro-Linguistic Programming," 41-43; J. Bonasia, "Success: Why It Eludes Some of Us and How to Obtain It," *La Costan*, January 10, 1985.

[176] Bruce Grimley, "Origins of EMDR—A Question of Integrity?," *Psychologist* 27 (2014): 561.

movement techniques from NLP practitioners.[177] Recently, a 2023 article by Gerald Rosen argues, "Whatever reasons Shapiro had for reconstructing her history and the origins of EMDR it is time to consider the therapeutic use of eye movement patterns in a full and accurate context."[178]

A Walk in the Park

Shapiro commonly refers to the conception of EMDR as a "chance discovery."[179] In May 1987, Shapiro was walking in a park in Los Gatos, California. As she walked, she suddenly realized that some distressing thoughts that were burdening her had gone silent. When she returned to thinking about these distressing thoughts, she noticed that the "negative charge" surrounding those thoughts was gone.[180] When she attempted to figure out why the negative emotions had left, she pinned down the reason to rapid eye movements that her body was spontaneously making while processing the negative thoughts. When she brought back these disturbing memories into her mind, she found that the "upsetting" nature of the memories disappeared and dissipated.[181] In *Getting Past Your Past*, Shapiro recounts her thoughts after her initial discovery:

> I was surprised and wondered what caused this reaction. So as I walked along, I started to pay careful attention. I noticed that when the kind of thought came to mind, my eyes started moving very rapidly back and forth diagonally in a certain way. Then the thought shifted from my consciousness. When I brought it back again, it had lost its power. This fascinated me, so I started doing it deliberately. I brought up something that bothered me, and I started doing the eye movements. The same thing happened. My feelings changed.[182]

---

[177] NLP Akademie Schweiz, "EMDR, EMI and Wingwave," last modified April 7, 2021, https://www.nlp.ch/pdfdocs/Historie_EMDR_Wingwave.pdf.

[178] Rosen, "Revisiting the Origins of EMDR," 294.

[179] Luber and Shapiro, "Interview with Francine Shapiro," 218.

[180] Shapiro and Forrest, *EMDR*, 21.

[181] Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd ed. (New York: Guilford Press, 2017), 2.

[182] Shapiro, *Getting Past Your Past*, 24.

After this incident in the park, Shapiro began to deliberately attempt to use rapid eye movements to subdue disturbing thoughts. Shapiro noticed that her eye movements were able to overcome the "negative emotional charge" associated with negative thoughts every time.[183]

After her discovery, Shapiro began to conduct experiments regarding eye movements and disturbing thoughts on willing participants, including friends, students and colleagues. While all the participants had negatively charged thoughts, none of these participants had traumas deemed worthy of psychotherapy.[184] Shapiro noted that the use of eye movements seemed to work on her collaborators; however, she noticed that she would often need to use her fingers to help guide the necessary eye movements of other persons. As Shapiro continued to research her discovery, she believed that she had tapped into "the brain's natural healing process."[185]

Of importance, Shapiro began work on EMDR believing that her new form of therapy was a form of exposure therapy.[186] Shapiro's research was greatly impacted by the work of Joseph Wolpe, who was famous for his work in systematic desensitization.[187] Wolpe's systematic desensitization technique sought to combine relaxation techniques with the gradual exposure to traumatic memories. Originally, Shapiro believed that her technique worked similarly to systematic desensitization, where the clinician desensitized survivors to their trauma through the assistance of eye movements.[188] When Shapiro

---

[183] Shapiro and Forrest, *EMDR*, 21.

[184] Shapiro and Forrest, *EMDR*, 21.

[185] Shapiro, *Getting Past Your Past*, 25.

[186] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 12-13.

[187] Luber and Shapiro, "Interview with Francine Shapiro," 218.

[188] Shapiro and Maxfield, "EMDR and Information Processing in Psychotherapy Treatment," 196.

initially named her new technique, the name was an homage to systematic desensitization: Eye Movement Desensitization (EMD).[189]

The EMD Pilot Study

In November 1987, Shapiro began her first official controlled study on the efficacy of EMD.[190] Shapiro used EMD as the subject of her doctoral dissertation at the Professional School for Psychological Studies.[191] The pilot study analyzed twenty-two patients with long-standing (one or more years) of PTSD symptoms due to sexual assault, child molestation or combat. Shapiro found subjects at two sexual assault counseling centers and one veterans outreach program in northern California.[192] Shapiro gave the EMD treatment to half of the participants, and the other half were the control group, receiving talk therapy, which Shapiro considered an inert placebo treatment.[193] Shapiro used three measurements to determine the efficacy of the different treatments. First, Shapiro utilized the measurement Subjective Units of Disturbance (SUD), which was associated with systematic desensitization. In this measurement, the patient rates how disturbing the traumatic event makes them feel on a scale from 0 (no disturbance) to 10 (greatest disturbance imaginable) before and after treatment.[194] Second, Shapiro asked her clients to measure their negative core beliefs (i.e., "I am worthless," "I'm damaged goods," etc.) on a scale from 1 (completely false) to 7 (completely true) before and after treatment.[195] Shapiro would entitle this measurement as Validity of Cognition (VOC).

---

[189] Wartik, "The Amazingly Simple, Inexplicable Therapy That Just Might Work."

[190] Shapiro, *Eye Movement Desensitization and Reprocessing*, 8.

[191] Rosen, "Revisiting the Origins of EMDR," 289.

[192] Shapiro, *Eye Movement Desensitization and Reprocessing*, 8-9.

[193] Francine Shapiro, "Efficacy of the Eye Movement Desensitization Procedure in the Treatment of Traumatic Memories," *Journal of Traumatic Stress* 2, no. 2 (1989): 202.

[194] Shapiro and Forrest, *EMDR*, 29.

[195] Shapiro and Forrest, *EMDR*, 29.

Finally, Shapiro measured the client's presenting PTSD symptoms to determine whether these symptoms were reduced over the course of the treatment. Over the course of three months, the study measured the patients' SUDs, VOCs and PTSD symptoms to see the impact of EMD treatment and the placebo treatment.

Overall, Shapiro's initial controlled study found that the EMD treatment had a positive impact on her clients. In the EMD treatment group, participants saw a significant reduction in anxiety (as measured in SUDs), changes in negative cognitions (as measured in VOCs) and reduction in presenting problems. Astonishingly, Shapiro reported that "alleviation of presenting complaints occurred for all subjects."[196] Even at this early stage, observers of Shapiro's EMD technique began to wonder why her technique worked:

> Indeed, when I was using EMD at that first vet center, I was videotaping sessions, and the other clinicians were observing the tapes. I remember saying to them, "All I am doing is the eye movements." And, they turned to me and said, "No, you are not. You are doing much more than that." I had to really pay attention to all of the other elements that were involved, and that was wonderful to have that feedback from other people because it did open my awareness to all of the things that I was bringing into it that was simply natural for me. It was simply who I was.[197]

Over the course of 1988, Shapiro made follow-up interviews with the clients from the initial study, and determined that the EMD treatment had long-term, lasting positive impacts on her clients. All but one of her clients experienced no negative recurrence or changes in their PTSD symptoms.[198]

When Shapiro published the report of her controlled study in 1988, Shapiro makes some self-described "conjectures" about how her EMD procedure worked.[199] As Shapiro originally conceived EMD as an iteration of systematic desensitization, she

---

[196] Shapiro, "Efficacy of the Eye Movement Desensitization Procedure," 216.

[197] Luber and Shapiro, "Interview with Francine Shapiro," 225.

[198] Shapiro and Forrest, *EMDR*, 36.

[199] Shapiro, "Efficacy of the Eye Movement Desensitization Procedure," 219.

needed to explain why EMD had far better results than other forms of exposure therapy. Since both exposure therapy and EMD involved exposure to traumatic memories, the process of memory exposure was considered not to be the critical component of change. As the key difference between exposure therapy and EMD was the addition of the eye movements, Shapiro believed that the eye movements must have generated the positive change in results. Shapiro states, "It would therefore appear, congruent with the author's personal experience, that the crucial component of the EMD procedure is the repeated eye movements while the memory is maintained in awareness."[200] Shapiro further elaborated that she believed that the eye movements were saccadic, mimicking the eye movements that people experience during sleep. As such, Shapiro believed that the eye movements triggered the self-healing process the body naturally generates during REM sleep. The introduction of the saccadic eye movements would allow the individual to become desensitized to their traumatic memories.

However, the most controversial claim of the pilot study was the rapid reduction of the symptoms of PTSD. In the published results of her pilot study, Shapiro stated: "The evidence clearly indicates that a single session of the EMD procedure is effective in desensitizing memories of traumatic incidents and changing the subjects' cognitive assessments of their individual situations."[201] As a result, incredulousness began to rise amongst many researchers and clinicians, who found Shapiro's claim to be incongruent with their experiences with the difficulty of treating PTSD.[202] In 2009, Shapiro believed that her pronouncement of EMDR's rapid results sabotaged studies by early researchers: "It was wrongly assumed that the entire treatment could consist of a

---

[200] Shapiro, "Efficacy of the Eye Movement Desensitization Procedure," 220.

[201] Shapiro, "Efficacy of the Eye Movement Desensitization Procedure," 216.

[202] Robert Oswalt et al., "Evaluation of the One-Session Eye-Movement Desensitization Reprocessing Procedure for Eliminating Traumatic Memories," *Psychological Reports* 73, no. 1 (1993): 104.

very short amount of time."[203]

Early EMD Research

During her pilot study, EMDR received a major endorsement from Shapiro's well-regarded mentor, Joseph Wolpe, which served to give EMD credibility in the psychiatric community.[204] In 1988, Shapiro approached Wolpe with the results of her initial pilot study, so Wolpe endeavored to try out the procedure for himself. As a result of dabbling with the procedure, Wolpe published his own EMDR case study in 1991. Wolpe conducted EMD therapy sessions with a forty-three year old rape survivor, who experienced anxiety regarding being raped again.[205] At the end of fifteen sessions, the rape survivor stated that she no longer lived in fear of being raped again, and no longer believed that another rape would cause her death.[206] Wolpe found the results of his own study to be astonishing: "There are certain cases where eye movement desensitization is dramatically rapid, cases that, as far as I know, are unparalleled. I published one study of a woman who had been traumatized by a rape nine years ago. She had not improved at all with other therapy. With this, she was virtually cured after seven sessions. It was striking."[207]

After Wolpe's endorsement, word of Shapiro's new form of PTSD treatment spread rapidly throughout the psychiatric community. In particular, the US Veterans Administration (VA) was intrigued by the technique, since the VA believed that PTSD in

---

[203] Luber and Shapiro, "Interview with Francine Shapiro," 221.

[204] Wartik, "The Amazingly Simple, Inexplicable Therapy That Just Might Work."

[205] Joseph Wolpe and Janet Abrams, "Post-Traumatic Stress Overcome by Eye-Movement Desensitization: A Case Report," *Journal of Behavior Therapy and Experimental Psychiatry* 22, no. 1 (1991): 41-43

[206] Wolpe and Abrams, "Post-Traumatic Stress Overcome by Eye-Movement," 43.

[207] Wartik, "The Amazingly Simple, Inexplicable Therapy That Just Might Work."

veterans—particularly Vietnam veterans—was nearly impossible to treat.[208] As a result, the VA commissioned several studies regarding the impact of EMD on PTSD in veterans, including a 1993 pilot study conducted by Boudewyns, Stwertka, Hyer, Albrecht, and Sperr on EMD in Vietnam veterans.[209] This study produced mixed results, showing that subjects had a lower level of self-reported subjective units of disturbance (SUDs) using EMDR as compared to exposure therapy. [210] However, the study's physiological and psychophysiological outcome measures did not support the effectiveness of EMDR.[211] Similarly, a 1995 controlled study of Vietnam veterans by Pitman, Orr, Altman, Longpre, Poire and Macklin compared the EMDR procedures with and without the eye movements.[212] Ultimately, the Pitman et al. study concluded that the eye movements in the EMDR procedures were not efficacious: "Data do not support a role for eye movements in emotional processing during EMDR."[213]

In the broader psychiatric community, the research conducted into EMDR in the 1990s was mired by controversy.[214] Many of the initial published reports touting the positive effects of EMDR were case studies, which offered anecdotal accounts of EMDR use without substantial methodological rigor.[215] In 1996, Scott Lilienfeld reported that eight case studies had been published on EMDR, but these cases studies were "seriously

---

[208] Wartik, "The Amazingly Simple, Inexplicable Therapy That Just Might Work."

[209] Patrick A. Boudewyns et al., "Eye Movement Desensitization for PTSD of Combat: A Treatment Outcome Pilot Study," *Behavior Therapist* 16, no. 2 (1993): 29-33.

[210] Boudewyns et al., "Eye Movement Desensitization for PTSD of Combat," 32.

[211] Boudewyns et al., "Eye Movement Desensitization for PTSD of Combat," 32.

[212] Roger K. Pitman et al., "Emotional Processing during Eye Movement Desensitization and Reprocessing Therapy of Vietnam Veterans with Chronic Posttraumatic Stress Disorder," *Comprehensive Psychiatry* 37, no. 6 (1996): 426-27.

[213] Pitman et al., "Emotional Processing during Eye Movement Desensitization ," 426-27.

[214] Grant Devilly, "Eye Movement Desensitization and Reprocessing: A Chronology of Its Development and Scientific Standing," *Scientific Review of Mental Health Practice* 1, no. 2 (2002): 113-38.

[215] Devilly, "Eye Movement Desensitization and Reprocessing," 117.

flawed as persuasive evidence of its effectiveness."[216] In a 1998 review, Kathryn MacCluskie criticized that all the outcomes of these case studies were based on the subjective self-reporting measures, such as SUDs, instead of objective measures.[217]

Once more rigorous controlled research studies began to emerge, their findings were mixed. Aside from Shapiro's 1989 pilot study, controlled research studies by Jensen (1994)[218], Wilson et al. (1995)[219] and Carlson et al. (1998)[220] showed that EMDR treatment had a positive effect on PTSD symptoms. However, controlled research studies by Sanderson and Carpenter (1992),[221] Lohr et al. (1995),[222] DeBell and Jones (1997),[223] and Devilly, Spence and Rapee (1998)[224] found less than compelling results of the efficacy of EMDR treatment. Overall, MacCluskie offered a summary of the state of research at this timeframe: "The literature is replete with studies supporting EMDR, refuting the efficacy of EMDR, and criticizing the research on either side of the

---

[216] Scott Lilienfeld, "EMDR Treatment: Less Than Meets the Eye," *Skeptical Inquirer* 20, no. 1 (1996): 27-28.

[217] Kathryn MacCluskie, "A Review of Eye Movement Desensitization and Reprocessing (EMDR): Research Findings and Implications for Counselors," *Canadian Journal of Counselling* 32, no. 2 (1998): 122.

[218] James Jensen, "Efficacy of Eye Movement Desensitization and Reprocessing as a Treatment for PTSD Symptoms of Vietnam Combat Veterans," *Behavior Therapy* 25 (1992): 311-25.

[219] Sandra Wilson, Lee Becker, and Robert Tinker, "Eye Movement Desensitization and Reprocessing (EMDR) Treatment for Psychologically Traumatized Individuals," *Journal of Consulting and Clinical Psychology* 63, no.6 (1995): 928-37.

[220] John Carlson et al., "Eye Movement Desensitization and Reprocessing (EMDR): Treatment for Combat-Related Post-Traumatic Stress Disorder," *Journal of Traumatic Stress* 11, no. 1 (1998): 3-24.

[221] Alan Sanderson and Roger Carpenter, "Eye Movement Desensitization Versus Image Confrontation: A Single-Session Crossover Study of 58 Phobic Subjects," *Journal of Behavior Therapy and Experimental Psychiatry* 23 (1992): 269-75.

[222] Jeffrey Lohr, David F. Tolin, and Scott O. Lilienfeld, "Efficacy of Eye Movement Desensitization and Reprocessing: Implications for Behavior Therapy," 123-56.

[223] Camille DeBell and R. Deniece Jones, "As Good as It Seems? A Review of EMDR Experimental Research," *Professional Psychology: Research and Practice* 28, no. 2 (April 1997): 153-63.

[224] Grant Devilly, Susan Spence, and Ronald Rapee, "Statistical and Reliable Change with Eye Movement Desensitization and Reprocessing: Treating Trauma Within a Veteran Population," *Behavior Therapy* 29 (1998): 435-55.

debate."[225]

A common focus amongst the early research was on the efficacy of the eye movement aspect of EMDR.[226] In 1994, George Renfrey and Richard Spates conducted the first partial dismantling study into the efficacy of eye movements and concluded that "eye movements do not appear to play a necessary role" in the overall outcome of EMDR treatment.[227] In 2002, Grant Devilly summarized the results of the dismantling studies into the efficacy of eye movements:

> Eleven out of the 13 dismantling studies assessing the utility of eye movements found no significant benefit to their inclusion in the procedure. The two studies that did find a superiority for eye movements (Shapiro, 1989; Wilson et al., 1996) did not utilize standardized measures, control for therapy credibility/expectancy, investigate treatment fidelity, or maintain the various no-eye-movement groups until follow-up. It appears . . . that there is now reasonably conclusive evidence that the eye movements are not in themselves curative, a conclusion consistent with that of past reviews (e.g., Lohr et al., 1998).[228]

As a result, the Sanderson and Carpenter study (1992) and the Lohr et al. study (1994) hypothesized that EMDR was simply an exposure technique, and that imaginal exposure (like in PE) was the mechanism of action in the EMDR procedures.[229] Summarizing this position, Harvard University psychologist Richard McNally stated, "What is effective in EMDR is not new, and what is new is not effective."[230]

---

[225] MacCluskie, "A Review of Eye Movement Desensitization and Reprocessing (EMDR)," 127.

[226] Devilly, "Eye Movement Desensitization and Reprocessing," 117; Lee Hyer and Jeffrey M. Brandsma, "EMDR Minus Eye Movements Equals Good Psychotherapy," *Journal of Traumatic Stress* 10, no. 3 (1997): 516.

[227] George Renfrey and C. Richard Spates, "Eye Movement Desensitization: A Partial Dismantling Study," *Journal of Behavior Therapy and Experimental Psychiatry* 25, no. 3 (1994): 238.

[228] Devilly, "Eye Movement Desensitization and Reprocessing," 132.

[229] Lohr, Tolin, and Lilienfeld, "Efficacy of Eye Movement Desensitization," 123-56; Sanderson and Carpenter, "Eye Movement Desensitization Versus Image Confrontation," 269-75.

[230] Richard J. McNally, "On Eye Movements and Animal Magnetism: A Reply to Greenwald's Defense of EMDR," *Journal of Anxiety Disorders* 13, no. 6 (1999): 619.

Early Controversy

Shortly after completing her doctorate, Shapiro trademarked the term EMDR, founded the EMDR Institute, and began training mental health professionals in EMDR.[231] For her part, Shapiro stated she had heard anecdotes about mental health professionals causing harm to patients with EMD, and the trainings were a method of ensuring that patients were not harmed by the procedure.[232] In addition, Shapiro had heard that other clinicians were offering trainings in EMD without her knowledge.[233] In early 1990, Shapiro offered her initial EMD training to about 250 clinicians.[234] Between early 1990 and 1991, the depth of Shapiro's EMDR training would evolve from a one-day workshop to a two weekend, 34-hour training with an additional thirteen hours of supervised practice.[235] Shapiro would found the EMDR Institute in 1993, and manualized the EMDR procedures through her first book in 1995.[236] By 1997, the EMDR Institute had trained over 25,000 mental health professionals in EMDR.[237] Until 2007, the training program consisted of Level I and Level II training (which has now been combined into a Basic Training Program), and various hierarchies of certification and training still exist today.[238]

---

[231] Andrew M. Leeds, *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants*, 2nd ed. (New York: Springer, 2016), 13.

[232] Leeds, *A Guide to the Standard EMDR Therapy Protocols*, 13; Gerald Rosen, "Treatment Fidelity and Research on Eye Movement Desensitization and Reprocessing (EMDR)," *Journal of Anxiety Disorders* 13, no. 1-2 (1999): 176.

[233] Leeds, *A Guide to the Standard EMDR Therapy Protocols*, 14.

[234] Leeds, *A Guide to the Standard EMDR Therapy Protocols*, 14.

[235] Leeds, *A Guide to the Standard EMDR Therapy Protocols*, 14.

[236] EMDR Institute Inc, "The History of EMDR Therapy," accessed April 16, 2024, https://www.emdr.com/history-of-emdr/.

[237] James D. Herbert et al., "Science and Pseudoscience in the Development of Eye Movement Desensitization and Reprocessing: Implications for Clinical Psychology," *Clinical Psychology Review* 20, no. 8 (2000): 947.

[238] "EMDR Therapy Basic Training," EMDR Institute Inc., accessed April 16, 2024, https://www.emdr.com/us-basic-training-overview/.

Shapiro's swift transition from pilot study to training and promotion raised eyebrows in the psychiatric community and would become one of the lingering criticisms of EMDR.[239] Through trademarks and the establishment of the EMDR Institute, Shapiro continuously held a financial stake in the success or failure of EMDR, raising concerns that Shapiro could not be an objective researcher.[240] Gerald Rosen made the following financial observations after attending a Level II EMDR training in 1995:

> A number of observers have expressed concerns about the marketing of EMDR and the extent which economic factors have influenced its development. This is a difficult issue to assess, but some facts were objectively determined with regard to my Level II training. The early registration fee was $325, and sign up sheets at the worship showed 172 registrants. These figures suggest gross revenue for the 2-day workshop as high as $55,000 . . . One promotional flyer that covered *only* Level I training listed an average of five workshops every month through the first half of 1996.[241]

Despite her personal conflict, Shapiro continuously remained a staunch promoter of her new technique. In its 2002 overview of EMDR, the Harvard Mental Health Letter partially attributed the success of EMDR to Shapiro's "aggressive promotion."[242] For example, Shapiro's initial EMDR book heralded the technique as a "paradigm shift," and her second EMDR book's title labelled EMDR as a "breakthrough therapy."[243] Over time, the EMDR Institute's promotion of EMDR as a remedy for a myriad of psychological conditions, such as attention-deficit disorder, self-esteem issues and personality disorders, continuously outpaced the research supporting these claims.[244]

---

[239] Gerald Rosen, "On the Origin of Eye Movement Desensitization," *Journal of Behavior Therapy and Experimental Psychiatry* 26, no. 2 (1995): 76.

[240] Gerald Rosen, Richard McNally, and Scott Lilienfeld, "Eye Movement Magic: Eye Movement Desensitization and Reprocessing a Decade Later," *Skeptic* 7, no. 4 (1999): 67-68.

[241] Rosen, "On the Origin of Eye Movement Desensitization," 76.

[242] President and Fellows of Harvard College, "EMDR," *Harvard Mental Health Letter* 18, no. 8 (February 2002), 4.

[243] Shapiro, *Eye Movement Desensitization and Reprocessing*, viii.

[244] Herbert et al., "Science and Pseudoscience in the Development of Eye Movement Desensitization and Reprocessing: Implications for Clinical Psychology," *Clinical Psychology Review* 20, no. 8 (2000): 947.

Another concern for the psychiatric community was the proprietary nature of the training process. The EMDR Institute's training process would include a written agreement that clinicians would not train others in EMDR—unless qualified by the EMDR Institute.[245] In 1992, multiple clinicians who attended EMDR trainings began to publicly grouse at these written agreements and the "possessiveness and exclusivity associated with (EMDR)."[246] As result, a group of clinicians publicly accused the EMDR training process of becoming a "granfalloon," or a means of establishing social identity among consumers.[247] In essence, the exclusive knowledge set and financial buy in of the multiple levels of EMDR training could be used to establish a social identity, where EMDR trainees felt compelled to support and protect the EMDR procedure. As a result, articles by Rosen, McNally, and Lilienfeld as well as DeBell and Jones wondered how the validation process for EMDR could be objective and unbiased if Shapiro held a proprietary training required for persons researching EMDR.[248]

Both Shapiro and Ricky Greenwald, another early EMDR trainer and practitioner, would become EMDR's most staunch supporters, refuting multiple research studies based on the issue of a lack of "fidelity" to the EMDR protocols.[249] In 1992, Shapiro challenged the results of a case study by Metter and Michelson, who had

---

[245] Hara Estroff Marano, "Wave of the Future."

[246] Oswalt et al., "Evaluation of the One-Session Eye-Movement Desensitization Reprocessing Procedure," 100.

[247] Herbert et al., "Science and Pseudoscience in the Development of Eye Movement Desensitization and Reprocessing," 959.

[248] Rosen, McNally, and Lilienfeld, "Eye Movement Magic," 67; DeBell and Jones, "As Good as It Seems?," 153.

[249] Francine Shapiro, "Eye Movement Desensitization and Reprocessing (EMDR) in 1992." *Journal of Traumatic Stress* 6, no. 3 (1993): 417-21; Francine Shapiro, "Alternative Stimuli in the Use of EMD(R)," *Journal of Behavior Therapy and Experimental Psychiatry* 25, no. 1 (1994): 89; Francine Shapiro, "Eye Movement Desensitization and Reprocessing (EMDR): Evaluation of Controlled PTSD Research," *Journal of Behavior Therapy and Experimental Psychiatry* 27, no. 3 (1996): 209-18; Francine Shapiro, "Errors of Context and Review of Eye Movement Desensitization and Reprocessing Research," *Journal of Behavior Therapy and Experimental Psychology* 27, no. 3 (1996): 313-17; Ricky Greenwald. "The Information Gap in the EMDR Controversy," *Professional Psychology: Research and Practice* 27, no. 1 (1996): 67-72.

replicated the procedures they learned from attending Shapiro's EMDR workshop: "I can only deduce from the description in M/M's letter that an aberrant version was practiced, not surprisingly with negative results."[250] In 1996, Shapiro challenged studies by Acierno et al. (1994), Jensen (1994) and Boudewyns et al. (1996), for a lack of "fidelity checks," asserting that these researchers were not adhering to her EMDR protocols.[251] In his 1996 analysis of why different EMDR studies had reached different conclusions, Ricky Greenwald stated,

> The discrepant conclusions about EMDR's efficacy can be traced directly to (a) the substantial information gap between those who have and those who have not undergone the formal, supervised training provided by Shapiro's EMDR Institute, and (b) the failure by many to recognize that such a gap exists or to appreciate its import—in part because of their lack of information![252]

In response, many professionals criticized that the EMDR training process had overtaken the available research.[253] While the EMDR Institute had trained 14,000 therapists to conduct EMDR treatment by mid-1995, DeBell and Jones pointed out that only seven experimental studies on EMDR treatment had been published in major journals to different results and assessments regarding PTSD treatment.[254] In a 1994 *Psychology Today* article, psychologist Neil Jacobson complained, "There are lots of claims but no data. People should not be allowed to make claims that go beyond what we know . . . . The overselling of this procedure can be harmful."[255]

---

[250] Francine Shapiro, "Eye Movement Desensitization and Reprocessing (EMDR) in 1992," 418.

[251] Shapiro, "Errors of Context and Review of Eye Movement Desensitization and Reprocessing Research," 315-16.

[252] Ricky Greenwald. "The Information Gap in the EMDR Controversy," 67.

[253] Hara Estroff Marano, "Wave of the Future."

[254] DeBell and Jones, "As Good as It Seems?," 154.

[255] Hara Estroff Marano, "Wave of the Future."

From EMD to EMDR

In 1991, Shapiro wrote a research analysis that radically shifted her theoretical underpinnings about how EMD worked. Two factors necessitated that Shapiro examine the theoretical underpinnings of her work. First, Shapiro could not reconcile the speed of the results with the principles of exposure therapy—most notably systematic desensitization.[256] By nature, systematic sensitization is a process where mental health professionals gradually expose clients to their fears over an extended duration of time.[257] If EMD was merely exposing people to their fears, EMD's rapid results would appear to be incongruent with the principles of systematic desensitization.[258]

Second, Shapiro discovered that free association produced the best results in the EMD process.[259] In essence, the emerging EMDR procedures allowed for free association with the mind, which often leads to connections between memories. In *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma*, Shapiro recounts the story of a client who had trouble with anxiety regarding airline travel. As Shapiro went through the EMDR procedures with this client, her memory turned to a time when her parents said goodbye her at a train station at six years old, leaving her with "upsetting" feelings.[260] In this manner, the EMDR procedures often allow people to leave a recent distressing memory and branch out to a core negative memory, which might be the actual source of the anxiety or trauma.[261] Instead of allowing the client to jump between associated memories, systematic desensitization attempts to discover the origin

---

[256] Francine Shapiro, "Eye Movement Desensitization: A New Treatment for Post-Traumatic Stress Disorder," *Journal of Behavior Therapy and Experimental Psychiatry* 20, no. 3 (1989): 216.

[257] Dudley F. McGlynn, "Systematic Desensitization." In *Encyclopedia of Psychotherapy*, edited by Michel Herson and William Sledge, vol. 2. (San Diego, CA: Academic Press, 2002), 756.

[258] Shapiro and Forrest, *EMDR*, 38.

[259] Shapiro, *Getting Past Your Past*, 77-78.

[260] Shapiro and Forrest, *EMDR*, 23.

[261] Shapiro and Forrest, *EMDR*, 22-23.

point of the traumatic memories and singularly focus on that trauma.[262] Practitioners of exposure therapy generally have found that extraneous details can be counterproductive to the therapy process.[263]

Because of these contradictions, Shapiro's research assistant, Mark Russell, suggested that she look into information processing as a means of explaining the results of the pilot study.[264] Upon further study, Shapiro came to believe that the EMD technique was actually reprocessing a client's "memories and personal attributions."[265] When interviewed in 2009, Shapiro stated that her initial work was overly influenced by her "behavioral orientation," and conceived of the procedure as a desensitization technique.[266] In a 2009 interview, Shapiro spoke about the name change: "In 1991, I officially changed the name from EMD to EMDR because of this shift to the reprocessing perspective. I felt constrained to keep the 'EMD' because it was already widely known by that name."[267] Shapiro would argue that the goal of desensitization is the reduction in anxiety levels, but, instead, EMDR produces changes in core beliefs and behaviors.[268] Instead of simply exposing clients to anxiety producing situations, Shapiro argues EMDR reprocesses—or modifies—the "maladaptive information upon which the experientially forged psychopathology is assumed to be based."[269] The current language of EMDR often speaks of the "installation" of new core beliefs and behaviors—similar to the

---

[262] Dudley F. McGlynn, "Systematic Desensitization," 756.

[263] Susan Rogers and Steven M. Silver, "Is EMDR an Exposure Therapy? A Review of Trauma Protocols," *Journal of Clinical Psychology* 58, no. 1 (2002): 51.

[264] Leeds, *A Guide to the Standard EMDR Therapy Protocols*, 12.

[265] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 10.

[266] Luber and Shapiro, "Interview with Francine Shapiro," 218.

[267] Luber and Shapiro, "Interview with Francine Shapiro," 218.

[268] Francine Shapiro, "EMDR 12 Years after Its Introduction: Past and Future Research," *Journal of Clinical Psychology* 58, no. 1 (2002): 1.

[269] Shapiro, "EMDR 12 Years after Its Introduction," 2.

installation of an operating system on a virus-corrupted computer.[270] As such, Shapiro no longer considered EMDR as a behavioral technique, but, rather, considered EMDR as "unique treatment" that integrated multiple elements of psychotherapy.[271] As the orientation of EMDR shifted away from treating the anxiety associated with traumatic events, this paradigm shift would open the doors for EMDR to be used as a treatment for multiple other psychiatric disorders. In fact, Shapiro would eventually state, "If I had it to do over again, I'd call it Reprocessing Theory. Unfortunately, it's too late."[272]

From Eye Movement to Bilateral Stimulation

Another significant change was the shift in emphasis on eye movements to bilateral stimulation. Between 1989 and 1991, Shapiro stated researchers began to experiment with procedures mimicking rapid eye movements that could be used for patients with blindness, visual impairment, or struggles with eye strain.[273] Alternative methods of stimulating the senses, such as alternating tones, shoulder taps, and vibrations, would become acceptable options for EMDR; however, research would show these alternative methods (dubbed "bilateral stimulation") might be less effective than eye movements.[274] Expressing her regret of the inaccurate naming of EMDR, Shapiro states, "The name has in many ways served to confuse. In fact, eye movement is only one form of dual stimulation used, along with hand taps and tones."[275]

With the publishing of the first edition of Shapiro's EMDR textbook, *Eye*

---

[270] Laurel Parnell, *Transforming Trauma: EMDR, The Revolutionary New Therapy for Freeing the Mind, Clearing the Body, and Opening the Heart* (New York: W. W. Norton, 1998), 66.

[271] Shapiro, "EMDR 12 Years after Its Introduction," 2.

[272] Lentz, "In the Spirit of Therapy," 22.

[273] Francine Shapiro, "Eye Movement Desensitization and Reprocessing (EMDR) in 1992," 418.

[274] Leeds, *A Guide to the Standard EMDR Therapy Protocols*, 14.

[275] Shapiro, "EMDR 12 Years after Its Introduction," 1.

Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures, in 1995, Shapiro started to back away from any assertion that eye movement was the only active ingredient in the EMDR technique.[276] To this end, Shapiro would argue that EMDR was not just bilateral stimulation, but, instead, EMDR was a complete eight phase package—of which bilateral stimulation was only a part. Shapiro would argue that any research regarding EMDR should focus on the entire eight phase process, and any research on eye movements or bilateral stimulation alone were irrelevant to EMDR's efficacy in treating trauma.[277] In 2009, Shapiro would state, "I think that part of the problem . . . was the inaccurate belief that it would be a zero-sum game, meaning that the eye movements would be the only thing that would have an effect, and the rest of the procedures viewed as practically inert."[278]

In response, Devilly, Spence and Rapee expressed frustration with the shifting theoretical underpinnings and procedures associated with EMDR.[279] Renfrey and Spates considered EMDR's shift from eye movement to bilateral stimulation directly related to dismantling research that questioned the importance of the eye movements.[280] Similarly, a 1998 study by Devilly, Spence and Rapee said that Shapiro's shift toward bilateral stimulation was a "timely change in perspective" considering negative research about the efficacy of eye movements.[281] In a 2000 critique in *Skeptic* magazine, Gerald Rosen,

---

[276] Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures* (New York: Guilford Press, 1995), 67-68.

[277] Ricky Greenwald and Francine Shapiro, "What Is EMDR? Concluding Commentary by Greenwald and Response by Shapiro," *Journal of EMDR Practice and Research* 5, no. 1 (2011): 27.

[278] Luber and Shapiro, "Interview with Francine Shapiro," 222.

[279] Devilly, Spence, and Rapee, "Statistical and Reliable Change with Eye Movement Desensitization and Reprocessing," 435-55; Rosen, McNally, and Lilienfeld, "Eye Movement Magic," 67-68.

[280] Renfrey and Spates, "Eye Movement Desensitization," 231-39; Rogers and Silver, "Is EMDR an Exposure Therapy?," 44; Lohr, Tolin, and Lilienfeld, "Efficacy of Eye Movement Desensitization and Reprocessing: Implications for Behavior Therapy," 148.

[281] Devilly, Spence, and Rapee, "Statistical and Reliable Change with Eye Movement Desensitization and Reprocessing," 451.

Richard McNally, and Scott Lilienfeld opined,

> The shifting procedures and training requirements for EMDR have created a seemingly endless catchup game for scientists. How can scientists test a method whose proponents insist on treatment fidelity for the introduction of eye movements, then state that alternate tapping strategies are possible, next argue that various protocols must be followed, and then switch the decision rules for those protocols? How can scientists know they have been properly trained in a method when simple written descriptions first sufficed, then a Level I workshop was required, and then Level II training was the minimum standard? One can easily comprehend how the strategy adopted by Shapiro and other EMDR enthusiasts has created a slippery slope where refuted hypotheses constantly change, and the data never catch up. Like the Red Queen in Lewis Carroll's *Through the Looking Glass*, scientists who investigate the efficacy of EMDR are forced to keep running just to stay in place.[282]

Some critics have argued that scientists should be able to study the components of EMDR without the required training. Catherine DeBell and Deniece Jones argued, "Although we support appropriate training, we do not believe this is a substitute for empirical inquiry and the cross-validation of any new procedure."[283]

From Skepticism to Acceptance

Over time, the number of research studies about EMDR grew from two studies in 1989 to 257 studies by the end of 2001.[284] In the 2018 edition of *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols and Procedures*, Shapiro boasted that 20 controlled randomized studies of EMDR had been published supporting the efficacy of EMDR.[285] As the number of studies showing a positive impact of EMDR on PTSD grew, an increasing number of mental health organizations began to accept and advocate EMDR. The American Psychological Association (APA) currently conditionally recommends EMDR for treatment of PTSD in

---

[282] Rosen, McNally, and Lilienfeld, "Eye Movement Magic," 68.

[283] DeBell and Jones, "As Good as It Seems?," 160.

[284] Leeds, *A Guide to the Standard EMDR Therapy Protocols*, 14.

[285] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 11.

its Clinical Practice Guidelines for the Treatment of PTSD.[286] This conditional recommendation was due to the ongoing research into EMDR, and the APA noted EMDR is likely to move to the strongly recommended category in the future.[287] In 2010, the US Veterans Administration added EMDR to its list of strongly recommended treatments for PTSD.[288] In 2013, the World Health Organization recommended EMDR for the treatment of PTSD in children, teenagers, and adults.[289]

As of 2019, researchers had produced more than 30 randomized clinical trials (RCTs) comparing EMDR treatment of PTSD to "inert" comparative conditions.[290] Of note, a 2007 randomized controlled trial by Van der Kolk et al. compared EMDR to fluoxetine and placebo in the treatment of 88 PTSD sufferers, and found that EMDR was superior to fluoxetine and placebo in remission of PTSD symptoms at 6 months post-treatment.[291] A randomized control trial by Acarturk et al. (2014) found EMDR significantly lowered Impact of Event Scale-Revised (IES-R) scores in PTSD symptoms among Syrian refugees as compared to wait list conditions.[292] Finally, a RCT of German military veterans by Kohler et al. (2017) found that EMDR treatment caused a significant lowering of PTSD symptoms (i.e., avoidance, reexperiencing and hyperarousal) as

---

[286] American Psychological Association, *Clinical Practice Guideline for the Treatment of PTSD*.

[287] American Psychological Association, *Clinical Practice Guideline for the Treatment of PTSD*, 91.

[288] Department of Veterans Affairs, *VA/DOD Clinical Practice Guideline*.

[289] World Health Organization, *Guidelines for the Management of Conditions Specifically Related to Stress* (Geneva: World Health Organization, 2013), 8.

[290] Ad de Jong et al., "The Status of EMDR Therapy in the Treatment of Posttraumatic Stress Disorder 30 Years After Its Introduction," *Journal of EMDR Practice and Research* 13, no. 4 (2019): 262.

[291] Bessel Van der Kolk et al., "A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder: Treatment Effects and Long-Term Maintenance," *Journal of Clinical Psychiatry* 68, no. 1 (2007): 41-42.

[292] Ceren Acarturk et al., "EMDR for Syrian Refugees with Posttraumatic Stress Disorder Symptoms: Results of a Pilot Randomized Controlled Trial," *European Journal of Psychotraumatology* 6 (2015): 4-5.

compared to control conditions.[293] One key observation about all these studies is the high level of heterogeneity in the populations (i.e., rape victims, military veterans and refugees) included in the studies.[294] In addition, Grant Devilly argues that studies that compare a treatment method to wait list control generally provide very little information regarding the efficacy of treatment "because almost all treatments will out-perform a wait list control."[295]

However, comparative research between EMDR and various forms of CBT in the treatment of PTSD has produced mixed results. As of 2019, researchers had conducted 13 randomized clinical trials (RCTs) comparing the effectiveness of EMDR to CBT in the treatment of PTSD.[296] Out of these 13 RCTs, five RCTs found no difference between EMDR and CBT, six studies found EMDR to be more effective than CBT, and two studies found CBT to be more effective than EMDR.[297] In addition, most meta-analyses (Bisson et al. (2013);[298] Ehring et al. (2014);[299] Gerger et al. (2014);[300] and Ho and Lee (2012) [301]) have not shown significant differences between EMDR and CBT in the

---

[293] Kai Kohler et al., "Effectiveness of Eye Movement Desensitization and Reprocessing in German Armed Forces Soldiers With Post-Traumatic Stress Disorder Under Routine Inpatient Care Conditions," *Military Medicine* 182, no. 5/6 (2017): 1672-680.

[294] Ad de Jong et al., "The Status of EMDR Therapy," 262.

[295] Devilly, "Eye Movement Desensitization and Reprocessing," 124.

[296] Ad de Jong et al., "The Status of EMDR Therapy," 262.

[297] Ad de Jong et al., "The Status of EMDR Therapy," 262.

[298] Bisson J. I., et al., "Psychological Therapies for Chronic Post-Traumatic Stress Disorder (PTSD) in Adults," *Cochrane Database of Systematic Review* 12 (2013).

[299] Thomas Ehrinig et al., "Meta-Analysis of Psychological Treatments for Posttraumatic Stress Disorder in Adult Survivors of Childhood Abuse," *Clinical Psychology Review* 34, no. 8 (2014):645-57.

[300] H. T. Gerger et al., "Integrating Fragmented Evidence by Network Meta-Analysis: Relative Effectiveness of Psychological Interventions for Adults with Post-Traumatic Stress Disorder," *Psychological Medicine* 44 (2014): 3151-164

[301] M. S. K. Ho and Christopher William Lee, "Cognitive Behavior Therapy Versus Eye Movement Desensitization and Reprocessing for Post-Traumatic Disorder—Is It All In the Homework Then?," *European Review of Applied Psychology* 58 (2002): 253-60

treatment of PTSD. However, two meta-analyses by Chen et al. (2014)[302] and Khan et al. (2018) [303] showed that EMDR had moderate effectiveness over CBT in the treatment of PTSD. However, the Khan et al. meta-analysis found that no significant difference between EMDR and CBT at 3 months out from post-treatment.[304] Ultimately, a 2020 meta-analysis by Cuijpers et al. states that much of the comparative research between EMDR and other forms of PTSD treatment is questionable due to risk of bias:

> EMDR was found to be significantly more effective than other therapies in the treatment of PTSD. However, these results are not convincing for a number of reasons. First, there were few studies with low risk of bias. Furthermore, studies with low risk of bias did not point at a significant difference between EMDR and other therapies. The difference between studies with low risk of bias and those with at least some risk of bias was significant and we found considerable indications for researcher allegiance. Because studies with low risk of bias found no difference between EMDR and other therapies, we conclude that there is not enough evidence to decide about the comparative effects of EMDR.[305]

In addition, psychology professor Pim Cuijpers has argued that the current quality of research into EMDR is problematic.[306] In 2013, Cuijpers and his colleague Christopher William Lee published a meta-analysis of twenty-six controlled trials that concluded that "it seems safe to conclude that the eye movements do have an additional value in EMDR treatments."[307] In 2020, Cuijpers, van Veen, Sijbrandij, Yoder and Cristea produced

---

[302] Ling Chen et al., "Eye Movement Desensitization and Reprocessing Versus Cognitive-Behavioral Therapy for Adult Posttraumatic Stress Disorder: Systematic Review and Meta-Analysis," *Journal of Nervous and Mental Disease* 203, no. 6 (2015): 443-51.

[303] Ali M. Khan et al., "Cognitive Behavioral Therapy Versus Eye Movement Desensitization and Reprocessing in Patients with Post-traumatic Stress Disorder: Systematic Review and Meta-analysis of Randomized Clinical Trials," *Cureus* 10, no. 9 (2018): 32-50.

[304] Khan et al., "Cognitive Behavioral Therapy," 14.

[305] Cuijpers et al., "Eye Movement Desensitization and Reprocessing for Mental Health Problems: A Systematic Review and Meta-Analysis," *Cognitive Behavior Therapy* 49, no. 3 (2020): 175.

[306] Meg Bernhard, "The Enigmatic Method," *VQR*, last modified June 12, 2023, https://www.vqronline.org/reporting-articles/2023/06/enigmatic-method.

[307] Christopher William Lee and Pim Cuijpers, "A Meta-Analysis of the Contribution of Eye Movements in Processing Emotional Memories," *Journal of Behavioral Therapy and Experimental Psychiatry* 44, no. 2 (2013): 238.

another meta-analysis of seventy-six controlled trials that was more cautious in its conclusions:

> We could not confirm the results of an earlier meta-analysis comparing EMDR with the same procedure but without the eye-movements due to a lack of studies (Lee & Cuijpers, 2013). That is probably caused by differences in inclusion criteria. We only included studies in participants with existing mental health problems and we only focused on clinical outcomes, while the earlier meta-analysis mainly included experimental studies with healthy participants and results on process measures. However, due to the fact that only few trials in the current study had a low risk of bias, the inability to reproduce the aforementioned previous findings does indicate that the difference between EMDR with and without eye movements may not be as robust as previously suggested.[308]

In a 2023 interview, Cuijpers stated that the quality of research studies into EMDR is "horrible," and that "there is some evidence (for EMDR), but it's very low, extremely low quality."[309] In Cuijpers et al. 2020 meta-analysis, the greatest criticism of current research studies is the high potential for researcher bias due to lack of randomization in trials and lack of independent observers.[310] Cuijpers stated that only one of the seventy-six clinical trials examined in their 2020 meta-analysis met the standards for "quality research."[311] Cuijpers et al. also note other common limitations in EMDR research studies include small sample sizes, limited follow-up data, and heterogeneity of research studies.[312] In addition to the 2020 Cuijpers meta-analysis, other meta-analyses similarly cited concerns about small sample sizes and heterogeneity of research.[313]

The allure of EMDR lies with the short timeframe in which mental health

---

[308] Cuijpers et al., "Eye Movement Desensitization," 176.

[309] Meg Bernhard, "The Enigmatic Method."

[310] Cuijpers, et al., "Eye Movement Desensitization," 175-76.

[311] Meg Bernhard, "The Enigmatic Method."

[312] Cuijpers et al., "Eye Movement Desensitization," 175-76.

[313] Khan et al., "Cognitive Behavioral Therapy," 15; Gerger et al., "Integrating Fragmented Evidence by Network Meta-Analysis," 3160; Ehrinig et al., "Meta-Analysis of Psychological Treatments for Posttraumatic Stress Disorder in Adult Survivors of Childhood Abuse," 654.

professionals can heal traumas. During the early 1980s, many mental health clinicians considered PTSD—especially in veterans—to be intractable and painfully slow to treat through forms of exposure therapy.[314] For her part, Shapiro has consistently indicated that traditional PTSD treatments, such as CBT, can assist trauma survivors; however, she also critiques that these traditional therapies can take months of treatment.[315] While Shapiro has moved away from her initial claims of EMDR being a one session wonder, Shapiro and Forrest's 2016 EMDR overview offers hope that EMDR treatment will provide expeditious relief to PSTD sufferers: "Research has shown that about five hours of EMDR treatment eliminates PTSD in 84 to 100 percent of civilians with a single trauma experience, including rape, accident, or disaster."[316] EMDR advocate and author Laurel Parnell opines, "Why should clients spend years and thousands of dollars lying on a couch when they could be enjoying life to the fullest?"[317] However, Shapiro and Parnell's boasts of EMDR's efficiency might over-stated. The VA/DoD clinical treatment guidelines currently recommend the same number and frequency of treatment sessions (10 to 12 weekly sessions) for all its strongly recommended treatments for PTSD, including CBT, PE and EMDR.[318] Similarly, the APA recommends 9 to 12 weekly sessions of PE, 12 total sessions of CPT, or 6 to 12 weekly or twice weekly sessions of EMDR for the treatment of EMDR.[319] Neither of these clinical treatment guidelines offer a huge edge in efficiency to EMDR treatment for PTSD sufferers (as compared to CBT).

However, the biggest outstanding critique of EMDR is the lack of understanding

---

[314] Shapiro, *Getting Past Your Past*, 26.

[315] Shapiro and Forrest, *EMDR*, 23.

[316] Shapiro and Forrest, *EMDR*, 5.

[317] Parnell, *Transforming Trauma*, 44.

[318] Department of Veterans Affairs. *VA/DOD Clinical Practice Guideline*.

[319] American Psychological Association, *Clinical Practice Guideline for the Treatment of PTSD*.

regarding why and how the procedure works. Ever since Shapiro's 1989 pilot study, researchers have been making conjectures and hypotheses regarding how EMDR works, and this theorizing continues to the present day. The 2020 meta-analysis by Cuijpers et al. concluded, "The original controversy on the effects of EMDR is therefore not solved, but the assumption that EMDR only works through cognitive-behavioral elements seems to be too simple."[320] In the end, Shapiro has argued that the validity of the procedure's effectiveness overrides any concerns regarding how the procedure works: "One might wonder how any intervention as seemingly innocuous as the present one could have such dramatic psychological effects. Although whether or not one understands the basis of this or any clinical procedures effectiveness has no bearing on its validity, it is useful to speculate on the potential underlying mechanisms."[321] Other prominent researchers, such as Bessel van der Kolk, have a similar perspective of EMDR: "While we don't yet know precisely how EMDR works, the same is true of Prozac. . . . Clinicians have only one obligation: to do whatever they can to help their patients get better."[322] In spite of his concerns about the quality of EMDR research, Pim Cuijpers has the same perspective as van der Kolk: "If it helps somebody, why would it be less valuable?"[323] In essence, a general sentiment prevails that the effectiveness of EMDR in treating PTSD overrides any concerns about how the procedure works.

---

[320] Cuijpers et al., "Eye Movement Desensitization," 176.

[321] Francine Shapiro, "Eye Movement Desensitization and Reprocessing Procedure: From EMD to EMD/R—A New Treatment Model for Anxiety and Related Traumata," *Behavior Therapist* 14, no. 5 (1991): 134.

[322] Van der Kolk, *The Body Keeps the Score*, 264.

[323] Meg Bernhard, "The Enigmatic Method."

CHAPTER 3

THE ADAPTIVE INFORMATION PROCESSING MODEL

The adaptive information processing model is the theoretical underpinning of EMDR and the explanation Francine Shapiro advances for why EMDR "works." To understand Shapiro's AIP model, one must understand the cognitive behavioral therapy foundations of EMDR as well as Shapiro's turn towards a neurobiological understanding of EMDR. Overall, the AIP model holds that dissociation is the essence of the pathology regarding PTSD. The DSM-V defines dissociation as "a disruption and/or discontinuity of the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior."[1] In *The Body Keeps the Score*, Bessel van der Kolk describes the phenomenon of dissociation: "The overwhelming experience is split off and fragmented, so that the emotions, sounds, images, thoughts and physical sensations related to the trauma take on a life of their own."[2] Based on this understanding of disassociation, Shapiro argues that proper information processing of the mind, in part physiologically mediated by the brain, is the best solution towards the elimination of PTSD symptoms.

The Worldview of EMDR

To fully understand the adaptive information processing model, an assessment of the worldview of the EMDR literature is necessary. In *What's Your Worldview*?,

---

[1] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-V-TR*, 5th ed. (Washington, DC: American Psychiatric, 2023), 291.

[2] Bessel van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2014), 66.

Reformed Theological Seminary professor John Anderson defines the term "worldview" as "your most fundamental beliefs and assumptions about the universe you inhabit."[3] In essence, one's worldview is the environment in which shapes our perspective of the world around us. Much of the secular literature regarding trauma holds a naturalistic worldview, betraying an anthropology vastly different from traditional Christian thought.

The Physicalism of EMDR

Physicalism is the position that the universe is solely composed of basic physical particles. Therefore, physicalism argues that human persons are composed of one substance: a material body. Theologians Kevin Corcoran and Kevin Sharpe cheekily describe physicalism as the "Madonna Metaphysic," meaning that "we are material boys and girls living in a material world."[4] The physicalist presumes that everything is material; therefore, the human brain is the part of the body that controls a human being's basic body functions, thoughts, memories, and emotions. When physicalists speak of the "mind," they are using a shorthand to refer to one's behavior and are not referring to a distinct substance within a human being. To the physicalist, the mind cannot exist apart from the human brain. In this context, advances in neuroscientific equipment (i.e., CAT scans and PET scans) have supported the view that "bottom up" causes (i.e., genetics and brain chemistry) largely affect human thoughts, emotions, and behavior. Since human beings are a product of their brain activity, physicalists will often argue that human beings are not fully responsible for their thoughts, actions, and emotions. In essence, the human body is the "culprit" in the development of negative behaviors, such as

---

[3] James Anderson, *What's Your Worldview? An Interactive Approach to Life's Big Questions* (Wheaton, IL: Crossway, 2014), 12.

[4] Kevin Corcoran and Kevin Sharpe, "Neuroscience and the Human Person," in *Neuroscience and the Soul: The Human Person in Philosophy, Science and Theology*, ed. Thomas M. Crisp, Steven L. Porter, and Gregg A. Ten Elshof (Grand Rapids: William B. Eerdmans, 2016), 121.

alcoholism, pornography addiction, and other forms of addition.[5]

Many of the most renowned secular scholars in the field of trauma hold to a strict physicalist perspective of the human body. In *Does Stress Damage the Brain*?, J. Douglas Bremner states, "Stress-induced brain damage underlies and is responsible for the development of a spectrum of trauma-related psychiatric disorders, making these psychiatric disorders, in effect, the rest of neurological damage."[6] Similarly, Peter Levine definitively states that "trauma is physiological" and that "the key to healing traumatic symptoms in humans is in our physiology."[7] Physicalists commonly picture traumatic memories as an evolutionary outcome of the human beings' survival instinct, where the threat of danger "results in an overwhelming sense of fear and terror accompanied by intense psychological arousal."[8] Physicalists often speak of trauma as an overwhelming of the most basic systems that human beings use to adapt to life's challenges.[9] The theoretical tiger in the field awakens an instinctual fight or flight response that nature has ingrained within each human being. Physicalists perceive trauma as the mind and the body malfunctioning because of the overwhelming nature of intense and/or repeated suffering. With the aid of modern neurological scanning, van der Kolk (and a myriad of other neuroscientists) have found portions of the brain that "go into overdrive," "collapse," and "shut down" because of trauma.[10] As such, most modern scholars view

---

[5] Jeff Forrey and Jim Newheiser, "The Influences on the Human Heart," in *Christ-Centered Counseling: Changing Lives with God's Timeless Truth*, ed. Bob Kellemen and Steve Viars (Eugene, OR: Harvest House, 2021), 129.

[6] J. Douglas Bremner, *Does Stress Damage the Brain? Understanding Traumas-Related Disorders from a Mind-Body Perspective*, 4.

[7] Peter A. Levine and Ann Frederick, *Waking the Tiger: Healing Trauma* (Berkeley, CA: North Atlantic Books, 1997), 17.

[8] Van der Kolk, *The Body Keeps the Score*, 97.

[9] Judith Herman, *Trauma and Recovery: The Aftermath of Violence, From Domestic Abuse to Political Terror* (New York: Basic Books, 2015), 33.

[10] Van der Kolk, *The Body Keeps the Score*, 68-71.

traumatic memories as a physical illness that medical professionals must heal instead of a spiritual matter of the soul.

Like other secular experts in the field of trauma, Francine Shapiro has unfailingly held to physicalism, which is consistent with EMDR's foundations in behaviorism and neurobiology. When Shapiro speaks of trauma, she speaks from this perspective that trauma is only a physical issue:

> Psychological trauma is associated with numerous changes in the nervous system caused by cortisol release, spikes of adrenaline, fluctuations in neurotransmitters, and so forth, the result of which is a loss of neural homeostasis. . . . Due to this imbalance, the information-processing system is unable to function optimally, and the information acquired at the time of the event, including images, sounds, affect, and physical sensations, is stored in its disturbing state. . . . The hypothesis is that the procedural elements of EMDR therapy, including the bilateral dual attention stimuli, trigger a physiological state that facilitates information processing."[11]

In short, Shapiro holds that a traumatic experience damages the information processing ability of the human brain. When the brain's ability to process memories malfunctions, traumatic memories go undigested in the brain, leading to trauma survivors reliving the experience through nightmares, flashbacks, and other PTSD symptoms. Shapiro describes PTSD as the body's loss of time-space: "Our perceptions of the terrible event (what we saw, heard, felt, and so on) may be stuck in our nervous system in the same form as when we experienced them."[12] In this manner, Shapiro uses similar language to van der Kolk that trauma gets stuck in the nervous system—like marbles clogging a drainpipe. In this perspective, clinicians become proverbial plumbers, helping to "clean out" the nervous system of "dysfunctionally stored material" to allow freedom of information movement.[13] A similar metaphor that Shapiro uses to describe the

---

[11] Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd ed. (New York: Guilford Press, 2017), 27.

[12] Francine Shapiro and Margot Silk Forrest, *EMDR: The Breakthrough "Eye Movement" Therapy for Overcoming Anxiety, Stress, and Trauma* (New York: Basic Books, 2016), 41.

[13] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 30-31.

relationship between PTSD and EMDR is a passenger train moving along its route.[14] The memory network of the human brain is akin to the train, moving its passengers—or memories—to be stored in their final destination. As a result of trauma, the train gets stuck, unable to take passengers to their proper destination, and the trauma survivor needs a neurological intervention, such as EMDR, to get the train and its passengers moving again. Both metaphors for PTSD (i.e., plumbing and trains) firmly align with the medical model of understanding illnesses, where neuroscientists theorize that many traditionally psychological diseases have a bodily root cause.

The Determinism of EMDR

Within the field of neurobiology, the largest philosophical controversy is about the existence of human choice and free will. Due to their naturalistic affinities, many neurobiologists are reductionists, who believe that "everything can and should be explained in the simplest possible physical terms."[15] The heart of reductionism is a philosophy of simplicity, meaning that the activities of the physical world should be explained by its most basic components, such as atoms, cells, chemistry, and laws of physics, instead of complex systems, such as economics, politics, or sociology. When most neurobiologists ask the question of who is responsible for one's emotions and actions, the answer is elegantly simple: we are our bodies. Christian scholar Joel Green explains reductionism in this manner: "The human person is a physical (or material) organism whose emotional, moral and religious experiences will ultimately be explained by the natural sciences. People are nothing more but the product of organic chemistry."[16] Similarly, molecular biologist Francis Crick summarizes the reductionist position well

---

[14] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 37.

[15] Alison J. Gray, "Whatever Happened to the Soul? Some Theological Implications of Neuroscience," *Mental Health, Religion and Culture* 13, no. 6 (September 2010): 642.

[16] Joel B. Green, ed., *In Search of the Soul: Perspectives on the Mind-Body Problem*, 2nd ed. (Eugene, OR: Wipf and Stock, 2010), 13.

when he states, "'[You],' your joys and your sorrows, your memories and your ambitions, your sense of identity and free will, are in fact no more than the behavior of a vast assembly of nerve cells and their associated molecules."[17] In the area of trauma, the reductionist would argue that the victim's fractured and maladapted neurological functioning produces negative behaviors, such as hypervigilance, depression, and anxiety. In this manner, the body bears responsibility for our actions, creating substantial grey area in terms of the morality and ethics of human beings.

Throughout her works, Shapiro repeatedly affirms that human beings are the product of two things: genetics and experiences. When assessing the cause of human actions, Shapiro places greater weight on life experiences instead of genetics: "Unless the cause of the problem is organic, or biochemical, everything we feel or do, every action we take, is guided by previous life experiences, because all of them are linked together in an associative memory network."[18] Shapiro's position is not a reinterpretation of the classic nature versus nurture debate. Instead, Shapiro holds that traumatic events lead to bodily impacts through the brain's neuroplasticity, creating a significant physical problem to overcome. However, Shapiro does not deny that clinicians should consider genetics in the assessment of proper clinical treatment. Genes can predispose people to certain physical and mental disorders, such as bi-polar disorder and schizophrenia, and horrific recent situations, such as sexual assault or physical abuse, can radically re-order the course of someone's life. Shapiro believes that the impact of negative experiences depends on "genetic predispositions, the number and type of preceding events that may have engendered a greater resiliency, or a corrective emotional experience that may

---

[17] Francis Crick, *The Astonishing Hypothesis: The Scientific Search for the Soul* (New York: Touchstone, 1994), 3.

[18] Shapiro and Forrest, *EMDR*, 81.

occurred within a window of opportunity immediately following the event."[19] In Shapiro's mind, this combination of biological and experiential factors makes the assessment process difficult for clinicians. When clients suffer from PTSD, depression, anxiety, or other troubling conditions, clinicians will regularly have trouble whether their problem's source is genetic, experiential, or some combination of both. For this reason, phase 1 of EMDR, which is the assessment process, is critical to the proper treatment of PTSD and other sufferers.

Shapiro goes on to explain that the human response to life experiences is generally unconscious. *Getting Past Your Past* opens by asserting that human beings are generally "running on automatic."[20] By this statement, Shapiro holds that the unconscious process of the human mind drives our moment-to-moment choices. The example Shapiro commonly gives is the recitation of the childhood poem, "Roses are Red." When most Americans think of these opening words, they automatically put together the next line of poem, "Violets are blue."[21] To this end, Shapiro argues the human brain makes mental connections without conscious decision-making. For example, the singe of steaming hot coffee on the tongue automatically makes most people recoil or spit the hot substance out. Overall, the human brain functions by constantly making connections which are outside of the conscious awareness of people. Shapiro explains, "The responses come from a part of our brain that is not governed by the rational mind. The automatic reactions that control our emotions come from neural associations within our memory networks that are independent of our higher reasoning power."[22] However, our

---

[19] Francine Shapiro, ed., *EMDR as an Integrative Psychotherapy Approach*, 3rd ed. (Washington, DC: American Psychological Association, 2007), 14.

[20] Francine Shapiro, *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (New York: Rodale, 2012), 1.

[21] Shapiro, *Getting Past Your Past*, 2.

[22] Shapiro, *Getting Past Your Past*, 9.

unconscious choices are not indiscriminate, arbitrary, or random; instead, they are informed reactions to the well-organized memory networks that the human brain creates.

Moreover, Shapiro holds that the unconscious mind drives most human cognitions and behaviors. The AIP model holds that the human brain processes information on a routine basis, so that the brain can learn from and adapt to earlier experiences. This process of learning does not typically cause dysfunctional emotions or behavior; instead, this process teaches human beings core beliefs that become integrated into current decision-making processes.[23] Shapiro describes the brain's information processing in this manner: "Every experience we've had in our lives has become a building block in our inner world, governing our reactions to everything and every person we encounter."[24] However, one's traumatic life experiences can also become stumbling blocks to how people interact with the world around them. Shapiro gives the example of Justine, who sought treatment about her poor relationships with men. Justine's dating pattern was to act clingy with her boyfriends, and this negative pattern would ultimately result in the dissolution of the relationship. Shapiro attributes this clingy behavior to Justine's experience as a six year old, where her mother and father ignored her cries during a terrible thunderstorm. [25] Just like the example of Justine, Shapiro would argue that one's experiences shape the unconscious emotions that people feel as well as the actions that people make: "It's useful to remember that whatever the persistent negative emotion, belief or behavior that has been bothering you, it's not the cause of suffering—it's the symptom. The likely cause is the memory that's pushing it."[26] To Shapiro, the proper question is not whether our brains are making unconscious

---

[23] Shapiro and Forrest, *EMDR*, 61.

[24] Shapiro, *Getting Past Your Past*, 3.

[25] Shapiro, *Getting Past Your Past*, 4.

[26] Shapiro, *Getting Past Your Past*, 11.

connections; instead, Shapiro believes that the proper question is, "Are we being guided appropriately by our memories, or are they pushing us to do things we shouldn't do—and preventing us from doing things we should?"[27]

In discussing how unconscious thoughts affect our emotions and beliefs, one of Shapiro's core beliefs is that childhood has the most pronounced impact on adulthood: "Whatever happened in childhood helped forge who you are today."[28] In explaining this belief, Shapiro holds that children have little choice or power over their childhood experiences and, therefore, are highly vulnerable to negative actions of the adults around them: "These kinds of problems can occur because childhood is a time when we're vulnerable. We're small in a land of giants. We don't have any power. So even in the best of childhoods, we may have experiences that are stored unprocessed with emotions, physical sensations and beliefs we had at the time."[29] Admittedly, most people would argue their childhood experiences were generally good and would not consider that their childhood would have any traumatic effect on adulthood. However, Shapiro would argue that even the best parents often make negative choices that have long-lasting impacts on the mental health of their children.[30]

As a result of these positions, Shapiro holds that human beings have very little personal responsibility for their emotions and actions. In *Getting Past Your Past*, Shapiro routinely asks the question, "Who's running your show?"[31] According to Shapiro, the answer to this question is the unconscious choices that our bodies make in response to

---

[27] Shapiro, *Getting Past Your Past*, 43.

[28] Shapiro, *Getting Past Your Past*, 105.

[29] Shapiro, *Getting Past Your Past*, 41.

[30] Shapiro, *Getting Past Your Past*, 12.

[31] Shapiro, *Getting Past Your Past*, 64.

our memories. In Shapiro's words, people are "generally on automatic pilot."[32] The responsibility ultimately falls to our bodies, which often do not move forward from traumatic events and get stuck. If PTSD sufferers could simply consciously choose to move on, they simply would; however, their memory networks are holding them back from progress. Unsurprisingly, Shapiro casts most of the blame for one's negative cognitions and behaviors on childhood traumas: "You didn't ask to have this disturbing childhood experience negatively stored in your brain when you were a child. And you didn't ask for the negative aftereffects of whatever it is that happened."[33]

The Humanism of EMDR

Since neurobiologists generally argue that PTSD is physiological in nature, these scholars will argue the ultimate solution is through physical interventions. The goal for most neurologists is to eliminate traumatic memories from the body instead of simply addressing the symptoms of trauma. For this reason, many of the leading trauma experts have begun to turn away from interventions that simply modify behaviors, such as CBT and medications. The APA has argued CBT has not fared well in the treatment of PTSD, and many counselees have adverse reactions to being re-exposed to traumatic memories during treatment.[34] Similarly, the APA notes that the Food and Drug Administration (FDA) has only recommended two SSRIs for PTSD treatment, and "there are differing levels of evidence" regarding other "off label" drugs.[35] In *The Body Keeps the Score*, Bessel van der Kolk argues against the use of medications to treat trauma: "Drugs cannot 'cure' trauma; they can only dampen the expressions of disturbed physiology. And they

---

[32] Shapiro, *Getting Past Your Past*, 68.

[33] Shapiro, *Getting Past Your Past*, 61.

[34] Van der Kolk, *The Body Keeps the Score*, 223.

[35] American Psychological Association, "Medications for PTSD," Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder, last modified July 31, 2017, https://www.apa.org/ptsd-guideline/treatments/medications.

do not teach the lasting lessons of self-regulation."[36] Instead, van der Kolk advocates for mindfulness, self-regulation, communal relationships, and forms of applied neuroscience—such as EMDR—as methods for treatment of PTSD. Ultimately, many experts have looked to find interventions that better handle the brain's storage of traumatic memories, such as EMDR, instead of managing PTSD symptoms.

Shapiro argues that the key to change is helping people make connections between their past experiences and their unconscious choices. Shapiro wants to use EMDR to help people see the "why" in their lives and other peoples' lives.[37] EMDR seeks to identify where people are "stuck" and to help them understand their "knee-jerk" reactions to their experiences.[38] For this reason, EMDR does not follow the lead of many cognitive behavioral therapies for PTSD, where the clinician often asks the client to focus on one particular traumatic memory. Instead, EMDR's mantra is "whatever happens, happens."[39] EMDR encourages clients to move from memory to memory to explore connections between one's current emotions and their memories. EMDR holds that a series of similar traumatic memories might cause the brain to get stuck, so counselees must explore and associate all the potential memories in their past. Since the client is exploring their memories and unconscious minds, Shapiro argues that the associations developed through EDMR can be surprising and unexpected.[40]

Shapiro holds that EMDR helps people see the connections between their history and their unconscious choices. A key concept in EMDR is "touchstone memories," which are the key underlying unprocessed memories that represent the true

---

[36] Van der Kolk, *The Body Keeps the Score*, 226.

[37] Shapiro, *Getting Past Your Past*, 15.

[38] Shapiro, *Getting Past Your Past*, 7.

[39] Shapiro, *Getting Past Your Past*, 33.

[40] Shapiro, *Getting Past Your Past*, 35.

source of one's suffering.[41] These touchstone memories may not be the client's presenting issues but might be other negative memories associated in the brain with the presenting problem. EMDR seeks to help clients identify these touchstone memories and to understand connections between various touchstone memories and present emotions and behavior. EMDR's process of finding touchstone memories is the critical first step in healing, as Shapiro states, "Identifying the memory connections is just the first step in changing how we think, act and feel."[42] Often, people do not understand why they make certain decisions. Shapiro attributes this lack of understanding to a lack of understanding of the unconscious mind: "Since we all walk around automatically responding to the world around us, it's important to begin noticing whether as disturbing reaction is appropriate."[43] Once the improperly stored memories are identified, EMDR can be used to digest and properly store the traumatic memories so that the counselee can move forward in their life.

Shapiro also places a great deal of confidence in peoples' ability to heal themselves, often stating that EMDR taps into the body's self-healing process. One of Shapiro's key beliefs is that the human body, including the brain, is a self-healing unit and that EMDR practitioners simply help the brain in getting un-stuck from traumatic memories. Through Shapiro's works, the emphasis is always clear: "People were healing themselves through EMDR."[44] Similarly, Shapiro typically describes the EMDR practitioner as a guide, a facilitator, or even a witness.[45] The EMDR process allows the client to follow whatever comes to mind in processing their cognitions and memories of

---

[41] Shapiro, *Getting Past Your Past*, 75.

[42] Shapiro, *Getting Past Your Past*, 5.

[43] Shapiro, *Getting Past Your Past*, 52.

[44] Shapiro and Forrest, *EMDR*, 38.

[45] Shapiro and Forrest, *EMDR*, 38.

the traumatic event. On this level, Shapiro echoes the tenets of humanism, holding that human beings are inherently good and have spectacular ability to heal themselves. In this manner, EMDR is a pathway to change instead of the power to change.

Like many other neurobiologists, Shapiro often pushes against the effectiveness of other treatments for PTSD, such as CBT, medications, and talk therapy. Shapiro argues that many popular PTSD treatments change the "weather" instead of the changing the "climate."[46] In other words, proper treatment of PTSD addresses the underlying unprocessed memories that create PTSD instead of simply dealing with PTSD symptoms. If a counselee does not properly address the unprocessed memories, the hypervigilance, flashbacks, and other symptoms associated with PTSD will not be eliminated. For this reason, Shapiro is critical of the use of medications to treat PTSD: "There are studies showing that once the medication is stopped, the symptoms can return."[47] Similarly, CBT teaches the client techniques to manipulate their present-day behaviors and beliefs connected to the traumatic event. In this manner, both medications and CBT mitigate the client's present circumstances but do not address the underlying past causes of their trauma response. Ultimately, PTSD and other psychological maladies can be like a "snake in the grass," where conditions—if not properly treated—remain in hiding to harm us once again.[48] For this reason, Shapiro holds a different view than the APA regarding PTSD treatment, holding that talk therapy, behavioral therapies, CBT, and pharmacology have been found lacking in the treatment of PTSD: "None of these approaches completely solved the problem."[49] Shapiro believes that EMDR is so rapid because it rewires the body's adaptive processing systems on a neurological level, which

---

[46] Shapiro, *Getting Past Your Past*, 67.

[47] Shapiro, *Getting Past Your Past*, 67.

[48] Shapiro, *Getting Past Your Past*, 67.

[49] Shapiro, *Getting Past Your Past*, 46.

better gets to the physical roots of the problem of PTSD. Quite axiomatically, Shapiro makes the following blanket statement about all treatment paths for all mental disorders: "Any form of successful therapy is ultimately correlated with a neurophysiological shift."[50]

The Pragmatism of EMDR

Historically, the extended timeframe needed for the treatment of PTSD confounded clinicians. During the 1980s, most clinicians clashed on an effective form of treatment for PTSD but were able to agree that PTSD was difficult to cure. The most common approaches to treating PTSD were psychodynamic therapy, CBT, and medication. Psychodynamic therapy urged patients to talk about their traumas so that they could conquer their pasts. For veterans, group therapy sessions showed that other people understood the horrors of combat but could not eliminate the underlying symptoms of PTSD.[51] CBT looked to decondition patients to the negative beliefs and behaviors associated with traumatic experiences. The rise of the pharmaceutical industry drove the use of mind-altering medications to curb the negative behaviors associated with PTSD. When these medications are removed from a survivor's treatment, clinical trials have proven that PTSD sufferers often go back to negative beliefs and behaviors.[52] However, Shapiro recalls that "few clients walked away from the consulting room or the hospital symptom-free."[53] Prior to the advent of EMDR, none of randomized controlled trials (RCTs) about PTSD treatment reached a treatment success rate higher than 30 percent.[54] One of the allures of EMDR has been the promise of exponentially quick

---

[50] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 15.

[51] Shapiro and Forrest, *EMDR*, 51.

[52] Shapiro, *Getting Past Your Past*, 67.

[53] Shapiro and Forrest, *EMDR*, 45.

[54] Shapiro and Forrest, *EMDR*, 50-51.

healing from traumatic memories and other maladies.

One of Shapiro's greatest concerns is the expeditiousness of clinical treatment of PTSD. When Shapiro published her first EMDR study in 1987, she claimed that a "single session" of EMDR could desensitize clients from their traumatic memories.[55] These claims of rapid treatment of the diagnosis of PTSD, which many professionals considered to be intractable, raised a stir amongst the psychiatric community. However, many subsequent randomized controlled trials confirmed that EMDR could treat PTSD in a more efficient manner. In *Getting Past Your Past*, Shapiro touts that "84 to 100% of single traumas can be processed within about three 90-minute sessions."[56] In showing the efficiency of EMDR, Shapiro's most common target is CBT, which is the most prevalent treatment for PTSD. The APA states that EMDR can treat most PTSD symptoms in six to twelve individual sessions.[57] In comparison, the APA states that CBT takes twelve to sixteen individual or group sessions to treat PTSD symptoms. [58] Similarly, Shapiro also boasts that nine out of eleven RCTs found EMDR to be superior to CBT in due to "rapid declines in anxiety."[59]

Importantly, Shapiro believes EMDR is efficient because of its effectiveness. Part of Shapiro's beliefs about the efficiency of EMDR come from her beliefs about the natural self-healing capacity of the human body—including the brain: "With the appropriate medical care, the body may repair its wounds in days or weeks. Why do we

---

[55] Shapiro, "Efficacy of the Eye Movement Desensitization Procedure," 216.

[56] Shapiro, *Getting Past Your Past*, 38.

[57] American Psychological Association, "Eye Movement Desensitization and Reprocessing (EMDR) Therapy," Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder, last modified July 31, 2017, https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing

[58] American Psychological Association, "Cognitive Behavioral Therapy (CBT)," Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder, last modified July 31, 2017, https://www.apa.org/ptsd-guideline/treatments/cognitive-behavioral-therapy.

[59] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 21.

think that the mind should take longer to heal?"[60] Essentially, the brain's natural process of adaptive resolution seeks to absorb traumatic events, but often need medical professionals to help these traumatic events to get unstuck. More importantly, Shapiro believes that other forms of treatment address the symptoms of traumatic memories but do not engage the adaptive resolution process of the brain, which presents a genuine conclusion. By nature, CBT looks to target the beliefs and behaviors associated with traumatic memories, particularly by exposing counselees to negative stimuli. Similarly, medications can augment the emotions and behaviors associated with PTSD but must be coupled with other forms of treatment to supply genuine, long-term relief. In recounting her experience with a war veteran named Josh, Shapiro states that talk therapy and medications have a place but "it just wasn't enough."[61]

Overall, Shapiro's concerns about efficiency seem to come from a sympathetic place. In *Getting Past Your Past*, Shapiro talks about one of her patients, Stacey, that had been to multiple clinicians for years and had experienced over one hundred different types of therapy.[62] In many of these stories that Shapiro shares, Stacey's starting point is a common theme: people with serious problems who cannot find relief from symptoms in the mental health system. The plight of inefficient treatment was the theme of many veterans following the Vietnam War: "Thousands of Vietnam veterans had been trying all known forms of therapy for two decades, and for many, no form of therapy had made much of a dent in the suffering."[63] The premise of traumatized persons bouncing around from practice to practice for years without effective treatment is a genuinely scary assessment. As such, Shapiro's works often read like an indictment of the mental health

---

[60] Shapiro and Forrest, *EMDR*, 41.

[61] Shapiro and Forrest, *EMDR*, 62.

[62] Shapiro, *Getting Past Your Past*, 12.

[63] Shapiro and Forrest, *EMDR*, 46.

system, wondering why people bother with less effective treatments when EMDR is available. Using Shapiro's analogy, she is ultimately concerned that most PTSD treatments address the "weather" (i.e., the person's beliefs and behaviors) instead of the "climate" (i.e., the traumatic memories).[64]

Shapiro's Perspective of Christianity

When speaking of the compatibility of EMDR and biblical counseling, another intriguing question is: Does Shapiro even believe that EMDR is compatible with religious belief—including orthodox Christian doctrine? Importantly, Shapiro's works rarely speak of religion; however, Shapiro lumps all religious experiences in the same bucket. In the same breath, Shapiro often shifts back and forth between discussions of Christian prayer and Buddhist meditation.[65] In *Getting Past Your Past*, Shapiro states that the "goal of religion is to foster more meaningful connections with our inner world and with those around us."[66] Similarly, Shapiro argues that "spiritual development" translates into "a growth in understanding and a feeling of connection beyond our personal confines as mortals on this planet."[67] These statements clarify that Shapiro views all religious practice as more of a personal expression of choice instead of a theological truth. The only form of religious experience that Shapiro does advocate is "mindfulness," which Shapiro often uses synonymously with Eastern "meditation."[68] However, Shapiro advocates using "your religious practices" as the mantra for personal meditation, stating that one's personal mantra can range from "God is good," "God is one," "God is great,"

---

[64] Shapiro, *Getting Past Your Past*, 67.

[65] Shapiro, *Getting Past Your Past*, 294.

[66] Shapiro, *Getting Past Your Past*, 290.

[67] Shapiro, *Getting Past Your Past*, 288.

[68] Shapiro, *Getting Past Your Past*, 295.

"peace," "love," or even "om" in the Hindu and Buddhist traditions.[69]

If anything, the ultimate bent of Shapiro's works is secular humanism, which is an atheistic worldview that holds that "humans must take responsibility for themselves" due to the absence of a higher power.[70] At the closing of *Getting Past Your Past*, Shapiro recounts an experience where she witnessed a group of people joining hands to rescue persons from the depths of the ocean. Shapiro then allegorizes this experience to explain her purpose for EMDR: "To join with those who are willing to link arms, to help bring everyone back in, so that no one has to be out there alone drowning the dark."[71] In other words, human beings have the resources and the power to change lives, and should be willing to "support the work" of helping the world overcome trauma.[72] Just like the example of people joining hands, Shapiro presents human beings as inherently good people that desire to meet basic human needs: "The willingness to reach out to comfort and care for others is another commonality that we share."[73] Similarly, Shapiro closes *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma* with a sincere hope that the practice of EMDR will result in the "eventual healing of us all."[74] This humanistic bent to Shapiro's works should make biblical counselors, who believe in the power of God to change people, extremely uneasy (Phil 2:12-13).

Contrary to its common presentation, EMDR is not a neutral product devoid of any belief system. Shapiro developed her perspectives on the traumatic experience amidst a soup of New Age seminars, CBT, and the self-help work of Norman Cousins. Since a

---

[69] Shapiro, *Getting Past Your Past*, 295.

[70] "Secular Humanism Defined," Free Inquiry, accessed November 7, 2023, https://secularhumanism.org/what-is-secular-humanism/secular-humanism-defined/.

[71] Shapiro, *Getting Past Your Past*, 301.

[72] Shapiro, *Getting Past Your Past*, 301.

[73] Shapiro, *Getting Past Your Past*, 299.

[74] Shapiro and Forrest, *EMDR*, 268.

radical shift from EMD to EMDR, Shapiro has squarely advocated a perspective of neurobiology akin to most modern trauma scholars. As a result, the literature regarding EMDR presents a perspective about who God is, who people are, how people make decisions, and how human beings change that is antithetical to the gospel. However, Shapiro often speaks about religious experience from the perspective of a salesperson trying to sell a product to a variety of customers. Shapiro's books often have a messianic tone, where EMDR is presented as mankind's rescue from an increasing number of problems, such as addiction, grief, and disability. EMDR has no need for saviors, since EMDR has come to save everyone.

Behavior Therapy Foundations

Shapiro's AIP model is linked to behavior therapy at its foundations, and to an overlapping discipline, CBT. CBT is known for its reliance on empiricism to explain human behaviors—particularly neuroses and other abnormal behaviors.[75] The contemporary concept of CBT represents the merger of two historical streams of psychotherapy: Behavior therapy and cognitive therapy.[76] One of the original key figures of behavior therapy is Russian scientist Ivan Pavlov, who developed the theory of classical conditioning.[77] In the 1920s, Pavlov and his students conducted a series of now-famous experiments on dogs, discovering that they could condition, or change a dog's behavioral responses, to a stimulus introduced by researchers. In addition, Pavlov and his students discovered that he could generate various pathologies in dogs through the

---

[75] Nancy Smyth and Desmond Poole, "EMDR and Cognitive-Behavioral Therapy: Exploring the Convergence and Divergence," in *EMDR as an Integrative Psychotherapy Approach*, ed. Francine Shapiro, 3rd ed. (Washington, DC: American Psychological Association, 2007), 152.

[76] Nathan Thoma, Brian Pilecki, and Dean McKay, "Contemporary Cognitive Behavior Therapy: A Review of Theory, History and Evidence," *Psychodynamic Psychiatry* 43, no. 3 (2015): 424.

[77] American Psychological Association, "Classical Conditioning," accessed April 16, 2024. https://dictionary.apa.org/classical-conditioning.

introduction of various stimuli.[78] One of Pavlov's contemporaries, John Watson, would apply these theories to humans, arguing that the psychologists could similarly condition desired responses in humans using chosen stimuli.[79]

One of the early influences of Francine Shapiro was South African psychologist Joseph Wolpe, who many psychologists consider one of the pioneers of behavior therapy.[80] In the 1940s, Wolpe continued Pavlov's behavior experiments using electrical shocks on cats. In Wolpe's experiments, he introduced a painful shock to cats in an experimental cage and attempted to make the cats "neurotic" (or fearful) of the cage.[81] As a result, the cats would refuse to eat in the experimental cage but would be receptive to eating in their habitation cages. Over time, Wolpe would gradually introduce cats to rooms that were similar (but not identical) to the experimental cage, and cats would reluctantly eat in these environments. Wolpe progressively made changes to make the cat's eating environment more closely resemble the experimental cage where the electrical shocks took place. Eventually, the cats began to eat in environments resembling the original experimental cage where the electrical shocks took place. As a result, Wolpe began to theorize that psychologists could treat neurosis in human beings through gradual exposure to negative environments. This process of gradually conditioning clients to negative environments, known as "systematic desensitization," would become a foundation of Shapiro's initial work into EMDR.[82]

In the 1960s, many behavior therapists noticed the "limited success" of

---

[78] Thoma, Pilecki and McKay, "Contemporary Cognitive Behavior Therapy," 424.

[79] Thoma, Pilecki and McKay, "Contemporary Cognitive Behavior Therapy," 425.

[80] Smyth and Poole, "EMDR and Cognitive-Behavioral Therapy," 154.

[81] Joseph Wolpe and David Wolpe, *Life without Fear*, 2nd ed. (Oakland, CA: New Harbinger, 1988), 32.

[82] Marilyn Luber and Francine Shapiro, "Interview with Francine Shapiro: Historical Overview, Present Issues, and Future Directions of EMDR," *Journal of EMDR Practice and Research* 3, no. 4 (2009): 218.

behavior therapy in the treatment of depression.[83] In this void, American psychiatrist Aaron Beck began to analyze the cognitive distortions of his depressive patients and came to believe that changing the underlying beliefs of patients was critical to emotional wellness.[84] As a result of his research, Beck wrote several works in the 1970s, including *Cognitive Therapy and the Emotional Disorders*, which branded his new approach as cognitive therapy.[85] Overall, Beck's cognitive therapy holds that "people's excessive affect and dysfunctional behavior is due to excessive or inappropriate ways of interpreting their experiences."[86] As a result of the popularity of Beck's approach, behavior therapies began to merge with Beck's cognitive treatments to address the dysfunctional thoughts associated with various emotional disturbances. The result of this merging of perspectives resulted in the modern CBT.[87]

CBT has historically been one of the earliest treatment methods for PTSD. One of the most prevalent forms of CBT for the treatment of PTSD is prolonged exposure (PE), which seeks to treat various phobias, such as fear of snakes or spiders, by exposing clients to their fears.[88] PE clinicians expose their clients to negative memories ("imaginal exposure") or anxiety-invoking situations ("in vivo exposure") to desensitize them to their phobias.[89] Similar to the classical conditioning experiments of Pavlov and Wolpe, the goal of the exposure is to gradually change the behavior of the clients, so that they are

---

[83] Smyth and Poole, "EMDR and Cognitive-Behavioral Therapy," 154.

[84] Thoma, Pilecki and McKay, "Contemporary Cognitive Behavior Therapy," 429.

[85] Thoma, Pilecki and McKay, "Contemporary Cognitive Behavior Therapy," 429.

[86] Stephen G. Weinrach, "Cognitive Therapist: A Dialogue with Aaron Beck," *Journal of Counseling and Development* 67, no. 3 (November 1988): 159.

[87] Thoma, Pilecki and McKay, "Contemporary Cognitive Behavior Therapy," 429-30.

[88] Alan L. Peterson, Edna B. Foa, and David S. Riggs, "Prolonged Exposure Therapy," in *Treating PTSD in Military Personnel*, ed. Bret A. Moore and Walter E. Penck, 2nd ed. (New York: Guilford Press, 2019), 46-47.

[89] Van der Kolk, *The Body Keeps the Score*, 222.

less upset and, ultimately, desensitized by the negative stimulus.[90] In addition, the client's traumatic memories are associated with positive cognitions of security and safety. As a result of this immersion, the therapy can assist the client in dealing with their memories of and reactions to the original trauma.[91] In recent years, many neurobiologists, such as Bessel van der Kolk, are critical of CBT in the treatment of PTSD, arguing that CBT is often too intensive, too time-consuming and, ultimately, ineffective compared to other PTSD treatments.[92]

In her original study, Shapiro conceived of EMDR as a desensitization procedure, believing that Pavlov and Wolpe's theories could largely explain the mechanics of how EMDR worked.[93] To this end, Shapiro states, "One of the most potentially fruitful areas of study involves Pavlov's (1927) theory of psychotherapeutic effect and the basis of neurosis which involves a balance between excitatory and inhibitory processes."[94] Like forms of CBT, one of the core elements of EMDR is simply the client's exposure to troublesome memories, which is the fourth stage of the EMDR procedures.[95] However, EMDR and CBT diverge in terms of their approach to desensitization. Most CBT methods, such as PE, tend to focus on changing cognitions and behavior related to the abnormal memory over an extended period.[96] In contrast, the approach and philosophy of EMDR tends to be "whatever happens," allowing the client

---

[90] Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 47.

[91] Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 47.

[92] Van der Kolk, *The Body Keeps the Score*, 223.

[93] Francine Shapiro, "Efficacy of the Eye Movement Desensitization Procedure in the Treatment of Traumatic Memories," *Journal of Traumatic Stress* 2, no. 2 (1989): 220.

[94] Shapiro, "Efficacy of the Eye Movement Desensitization Procedure," 220.

[95] Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd ed. (New York: Guilford Press, 2017), 141-43.

[96] Peterson, Foa, and Riggs, "Prolonged Exposure Therapy," 49-50.

to move beyond the target memory to whatever past abnormal memories come up.[97] In addition, EMDR "overlaps" with CBT in terms of "trauma image, body sensations, associated affect and beliefs."[98] Borrowing from CBT, the EMDR clinician helps the client to visualize their past trauma, to identify their negative/distorted cognitions associated with the traumatic event and to install new, positive cognitions regarding themselves. During the identification of the negative cognitions, the clinician will ask the client questions such as, "State what you think of yourself at your worst moments," "What words go best with the picture that express your negative belief about yourself," or "What thoughts do you have about yourself?"[99] Next, the clinician asks the client what they would like to believe about themselves and works to install that new belief during the EMDR process.[100] In conjunction, the emphasis on behavioral measurements, such as subjective units of disturbance and validity of cognition, and positive/negative cognitions borrow from CBT methodologies.[101]

Particularly in the field of PTSD treatment, the relationship between EMDR and CBT has been fraught with tension. The lingering question among many CBT proponents is the efficacy of the eye movements and whether EMDR is merely CBT in disguise. In their exploration of connections between EMDR and CBT, Nancy Smyth and Desmond Poole even note, "EMDR, minus the eye movements, can be considered a parsimonious integration of all of the core elements of old and new behavioral treatment methods."[102] Shapiro even states that "attention to negative and positive beliefs is

---

[97] Luber and Shapiro, "Interview with Francine Shapiro," 225.

[98] Smyth and Poole, "EMDR and Cognitive-Behavioral Therapy Divergence," 159.

[99] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 126.

[100] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 151-53.

[101] Shapiro, "Efficacy of the Eye Movement Desensitization Procedure in the Treatment of Traumatic Memories," 203.

[102] Smyth and Poole, "EMDR and Cognitive-Behavioral Therapy," 159.

congruent with a cognitive therapy framework . . . and the use of baseline rating scales is part of the behavioral heritage."[103] To this end, the foundation of EMDR is inexorably linked and indebted to behavior therapy.

Neurobiological Foundations

In recent years, neurobiologists have tried to explain trauma in more physiological terms. In fact, Peter Levine emphatically argues in *Waking the Tiger*, "The key to healing traumatic symptoms in humans is in our physiology."[104] According to this perspective, the normal human brain routinely finds a way to adapt and overcome a traumatic event.[105] As such, a functional human brain can integrate, or associate, the experiences from a traumatic event so that the brain learns to adapt and overcome future experiences.[106] A wide range of influences, such as drugs, anesthesia, or neural injury, can impair our human consciousness, but neurobiologists also postulate that traumatic events impair human consciousness too.[107] In a person with PTSD symptoms, the brain's process for properly integrating the traumatic event goes haywire. PTSD sufferers have "particular emotions, images, sensations and muscular reactions related to the trauma" which are "deeply imprinted on their minds."[108] The amygdala goes into overdrive, triggering stress hormones, including cortisol and adrenaline, that increase heart rate, breathing, and blood pressure.[109] In addition, the medial prefrontal cortex (MPFC), which

---

[103] Francine Shapiro, ed., *EMDR as an Integrative Psychotherapy Approach*, 41.

[104] Levine and Frederick, *Waking the Tiger: Healing Trauma*, 17.

[105] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 27-29.

[106] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 27-29.

[107] Uri Bergmann, *Neurobiological Foundations for EMDR Practice* (New York: Springer, 2012), 121.

[108] Bessel van der Kolk, "Beyond the Talking Cure: Somatic Experience and Subcortical Imprints in the Treatment of Trauma," in Shapiro, *EMDR as an Integrative Psychotherapy Approach*, 57-58.

[109] Bremner, *Does Stress Damage the Brain?*, 91-93.

is the rational decision-making center of the brain, becomes overridden by the emotional responses to the traumatic event.[110] More importantly, the thalamus, which is the sensory center of the brain, stops effectively processing the sensory input, such as sights, sounds, and smells, of the traumatic event.[111] As normal sensory processing breaks down, the thalamus begins to encode the sensory information in fragmented, or disassociated, elements. The sights, sounds, and smells of the traumatic event become unmoored from time, where the PTSD sufferer's brain does not distinguish the past from the present.[112] Overall, this combination of factors creates a state of hyperarousal in PTSD sufferers, where they have trouble distinguishing the past dangers from their present situation.[113]

In *The Body Keeps the Score*, van der Kolk argues, "Disassociation is the essence of trauma."[114] On a basic level, neurobiologists and neuropsychologists believe that disassociation is one of the body's responses that helps it cope with a traumatic event. Peter Levine describes disassociation as "a breakdown in the continuity of a person's felt sense," including "distortions of time and perception."[115] In this manner, the body can cope with life-threatening situations by essentially disconnecting one's consciousness from the body, allowing people to endure all manner of horrific events. Most dissociative events, such as daydreaming or fantasy, are not pathological, but, instead, are a normal part of the human experience. However, many persons that have suffered traumatic events may have a long-term inability to process or integrate the horrible things that have occurred into their consciousness. Uri Bergmann argues,

---

[110] Van der Kolk, *The Body Keeps the Score*, 62.

[111] Van der Kolk, *The Body Keeps the Score*, 62.

[112] Bremner, *Does Stress Damage the Brain?*, 45-46.

[113] Herman, *Trauma and Recovery*, 37-40.

[114] Van der Kolk, *The Body Keeps the Score*, 66.

[115] Levine and Frederick, *Waking the Tiger*, 137.

"Traumatic events produce lasting impairments in physiological arousal, emotions, cognition and memory, severing these normally integrated functions from each other."[116] Similarly, Judith Herman argues that the PTSD sufferer's memory, cognition, and affect become disconnected from one another, where each system now takes on a life of their own. [117] To cope with extreme trauma, neuropsychologists suggest that the brain stops working as one cohesive unit, and each system within the brain effectively goes rogue.[118] Similarly, Robert Stickgold theorizes that PTSD occurs when the body does not integrate the traumatic memory from episodic memory to semantic memory.[119] Therefore, the goal of any PTSD therapy should be to help the human brain to start to integrate, or associate, the traumatic memories and to cause the various brain functions to start working together in one cohesive unit.[120]

With an article in 1991, Francine Shapiro began to shift the theoretical underpinnings of EMDR away from behavioral theory to a neurobiological approach.[121] As a result, the AIP model makes several broad assumptions that find their foundations in neurobiology. As referenced earlier, Shapiro posits that the brain normally "metabolizes" or "digests" new memories into existing memory networks to develop a particular behavior.[122] Neurobiologists often refer to these existing memory networks as "nodes" or

---

[116] Bergmann, *Neurobiological Foundations for EMDR Practice*, 122.

[117] Herman, *Trauma and Recovery*, 51-56.

[118] Van der Kolk, *The Body Keeps the Score*, 65.

[119] Robert Stickgold, "EMDR: A Putative Neurobiological Mechanism of Action," *Journal of Clinical Psychology* 58, no. 1 (2002): 67.

[120] Van der Kolk, *The Body Keeps the Score*, 69.

[121] Francine Shapiro, "Eye Movement Desensitization and Reprocessing Procedure: From EMD to EMD/R—A New Treatment Model for Anxiety and Related Traumata," *Behavior Therapist* 14, no. 5 (1991): 133.

[122] Francine Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," *Journal of EMDR Practice and Research* 1, no. 2 (2007): 70.

linkages between various life events.[123] Sandra Barker and Clair Hawes expound that "neurophysiological mechanisms in the brain enable information to the processed and integrated into existing memory schema where it remains accessible for future use."[124] For example, a person uses earlier life experiences about how to drink from a cup to inform future drinking experiences. In some circumstances, a negative life event links up to positive events in our memory networks to develop a positive resolution. For example, the child who falls off his bike might use those experiences to develop a more effective future bike ride. However, the negative memory might be so upsetting that the brain reaches no adaptive resolution, and the negative memory creates a link with other traumatic memories.[125] Shapiro states, "The information stored in the neurophysiological memory network may be manifested by all elements of the event: images, physical sensations, tastes and smells, sounds, affect and cognitions such as assessment and belief statements."[126] In the EMDR process, the clinician will ask the counselee to focus on a specific pivotal memory, or a "target, which will be focus on the initial EMDR treatment. However, the therapy might drift to other memories associated with the "target" because there is a "constellation" of associated memories surrounding that "target" memory.[127] For example, the traumatized combat soldier might begin EMDR with a target of a negative experience with their combat experience, but, through the EMDR process, this specific memory shifts to other childhood memories associated with that experience. In this manner, EMDR is principally concerned with groups of memories rather than focusing on one specific traumatic memory.

---

[123] Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 70.

[124] Sandra Barker and Clair Hawes, "Eye Movement Desensitization and Reprocessing in Individual Psychology," *Individual Psychology* 55, no. 2 (Summer 1999): 147.

[125] Francine Shapiro, *Getting Past Your Past*, 62.

[126] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 41.

[127] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 30.

In addition, Shapiro holds to the concept of "psychological self-healing," which presumes that the human body is continually working towards a state of healing.[128] For example, the body works to heal a broken bone when one falls on the pavement; however, the wound might not heal if an object within the body blocks the healing process. In this instance, a trained physician would need to remove the object and clean the wound for the healing process to begin in the body. The "psychological self-healing" model similarly presumes that the brain works towards a "state of mental health" with its healing processes.[129] When the body encounters disturbing events, the nervous system works to process those events, so that the disturbance is eliminated, and vital information is secured for the future. EMDR expert Laurel Parnell states, "In theory, the brain has an information processing system which works toward keeping us in a balanced state of mental health, just as the body has a natural healing response to physical injury."[130] If a traumatic event blocks the nervous system, Shapiro argues a trained professional needs to "reach resolution and complete processing."[131]

Finally, disturbances in the human body may arise when the body does not properly "process" traumatic events.[132] When the body experiences trauma, Shapiro holds that the brain can become "frozen" or "stuck" instead of adapting when a person experiences trauma.[133] Overall, Shapiro argues that a traumatic event can create a state of "traumatic overload" in the human brain, whereby the incident remains "in its anxiety

---

[128] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 28.

[129] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 28.

[130] Laurel Parnell, *Transforming Trauma: EMDR, The Revolutionary New Therapy for Freeing the Mind, Clearing the Body, and Opening the Heart* (New York: W. W. Norton, 1998), 54.

[131] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 28.

[132] Shapiro, *Getting Past Your Past*, 59.

[133] Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 70.

producing form."[134] The human nervous system produces cortisol and adrenaline in response to trauma, which causes a chemical imbalance that causes the nervous system to function improperly. In addition, Shapiro argues these traumatic situations lead to the symptoms of PTSD, such as nightmares, flashbacks, and anxiety. Again, Shapiro often gives the example of a child who has fallen off their bike. While some children overcome the experience of falling off their bike, other children can develop an overwhelming fear of riding a bike and insist on not riding their bike again. In the future, the anxious bike rider might be able to fully visualize or feel the sensation of the bike crash. Shapiro argues that the reason why the child stays fearful is that "the information processing system has stored the experience without adequately processing it to an adaptive resolution." [135] In essence, "the information is frozen in time, isolated in its own neural network, and stored in its originally disturbing state-specific form."[136] Similarly, Shapiro often asked conference attendees and book readers to imagine a humiliating event from their grade school days. As one closes their eyes and remembers the event, one often feels the same emotions of hurt and regret from the original traumatic event.[137] Shapiro would argue that these negative emotions, sensations and thoughts are evidences that the body has not properly processed the disturbing event.[138] When events remain unprocessed, they trigger glands and bodily systems that produce fight or flight responses, and, thus, counselees would experience the same emotions of the original event.

---

[134] Shapiro, "Eye Movement Desensitization and Reprocessing Procedure," 135.

[135] Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 70.

[136] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 37.

[137] Shapiro, *Getting Past Your Past*, 59.

[138] Shapiro, *Getting Past Your Past*, 59.

Adaptive Information Processing Model

Overall, the neurobiological theories about the dissociative pathology of memories represents the backbone of EMDR. The AIP model holds that traumatic events interfere with the normal information processing functions of the human brain, so new connections between the traumatic event and existing neural networks are not set up.[139] The dissociative pathology of PTSD causes excessive neural stimulation, where emotions and sensations related to traumatic events are unmoored in time and context.[140] Since the traumatic events are believed to be maladaptively coded in the brain, EMDR seeks to establish linkages with other memory networks and to adequately process or associate the traumatic information.[141] According to Uri Bergmann, the AIP model "views information processing as the linking of neural networks related to our experience, which include thoughts/beliefs, images, emotions and sensations."[142] In essence, the interconnectedness of various life experiences allows the client to rapidly associate their current problems to unprocessed life experiences. Shapiro holds that "the rapid processing that EMDR affords generally reveal to the client's consciousness the interconnectedness of memories."[143]

Based on these neurobiological concepts, Shapiro believes that EMDR simply jump starts the natural healing processes of the brain.[144] The AIP model argues that EMDR's procedures access the dysfunctionally stored regions of the brain and stimulate the brain's adaptive processing network to reach an adaptive resolution.[145] The rational beliefs and the emotions regarding the event are stored in different neurological

---

[139] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 30-31.

[140] Francine Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 7.

[141] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 30-31.

[142] Bergmann, *Neurobiological Foundations for EMDR Practice*, 172.

[143] Shapiro, *EMDR as an Integrative Psychotherapy Approach*, 17.

[144] Shapiro, "EMDR Treatment: Overview and Integration," 42-43.

[145] Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 71.

networks, and EMDR allows the brain to link these two areas together. Neurobiologist Robert Stickgold argues that the adaptive resolution moves the traumatic information from the implicit memory system to the episodic memory system and, ultimately, to the semantic memory.[146] In this manner, EMDR "mimics" the spontaneous information processing of the brain, setting motion the brain's intrinsic information processing system.[147] The EMDR clinician simply aims to guide the EMDR session so that the body's natural self-healing process is jump started. According to Shapiro, the "healing process" associated with EMDR comes "from within," and commonly speaks of people "healing themselves" through EMDR.[148] In *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma*, Shapiro states,

> The healing process came from within. I was a guide, a facilitator, and a witness, but I hadn't caused my subjects to change. . . . In fact, my subjects' insights had followed their own logical (and emotionally healthy) train of thought, moving, for example, from "I was to blame," to "I was very young," through "I did the best I could," and finally to "it wasn't my fault. I am fine as I am."[149]

Shapiro also adds, "The more closely the deliberate activation mimics spontaneous processing, the more productive it is."[150]

In this manner, Shapiro believes that "past experiences lay the groundwork for present dysfunction."[151] Specifically, past traumas—particularly childhood traumas—create the foundation upon which present dysfunctions are built.[152] For example, an unprocessed experience with an angry parent might unwittingly lead into

---

[146] Stickgold, "EMDR: A Putative Neurobiological Mechanism of Action," 72.

[147] Shapiro, "EMDR Treatment: Overview and Integration," 42.

[148] Shapiro and Forrest, *EMDR*, 38.

[149] Shapiro and Forrest, *EMDR*, 38.

[150] Shapiro, "EMDR Treatment: Overview and Integration," 43.

[151] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 41.

[152] Francine Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 8.

unmanageable social phobias in adulthood. While CBT seeks to impact a person's negative emotions and beliefs by changing a client's thinking and behaviors, EMDR believes that negative emotions and beliefs are the symptom of the problem instead of the cause.[153] In essence, EMDR looks to address the negative memories that are the root of the problem. A person might not be aware of their unprocessed traumatic memories, but "the dysfunctionally stored emotions, physical sensations, and perspectives are the reflexive responses to current events and drive the person's behaviors."[154] Therefore, unprocessed traumatic event experienced during childhood, which appear to be small, might evolve into major dysfunctions in adulthood. In Shapiro's words, many counselees might have no clue that their disturbing memories are still "running the show."[155] Some counselees will believe that their childhood is irrelevant, but, instead, the traumas of the past might be highly relevant about impacts on the present. In short, Shapiro argues, "The past is present."[156]

As a result, Shapiro argues that traditional forms of therapy do not work on counselees with PTSD.[157] Since these disturbing experiences remain undigested in the body, traditional therapies, such as reading books or talk therapy, will prove ineffective, since they do work to remove the memories that are "stuck."[158] As long as negative memories remain unprocessed, these memories will continue to produce negative impacts on the present. Shapiro believes the goal of EMDR treatment is unique: "To liberate the client from the dysfunctionally stored memories that contain the affects and perspectives

---

[153] Shapiro, *Getting Past Your Past*, 64.

[154] Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 71.

[155] Shapiro, *Getting Past Your Past*, 64.

[156] Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 71.

[157] Shapiro, *Getting Past Your Past*, 62.

[158] Shapiro, *Getting Past Your Past*, 62.

driving the current pathology."[159] Other forms of therapy focus on managing or inhibiting disruptive situations and behaviors instead of integrating traumatic memories to an adaptive resolution.[160] In addition, EMDR therapy allows the client to handle future traumatic situations better, because the past traumatic memories have been resolved and moved towards this adaptive resolution.[161] Based on these theories, van der Kolk's hope for EMDR is that "people may be able to heal from trauma without talking about it."[162]

Other Theories

Of note, Shapiro's neurobiologically driven AIP model is not the only accepted working theory of EMDR. Regarding the validity of the AIP model, Shapiro states, "It is important to understand that while this model was initially offered as a working hypothesis only and is subject to modification based on further laboratory and clinical observation."[163]

Cognitive Behavioral Therapy

One ongoing stream of thought is that EMDR is simply CBT plus eye movements, and that the eye movements do not contribute to the success or failure of the procedure. [164] In this manner, EMDR could be considered a form of exposure therapy,

---

[159] Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 82.

[160] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 36-37.

[161] Francine Shapiro, "EMDR, Adaptive Information Processing, and Case Conceptualization," 8.

[162] Van der Kolk, *The Body Keeps the Score*, 255.

[163] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 26.

[164] For research supporting the cognitive-behavior therapy view of EMDR, see Robert May, "How Do We Know What Works?," *Journal of College Student Psychotherapy* 19, no. 3 (2005): 69-73; Grant Devilly, Susan Spence, and Ronald Rapee, "Statistical and Reliable Change with Eye Movement Desensitization and Reprocessing: Treating Trauma Within a Veteran Population," *Behavior Therapy* 29 (1998): 435-55; George Renfrey and C. Richard Spates, "Eye Movement Desensitization: A Partial Dismantling Study," *Journal of Behavior Therapy and Experimental Psychiatry* 25, no. 3 (1994): 231-39; Roger K. Pitman et al., "Emotional Processing during Eye Movement Desensitization and Reprocessing Therapy of Vietnam Veterans with Chronic Posttraumatic Stress Disorder," *Comprehensive Psychiatry* 37, no. 6 (1996): 419-29; Robert Oswalt et al., "Evaluation of the One-Session Eye-Movement Desensitization Reprocessing Procedure for Eliminating Traumatic Memories," *Psychological Reports* 73, no. 1 (1993):

where the efficacious element of the treatment is the client's exposure to the negative memories. Shapiro's own narrative regarding the development of EMDR supports this viewpoint, since Shapiro admits to intentionally borrowing concepts from systematic desensitization. [165] To this end, J. Douglas Bremner states, "Many of the elements of EMDR include treatments that have been previously utilized in PTSD, such as hypnosis and exposure therapies . . . . The exposure to images running through a patient's mind is similarly related to the techniques utilized by behavioral therapies involving flooding."[166] Similarly, Rosen et al. argued, "After all, if one removes the E and M from EMDR, we are left with traditional elements of behavior therapy—Desensitization and Cognitive Processing."[167] Shapiro combats the perspective that EMDR is simply exposure therapy by pointing out that PE focuses on one traumatic image where EMDR allows the client to free associate between various traumatic images.[168] In terms of other dissimilarities to CBT, EMDR's exposure to the traumatic image does not involve detailed descriptions of the traumatic event, challenging of cognitions, extended exposure to traumatic events, or homework assignments.[169] In essence, Shapiro admits that EMDR exposes clients to traumatic memories, but argues that a difference in methodology makes EMDR separate from other CBT treatments.

99-104; Marcel van den Hout and Iris Engelhard, "How Does EMDR Work?," *Journal of Experimental Psychopathology* 3, no. 5 (2012): 724-38.

[165] Shapiro, "Efficacy of the Eye Movement Desensitization Procedure in the Treatment of Traumatic Memories," 200.

[166] Bremner, *Does Stress Damage the Brain?*, 260.

[167] Gerald Rosen et al., "A Realistic Appraisal of EMDR," *California Psychologist* 31 (1998): 25.

[168] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 22.

[169] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 22-23.

Taxing Working Memory

A more accepted view of EMDR is the view that the procedure taxes working memory.[170] While the brain's long-term memory is extremely voluminous, the capacity of a person's working memory, which is one of the brain's executive functions, is limited.[171] When a person attempts to perform two tasks at once, these two tasks complete for the limited capacity of the working memory. In addition, long-term memories are "labile," meaning that the brain decides how vividly and extensively the memory becomes restored.[172] If the brain attempts to focus on two things at once, the working memory might recall a fuzzier version of the events, creating a less detailed image of past events. Several studies have shown that focusing on certain tasks, such as performing arithmetic, calculating out loud, or playing video games, effectively tax the working memory, so that the brain's ability to vividly recall a memory are impaired.[173] Some researchers, such as Marcel van den Hout and Iris Engelhard, have argued that the eye movements of EDMR simply tax the working memory so that the client does not vividly recall the traumatic images.[174] To this end, van den Hout and Englehard produced a study demonstrating that eye movements slow reaction times for clients, impacting memory accessibility.[175] In this manner, the taxing working memory theory of EMDR

---

[170] For research supporting the taxing working memory view of EMDR, see Van den Hout and Engelhard, "How Does EMDR Work?," 724-38; Marcel van den Hout, Nicola Bartelski, and Iris Engelhard, "On EMDR: Eye Movements during Retrieval Reduce Subjective Vividness and Objective Memory Accessibility During Future Recall," *Cognition and Emotion* 27, no. 1 (2013): 177-83; Dany Laure Wadji, C. Martin-Soelch, and V. Camos, "Can Working Memory Account for EMDR Efficacy in PTSD?," *BMC Psychology* 10, no. 1 (2022): 1-12; Suzanne Van Veen, Sahaj Kang, and Kevin van Schie, "On EMDR: Measuring the Working Memory Taxation of Various Types of Eye (Non-)Movement Conditions," *Journal of Behavioral Therapy and Experimental Psychiatry* 65 (2019): 1-5; and Iris Engelhard, Sophie L. van Uijen and Marcel van den Hout, "The Impact of Taxing Working Memory on Negative and Positive Memories," *European Journal Psychotraumatology* 1 (2010): 1-8.

[171] Van den Hout and Engelhard, "How Does EMDR Work?," 728.

[172] Van den Hout and Engelhard, "How Does EMDR Work?," 728

[173] Engelhard, van Uijen and Van den Hout, "The Impact of Taxing Working Memory on Negative and Positive Memories," 1-8.

[174] Van den Hout and Engelhard, "How Does EMDR Work?," 726.

[175] Van den Hout, Bartelski, and Engelhard, "On EMDR," 177.

argues that the eye movements are efficacious but the reason for that success is not necessarily related to the brain's reprocessing of traumatic memories.

Orienting Response

Another major theory regarding EMDR is that the eye movements illicit an orienting response in the human body.[176] The orienting response is a "freeze" response to a traumatic event, which quickly resolves into relaxation within 10 seconds.[177] The body's orienting response occurs when people respond to sudden and potentially dangerous scenarios.[178] The response causes the human body to stop and focus its sensory functioning to assess new threats.[179] Interest in the orienting response has been associated with the psychophysiological responses to the eye movement component of EMDR treatment.[180] Some of the psychophysiological responses to the eye movements in EMDR, such as decreased heart rate, decreased galvanic skin response and increased finger temperature, seem to mirror the body's orienting response, and, therefore, advocates of this position argue that EMDR produces a de-arousal response to traumatic

---

[176] For research supporting the orienting response view of EMDR, see Olivia Calancie et al., "Eye Movement Desensitization and Reprocessing as a Treatment for PTSD: Current Neurobiological Theories and a New Hypothesis," *Annals of the New York Academy of Sciences* 1426 (2018): 127-45; Ramon Landin-Romero et al., "How Does Eye Movement Desensitization and Reprocessing Therapy Work? A Systematic Review on Suggested Mechanisms of Action," *Frontiers in Psychology* 9 (2018): 1-23; Ulf O. E. Elofsson et al., "Physiological Correlates of Eye Movement Desensitization and Reprocessing," *Journal of Anxiety Disorders* 22 (2008): 622-34; Alastair Barrowcliff et al., "Eye-Movements Reduce the Vividness, Emotional Valence and Electrodermal Arousal Associated with Negative Autobiographical Memories," *Journal of Forensic Psychiatry and Psychology* 15, no. 2 (2004): 325-45; Sarah Schubert, Christopher W. Lee, and Peter D. Drummond, "Eye Movements Matter, But Why? Psychophysiological Correlates of EMDR Therapy to Treat Trauma in Timor-Leste," *Journal of EMDR Practice and Research* 10, no. 2 (2016): 70-80.

[177] Elofsson et al., "Physiological Correlates of Eye Movement Desensitization and Reprocessing," 632.

[178] Olivia Calancie et al., "Eye Movement Desensitization and Reprocessing as a Treatment for PTSD," 132.

[179] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 371.

[180] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 372.

events.[181] Essentially, this viewpoint argues that the pairing of physical de-arousal with imaginal exposure to traumatic memories leads to the extinction of the anxiety associated with the traumastic event.[182]

REM Sleep

Some researchers are still open to Shapiro's original theory that the bilateral stimulation of EMDR processes traumatic memories through brain processes like REM sleep.[183] Research has showed that sleep and dreams are related to a person's mental health.[184] Similar to EMDR, one's eyes move backward and forwards during REM sleep in saccadic eye movements.[185] Stickgold's studies have shown that REM sleep also works to process one's memories by increasing the imprint of relevant information and allowing irrelevant information to fade.[186] As such, Stickgold still suggests that a linkage between REM sleep and EMDR exists: "If the particular physiological state encountered during REM sleep is supportive of memory integration necessary for recovery, then it is not unreasonable to conclude that interventions which shift the brain toward this state likewise would be beneficial."[187] Similarly, Elofsson et al. have agreed that the physiological activity in the human body during EMDR fits well with the REM sleep theory.[188] In *The Body Keeps the Score*, Bessel van der Kolk appears open to this

---

[181] Ramon Landin-Romero et al., "How Does Eye Movement Desensitization and Reprocessing Therapy Work?," 14.

[182] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 372.

[183] For research supporting the REM sleep view of EMDR, see Robert Stickgold, "EMDR: A Putative Neurobiological Mechanism of Action," 61-75; Elofsson et al., "Physiological Correlates of Eye Movement Desensitization and Reprocessing," 622-34.

[184] Van der Kolk, *The Body Keeps the Score*, 262.

[185] Stickgold, "EMDR: A Putative Neurobiological Mechanism of Action," 70.

[186] Van der Kolk, *The Body Keeps the Score*, 262.

[187] Stickgold, "EMDR: A Putative Neurobiological Mechanism of Action," 70.

[188] Elofsson et al., "Physiological Correlates of Eye Movement Desensitization and Reprocessing," 629-631.

mechanism of action for EMDR, and announces research into the connection between saccadic eye movements and traumatic memories.[189] However, this theory seems to be at odds with research using other forms of bilateral stimulation with EMDR.

Combination of Factors

Of course, Shapiro notes that these differing theories regarding information processing are not "mutually exclusive."[190] To this end, Shapiro admits that much of the research regarding other mechanisms of action in EMDR has proven to be broader than the AIP model.[191] In particular, bilateral stimulation has been proven to tax working memory, and some research has demonstrated that bilateral stimulation mimics the integrative process found in REM sleep.[192] Shapiro's answer to this conundrum seems to be that the brain's information processing system is complex and that various factors might be at play during the EMDR procedures.[193] While the working memory theory might explain the decrease in the vividness of the traumatic memory through EMDR, Shapiro argues that the rapid and often spontaneous processing of memory is best explained by the AIP model.[194] Similarly, the REM sleep hypothesis does not fully account for the effectiveness of other forms of bilateral stimulation, such as taps or tones, or the increase in positive imagery experienced during EMDR.[195]

---

[189] Van der Kolk, *The Body Keeps the Score*, 262.

[190] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 28.

[191] Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 27.

[192] Stickgold, "EMDR: A Putative Neurobiological Mechanism of Action," 71.

[193] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 28.

[194] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 375.

[195] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 375.

The Eight Phases of EMDR Therapy

Based on the theories presented, Shapiro has developed a strict eight-phase treatment process for EMDR.[196] The length of time and amount of attention that the therapist spends on each phase varies from client to client. Shapiro considers the EMDR treatment process to be fully integrative, including procedures from various forms of psychology, such as behavior therapy and neurobiology. Of importance, Shapiro notes that "the model is not the method."[197] In essence, the validity and efficacy of the current EMDR procedures is not inexorably coupled to the validity or the acceptance of the AIP model. As such, various psychologists representing different branches of study can utilize the framework of EMDR, since the integrative approach attempts to encompass multiple therapeutic approaches.

Phase 1: Client History and Treatment Planning

The initial phase of EMDR treatment involves the therapist taking a thorough intake of the client's history. Essentially, the purpose of this phase is to help the therapist understand how and when to use EMDR treatment with the client. First, the therapist needs to determine any potential safety concerns about the use of EMDR on the client, such as "personal stability" or "current life situations."[198] For example, a person undergoing a divorce or experiencing a heart condition might not be too distracted for potential EMDR treatment. If safety concerns exist, the therapist might choose to delay treatment until such safety concerns have subsided. Next, the therapist needs to design

---

[196] Many of Francine Shapiro's descriptions of the eight phases of EMDR are similar (if not duplicative) across her many publications. As such, this section of the research paper will principally cite from Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*). However, similar descriptions of the eight phases of EMDR can be found in Shapiro, "EMDR Treatment: Overview and Integration," 30-41; Francine Shapiro and Louise Maxfield, "Eye Movement Desensitization and Reprocessing (EMDR): Information Processing in the Treatment of Trauma," *Psychotherapy in Practice* 58, no. 8 (2002): 933-46; Francine Shapiro, "EMDR, Adaptive Information Processing Perspective and Case Conceptualization," 3-35.

[197] Shapiro, "EMDR Treatment: Overview and Integration," 31.

[198] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 66.

the EMDR treatment plan. Overall, the therapist tries to determine the big picture of the client's needs, including "dysfunctional behaviors, symptoms and characteristics that need to be addressed."[199] In addition, the therapist seeks to determine the understand that events that set the client's dysfunctions into motion and the potential targets that need to be processed.

Phase 2: Preparation

Following the initial client history, the therapist would then explain the procedures of EMDR to the client. Overall, the therapist would need to inform the client about theories of why and how EMDR treatment works. In addition, the therapist would want to warn the client that emotional disturbances are possible during the EMDR treatment process. Without information about EMDR treatment and potential adverse effects, the client would be unable to properly consent to EMDR treatment. Also, the therapist needs to work on relaxation techniques that would be used in the session as well as out of the session. The therapist needs to warn the client that emotional disturbances might occur outside of the treatment session, and the client needs to have adequate tools available to potentially handle any adverse impacts of treatment.

Phase 3: Assessment

The third phase of the treatment involves the therapist assessing the target memory as well as the client's baseline response to the target as measured in subjective units of disturbance and validity of cognition scales. First, the therapist asks the client to select an image that best represents the target that has been selected. Then, the therapist would ask the client to assess their negative cognition (or belief) that goes along with the negative memory. Negative cognitions are the maladaptive beliefs that go along with the memory, such as "I am worthless" or "I am dirty." To go along with the negative

[199] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 66.

cognition, the therapist also asks the client to select a positive cognition (or belief), which will replace the negative cognition during later in the EMDR process. The positive cognition, such as "I am worthwhile" or "I can succeed," should help the client to later take control over the situation. The therapist would then ask the client to rate their belief in the positive cognition on a seven-point VOC scale. Next, the therapist asks to rate the level and intensity of negative emotions associated with the event on a ten-point SUD scale. The VOC and SUD ratings set up a baseline to determine the future effectiveness of the EMDR treatment. During this phase, the therapist also seeks to determine where the physical sensations associated with the disturbance are located in the client's body.

Phase 4: Desensitization

During the desensitization phase, the eye movement phase of the EMDR treatment begins. According to Shapiro, this phase of desensitization is a byproduct of reprocessing, and should not be confused with merely exposing the client to traumatic memories.[200] During this phase, the EMDR process will positively restructure the cognition and produce new insights from the client. The goal of the process is to process all the dysfunctional material in the node related to the traumatic event. In this manner, the clinician is not merely asking the client to focus on one negative memory; instead, the client's past experiences might be linked to various traumatic events. Therefore, the clinician allows the client to freely associate between various interconnected traumatic events in their past. For EMDR to be effective, the clinician must process all of the dysfunctional material in that "channel" of events, which is the series of interconnected events.[201] This phase has not been completed until the client's SUD rating reaches zero (or another rating deemed appropriate by the therapist), meaning that "the primary

---

[200] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 141.

[201] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 142.

dysfunction involving the targeted event has been cleared."[202]

Phase 5: Installation

During the installation phase, the EMDR treatment focuses on the replacement of the negative cognitions from the target with the client's selected positive cognitions. The dual attention on the negative memory and the positive cognition tries to create an association in the brain between the two elements. Shapiro gives the example of a molested women starting with the negative cognition of "I am powerless" and seeking to install the positive cognition of "I am in control."[203] At this point, the clinician would ask the client to hold their target memory in their mind along with the selected positive cognition. This phase of the treatment process would continue until the client's VOC rating reaches a level of seven, meaning that the client confidently believes the statement is true. During this phase, the clinician will continue with series of eye movements to aid in the installation of the positive cognition. At the end of the phase, the clinician should check to see whether the client has any other negative cognitions associated with the event, which may require further EMDR treatment. Shapiro points out that the installation phase is the most critical component of the EMDR process: "The very existence of negative cognitions is an indication that the traumatic event is a powerfully defining factor in a person's life, one that has not been adequately assimilated into an adaptive framework."[204]

Phase 6: Body Scan

This phase relies on Shapiro's belief that a connection exists between negative

---

[202] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 68.

[203] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 68.

[204] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 69.

bodily sensations and traumatic events.[205] During this phase, the clinician asks the client to focus on the traumatic event and the positive cognition, and then asks the client to scan their bodies mentally for the presence of any negative bodily sensations. The presence of a physical discomfort is a sign that unprocessed information still remains, and that the clinician needs to conduct additional treatment on the traumatic memories.

Phase 7: Closure

Regardless of whether the installation component of the EMDR process is complete, clinician sessions do have a limited time frame, so the clinician must take time to bring the client back to an emotionally stable place at the end of each session. The clinician needs to remind the client that the traumatic memories might arise in between sessions and to remind the client of relaxation techniques to handle such re-emergences. Shapiro believes that the re-emergence of the traumatic memories in between sessions is a "positive sign," demonstrating that the body is working to process the traumatic events.[206] On such occasions, the clinician might ask the client to journal or to develop a log about disturbances to inform the nature of the disturbances for future EMDR sessions.

Phase 8: Re-Evaluation

Finally, the clinician conducts a re-evaluation at the beginning of each new session of EMDR. The clinician will ask the client to re-assess the previously focused target memories to determine the effects of previous EMDR sessions. In addition, the clinician will ask the client about any disturbances that have occurred in between sessions as measured through their journals or logs. Based on this re-evaluation, the clinician must decide whether use the EMDR sessions to focus on previous targets or on newly emerged

---

[205] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 70.

[206] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 70.

targets.

CHAPTER 4

BIBLICAL APPRAISAL OF EMDR

Recent advances in neuroscience have added color to our already rich perspective of the traditional biblical understanding of anthropology—meaning the storyline of who human beings are and how they relate to God. Throughout most of human history, the human brain has been a black box that has eluded scientific investigation and explanation. Throughout the twentieth century, neuroscientists and cognitive scientists gathered a dizzying amount of information about the operations of the human brain through rapid technological advancement. By the late 1950s, neuroscience began to posit that pharmacology, brain damage, disease, surgery, or other modifications could alter a person's consciousness through alteration of various areas of the brain.[1] As technology marched forward in the 1980s, CT scans, MRIs, PET scans and other body/brain imaging devices gave neuroscientists new windows into the brain. As a result, neuroanatomy mapped out the basic components of the brain, and neurophysiology showed the various purposes of the brain.[2] After its conception, EMDR stepped wholeheartedly into the naturalistic worldview of neuroscience, holding that human beings are physical bodies largely driven by unconscious brain processes. This perspective diverges from a traditional Christian understanding of the human being, which asserts that human beings are body-soul unities driven by the conscious choices of the heart. Overall, EMDR and Scripture tell radically different versions of the human

---

[1] Kevin J. Corcoran, *Rethinking Human Nature: A Christian Materialist Alternative to the Soul* (Grand Rapids: Baker Academic, 2006), 34.

[2] Nancey Murphy, "Human Nature: Historical, Scientific and Religious Issues," in *Whatever Happened to the Soul? Scientific and Theological Portraits of Human Nature*, ed. Warren S. Brown, Nancey Murphy, and H. Newton Malony (Minneapolis: Fortress Press, 1998), 13.

story, including who human beings are, how human beings make choices, how human beings change and, ultimately, how quick people change.

Who Human Beings Are

In contrast to physicalism, the prevailing position within biblical counseling about the composition of the human being is holistic dualism, meaning human beings are created with soul and body, a psychosomatic unity of two substances.[3] Most commonly, dualism (or dichotomy) refers to the presence of two different substances within the body: the material body and the immaterial soul. Heath Lambert explains Biblical anthropology from the perspective of holistic dualism:

> When God made the first person, he paired the physical with the spiritual, and the combination created a living person. The spiritual aspect of humanity is described as God's own breath, which God has given to no other creature in his world . . . . The Bible makes a distinction between these two aspects of humanity, but it never makes an ultimate division. In biblical terms, there is no such thing as a person who is not both a body and a soul together in one human being. This biblical reality is called "dichotomy," which refers to the fact that human beings consist of two aspects.[4]

The Bible often refers to the material components of the person as the "outer" man and the immaterial components of the person as the "inner" man.[5] God created the human body as a beautiful gift, not something inherently evil. As opposed to other descriptors of God's creation process in Genesis 1-2, Genesis 2:7 describes God uniquely forming the physical bodies of the first people: "Then the Lord God formed the man of

---

[3] Biblical counseling literature supporting a view of holistic dualism includes Heath Lambert, *A Theology of Biblical Counseling: The Doctrinal Foundations of Counseling Ministry* (Grand Rapids: Zondervan, 2016); Jeremy Lelek, *Post-Traumatic Stress Disorder: Recovering Hope*, Gospel for Real Life (Phillipsburg, NJ: P & R, 2013); Robert D. Jones, Kristen L. Kellen, and Rob Green, *The Gospel for Disordered Lives: An Introduction to Christ-Centered Biblical Counseling* (Nashville: B & H Academic, 2021); Jeremy Pierre, *The Dynamic Heart in Daily Life* (Greensboro, NC: New Growth Press, 2016); Curtis Solomon, *I Have PTSD: Reorienting after Trauma* (Greensboro, NC: New Growth Press, 2023).

[4] Heath Lambert, *A Theology of Biblical Counseling*, 192.

[5] Winston Smith, "Dichotomy or Trichotomy? How the Doctrine of Man Shapes the Treatment of Depression," *Journal of Biblical Counseling* 18, no. 3 (2000): 23.

dust from the ground."[6] Similarly, the whole of Psalm 139:13-14 describes the human body as the wonderful creation of God: "For you have formed my inward parts; you knitted me together in my mother's womb. I praise you, for I am fearfully and wonderfully made." Along with the whole of creation, human sinfulness has broken the human body, which is slowly deteriorating towards the point of bodily death (Rom 8:22). In the curses God issues after mankind's fall, God promises that the material body will ultimately end with an ironic reversal from God's creation: "For you are dust, and to dust you shall return" (Gen 3:19). As such, the Bible describes the "outer" man, or physical body, as "wasting away" towards death (Rom 5:12; 2 Cor 4:16). When God regenerates the believer, God redeems the human body to positively respond to the Holy Spirit (Rom 8:9; Gal 5:16-17), to be offered up as a living sacrifice (Rom 12:1-2) and to act as a temple of the Holy Spirit (1 Cor 6:19).

The Bible uses multiple, overlapping terms for the immaterial part of people—including soul, heart, spirit, and mind. However, the most common biblical term for the inner person is the heart (*kardia*), which the Hebrews considered the seat of a person's beliefs, desires, emotions, and worship. Genesis 2:7 continues by describing God imbibing the first man's material body with an immaterial soul: "The Lord God . . . breathed into his nostrils the breath of life, and the man became a living creature." The immaterial soul is the part of the human being that only God sees (1 Sam 16:7; Heb 4:13). While the believer's body is wasting away, God is progressively renewing the believer's soul on a regular basis (2 Cor 4:16; Eph 3:16; Col 3:10). Most importantly, the Bible asserts that the state of our hearts drives the quality of our thoughts, actions, and emotions. In Luke 6:45, Jesus explains the relationship between one's heart and body: "The good person out of the good treasure of his heart produces good, and the evil person

[6] Unless otherwise indicated, all Scripture quotation will be from the English Standard Version.

out of his evil treasure produces evil, for out of the abundance of the heart his mouth speaks." Similarly, the Bible speaks of the body's "members" (Rom 6:13), "feet" (Prov 1:16) and "hands" (Prov 12:14) carrying out the desires of the inner person.

Holistic dualism holds that God miraculously interweaves the material and immaterial components of our body, whereby the body's immaterial and material substances function as a unified whole instead of a fractured compartmentalization. Biblical counselors often speak of human beings being "psychosomatic wholes," meaning that our minds and bodies have an influence on one another. In *The Dynamic Heart in Daily Life*, Jeremy Pierre speaks of the simple indivisibility of the human being: "People are unified beings, their inner experience is not fragmented into multiple, often disconnected, often conflicting forces."[7] Since the fall affects human bodies (Rom 6:23; 8:20-23), the body's weaknesses "will set limitations on how the desires of the heart are expressed," so temporary limitations and long-term disabilities have an impact on the soul.[8] A key example is found in 1 Kings 19:4-8, where the prophet Elijah is highly distressed when he must flee to the wilderness from the wrath of King Ahab. In response to Elijah's lament, God miraculously offers water, food, and rest to the prophet, commanding Elijah, "Rise and eat" (1 Kgs 19:5). The account of Elijah shows that the prophet's spiritual distress was interrelated with his physical needs. However, one's physical makeup—as designed by our sovereign Creator—only serves as the "blueprint" for certain behavioral traits.[9] While human beings' thoughts, actions, and emotions are vulnerable to their bodily dispositions (i.e., genetics), the Bible never speaks of people in reductionistic language. Instead, the message of Scripture is the heart has full control over and responsibility for our course of actions.

---

[7] Jeremy Pierre, *The Dynamic Heart in Daily*, 15.

[8] Forrey and Newheiser, "The Influences on the Human Heart," 128.

[9] Forrey and Newheiser, "The Influences on the Human Heart," 129.

This holistic perspective of dualism requires some discernment from the counselor, so that the counselor can decide the source of the counselee's presenting problems. As such, the involvement of the material and the immaterial in life's problems can often make counseling solutions more complex for the counselor. Heath Lambert speaks of the interaction between body and soul in counseling: "The complex interaction of body and soul, combined with our limited knowledge as human beings, may make it complicated or even impossible to identify a singular genesis of a given problem as physical, spiritual, or both."[10] As a result, this position can mean that counselors need to admit their limited knowledge over the physical conditions of the human body and must stand ready to work with physicians to solve valid medical issues. Counseling from a dualistic perspective never ignores the physical nature of human beings. However, counselors should continue to understand that "problems people have are never merely physical."[11] Even if a physical condition, such as diabetes, thyroid conditions, or cancer, presses on the soul's health, people will still need counseling to help with spiritual issues, such as grief, loss, and depression. Anthony Hoekema applies this principle to the work of the church: "The church must be concerned about the whole person . . . . Though the chief purpose of missions is to confront people with the gospel so that they may repent of their sins and be saved through faith in Christ, yet the church must never forget that the objects of its mission enterprise have bodily as well as spiritual needs."[12]

In contrast to the physicalist perspective of trauma, the Bible speaks of "extreme suffering," which affects the body and the soul.[13] The physical aspects of

---

[10] Lambert, *A Theology of Biblical Counseling*, 201.

[11] Lambert, *A Theology of Biblical Counseling*, 202.

[12] Anthony A. Hoekema, *Created in God's Image* (Grand Rapids: William B. Eerdmans, 1986), 222.

[13] Darby Strickland, "Foundations of Trauma Care for Biblical Counselors," *Journal of Biblical Counseling* 36, no. 2 (2022): 35.

trauma are more clearly visible within the human experience. Scripture does affirm that the human body is "fearfully and wonderfully made" (Ps 139:13-14), and, as such, God designed human beings to respond to times of extreme suffering through a "fight or flight" response. When a potential threat appears, a portion of the brain called the hypothalamus activates a release of hormones, such as adrenaline, noradrenaline, and cortisol, which prime our body with energy to fight or to flee from the situation.[14] When someone experiences a horrific car accident, the fight or flight response can move human beings to use extraordinary ability to rescue themselves and others from harm's way. However, excessive human suffering can lead to the body's fight or flight response to go haywire. Over time, this overstimulation and continual exposure to trauma can cause the brain to react as if past suffering is occurring the present day.[15] This intrusion of past suffering can place the body in a perpetual state of high alert through a surging of adrenaline. The biblical account of Job shows that the body can have a physical reaction to a traumatic experience, including difficulties with eating and sleeping (Job 6:7; 7:4), hypervigilance (3:25-26), intrusive thoughts (7:13-15), and avoidance (6:8-9).[16]

As such, biblical counselors must avoid any tendency to hyper-spiritualize traumatic events by denying that the body physically reacts to the horror of traumatic memories. 1 Thessalonians 5:14 urges Christians to "warn those who are idle and disruptive, encourage the disheartened, help the weak, be patient with everyone." When counseling a PTSD sufferer, the Biblical counselor can be encouraging and patient through a healthy understanding of the physiological aspects of trauma. Curtis Solomon states, "Those who have been diagnosed with PTSD gain comfort from knowing that their experiences are grounded in reality and that there are physiological explanations for

---

[14] Jeremy Lelek, *Post-Traumatic Stress Disorder*, 9.

[15] Judith Herman, *Trauma and Recovery: The Aftermath of Violence, From Domestic Abuse to Political Terror* (New York: Basic Books, 2015), 37.

[16] Strickland, "Foundations of Trauma Care for Biblical Counselors," 36.

the symptoms that they have been suffering."[17]

Conversely, the Biblical counselor cannot allow their counselee to become entrenched in a physiological model of PTSD. If a counselee holds fast to a physiological understanding of PTSD, the counselee might be tempted to believe that Scripture offers little help to what the psychiatric community believes to be a strictly medical disorder. The APA defines the term "disorder" as "a group of symptoms involving abnormal behaviors or physiological conditions, persistent or intense distress, or a disruption of physiological functioning."[18] Therefore, many people with a PTSD diagnosis presume that they are physiologically abnormal or hopelessly damaged with a medical problem or disease.[19] For this reason, Curtis Solomon argues that Biblical counselors should call the survivor's experience as "post-traumatic stress (PTS)" instead of PTSD:

> The disorder language tends to communicate that PTSD is a medical problem or disease. Some mental health care professionals will even say things like, "You have PTSD, and there is no known cure." This robs those who are suffering of hope, making them believe they are trapped in that horrifying state and there is nothing to be done about it. Importantly, this conception of PTSD is rooted in a worldview that accepts that the physical world is all there is.[20]

In addition, the counselee might believe that their situation is hopeless since PTSD has been commonly associated with a medical diagnosis. Some PTSD sufferers might feel like their bodies have betrayed them, and they are now imprisoned inside a malfunctioning system. The psychological language of PTSD treatment betrays this perspective. Many of the cognitive iterations of PTSD therapy speak of the PTSD

---

[17] Curtis Solomon, "Evaluating the Legacy Program of the Mighty Oaks Foundation," (PhD diss., The Southern Baptist Theological Seminary, 2020), 41.

[18] American Psychological Association, "Disorder," accessed April 16, 2024. https://dictionary.apa.org/disorder.

[19] Curtis Solomon, *I Have PTSD*, 22-23.

[20] Solomon, *I Have PTSD*, 23.

sufferer being "stuck" due to their traumatic experiences[21] In terms of EMDR, Francine Shapiro illustrates PTSD as marbles clogging a drainpipe,[22] undigested food,[23] or a train that cannot reach its destination.[24] Biblical counselors can convey hope by dissuading counselees of the notion that they are stuck within an endless cycle of intrusion and avoidance. While no form of treatment cannot rewind the past to eliminate traumatic events, Scripture does teach us that God makes purpose and meaning through our traumatic events.[25] By God's grace, human suffering can propel believers forward towards a greater sanctification instead of imprison us in cages of the past (Rom 8:28-29). For this reason, Jeremy Lelek argues, "PTSD should not be considered exclusively a psychiatric disorder or a biological issue. Actually, viewing it as such would be quite limiting to the process of healing and ultimate holiness."[26]

While the spiritual aspects of trauma can be more difficult to see with human eyes, biblical counselors must also affirm that traumatic events have a real spiritual impact on the whole person. Three ways that people can see the spiritual aspects of the traumatic experience include existential questioning, problems of the heart and the need for genuine hope.

Existential Questioning

First, human suffering draws out the existential questions of the heart. Even neurobiologist J. Douglas Bremner admits, "The struggle to find meaning in the face of

---

[21] Patricia A. Resick, Shannon W. Stirman, and Stefanie T. LosSavio, *Getting Unstuck from PTSD: Using Cognitive Processing Therapy to Guide Your Recovery* (New York: Guilford Press, 2023).

[22] Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd ed. (New York: Guilford Press, 2017), 30-31.

[23] Francine Shapiro and Margot Silk Forrest, *EMDR: The Breakthrough "Eye Movement" Therapy for Overcoming Anxiety, Stress, and Trauma* (New York: Basic Books, 2016), 41.

[24] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 37.

[25] Pierre, *The Dynamic Heart in Daily Life*, 172.

[26] Lelek, *Post-Traumatic Stress Disorder*, 11.

psychological trauma is at the core of our western civilization."[27] Trauma survivors will commonly ask existential questions associated with human suffering, such as why suffering occurred or why God did not intervene.[28] Many survivors have difficulty living in a reality where a sovereign God and the presence of evil both exist.[29] In *The Combat Trauma Healing Manual*, Chris Adsit recounts the reaction of a combat veteran ("Mike") to the death of a fellow soldier: "It was in that moment . . . I knew there was no God."[30]

The real people who suffered in the chronicles of Scripture commonly ask these critical God-sized questions. The prophet Habakkuk opens his discourse with God with a prayer for the Lord to intervene on his nation's suffering: "O Lord, how long shall I cry for help, and you will not hear? Or cry to you 'Violence!' and you will not save? Why do you make me see iniquity, and why do you idly look at wrong?" (Hab 1:2-3a). Similarly, many Psalms ask big questions of the Lord during horrible events: "How long, O Lord? Will you forget me forever? How long will you hide your face from me?" (Ps 13:1). As human beings "groan" in their suffering, they look to God for firm footing amid the chaos of the earthly existence (2 Cor 5:2). As such, Jeremy Lelek argues that these existential struggles bring "our conversation into the arena of theology and philosophy circumvents the idea that it is a merely biological phenomenon."[31] While secular therapies tend to consider such existential questions irrelevant to the treatment of suffering, biblical counseling addresses the spiritual questions head-on, offering trauma survivors a safe place to ask the difficult questions of life and to find existential truth

---

[27] J. Douglas Bremner, *Does Stress Damage the Brain? Understanding Traumas-Related Disorders from a Mind-Body Perspective* (New York: W. W. Norton, 2002), 230.

[28] Christopher B. Adsit, *The Combat Trauma Healing Manual: Christ-Centered Solutions for Combat Trauma*, Bridges to Healing (Orlando, FL: Military Ministry Press, 2008), 11.

[29] Diane Mandt Langberg, *On the Threshold of Hope: Opening the Door to Healing for Survivors of Sexual Abuse*, AACC Counseling Library (Carol Stream, IL: Tyndale House, 1999), 130-31.

[30] Adsit, *The Combat Trauma Healing Manual*, 11.

[31] Lelek, *Post-Traumatic Stress Disorder,* 11.

from the Lord.

Problems of the Heart

Second, human suffering exposes the problems of the heart. In Deuteronomy 8:2, God explains that one reason for the Israelites' wandering is to reveal the evil in their hearts: "And you shall remember the whole way that the Lord your God has led you these forty years in the wilderness, that he might humble you, testing you to know what was in your heart, whether you would keep his commandments or not." In this manner, God often uses suffering to humble people so that they would clearly see their heart treasures something less than the Lord. In sharing his own experience with his physical suffering, Paul David Tripp muses on the biblical counseling implications of suffering: "Your responses to the situations in your life, whether physical, relational, or circumstantial, are always more determined by what is inside you (your heart) than by the things you are facing."[32] If someone's highest allegiance is to something less than God, this precarious situation will affect how they worship and, ultimately, the behaviors and actions that people take. Human beings are typically blind to their own sinfulness, and the shake-up of suffering exposes who people are and what they desire (2 Cor 4:4). Suffering is an opportunity for God to investigate one's own life and to align the treasure in one's heart to Christ alone.

Genuine Hope

Finally, human suffering demonstrates the need for genuine hope. Trauma survivors often lack the ability to see a future or to even continue in living life. Diane Langberg categorizes trauma as a "disorder of hope," where survivors fear hoping again

[32] Paul David Tripp, *Suffering: Gospel Hope for When Life Doesn't Make Sense* (Wheaton, IL: Crossway, 2018), 31.

in case they are let down by life again.[33] In the beginning of Job's discourse about his suffering, he expresses the hopelessness of his situation: "My days are swifter than a weaver's shuttle and come to their end without hope" (Job 7:6). Job's expression of hopelessness continues throughout his discourse until God intervenes (Job 14:19; 19:10; 27:8).

The hope found within the pages of Scripture is multi-faceted. First, Scripture affirms that God hears and sovereignly responds to the suffering of His people. Throughout the laments of the Psalms, many of the psalmists cry out to God amid their distress but hold out hope for the Lord's rescue. In Psalm 121:1, the psalmist urges his people to focus on the sovereignty of God in suffering: "My hope comes from the Lord, who made Heaven and earth." This type of hope expresses that God is sovereign over every human circumstance and is greater in power over every evil human being or disaster that befalls in life. Through the power of Christ, the Christian life helps the survivor carry out Paul's admonitions in Romans 12:12: "Rejoice in hope, be patient in tribulation, be constant in prayer."

Next, Scripture offers genuine hope that God has a purpose for our suffering. While the Bible speaks of variety of reasons why suffering exists in the believer's life, Romans 8:28-29 affirms that God is using every experience, including traumatic ones, in a fashion to conform the believer to Christ's image. In *I Have PTSD*, Curtis Solomon presents this purposeful view of traumatic suffering: "From the time you put your faith in him, everything that happens is a tool in the hand of a Master who wants to make you more like Jesus. Your traumatic experiences are no exception."[34] The Bible clearly shows God's sovereign purposes in our suffering through the biblical story of Joseph (Genesis 37-50). Throughout the course of his story, Joseph suffered through the betrayal of his

---

[33] Langberg, *On the Threshold of Hope*, 135.

[34] Solomon, *I Have PTSD*, 87.

family, sale into to slavery, sexual temptations, false accusations, imprisonment, and religious persecution. However, Joseph was able to see God's sovereign plans throughout his suffering and ultimately was able to proclaim: "As for you, you meant evil against me, but God meant it for good" (Gen 50:20). While the process of progressive sanctification is not painless, 2 Corinthians 4:7-12 affirms that God superintends the change process by protecting the believer and renewing the inner man. Ultimately, God can use the believer's suffering to comfort others in their suffering (2 Cor 1:3-7) and to shine the salt and light of Christ to the world (Matt 5:13).

Finally, Scripture offers genuine hope that God will cease human suffering upon Christ's return. The believer's soul longs for the spiritual consummation coming upon Christ's return, where all believers will experience the final death of sinfulness and the restoration of God's creation (Rom 8:18-25). Christ will put an end to the laborious suffering of living in a broken body in a malfunctioning world, and believers will have no more need for sorrow (Rev 21:4). Scripture does not affirm that people will live as disembodied spirits after Christ's return; instead, God will reunite human souls with a resurrection body (Job 19:26-27; 1 Cor 15:51-55; Phil 3:20-21). To move forward from difficult circumstances, the human soul needs the hope that one day all suffering will permanently cease. In contrast, secular therapies, such as CBT and medications, offer changes in behavior and cognitions but no real hope for the future—especially beyond death.

How Human Beings Make Choices

In response to Shapiro's question of who is "running the show," Scripture would resoundingly affirm a completely different answer: the human heart. While neuroscientists would argue that the responsibility for our thoughts, actions, and emotions falls to the human brain, Scripture holds that the human brain is simply a part of the body that mediates the immaterial soul. Laura Hendrickson compares the brain's

responsibilities as the "CEO" or "master controller" of the body.[35] One's brain chemistry is a physical reality but simply acts in response and in concert with the activity of the soul. As such, the heart holds ultimate responsibility for how human beings think (Matt 15:19; Mark 7:21; Heb 4:12), feel (Rom 9:2), speak (Luke 6:45), and act (Matt 15:18). The immaterial soul "initiates our capacities to relate, think, make choices, act, and feel; while the body is the instruct through which we express those capacities." [36]

As people created in the image of God, human beings can make volitional and purposeful choices. Bob Kellemen and Sam Williams describe the matter this way: "We are not animals who react on instinct, nor are we computers who act on input. We are human beings with a motivational capacity to act on the basis of our beliefs."[37] This capacity to make conscious choices is first demonstrated in Genesis 1:26-28, where mankind is given dominion over God's creation. This sense of dominion means that God called mankind to be co-rulers in keeping and expanding God's paradise on earth. However, the negative consequences of the ability to make choices plays out Genesis 3:6, where the first man and woman chose to willfully defy God's first command. Just like Adam and Eve, every human being can make choices according to or in bold defiance of God's purpose for his creation (Rom 5:12-14). In the Old Testament, Moses calls upon the Israelites to live according to the law instead of choosing death (Deut 30:9), and Joshua commands the Israelites to choose which gods they will serve in the Promised Land (Josh 24:14-18). Similarly, Christians have to make choices to walk according to the flesh or with the Spirit (Gal 5:16-26) as well as to put off the old life or put on our new life in Christ (Col 3:1-17). As such, human beings bear the ultimate responsibility

---

[35] Laura Hendrickson, "The Complex Mind/Body Connection," in Kellemen and Viars, *Christ-Centered Counseling*, 412.

[36] Hendrickson, "The Complex Mind/Body Connection," 412.

[37] Bob Kellemen and Sam Williams, "The Spiritual Anatomy of the Soul," in Kellemen and Viars, *Christ-Centered Counseling*, 112.

for the choices that they make in this life. In 2 Corinthians 5:10, Scripture speaks about each person's accountability for the good or bad choices made in life: "For we must all appear before the judgment seat of Christ, so that each one may receive what is due for what he has done in the body, whether good or evil." Similarly, Hebrews 9:27 affirms that God will judge everyone for the time that the Lord has given them. For the believer, Jesus's end times parable of the talents shows that God will reward Christians in the next life for their proper stewardship of God's gifts (Matt 25:14-30). Regardless of one's upbringing, genetics, or brain chemistry, human beings are "without excuse" for the sinful choices they make before the sovereignty of a holy God (Rom 1:20).

While human beings make conscious choices, biblical counselors can still affirm that personal experiences—whether positive or negative—have an impact on people. God has gifted human beings with memory to reinforce good decisions and to dissuade people from bad decisions. Throughout the Old Testament, God repeatedly tells the Israelites to remember the miraculous works he performed during the Exodus so that memory would help them to keep obedience to the law (Deut 6:12; 8:2; Ps 77:11; Isa 50:4). Similarly, God calls the Israelites to "remember the Sabbath" to remind them of God's goodness (Deut 5:15), and to engage in various festivals (e.g., Passover) to remind them of God's salvation through the exodus. God also urges his people to remember that they are created beings so that they would worship their true Creator (Job 10:9; Eccl 12:1). Based on this biblical understanding of the power of memory, biblical counselors can affirm that traumatic memories can intrude on our current experiences and dislocate our lives, leading to hypervigilance, flashbacks, anxiety, nightmares, and depression. God's gift of memory is a powerful force, and some trauma survivors have a difficult time escaping from the past.

In spite of the power of memory, Scripture does not affirm that personal experiences imprison human beings. In *Putting Your Past in Its Place*, Stephen Viars makes the point that "the past is not everything" and argues that "the Scripture does not

encourage us to view ourselves as hopeless victims whose choices today are outside our ability to understand or change."[38] A critical example of this principle is the extreme suffering of the apostle Paul, which he "boasts" about in 2 Corinthians 11:24-28:

> Five times I received at the hands of the Jews the forty lashes less one. Three times I was beaten with rods. Once I was stoned. Three times I was shipwrecked; a night and a day I was adrift at sea; on frequent journeys, in danger from rivers, danger from robbers, danger from my own people, danger from Gentiles, danger in the city, danger in the wilderness, danger at sea, danger from false brothers; in toil and hardship, through many a sleepless night, in hunger and thirst, often without food, in cold and exposure. And, apart from other things, there is the daily pressure on me of my anxiety for all the churches.

Paul continues this "boasting" in his sufferings 2 Corinthians 12:7-10, where he describes his "thorn in the flesh." While the explicit nature of Paul's "thorn in the flesh" is unclear, Paul does confirm that this affliction weakens him and causes him to cry out to God for salvation. Although this "thorn" might weaken Paul physically, the "power of God" strengthens him to continue to exhort the Corinthian church and to preach the gospel (2 Cor 12:9). Similarly, Paul speaks of his conscious choices in his Roman imprisonment in Philippians. Despite his imprisonment, Paul speaks of being able to share the gospel with the local prison guards (Phil 1:12-14). More importantly, Paul also expresses that he is "content" in every circumstance, including his imprisonment, due to the power of Christ in him (Phil 4:10-13). Paul might be physically imprisoned but his past or present experiences to not imprison him. Throughout Paul's story, Christ enabled and empowered Paul to live beyond his past and present experiences and to advance the gospel throughout the world. Like Paul and a great cloud of Christian witnesses that have gone before, God always gives Christians the ability to press on towards the goal of Christ regardless of the obstacles and suffering that are faced (Phil 3:14; Heb 12:1-2).

---

[38] Steve Viars, *Putting Your Past in Its Place: Moving Forward in Freedom and Forgiveness* (Eugene, OR: Harvest House, 2011), 18.

How Human Beings Change

Scripture would affirm that people are self-destructive instead of self-healing. From the fall onward, human beings have had a "disposition" towards sin, where people do not wish to conform to God's will or commands.[39] In terms of sinfulness, human beings are not only sinful through their actions, but are also sinful in terms of the heart's rebellious attitude towards God and his moral commandments. Jeremiah 17:9 assesses the poor condition of the human heart: "The heart is deceitful above all things and beyond cure. Who can understand it?" The inherent brokenness of the human heart produces sinful thoughts, emotions, and actions, which ultimately leads to a broken relationship with God and with others (Mark 7:21). The sinfulness of the human heart also leads to people desiring the wrong things, where people are "lured and enticed by his own desire" (Jas 1:14-15). Even worse, people are blind to their own sinfulness. Apart from Christ, Colossians 1:21 states that people are "alienated and hostile in mind," where human sinfulness corrupts peoples' ability to pursue God and understand their brokenness. The horrific consequences of sin, which are pain, loss, destruction, brokenness and—ultimately—death, show the gravity of mankind's rebellion against a holy God (Rom 6:23). In this manner, human beings are totally depraved, meaning that "sin pervasively touches all parts of us, including the inner and outer persons, our relationship with God and others, and our capacities to carry out what God has designed us to do."[40]

In contrast to Shapiro's hopefulness about human beings, Scripture presents people as weak and powerless, unable to change without radical intervention. In John 15, Jesus compares lost persons to dead branches disconnected from a lifegiving vine. The only way a vine can grow in maturity and ultimately bear spiritual fruit is to "abide" in the vine, which is Christ (John 15:5). Overall, Jesus affirms the powerlessness of human

---

[39] Lambert, *A Theology of Biblical Counseling*, 217.

[40] Robert D. Jones, Kristen L. Kellen, and Rob Green, *The Gospel for Disordered Lives: An Introduction to Christ-Centered Biblical Counseling* (Nashville: B & H Academic, 2021), 66.

beings: “Apart from me you can do nothing” (John 15:5). Another metaphor Scripture commonly uses about human helplessness is slavery. In John 8:34, Jesus speaks to a Jewish crowd about their lostness: “Truly, truly, I say to you, everyone who practices sin is a slave to sin.” Inherently, people apart from Christ are in bondage to sin, unable and unwilling to perform actions other than their master’s will. Similarly, Romans 6:16 affirms that humans cannot be slaves to sinfulness and Christ at the same time: “Do you not know that if you present yourselves to anyone as obedient slaves, you are slaves of the one whom you obey, either of sin, which leads to death, or of obedience, which leads to righteousness?” Human beings are not people that simply need clinical psychologists to reset their brains like a broken bone, giving the brain opportunity to heal itself. Instead, Scripture affirms that sin lords over human beings, bringing people inevitably closer to the ultimate punishment of death. As a result, Ephesians 2:2-3 presents a bleak picture of humanity as “dead” people who follow the prince of the power of the air (who is Satan) and indulge every desire of the flesh. Dead people do not need a gentle push in a positive direction; instead, they need a powerful God who is able to bring them back to life (Ezek 37:1-6; John 5:24; 11:25; Rom 6:23). Thomas Chalmers summarizes the lost person’s need for radical change in this manner: “The only way to dispossess (the heart) of an old affection, is by the expulsive power of a new one.”[41]

Fortunately, the gospel promises that God does not leave people lost in their sinfulness but, instead, offers the regenerative power of Christ that changes the human heart. Heath Lambert defines regeneration as “the sovereign and invisible work of God the Holy Spirit transforming us from people who are opposed to him to people who love him.”[42] Only God has the power of regeneration, meaning human beings do not have any

---

[41] Thomas Chalmers, *The Expulsive Power of a New Affection* (Franklin, TN: Steadfast Books, 2020), 20, Kindle.

[42] Lambert, *A Theology of Biblical Counseling*, 281.

operational role in the creation of new life. The apostle John speaks about God being the author and creator of new life: "[God] gave the right to become children of God, who were born, not of blood nor of the will of the flesh nor of the will of man, but of God" (John 1:13). Similarly, 1 Peter 1:3 plainly asserts that "[God] caused us to be born again to a living hope." In this sense, God causes people to be reborn and gives them the privilege of adoption into his family. The power of transformation squarely belongs to God and not human beings. The prime example is the apostle Paul, who Christ radically changed from persecutor to missionary through a divine encounter on the Damascus road (Acts 9:1-19). Just as Paul, human beings need a radical encounter with God to create a new heart and new disposition within them. Through Christ's regeneration, God transforms people dead in their sins into a radically new creation (2 Cor 5:17; Eph 2:1-5; Titus 3:5-6; Jas 1:17-18). In the Old Testament, Ezekiel 36:26-27 prophesies about the heart change Christ will bring to the believer: "And I will give you a new heart, and a new spirit I will put within you. And I will remove the heart of stone from your flesh and give you a heart of flesh. And I will put my Spirit within you, and cause you to walk in my statutes and be careful to obey my rules." Due to the death and resurrection of Christ, God offers people with that new heart and new spirit that allows people to walk in obedience to God's commands. To this end, Jesus describes the process of regeneration as being "born of the Spirit" and "born again" (John 3:7-8). While regenerate Christians still have inclinations towards sinfulness, the radical work of Christ now empowers the Christian to pursue and to better resemble Christ.

The regenerative power of Christ has real bearing on how to handle traumatic memories. Most people—even Christians—simply want their traumatic memories to go away. While many forms of secular therapy for PTSD (i.e., CBT and medications) do not promise the elimination of traumatic memories, EMDR taps into the popular desire for memories to vanish through treatment. Since its inception, the novelty of EMDR has been the promise of EMDR technicians permanently exorcising stuck memories from the

pipework of the mind. The elimination of negative memories is quite alluring to most trauma survivors, who deal with life-changing outgrowths like anxiety, nightmares, and hypervigilance. In contrast, the Scripture never promises that God will wipe away traumatic memories; however, God will change the human being into a new creation whose new heart is set free from the dominion of traumatic experiences (2 Cor 5:17). The spiritual reality of the trauma survivor is that Christ came to rescue them from their fallen existence and to give them inward renewal through the Holy Spirit (2 Cor 4:8-12). Christ can make sense of the puzzle of the past and give even the most troubled soul an eschatological hope for a new creation (Rev 21:1-5). Moreover, Christ experienced genuine suffering through the cross and now stands as an empathetic advocate for the believer before the throne of God (Heb 4:15-16; 1 John 2:1-2). As in the Psalms, believers can cry out to the Father in their time of need, knowing that he listens and is not indifferent to our plight (Ps 34:17). While EMDR presents trauma as an inevitable and purposeless event that clinicians must erase, Scripture holds that suffering is purposeful matter that God uses for our growth and his glory. The Christian's hope is not the forgetfulness of Homer's lotus-eaters but the remembrance that God is the Christian's help in times of suffering.

How Quickly Human Beings Change

Biblical counselors can sympathize with Shapiro's concern that traumatic events can be extraordinarily damaging to people and the American mental health system can be meandering and disorienting. As mentioned earlier, God's people have continuously cried out to God for an expeditious end their suffering: "How long?" (Hab 1:2-3a; Ps 13:1) These laments to the Lord acknowledge that the human soul longs for an end to human suffering. Today, PTSD sufferers continue to cry out to God for the end of their suffering. One of the core struggles with PTSD is the continuous intrusion of traumatic events into everyday life, where sufferers wind up in a perpetual state of

distress and exhaustion about their continuous suffering. In a 2001 *Psychology Today* article about EMDR, University of Arkansas professor Jeffrey Lohr states, "People want quick results, and they want them yesterday . . . . You can't fault people for wanting substantive relief, but you can fault the scientists who can't see through a worthless treatment."[43] Lohr's statement reminds us that PTSD sufferers also want effective solutions to PTSD, as ineffective treatments might only serve to enhance personal pain or feelings of hopelessness and helplessness. As most PTSD treatments involve re-experiencing trauma through imagination or real-life situations, PTSD sufferers want to know that the cost of re-experiencing the trauma will bear fruit into freedom.

However, Scripture affirms that there is no quick fix or miracle cure for traumatic experiences. The radical roadside experience of Paul is not the ending of his spiritual journey; instead, Paul continues to grow through godly discipleship, suffering, and obedience. Similarly, every Christian journey continues as a lifelong process of "putting off" the old life and "putting on" the new life (Col 3:9-10). Although the believer will have a radical break with their old life at the point of regeneration, the physical and spiritual perfection of the believer will not occur until Christ's return (Rom 6:5-10). Over the course of the believer's life, the Holy Spirit works to change the heart on an ongoing basis (Gal 5:16-18, 22-23; 2 Thess 2:13; 1 Pet 1:2). Theologians often refer to this enduring process of change as progressive sanctification, meaning that God works to separate the believer from sinfulness over the course of their lifetime. Second Corinthians 3:18 states that God's goal is the believer's transformation into the image of Christ: "We all . . . are being transformed into the same image from one degree of glory to another." In the next life, God's work of conforming the believer to the image of Christ will be complete, where the believer's body is fully glorified in its sinless resurrection

---

[43] Kelly McCarthy, "The Pursuit of Pseudoscience," *Psychology Today* (July/August 2001): 24.

form (Rom 8:28-29). This work of progressive sanctification in the believer is collaborative between God and the believer. In one sense, God is continuously working in the believer through the Holy Spirit (Rom 6:13; 12:1). In the same token, God calls the believer to work out their salvation with fear and trembling (Phil 2:12-13), and the believer must work to pursue holiness and flee immorality (Rom 8:13; 1 Cor 6:18; 2 Cor 7:1; Heb 12:14). In this manner, Scripture routinely refers to the Christian life as a race to run and a fight to endure, so as to emphasize the believer's role in the pursuit of holiness (1 Cor 9:24; 2 Tim 4:7).

If God speaks of spiritual healing as a lifelong journey, Shapiro's push for expeditious treatment of traumatic memories is highly concerning. EMDR simply follows decades of psychologists, pharmaceutical companies, and insurance companies attempting to discover the straightest line from pain to healing. More realistically, biblical change moves in crooked paths across mountainous terrain instead of well-paved easy streets. In his work on PTSD, Timothy Lane shared that "every believer, no matter what the issue, is in a process of lifelong change that includes good days and difficult days."[44] The process of change does not resemble a guaranteed delivery; instead, our sovereign God works on his own timeframes for his own purposes throughout the course of our lifetimes. Any human attempt to shortcut God's sovereignty over change or appeal to our own good works is sinful foolishness. The human cry that "it is taking too long" does not come from new life in Christ, where the spiritual fruit of patience is being born (Gal 5:22-23). Instead, the human yearning for rapid change comes from impatience and selfishness, wishing for our suffering to get better according to human standards on a prideful timetable. Meanwhile, God is patient with us during our worst days and vilest sins and, by his Spirit, he can grow believers to resemble his perfect patience.

---

[44] Timothy S. Lane, *PTSD: Healing for Bad Memories* (Greensboro, NC: New Growth Press, 2012), 15, Kindle.

For this reason, the Biblical counselor needs to convey Godly patience during the PTSD sufferer's healing process. The Biblical worldview is suffering is ever-present in the current existence, so believers must be "patient in tribulation" (Rom 12:12). The believer's steadfastness, or patience, in suffering is part of God's purposeful design. Biblical patience is Godly virtue that can help the believer to become "perfect and complete, lacking in nothing" (Jas 1:2-4). Early in the counseling process, the Biblical counselor should help set up clear expectations with the counselee about the extended nature of the healing process. In *Trauma*, Darby Strickland states,

> When you work with a trauma victim, everything feels urgent. So many of their needs feel like they should be addressed immediately, but there are usually no shortcuts, quick truths, or miracle prayers. Helping a traumatized person looks more like helping someone climb out of a valley one tiny step at a time. This is why it's helpful to think of trauma care as prepping for and being a guide on a long, challenging journey.[45]

While Biblical counselors must establish the Biblical hope of the Gospel within the counseling process, counselors must not hold out false hopes about living a pain-free existence and must not offer false promises about rapid resolution of negative memories, beliefs and emotions. Ultimately, the believer's hope is in the character and sovereignty of God instead of the immediate alleviation of our circumstances. God grieves the evil actions of sinful men (Isa 63:10; Eph 4:30) and will one day bring perfect justice to the world (2 Pet 3:1-13). Just like the cries of the Exodus generation (Exod 2:23-25), God has not forgotten about of the suffering of his people and, through Christ, is actively working to restore his creation (Rom 12:19). Ultimately, Jeremy Pierre reminds,

> Healing may take a lifetime, as feelings of shame or fear do not melt away without a trace. Instead, those feelings will be crowded by the added company of new emotions, like hope in the God who receives the broken and binds their wounds,

---

[45] Darby Strickland, *Trauma: Caring for Survivors* (Philipsburg, NJ: P & R, 2023), 12-13.

who has not forgotten them in their circumstances.[46]

[46] Pierre, *The Dynamic Heart in Daily Life*, 172.

CHAPTER 5

IMPLICATIONS FOR BIBLICAL COUNSELING

As EMDR has become more accepted in psychological fields, the Christian community has developed divergent perspectives on this emerging technique. Several Christian integrationist counseling organizations, such as American Association of Christian Counselors, have espoused support for counselors using EMDR.[1] Focus on the Family, a Christian para-church ministry focused on family-enrichment, has whole-heartedly endorsed EMDR as a method that Christians can use to overcome traumatic memories.[2] Christian apologist J. P. Moreland chronicles his personal story about overcoming anxiety and nervous breakdowns in *Finding Quiet* and gives a full endorsement of EMDR as a method of treatment for anxiety.[3] However, other biblical counselors have cautioned the use of EMDR in counseling practice. In a review of Bessel van der Kolk's *The Body Keeps the Score*, biblical counselor Ed Welch proclaims the primacy of the Word to bring change in the believer's life:

> Might biblical counselors pursue EMDR training and incorporate it into their help? My own experience is that Scripture brings the coherence that is sometimes claimed for EMDR, and the riches of the Word and prayer make this technique less compelling. But, as a matter of personal freedom, I would not stop a survivor from trying it. To advise "no," I believe, is to press Scripture into details in which we have freedom to decide. Better to give the congregant this freedom and then, regardless of the decision, help the person re-tell more of the past, present and future

---

[1] "Can Christian Clients Benefit from EMDR Therapy?," American Association of Christian Counselors, accessed November 7, 2023, https://aacc.net/2023/02/27/can-christian-clients-benefit-from-emdr-therapy/.

[2] "Eye Movement Desensitization and Reprocessing," Focus on the Family, accessed November 7, 2023, https://www.focusonthefamily.com/family-qa/eye-movement-desensitization-and-reprocessing-emdr/.

[3] J. P. Moreland, *Finding Quiet: My Story of Overcoming Anxiety and the Practices that Brought Peace* (Grand Rapids: Zondervan, 2019), 129-35.

around Jesus. This is what is of primary importance.[4]

Similarly, several biblical counseling organizations, including the Association of Certified Biblical Counselors and the Biblical Counseling Coalition, have spoken out against biblical counselors using EMDR to heal traumatic memories.[5] As Shapiro's adaptive information processing model is contrary to a biblical understanding of anthropology, EMDR is incompatible with and should not be incorporated into the paradigm of biblical counseling.

Why EMDR Represents Theological Compromise

In Colossians 2:8, the apostle Paul urges the churches, "See to it that no one takes you captive by philosophy and empty deceit, according to human tradition, according to the elemental spirits of the world, and not according to Christ." Here Paul does not refer to philosophy as a specific field of discipline, but as a worldview that does not mirror Scripture's sound doctrine. High-minded thinkers, such as the Gnostics, espoused eloquent and enthralling ideas that captivated the Colossian church.[6] Paul classifies these ideas as meaningless gibberish. The human traditions of the world will continually produce deceptive and alluring beliefs that tempt believers away to a different gospel. As such, Scripture urges believers to continually remind themselves of the truths of Scripture so that deceptive theologies do not lure them away from God's truths about his creation (Acts 20:29; 2 Cor 11:13-15; Eph 5:6; 1 Tim 6:3; 2 Tim 4:3-4; 2 Pet 2:1-3; 1 John 4:1).

---

[4] Ed Welch, "Trauma and the Body: An Introduction to Three Books," *Journal of Biblical Counseling* 33, no. 2 (2019): 82.

[5] Dale Johnson, "How Should Christian Counselors Assess EMDR Therapy?," Association of Certified Biblical Counselors, August 24, 2020, https://biblicalcounseling.com/resource-library/podcast-episodes/how-should-biblical-counselors-assess-emdr-therapy/; Biblical Counseling Coalition, "Statement on EMDR," accessed November 7, 2023, https://www.biblicalcounselingcoalition.org/wp-content/uploads/2021/12/Statement-on-EMDR-by-the-BCC.pdf.

[6] R. Kent Hughes, *Philippians, Colossians, and Philemon: The Fellowship of the Gospel and the Supremacy of Christ* (Wheaton, IL: Crossway, 2013), 272-73.

Shapiro's promise that EMDR will rapidly heal one's stubborn traumatic memories in a rapid fashion is extremely alluring. For many decades, various disciplines have looked to help victims of trauma leave their memories in the past. Many efforts to assuage PTSD symptoms have proven to be labor intensive and time consuming with varying levels of success.[7] Many trauma survivors and their caring clinicians—including Christians—have held out hope that EMDR can live up to being the sort of one session wonder that Shapiro's first study anticipated.[8] As Shapiro frequently boasts, an increasing number of controlled research studies have indeed demonstrated that EMDR does have a positive impact on the matter of traumatic memories.[9] The pragmatic promise of rapid healing and genuine freedom from traumatic memories glimmers to Christians who are haunted by the trauma of combat, abuse, and disaster. The promise of the alleviation of pain entices many Christians into believing that professional psychology holds the real solutions to trauma instead of the local church.

The problem hiding in plain sight is that Shapiro openly admits her working theories about EMDR remain unproven:

> Basically, there are several research-supported theories for why EMDR works, and there is a strong likelihood that all are correct and come into play at different times in the therapy process. However, there is not enough known in the area of brain physiology and neurobiology to know for sure. That is the case for any form of therapy. We know something works because we can observe the outcomes, but we don't know *why* it works. No one can explain on a neurobiological level why, for example, why family therapy works. We don't even know exactly why most medications work.[10]

The naked pragmatism of Shapiro's statement should prove troubling for Christians, who

---

[7] Marilyn Luber and Francine Shapiro, "Interview with Francine Shapiro: Historical Overview, Present Issues, and Future Directions of EMDR," *Journal of EMDR Practice and Research* 3, no. 4 (2009): 219.

[8] Francine Shapiro, "Efficacy of the Eye Movement Desensitization Procedure in the Treatment of Traumatic Memories," *Journal of Traumatic Stress* 2, no. 2 (1989): 216.

[9] Francine Shapiro and Margot Silk Forrest, *EMDR: The Breakthrough "Eye Movement" Therapy for Overcoming Anxiety, Stress, and Trauma* (New York: Basic Books, 2016), 17.

[10] Shapiro and Forrest, *EMDR*, 8.

should be highly suspicious of any theory that demands acceptance without understanding. Believers should not patently accept Shapiro's neurobiological assumptions about trauma simply because controlled research studies have shown that EMDR diminishes the impact of trauma. The effectiveness of EMDR does not infer that Shapiro's working theories about EMDR are correct. In fact, various scholars have argued that EMDR might work based on adaptive information processing, rapid eye movements, dual attention, or some combination thereof, and various studies still debate the efficacy of the eye movement part of the EMDR process.[11] So to speak, the jury is still out on the question of why EMDR works. As Shapiro consistently labels her AIP model as a "working hypothesis," Christians should consider Shapiro's beliefs about the traumatic experience as nothing more than conjecture.[12]

However, Colossians 2:8 reminds Christians that the key issue is not whether EMDR seems to work but whether the worldview of EMDR affords with sound Christian doctrine. In this regard, the biggest problem of integrating EMDR into biblical counseling is a clashing of anthropologies. EMDR presumes that trauma is wholly physiological in nature, which is inconsistent with a biblical understanding of anthropology. The experience of Job can be a guide for how trauma affects the whole person. As a result of his extreme suffering, Job experiences physical illness, including difficulties with eating and sleeping (Job 6:7; 7:4).[13] Job also experiences multiple symptoms commonly associated with trauma victims—including shame (Job 10:15), hypervigilance (3:25-26),

---

[11] Marcel Van den Hout and Iris Engelhard, "How Does EMDR Work?," *Journal of Experimental Psychopathology* 3, no. 5 (2012): 724-36; Christopher William Lee and Pim Cuijpers, "A Meta-Analysis of the Contribution of Eye Movements in Processing Emotional Memories," *Journal of Behavioral Therapy and Experimental Psychiatry* 44, no. 2 (2013): 231-39; Paul R. Davidson and Kevin C. H. Parker, "Eye Movement Desensitization and Reprocessing (EMDR): A Meta-Analysis," *Journal of Consulting and Clinical Psychology* 69, no. 2 (April 2001): 305-16; Robert Stickgold, "EMDR: A Putative Neurobiological Mechanism of Action," *Journal of Clinical Psychology* 58, no. 1 (2002): 61-75.

[12] Shapiro and Forrest, *EMDR*, 41.

[13] Darby Strickland, "Foundations of Trauma Care for Biblical Counselors," *Journal of Biblical Counseling* 36, no. 2 (2022): 35-36.

intrusive thoughts (7:13-15), and avoidance (6:8-9).[14] In numerous instances, Job appears to be overwhelmed with the depression of his entire experience: "For my sighing comes instead of my bread, and my groanings are poured out like water" (3:24). In addition, Job perceives a damaged relationship and loss of intimacy with God: "Oh, for the days when I was in my prime, when God's intimate friendship blessed my house" (29:4). Finally, Job asks some big spiritual questions about God's presence in suffering: "If I sin, what do I do to you, you watcher of mankind?" (7:20). A quick glimpse of Job's experience supplies an incredibly vivid picture of how extreme suffering affects the entire person as an intertwined body and soul. To integrate EMDR into biblical counseling, one must essentially eject the spiritual implications of trauma as either irrelevant or tertiary issues.

Considerations for Biblical Counselors

The exploration of EMDR leads to several important considerations for biblical counseling. Romans 1:16 emphasizes the source of change in the believer's life: "For I am not ashamed of the gospel, for it is the power of God for salvation to everyone who believes, to the Jew first and also to the Greek." The heart of the gospel is that mankind is wholly sinful and unable to meaningfully change apart from God's power (Ps 51:5; Jer 17:9; Rom 3:10-20). To rescue mankind, God sent his only Son, Jesus Christ, to suffer the punishment and wrath that man deserves for their rebellion, and mankind receives the righteousness of the sinless Christ (2 Cor 5:21). This precious gift of salvation is wholly due to the grace of God and not any merit found in mankind (Eph 2:1-10). For this reason, the apostle Paul stands confident in the saving work of Jesus Christ, which the world considers foolishness (1 Cor 1:23). In his commentary on Romans, Tony Merida states, "The gospel is not simply about the power of God (though it is), but it

[14] Strickland, "Foundations of Trauma Care for Biblical Counselors," 36.

contains the power of God—in the sense that God actualizes his saving work through it."[15] Similarly, biblical counselors should be ashamed at the saving power of the gospel in the sufferer's life. From the fall to the return of Christ, the Bible largely reflects on the suffering of mankind, supplying God's means of rescue from the brokenness of creation. The biblical counselor does not need to seek another source of power to transform people when the Word is readily available. Psychological techniques, such as EMDR, might offer the promise of escape from past suffering but cannot afford any shred of hope for a meaningful future. Counseling focused on God's Word is not lacking in power to rescue.

In addition, biblical counselors should emphasize the power of God to create change in the believer's life. Christians can most clearly see God's ongoing power in the role of the Holy Spirit, who lives inside the believer. At the moment of conversion, the Holy Spirit regenerates the believer, producing new life in the place of dead existence (Ezek 36:25-27; John 3:5). After the believer's conversion, the Holy Spirit continues to work in the believer's life, producing godly character and counseling Christians to make godly choices (Gal 5:22-23; Phil 2:12-13). The Holy Spirit convicts the believer of their sinfulness, reminds the believer of God's truth, and helps the believer in times of weakness (John 14:26; 16:8; Rom 8:26). Finally, the Holy Spirit gives believers the power to share how the gospel story has affected their lives (2 Tim 1:7). Biblical counselors should always remind counselees that hope for change does not come from within the human heart, which is "desperately wicked" (Jer 17:9). EMDR points to the lesser hope of human change instead of the glorious power of God to renew our lives.

Third, biblical counselors should approach counselees from the perspective of holistic dualism. God has constructed the human beings as a complex intertwining of body and soul. As such, biblical counselors cannot simply ask whether a counselee's

---

[15] Tony Merida, *Exalting Christ in Romans*, Christ-Centered Exposition (Nashville: Holman Reference, 2021), 18.

problems are spiritual or physical issues; instead, the complex nature of the human body does not point to simple divisions of body and soul. Therefore, biblical counselors must resist the temptation to reduce problems to the body or the spirit when God designed the person to act "intimately and continuously."[16] Amidst a growing chorus of neurobiology, counselees will be tempted to believe that traumatic experiences are brain matters that are outside of the scope of the church. Furthermore, the perspective of EMDR is that the brain condition of the traumatized person is wholly determinative of their actions. The biblical counselor can affirm that the human brain can experience extreme forms of suffering that have a negative influence on the person, and still recognize that people need God's counsel about human sinfulness in their lives and others. The great laments of the Psalms (such as Pss 55-57), the experience of Job, and the suffering of the prophets (such as Habakkuk and Jeremiah) have much to say to people suffering through life's horrors. Through the power of Scripture, the church can present the imminent hope of the gospel to those who struggle with traumatic experiences.

Fourth, biblical counselors should emphasize godly patience in suffering (Rom 12:12). People who sufferer typically desire an expeditious end to their suffering. Throughout Scripture, scores of believers have cried out "How long?" to God, wondering when God will bring an end to their suffering (Ps 13:1; Hab 1:2; Rev 6:10). In Romans 8:23, Paul perfectly expresses the believer's plight during our earthly existence: "And not only the creation, but we ourselves, who have the first fruits of the Spirit, groan inwardly as we wait eagerly for adoption as sons, the redemption of our bodies." Suffering ultimately emphasizes that the disordered nature of the world, and this brokenness stirs up emotions of helplessness and a desire for justice (Hab 1:2-4). Amidst the horror of a malfunctioning creation, people can become allured by claims of a quick fix to their pain,

---

[16] Sam Williams, "What About the Body?," in *Scripture and Counseling: God's Word for Life in a Broken World*, ed. Bob Kellemen (Grand Rapids: Zondervan, 2014), 146.

such as EMDR. Through Scripture, biblical counselors can offer gospel hope greater than the quick fix. The sufferer's desire for healing does not equate to God's forgetfulness: "The Lord is not slow to fulfill his promise as some count slowness" (2 Pet 3:9). God's work in the believer's life is often beyond mere sight. Although suffering may press and strike down the human body in its earthly existence, God never abandons the believer, working to inwardly renew those who eagerly await Christ's return (2 Cor 4:7-16). Ultimately, this inward renewal of the Holy Spirit is the guarantee of Christ's return when he will wipe out human suffering (Eph 1:14).

Finally, biblical counselors should approach any psychological technique with discernment, looking to consider whether that technique is compatible with sound doctrine. The advent of modern psychology has produced various trends, such as psychotherapy and behaviorism, that have ebbed and flowed in popularity. The tradition of psychology suggests those new methodologies, such as EMDR, will continue to appear. When new treatment models and psychotherapies gain popularity, Christians should not rush to fall into line with the latest fashions. Quite frankly, no one is neutral in their theological beliefs. R. C. Sproul famously said, "No Christian can avoid theology. Every Christian is a theologian . . . . The issue for Christians is not whether we are going to be theologians but whether we are going to be good theologians or bad ones."[17] As a result, biblical counselors should be slow to speak and methodical in understanding, looking to chew on the latest cultural trends thoroughly before digesting them (Jas 1:19). Colossians 2:8 reminds believers that not everything that emerges from popular culture fits properly with sound doctrine.

Further Research

Overall, several matters have arisen during this research thesis that merit

[17] R. C. Sproul, *Knowing Scripture* (Downers Grove, IL: InterVarsity Press, 1977), 19-20.

further research by future researchers.

The Impact of Trauma on the Whole Person

One area of future research would be how trauma affects the whole person as an interrelated body and soul. While an increasing number of biblical counselors have written on the biblical understanding of trauma, more research is needed on the spiritual aspects of the traumatic experience. Most popular works on trauma affirm the traumatic experience is merely a bodily problem. In *Waking the Tiger*, Peter Levine emphatically states that "trauma is physiological" and that "the key to healing traumatic symptoms in humans is in our physiology."[18] In popular culture, Oprah Winfrey and Bruce Perry's book on trauma, *What Happened to You*?, advances this brain oriented view of trauma: "Understanding trauma has always been linked to studying event-specific changes in the stress-response systems."[19] Other popular books on trauma by Bessel van der Kolk, Judith Herman, and Ilene Smith follow suit in this body-centered approach to trauma.[20] As a result, some Christian sources have co-opted a neurobiological approach to the traumatic experience. In *Treating Trauma in Christian Counseling*, William Struthers, Kerryn Ansell, and Adam Wilson define trauma from a neurobiological perspective: "Trauma is a condition of extreme complexity and severity. Stemming from a vast spectrum of acute or chronic stressors, trauma affects many facets of emotional and physical functioning, yielding serious short- and long-term neurobiological consequences

---

[18] Peter A. Levine and Ann Frederick, *Waking the Tiger: Healing Trauma* (Berkeley, CA: North Atlantic Books, 1997), 17.

[19] Oprah Winfrey and Bruce D. Perry, *What Happened to You?* (New York: Flatiron Books, 2021), 103, Kindle.

[20] Bessel van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2014); Judith Herman, *Trauma and Recovery: The Aftermath of Violence, From Domestic Abuse to Political Terror* (New York: Basic Books, 2015); Ilene Smith, *Moving Beyond Trauma: The Roadmap to Healing from Your Past and Living with Ease and Vitality* (Austin, TX: Lioncrest, 2019), Kindle.

for affected individuals."[21] In *Restoring the Shattered Self*, Heather Gingrich emphasizes the body's reaction to the traumatic experience, referring to Bessel van der Kolk's *The Body Keeps the Score* as a definitive text on the traumatic experience.[22] The struggle for the field of biblical counseling is to digest new research regarding the role of the brain in areas of extreme suffering while making the case that traumatic experiences disrupt the whole person, including the immortal soul. The impact of trauma on the soul has profound implications for the local church. If trauma is merely a neurological problem, this approach favors professional counselors and sidelines the church—particularly lay counselors—in the treatment of suffering persons. Gingrich makes this very point about the inability of lay people to treat complex trauma:

> Lay counselors can certainly be helpful in a supportive role, either as an adjunct to professional counseling as mentioned above, or as a way of helping individuals with a complex trauma background cope with the challenges of day-to-day life. . . . While this is difficult enough for professional counselors, lay counselors may struggle even more because they likely have less of an understanding of countertransference issues.[23]

As with the medicalization of other counseling issues (i.e., depression, anxiety), the medicalization of suffering threatens the ability of the church to speak truth into the lives of hurting people.

The "Origin Story" of EMDR

Recent information unearthed by Gerald Rosen about Shapiro's past affiliation with and support of neuro-linguistic programming (NLP) have challenged Shapiro's oft-

---

[21] William Struthers, Kerryn Ansell, and Adam Wilson, "The Neurobiology of Stress and Trauma," in *Treating Trauma in Christian Counseling*, ed. Heather Davediuk Gingrich and Fred C. Gingrich (Downers Grove, IL: IVP Academic, 2017), 67.

[22] Heather Davediuk Gingrich, *Restoring the Shattered Self: A Christian Counselor's Guide to Complex Trauma*, Christian Association for Psychological Studies Books, 2nd ed. (Downers Grove, IL: InterVarsity Press, 2020), 18-19.

[23] Gingrich, *Restoring the Shattered Self*, 222.

repeated "walk in the park" origin story of EMDR.[24] As a result, one emerging research question is whether EMDR really is a "chance discovery" by Shapiro or a borrowing of concepts from NLP.[25] Historical research has established that Shapiro had a financial interest in NLP, as she conducted regular NLP workshops for profit through her company, the Human Development Institute (HDI).[26] However, most notable area of investigation revolves around NLP's use of eye movements, which seems to bear a resemblance to EMDR.[27] New historical research will need to investigate whether NLP was simply the milieu where Shapiro's chance discovery developed or whether EMDR is a repackaging of NLP's concepts. In conjunction, there is a question of why Shapiro's frequently repeated autobiography omits her involvement in NLP.[28]

Why EMDR "Works"

Of course, the largest outstanding research question regarding EMDR lies outside of the realm of biblical counseling. Working theories about EMDR's mechanism of action have evolved from the initial suggestion of saccadic eye movements in 1989 to various explanations of orienting response, taxing working memory, REM sleep or a combination of factors in 2018.[29] The evolving nature of EMDR's procedures and explanations made Rosen, McNally, and Lilienfeld argue that Shapiro was not "playing

---

[24] Gerald Rosen, "Revisiting the Origin of EMDR," *Journal of Contemporary Psychotherapy* 53, no. 4 (2023): 289-96.

[25] NLP Akademie Schweiz, "EMDR, EMI and Wingwave," last modified April 7, 2021, https://www.nlp.ch/pdfdocs/Historie_EMDR_Wingwave.pdf.

[26] Dan McLean, "Aiming at Superachievers: NLP: Influencing Anybody to Do Just About Anything," *Los Angeles Times*, February 13, 1985

[27] Francine Shapiro, "Neuro-Linguistic Programming: The New Success Technology," *Holistic Life Magazine* (Summer 1995): 41-43

[28] For Shapiro's autobiography, see Luber and Shapiro, "Interview with Francine Shapiro," 217-31; Shapiro and Forrest, *EMDR*, 13-24; Francine Shapiro, *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (New York: Rodale, 2012), 24-28; Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd ed. (New York: Guilford Press, 2017), 7-11.

[29] Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 357-79.

fair with science."[30] In many aspects, the open-endedness of theories regarding EMDR's mechanism of action inhibits the ability of researchers to investigate the overall validity of EMDR. In 2002, University of Melbourne professor Grant Devilly argued this point:

> Good theories and treatment models evolve over time. However, such theories explicitly state the conditions under which they could be disconfirmed. Changes over time to the assumptions and procedures should also be made explicit and differentiated from earlier versions to preclude confusion. Failure to meet these criteria results in practices based upon unfalsifiable theories and general scientific disarray. It is, therefore, important to put EMDR to these tests if it is to be viewed as a serious scientific proposal.[31]

Some EMDR researchers, such as Laurel Parnell, Bessel van der Kolk and Pim Cuijpers, have stated they are more concerned with the efficacy of EMDR in treating traumas instead the matter of why EMDR works.[32] In addition, Pim Cuijpers et al. 2020 meta-analysis expressed doubt that randomized controlled trials could determine EMDR's mechanism of action:

> Whether or not EMDR actually works through the cognitive behavioral elements that are included, most notably exposure to the traumatic memory, cannot be established in randomized controlled trials. In fact, while it is relatively straightforward to examine if a psychological treatment works, it is a considerable challenge to show how such a treatment works. Trials can show if a treatment works, but to show how a treatment works is much more complicated and requires an extensive range of different types of treatments.[33]

For her part, Shapiro seemed content to accept a variety of explanations.[34] Prior to her death, Shapiro remained relatively indifferent in the matter of EMDR's active

---

[30] Gerald Rosen, Richard McNally, and Scott Lilienfeld, "Eye Movement Magic: Eye Movement Desensitization and Reprocessing a Decade Later," *Skeptic* 7, no. 4 (1999): 66.

[31] Grant Devilly, "Eye Movement Desensitization and Reprocessing: A Chronology of Its Development and Scientific Standing," *Scientific Review of Mental Health Practice* 1, no. 2 (2002): 133.

[32] Laurel Parnell, *Transforming Trauma: EMDR, The Revolutionary New Therapy for Freeing the Mind, Clearing the Body, and Opening the Heart* (New York: W. W. Norton, 1998), 55; Van der Kolk, *The Body Keeps the Score*, 264; Meg Bernhard, "The Enigmatic Method," *VQR*, last modified June 12, 2023, https://www.vqronline.org/reporting-articles/2023/06/enigmatic-method.

[33] Cuijpers et al., "Eye Movement Desensitization and Reprocessing for Mental Health Problems," 176.

[34] Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 365.

ingredients:

> The lack of a proven explanation should not stand in the way of people using EMDR therapy. Scientific discoveries are often made and used before they are understood. After all, it took forty years to understand why penicillin works, but not knowing why it worked did not stop physicians from using it or patients from being cured by it during that period.[35]

Until researchers develop a deeper understanding of why EMDR works, EMDR will remain a black box that is difficult to fully evaluate.

Conclusion

Most of the positive works regarding EMDR revolve around anecdotes about how people have experienced extreme suffering under outrageous circumstances. In *Transforming Trauma*, EMDR expert Laurel Parnell recounts the story of one of her clients, Veronica.[36] An intruder raped this client in her bedroom around the age of five years old. She felt helpless and hopeless as a young adult. Veronica simply wanted to sleep through the night without experiencing fear. Throughout scores of books and articles, EMDR practitioners have shared thousands of stories like Veronica's, where clients are seeking relief from past experiences of extreme suffering. One important takeaway is that people are looking for hope, and the gospel has a hope in Christ far more glorious than Shapiro's vision of EMDR (1 Tim 1:1). Trauma survivors have little hope if they stay in an uncertain existence without a reliable rescuer. EMDR cannot promise that a new horrific suffering will not unexpectedly arise, starting the cycle of trouble all over again. In contrast, Revelation 21-22 envisions a world devoid of death, suffering, pain, and hurt due to the work of Christ. Trauma survivors need more than a good night's sleep and a lessening of anxiety symptoms; instead, they need a Creator that can restore their inner being and recreate all of existence. Christ is a better, trustworthy rescuer, and

---

[35] Shapiro and Forrest, *EMDR*, 40.

[36] Parnell, *Transforming Trauma*, 94-101.

biblical counselors should encourage trauma survivors—like Veronica—that they can always find refuge in the shadow of his wings (Ps 57:1).

BIBLIOGRAPHY

Acarturk, Ceren, Emre Konuk, Mustafa Cetinkaya, Ibrahim Senay, Marit Sijbrandj, Pim Cuijpers and Tamer Aker. "EMDR for Syrian Refugees with Posttraumatic Stress Disorder Symptoms: Results of a Pilot Randomized Controlled Trial." *European Journal of Psychotraumatology* 6, no. 1 (May 2015): 1-9.

Adsit, Christopher B. *The Combat Trauma Healing Manual: Christ-Centered Solutions for Combat Trauma*. Bridges to Healing. Orlando, FL: Military Ministry Press, 2008.

American Association of Christian Counselors. "Can Christian Clients Benefit from EMDR Therapy?" Accessed November 7, 2023. https://aacc.net/2023/02/27/can-christian-clients-benefit-from-emdr-therapy/.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-III*. 3rd ed. Washington, DC: American Psychiatric, 1980.

———. *Diagnostic and Statistical Manual of Mental Disorders: DSM-V-TR*. 5th ed. Washington, DC: American Psychiatric, 2023.

American Psychological Association. *Clinical Practice Guideline for the Treatment of PTSD*. February 24, 2017. https://www.apa.org/ptsd-guideline/ptsd.pdf.

———. "Classical Conditioning." Accessed April 16, 2024. https://dictionary.apa.org/classical-conditioning.

———. "Disorder." Accessed April 16, 2024. https://dictionary.apa.org/disorder.

———. "Cognitive Behavioral Therapy (CBT)." Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. Last modified July 31, 2017. https://www.apa.org/ptsd-guideline/treatments/cognitive-behavioral-therapy.

———. *Cognitive Processing Theory Military/Veteran Version: Therapist and Patient Material Manual*. May 2014. https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-patient.pdf.

———. "Eye Movement Desensitization and Reprocessing (EMDR) Therapy." Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. Last modified July 31, 2017. https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing.

———. "Medications for PTSD." Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. Last modified July 31, 2017. https://www.apa.org/ptsd-guideline/treatments/medications.

———. “Policy Statement on Evidence-Based Practice in Psychology.” Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. Last modified July 31, 2017. https://www.apa.org/practice/guidelines/evidence-based-statement.

Anderson, James. *What’s Your Worldview? An Interactive Approach to Life’s Big Questions*. Wheaton, IL: Crossway, 2014.

Andreasen, Nancy C. “Post-Traumatic Stress Disorder: A History and a Critique.” *Annals of the New York Academy of Sciences* 1208, no. 1 (October 2010): 67-71.

Baldwin, Michael, and Deborah Korn. *Every Memory Deserves Respect: EMDR, the Proven Trauma Therapy with the Power to Heal*. New York: Workman, 2021.

Barker, Sandra, and Clair Hawes. “Eye Movement Desensitization and Reprocessing in Individual Psychology.” *Individual Psychology* 55, no. 2 (Summer 1999): 146-61.

Barrowcliff, Alastair, Nicolas S. Gray, Tom C. A. Freeman, and Malcolm J. MacCulloch. “Eye-Movements Reduce the Vividness, Emotional Valence and Electrodermal Arousal Associated with Negative Autobiographical Memories.” *Journal of Forensic Psychiatry and Psychology* 15, no. 2 (2004): 325-45.

Beaulieu, Henry. *PTSD Biblical Perspective for Hope and Help*. Bemidji, MN: Focus, 2018.

Benjet, Corina, Evelyn Bromet, Elie Georges Karam, Ronald C. Kessler, K. A. McLaughlin, V. Shahly, Dan J. Stein, Maria Petukhova, E. Hill, Jordi Alonso, Lukoye Atwoli, Barry Bunting, Ronny Bruffaerts, Jose Miguel Caldas-de-Almeida, Giovanni de Girolamo, S. Florescu, Oye Gureje, Y. Huang, Jeanne-Pierre Lepine, Norito Kawakami, Viviane Kovess-Masfety, Maria Elena Medina-Mora, Fernando Navarro-Mateu, Marina Piazza, Jose Posada-Villa, Kate M. Scott, Arieh Y. Shalev, Timothy Slade, Margreet ten Have, Y. Torres, Maria Carmen Viana, Zahari Zarkov, and Karestan C. Koenen. “The Epidemiology of Traumatic Event Exposure Worldwide: Results from the World Mental Health Survey Consortium.” *Psychological Medicine* 46, no. 2 (2016): 327-43.

Bernhard, Meg. “The Enigmatic Method.” *VQR*. Last modified June 12, 2023. https://www.vqronline.org/reporting-articles/2023/06/enigmatic-method.

Bergmann, Uri. *Neurobiological Foundations for EMDR Practice*. New York: Springer, 2012.

Biblical Counseling Coalition. “Statement on EMDR.” Accessed November 7, 2023. https://www.biblicalcounselingcoalition.org/wp-content/uploads/2021/12/Statement-on-EMDR-by-the-BCC.pdf.

Bisson J. I., Roberts N. P., Andrew M., Cooper R., Lewis C. “Psychological Therapies for Chronic Post-Traumatic Stress Disorder (PTSD) in Adults.” *Cochrane Database of Systematic Review* 12 (2013).

Bonasia, J. “Success: Why It Eludes Some of Us and How to Obtain It.” *La Costan*, January 10, 1985.

Boudewyns, Patrick A., Steven A. Stwertka, L. A. Hyer, J. William Albrecht, and Edwin V. Sperr. "Eye Movement Desensitization for PTSD of Combat: A Treatment Outcome Pilot Study." *Behavior Therapist* 16, no. 2 (1993): 29-33.

Bremner, J. Douglas. *Does Stress Damage the Brain? Understanding Traumas-Related Disorders from a Mind-Body Perspective*. New York: W. W. Norton, 2002.

Brown, Warren S., Nancey Murphy, and H. Newton Malony, eds. *Whatever Happened to the Soul? Scientific and Theological Portraits of Human Nature*. Minneapolis: Fortress Press, 1998.

Buono, Mark. "Post-Traumatic Stress Disorder: Rewriting the Narrative to Include Hope." In *The Christian Counselor's Medical Desk Reference*, edited by Charles D. Hodges Jr. 263-88. Greensboro, NC: New Growth Press, 2023.

Calancie, Olivia, Sarosh Khalid-Khan, Linda Booij, and Douglas P. Munoz. "Eye Movement Desensitization and Reprocessing as a Treatment for PTSD: Current Neurobiological Theories and a New Hypothesis." *Annals of the New York Academy of Sciences* 1426 (2018): 127-45.

Carlson, John, Claude M. Chemtob, Kristin Rusnak, Nancy L. Hedlund, and Miles Y. Muraoka. "Eye Movement Desensitization and Reprocessing (EMDR): Treatment for Combat-Related Post-Traumatic Stress Disorder." *Journal of Traumatic Stress* 11, no. 1 (1998): 3-24.

Chalmers, Thomas. *The Expulsive Power of a New Affection*. Franklin, TN: Steadfast Books, 2020. Kindle.

Chen, Ling, Guiqing Zhang, Min Hu, and Xia Liang. "Eye Movement Desensitization and Reprocessing Versus Cognitive-Behavioral Therapy for Adult Posttraumatic Stress Disorder: Systematic Review and Meta-Analysis." *Journal of Nervous and Mental Disease* 203, no. 6 (2015): 443-51.

Corcoran, Kevin J. *Rethinking Human Nature: A Christian Materialist Alternative to the Soul*. Grand Rapids: Baker Academic, 2006.

Corcoran, Kevin J., and Kevin Sharpe. "Neuroscience and the Human Person." In *Neuroscience and the Soul: The Human Person in Philosophy, Science, and Theology*, edited by Thomas M. Crisp, Steven L. Porter, and Gregg A. Ten Elshof, 121-36. Grand Rapids: William B. Eerdmans, 2016.

Corwin, Miles. "Bizarre Case Shows Flaky Underside of Santa Cruz." *Los Angeles Times*. January 28, 1988.

Coughlin, Steven S. "Post-traumatic Stress Disorder and Cardiovascular Disease." *Open Cardiovascular Medicine Journal* 5 (2011): 164-170.

Crick, Francis. *The Astonishing Hypothesis: The Scientific Search for the Soul*. New York: Touchstone, 1994.

Crisp, Thomas M., Steven L. Porter, and Gregg A. Ten Elshof, eds. *Neuroscience and the Soul: The Human Person in Philosophy, Science, and Theology*. Grand Rapids: William B. Eerdmans, 2016.

Croitoru, Tal. *The EMDR Revolution: Change Your Life One Memory at a Time, The Client's Guide*. New York: Morgan James, 2014.

Cuijpers, Pim, Suzanne van Veen, Marit Sijbrandij, Whitney Yoder, and Iona Cristea. "Eye Movement Desensitization and Reprocessing for Mental Health Problems: A Systematic Review and Meta-Analysis." *Cognitive Behavior Therapy* 49, no. 3 (2020): 165-80.

Damasio, Antonio. *The Feeling of What Happens: Body and Emotion in the Making of Consciousness.* London: Harcourt, 2000.

Davidson, Paul R., and Kevin C. H. Parker. "Eye Movement Desensitization and Reprocessing (EMDR): A Meta-Analysis." *Journal of Consulting and Clinical Psychology* 69, no. 2 (April 2001): 305-16.

DeBell, Camille, and R. Deniece Jones. "As Good as It Seems? A Review of EMDR Experimental Research." *Professional Psychology: Research and Practice* 28, no. 2 (April 1997): 153-63.

Department of Veterans Affairs. *VA/DOD Clinical Practice Guideline for the Management of Post-Traumatic Stress Disorder and Acute Stress Disorder*. June 2017. https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf.

De Jong, Ad, Benedikt L. Amann, Arne Hofmann, Derek Farrell, and Christopher W. Lee. "The Status of EMDR Therapy in the Treatment of Posttraumatic Stress Disorder 30 Years After Its Introduction." *Journal of EMDR Practice and Research* 13, no. 4 (2019): 261-69.

Devilly, Grant. "Eye Movement Desensitization and Reprocessing: A Chronology of Its Development and Scientific Standing." *Scientific Review of Mental Health Practice* 1, no. 2 (2002): 113-38.

Devilly, Grant, Susan Spence, and Ronald Rapee. "Statistical and Reliable Change with Eye Movement Desensitization and Reprocessing: Treating Trauma Within a Veteran Population." *Behavior Therapy* 29 (1998): 435-55.

Dobo, Andrew J. *Unburdening Souls at the Speed of Thought: Psychology, Christianity, and the Transforming Power of EMDR.* Sebastian, FL: Soul Psych, 2015.

Druckman, David, and John Swets. *Enhancing Human Performance: Issues, Theories and Techniques*. Washington, DC: National Academy of Science, 1988.

Ehring Thomas, Renate Welboren, Nexhmedin Morina, Jelte Wicherts, Janina Freitag, and Paul Emmelkamp. “Meta-Analysis of Psychological Treatments for Posttraumatic Stress Disorder in Adult Survivors of Childhood Abuse.” *Clinical Psychology Review* 34, no. 8 (2014): 645-57.

Elofsson, Ulf O. E., Bo von Scheele, Tores Theorell, and Hans Peter Sondergaard. “Physiological Correlates of Eye Movement Desensitization and Reprocessing.” *Journal of Anxiety Disorders* 22 (2008): 622-34.

EMDR Institute Inc. “EMDR Therapy Basic Training.” Accessed April 16, 2024. https://www.emdr.com/us-basic-training-overview/.

EMDR Institute Inc. “The History of EMDR Therapy.” Accessed April 16, 2024. https://www.emdr.com/history-of-emdr/.

Engelhard, Iris M., Sophie L. van Uijen, Marcel van den Hout. “The Impact of Taxing Working Memory on Negative and Positive Memories.” *European Journal Psychotraumatology* 1 (2010): 1-8.

Focus on the Family. “Eye Movement Desensitization and Reprocessing (EMDR).” Accessed November 7, 2023. https://www.focusonthefamily.com/family-qa/eye-movement-desensitization-and-reprocessing-emdr/.

Forrey, Jeff, and Jim Newheiser. “The Influences on the Human Heart.” In *Christ-Centered Counseling: Changing Lives with God’s Timeless Truth*, edited by Bob Kellemen and Steve Viars, 123-38. Eugene, OR: Harvest House, 2021.

Free Inquiry. “Secular Humanism Defined.” Accessed November 7, 2023, https://secularhumanism.org/what-is-secular-humanism/secular-humanism-defined/.

Gerger H, T. Munder, A. Gemperli, E. Nüesch, S. Trelle, P. Jüni, and J. Barth. “Integrating Fragmented Evidence by Network Meta-Analysis: Relative Effectiveness of Psychological Interventions for Adults with Post-Traumatic Stress Disorder.” *Psychological Medicine* 44 (2014): 3151-64.

Gifford, Greg. *Helping Your Family through PTSD*. Eugene, OR: Wipf and Stock, 2017.

Gingrich, Heather Davediuk. *Restoring the Shattered Self: A Christian Counselor’s Guide to Complex Trauma*. Christian Association for Psychological Studies Books. 2nd ed. Downers Grove, IL: InterVarsity Press, 2020.

Gingrich, Heather Davediuk, and Fred C. Gingrich, eds. *Treating Trauma in Christian Counseling*. Christian Association for Psychological Studies Books. Downers Grove, IL: IVP Academic, 2017.

Goldstein, Rise B., Sharon M. Smith, S. Patricia Chou, Tulshi D. Saha, Jeesun Jung, Haitao Zhang, Roger P. Pickering, W. June Ruan, Boji Huang, and Bridget F. Grant. “The Epidemiology of DSM-5 Posttraumatic Stress Disorder in the United States: Results from

the National Epidemiologic Survey on Alcohol and Related Conditions-III." *Social Psychiatry and Psychiatric Epidemiology* 51 (2016): 1137-48.

Gray, Alison J. "Whatever Happened to the Soul? Some Theological Implications of Neuroscience." *Mental Health, Religion and Culture* 13, no. 6 (September 2010): 637-48.

Green, Joel B., ed. *In Search of the Soul: Perspectives on the Mind-Body Problem*. 2nd ed. Eugene, OR: Wipf and Stock, 2010.

Greenwald, Ricky. "The Information Gap in the EMDR Controversy." *Professional Psychology: Research and Practice 27*, no. 1 (1996): 67-72.

Greenwald, Ricky, and Francine Shapiro. "What Is EMDR? Concluding Commentary by Greenwald and Response by Shapiro." *Journal of EMDR Practice and Research* 5, no. 1 (2011): 25-28.

Grimley, Bruce. "Origins of EMDR—A Question of Integrity?" *Psychologist* 27 (2014): 561.

Hendrickson, Laura. "The Complex Mind/Body Connection." In *Christ-Centered Counseling: Changing Lives with God's Timeless Truth*, edited by Bob Kellemen and Steve Viars, 409-22. Eugene, OR: Harvest House, 2021.

Hensley, Barbara J. *An EMDR Therapy Primer: From Practicum to Practice*. 2nd ed. New York: Springer, 2016.

Herbert James D., Scott O. Lilienfeld, Jeffrey M. Lohr, Robert W. Montgomery, William T. O'Donohue, Gerald M. Rosen, and David F. Tolin. "Science and Pseudoscience in the Development of Eye Movement Desensitization and Reprocessing: Implications for Clinical Psychology." *Clinical Psychology Review* 20, no. 8 (2000): 945-71.

Herman, Judith. *Trauma and Recovery: The Aftermath of Violence, From Domestic Abuse to Political Terror*. New York: Basic Books, 2015.

Herson, Michel, and William Sledge, eds. *Encyclopedia of Psychotherapy*, vol. 2. San Diego, CA: Academic Press, 2002.

Ho, M. S. K., and Christopher William Lee. "Cognitive Behavior Therapy Versus Eye Movement Desensitization and Reprocessing for Post-Traumatic Disorder—Is It All in the Homework Then?" *European Review of Applied Psychology* 58 (2002): 253-60.

Hodges, Charles D., Jr., eds. *The Christian Counselor's Medical Desk Reference*. Greensboro, NC: New Growth Press, 2023.

Hoekema, Anthony A. *Created in God's Image*. Grand Rapids: William B. Eerdmans, 1986.

Horwitz, Allan V. *PTSD: A Short History*. Baltimore: John Hopkins University Press, 2018.

Hughes, R. Kent. *Philippians, Colossians, and Philemon: The Fellowship of the Gospel and the Supremacy of Christ*. Wheaton, IL: Crossway, 2013.

Hyer, Lee and Jeffrey M. Brandsma. "EMDR Minus Eye Movements Equals Good Psychotherapy." *Journal of Traumatic Stress* 10, no. 3 (1997): 515-22.

Institute of Medicine of the National Academies. *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment*. Washington, DC: National Academies Press, 2014.

———. *Treatment of Post-Traumatic Stress Disorder: An Assessment of the Evidence*. Washington, DC: National Academies Press, 2008.

Jensen, James. "Efficacy of Eye Movement Desensitization and Reprocessing as a Treatment for PTSD Symptoms of Vietnam Combat Veterans." *Behavior Therapy* 25 (1992): 311-25.

Johnson, Dale. "How Should Biblical Counselors Assess EMDR Therapy?" Association of Certified Biblical Counselors. August 24, 2020. https://biblicalcounseling.com/resource-library/podcast-episodes/how-should-biblical-counselors-assess-emdr-therapy/.

Jones, Robert D., Kristin L. Kellen, and Rob Green. *The Gospel for Disordered Lives: An Introduction to Christ-Centered Biblical Counseling*. Nashville: B & H Academic, 2021.

Kellemen, Bob, ed. *Scripture and Counseling: God's Word for Life in a Broken World*. Grand Rapids: Zondervan, 2014.

Kellemen, Bob, and Steve Viars, eds. *Christ-Centered Counseling: Changing Lives with God's Timeless Truth*. Eugene, OR: Harvest House, 2021.

Kellemen, Bob, and Sam Williams. "The Spiritual Anatomy of the Soul." In *Christ-Centered Counseling: Changing Lives with God's Timeless Truth*, edited by Bob Kellemen and Steve Viars, 107-22. Eugene, OR: Harvest House, 2021.

Kessler, Ronald C., Amanda Sonnega, Evelyn Bromet, Michael Hughes, and Christopher Nelson. "Posttraumatic Stress Disorder in the National Comorbidity Survey." *Archives of General Psychiatry* 52 (1995): 1048-60.

Khan Ali M., Sabrina Dar, Rizwan Ahmed, Ramya Bachu, Mahwish Adnan, and Vijaya Kotapati. "Cognitive Behavioral Therapy Versus Eye Movement Desensitization and Reprocessing in Patients with Post-Traumatic Stress Disorder: Systematic Review and Meta-analysis of Randomized Clinical Trials." *Cureus* 10, no. 9 (2018): 32-50.

Kohler, Kai, Patrick Eggert, Sebastian Lorenz, Kersten Herr, Gerd Willmund, Peter Zimmermann, and Christina Alliger-Horn. "Effectiveness of Eye Movement Desensitization and Reprocessing in German Armed Forces Soldiers With Post-Traumatic Stress Disorder Under Routine Inpatient Care Conditions." *Military Medicine* 182, no. 5/6 (2017): 1672-80.

Lambert, Heath. *A Theology of Biblical Counseling: The Doctrinal Foundations of Counseling Ministry*. Grand Rapids: Zondervan, 2016.

Landin-Romero, Ramon, Ana Moreno-Alcazar, Marco Pagani, and Benedikt Amann. "How Does Eye Movement Desensitization and Reprocessing Therapy Work? A Systematic Review on Suggested Mechanisms of Action." *Frontiers in Psychology* 9 (2018): 1-23.

Lane, Timothy S. *PTSD: Healing for Bad Memories*. Greensboro, NC: New Growth Press, 2012. Kindle.

Langberg, Diane Mandt. *On the Threshold of Hope: Opening the Door to Healing for Survivors of Sexual Abuse*. AACC Counseling Library. Carol Stream, IL: Tyndale House, 1999.

———. *Suffering and the Heart of God: How Trauma Destroys and Christ Restores*. Greensboro, NC: New Growth Press, 2015.

Lauterbach, Dean, and Sarah Reiland. "Exposure Therapy and Post-Traumatic Stress Disorder." In *Handbook of Exposure Therapies*, edited by David C. S. Richard and Dean Lauterbach, 127-51. Burlington, MA: Academic Press, 2007.

Lee, Christopher William, and Pim Cuijpers, "A Meta-Analysis of the Contribution of Eye Movements in Processing Emotional Memories," *Journal of Behavior Therapy and Experimental Psychiatry* 44, no. 2 (2013): 231-39.

Leeds, Andrew M. *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants*. 2nd ed. New York: Springer, 2016.

Lelek, Jeremy. *Post-Traumatic Stress Disorder: Recovering Hope*. Gospel for Real Life. Philipsburg, NJ: P & R, 2013.

Lentz, John D. "In the Spirit of Therapy: Interview with Francine Shapiro, Ph.D." *Milton H. Erickson Foundation Newsletter* 33, no. 2 (2013): 1-4.

Lerner, Paul, and Mark Micale. "Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction." In *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age*. Edited by Paul Lerner and Mark Michale, 1-30. Cambridge Studies in the History of Medicine. New York: Cambridge University Press, 2001.

Levine, Peter A., and Ann Frederick. *Waking the Tiger: Healing Trauma*. Berkeley, CA: North Atlantic Books, 1997.

Lilienfeld, Scott. "EMDR Treatment: Less Than Meets the Eye?" *Skeptical Inquirer* 20, no. 1 (1996): 25-31.

Liu, Lynda. "Hand Waving: An Unconventional Treatment for Post-Traumatic Stress is Put to the Test." *The Sciences* 36, no. 4 (July/August 1996): 13.

Lohr, Jeffrey, David F. Tolin, and Scott O. Lilienfeld. “Efficacy of Eye Movement Desensitization and Reprocessing: Implications for Behavior Therapy.” *Behavior Therapy 2*9 (1998): 123-156.

Luber, Marilyn, and Francine Shapiro. “Interview with Francine Shapiro: Historical Overview, Present Issues, and Future Directions of EMDR.” *Journal of EMDR Practice and Research* 3, no. 4 (2009): 217-31.

Lyons, Judith and Terence M. Keane. “Implosive Therapy for the Treatment of Combat-Related PTSD.” *Journal of Traumatic Stress* 2, no. 2 (1989): 137-52.

MacCluskie, Kathryn. “A Review of Eye Movement Desensitization and Reprocessing (EMDR): Research Findings and Implications for Counselors.” *Canadian Journal of Counselling* 32, no. 2 (1998): 116-37.

Maiberger, Barb. *EMDR Essentials: A Guide for Clients and Therapists.* New York: W. W. Norton, 2009.

Maier, Thomas. “Post-Traumatic Stress Disorder Revisited: Deconstructing the A-Criterion.” *Medical Hypothesis* 66 (2006): 103-106.

Marano, Hara Estroff. “Wave of the Future.” *Psychology Today*. Last modified June 9, 2016. https://www.psychologytoday.com/us/articles/199407/wave-the-future.

May, Robert. “How Do We Know What Works?” *Journal of College Student Psychotherapy* 19, no. 3 (2005): 69-73.

McCarthy, Kelly. “The Pursuit of Pseudoscience.” *Psychology Today*. July/August 2001: 24-25.

McGlynn, Dudley F. “Systematic Desensitization.” In *Encyclopedia of Psychotherapy*, edited by Michel Herson and William Sledge, vol. 2. San Diego, CA: Academic Press, 2002.

McLean, Dan. “Aiming at Superachievers: NLP, Influencing Anybody to Do Just About Anything.” *Los Angeles Times*, February 13, 1985.

McNally, Richard J. “Can We Fix PTSD in DSM-V?” *Depression and Anxiety* 26, no. 7 (2009): 597-600.

———. “On Eye Movements and Animal Magnetism: A Reply to Greenwald’s Defense of EMDR.” *Journal of Anxiety Disorders* 13, no. 6 (1999): 617-20.

Merida, Tony. *Exalting Christ in Romans*. Christ-Centered Exposition. Nashville: Holman Reference, 2021.

Moore, Bret A., and Walter E. Penck, eds. *Treating PTSD in Military Personnel*. 2nd ed. New York: Guilford Press, 2019.

Moreland, J. P. *Finding Quiet: My Story of Overcoming Anxiety and the Practices That Brought Peace*. Grand Rapids: Zondervan, 2019.

Murphy, Nancey. "Human Nature: Historical, Scientific and Religious Issues." In *Whatever Happened to the Soul? Scientific and Theological Portraits of Human Nature*, edited by Warren S. Brown, Nancey Murphy, and H. Newton Malony, 1-30. Minneapolis: Fortress Press, 1998.

NLP Akademie Schweiz. "EMDR, EMI and Wingwave." Last modified April 7, 2021. https://www.nlp.ch/pdfdocs/Historie_EMDR_Wingwave.pdf.

Oswalt, Robert, Mark Anderson, Karen Hagstrom, and Bernard Berkowitz. "Evaluation of the One-Session Eye-Movement Desensitization Reprocessing Procedure for Eliminating Traumatic Memories." *Psychological Reports* 73, no. 1 (1993): 99-104.

Pai, Anushka, Alina Suris, and Carol S. Norris. "Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations." *Behavioral Sciences* 13, no. 7 (2017): 1-7.

Parnell, Laurel. *Transforming Trauma: EMDR, The Revolutionary New Therapy for Freeing the Mind, Clearing the Body, and Opening the Heart*. New York: W. W. Norton, 1998.

Peterson, Alan L., Edna B. Foa, and David S. Riggs. "Prolonged Exposure Therapy." In *Treating PTSD in Military Personnel*, edited by Bret A. Moore and Walter E. Penck, 46-62. 2nd ed. New York: Guilford Press, 2019.

Pierre, Jeremy. *The Dynamic Heart in Daily Life*. Greensboro, NC: New Growth Press, 2016.

Pitman, Roger K., Scott P. Orr, Bruce Altman, Ronald E. Longpre, Roger E. Poiré, and Michael L. Macklin. "Emotional Processing during Eye Movement Desensitization and Reprocessing Therapy of Vietnam Veterans with Chronic Posttraumatic Stress Disorder." *Comprehensive Psychiatry* 37, no. 6 (1996): 419-29.

President and Fellows of Harvard College. "EMDR." *Harvard Mental Health Letter* 18, no. 8 (February 2002): 4-5.

RAINN (Rape, Abuse and Incest National Network). "Scope of the Problem: Statistics." Accessed March 17, 2024. https://www.rainn.org/statistics/scope-problem.

Renfrey, George, and C. Richard Spates. "Eye Movement Desensitization: A Partial Dismantling Study." *Journal of Behavior Therapy and Experimental Psychiatry* 25, no. 3 (1994): 231-39.

Resick, Patricia A., Shannon W. Stirman, and Stefanie T. LosSavio. *Getting Unstuck from PTSD: Using Cognitive Processing Therapy to Guide Your Recovery*. New York: Guilford Press, 2023.

Richard, David C. S., and Dean Lauterbach, eds. *Handbook of Exposure Therapies*. Burlington, MA: Academic Press, 2007.

Roderique-Davis, Gareth. "Neuro-Linguistic Programming: Cargo Cult Psychology?" *Journal of Applied Research in Higher Education* 1, no. 2 (2009): 58-63.

Rogers, Susan, and Steven M. Silver. "Is EMDR an Exposure Therapy? A Review of Trauma Protocols." *Journal of Clinical Psychology* 58, no. 1 (2002): 43-59.

Rosen, Gerald. "Malingering and the PTSD Database." In *Post-Traumatic Stress Disorder: Issues and Controversies*, edited by Gerald M. Rosen, 85-100. West Sussex, England: John Wiley and Sons, 2004.

———. "On the Origin of Eye Movement Desensitization." *Journal of Behavior Therapy and Experimental Psychiatry* 26, no. 2 (1995): 121-22.

———, ed. *Post-Traumatic Stress Disorder: Issues and Controversies*. West Sussex, England: John Wiley and Sons, 2004.

———. "Revisiting the Origin of EMDR." *Journal of Contemporary Psychotherapy* 53, no. 4 (2023): 289-96.

———. "Treatment Fidelity and Research on Eye Movement Desensitization and Reprocessing (EMDR)." *Journal of Anxiety Disorders* 13, no. 1-2 (1999):173-84.

Rosen, Gerald, Richard McNally, and Scott Lilienfeld. "Eye Movement Magic: Eye Movement Desensitization and Reprocessing a Decade Later." *Skeptic* 7, no. 4 (1999): 66-69.

Rosen, Gerald, Richard McNally, Jeffrey Lohr, Grant Devilly, James Herbert, and Scott Lilienfeld. "A Realistic Appraisal of EMDR." *California Psychologist* 31 (1998): 25-27.

Rothbaum, Barbara O., Millie C. Astin, and Fred Marsteller. "Prolonged Exposure Versus Eye Movement Desensitization and Reprocessing (EMDR) for PTSD Rape Victims." *Journal of Traumatic Stress* 18, no. 6 (2005): 607-16.

Sanderson, Alan and Roger Carpenter. "Eye Movement Desensitization Versus Image Confrontation: A Single-Session Crossover Study of 58 Phobic Subjects." *Journal of Behavior Therapy and Experimental Psychiatry* 23 (1992): 269-75.

Schubert, Sarah, Christopher W. Lee, and Peter D. Drummond. "Eye Movements Matter, But Why? Psychophysiological Correlates of EMDR Therapy to Treat Trauma in Timor-Leste." *Journal of EMDR Practice and Research* 10, no. 2 (2016): 70-80.

Shapiro, Francine. "Alternative Stimuli in the Use of EMD(R)." *Journal of Behavior Therapy and Experimental Psychiatry* 25, no. 1 (1994): 89.

———. “Efficacy of the Eye Movement Desensitization Procedure in the Treatment of Traumatic Memories.” *Journal of Traumatic Stress* 2, no. 2 (1989): 199-223.

———. “EMDR, Adaptive Information Processing, and Case Conceptualization.” *Journal of EMDR Practice and Research* 1, no. 2 (2007): 68-87.

———. “EMDR. And Case Conceptualization from an Adaptive Information Processing Perspective.” In *Handbooks of EMDR and Family Therapy Processes*, edited by Francine Shapiro, Florence Kaslow and Louise Maxfield, 3-35. Hoboken, NJ: John Wiley and Sons, 2007.

———, ed. *EMDR as an Integrative Psychotherapy Approach*. 3rd ed. Washington, DC: American Psychological Association, 2007.

———. “EMDR: In the Eye of a Paradigm Shift.” *Behavior Therapist* 17, no. 7 (1994): 153-57.

———. “EMDR 12 Years after Its Introduction: Past and Future Research.” *Journal of Clinical Psychology* 58, no. 1 (2002): 1-22.

———. “Errors of Context and Review of Eye Movement Desensitization and Reprocessing Research.” *Journal of Behavior Therapy and Experimental Psychology* 27, no. 3 (1996): 313-17.

———. “Eye Movement Desensitization: A New Treatment for Post-Traumatic Stress Disorder.” *Journal of Behavior Therapy and Experimental Psychiatry* 20, no. 3 (1989): 211-17.

———. “Eye Movement Desensitization and Reprocessing (EMDR) in 1992.” *Journal of Traumatic Stress* 6, no. 3 (1993): 417-21.

———. “Eye Movement Desensitization and Reprocessing (EMDR): Evaluation of Controlled PTSD Research.” *Journal of Behavior Therapy and Experimental Psychiatry* 27, no. 3 (1996): 209-18.

———. *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*. New York: Guilford Press, 1995.

———. *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*. 3rd ed. New York: Guilford Press, 2017.

———. “Eye Movement Desensitization and Reprocessing Procedure: From EMD to EMD/R—A New Treatment Model for Anxiety and Related Traumata.” *Behavior Therapist* 14, no. 5 (1991): 133-35.

———. *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy*. New York: Rodale, 2012.

———. “Introduction: Paradigms, Processing, and Personality Development.” In *EMDR as an Integrative Psychotherapy Approach*, edited by Francine Shapiro, 3-26. 3rd ed. Washington, DC: American Psychological Association, 2007

———. “Neuro-Linguistic Programming: The New Success Technology.” *Holistic Life Magazine* (Summer 1995): 41-43.

———. “The Past Is Present.” Psychology Webinar Group. February 6, 2014. YouTube video, 58:57. https://www.youtube.com/watch?=lsQbzfW9txc.

Shapiro, Francine, Florence Kaslow, and Louise Maxfield, eds. *Handbooks of EMDR and Family Therapy Processes*. Hoboken, NJ: John Wiley and Sons, 2007.

Shapiro, Francine, and Louise Maxfield. “EMDR and Information Processing in Psychotherapy Treatment: Personal Development and Global Implications.” In *Healing Trauma: Attachment, Mind, Body and Brain*, edited by Marion Solomon and Daniel Siegel, 196-219. Norton Series on Interpersonal Neurobiology. New York: W. W. Norton, 2003.

———. “Eye Movement Desensitization and Reprocessing (EMDR): Information Processing in the Treatment of Trauma.” *Psychotherapy in Practice* 58, no. 8 (2002): 933-46.

Shapiro, Francine, and Margot Silk Forrest. *EMDR: The Breakthrough “Eye Movement” Therapy for Overcoming Anxiety, Stress, and Trauma*. New York: Basic Books, 2016.

Smith, Ilene. *Moving Beyond Trauma: The Roadmap to Healing from Your Past and Living with Ease and Vitality*. Austin, TX: Lioncrest, 2019. Kindle.

Smith, Winston. “Dichotomy or Trichotomy? How the Doctrine of Man Shapes the Treatment of Depression.” *Journal of Biblical Counseling* 18, no. 3 (2000): 21-29.

Smyth, Nancy, and Desmond Poole. “EMDR and Cognitive-Behavioral Therapy: Exploring the Convergence and Divergence.” In *EMDR as an Integrative Psychotherapy Approach*, edited by Francine Shapiro, 151-80. 3rd ed. Washington, DC: American Psychological Association, 2007.

Solomon, Curtis. *I Have PTSD: Reorienting after Trauma*. Greensboro, NC: New Growth Press, 2023.

———. “Evaluating the Legacy Program of the Mighty Oaks Foundation.” PhD diss., The Southern Baptist Theological Seminary, 2020.

Solomon, Marion, and Daniel Siegel, eds. *Healing Trauma: Attachment, Mind, Body and Brain*. Norton Series on Interpersonal Neurobiology. New York: W. W. Norton, 2003.

Sproul, R. C. *Knowing Scripture*. Downers Grove, IL: InterVarsity Press, 1977.

Stickgold, Robert. “EMDR: A Putative Neurobiological Mechanism of Action.” *Journal of Clinical Psychology* 58, no. 1 (2002): 61-75.

Strickland, Darby. “Foundations of Trauma Care for Biblical Counselors.” *Journal of Biblical Counseling* 36, no. 2 (2022): 25-56.

———. *Trauma: Caring for Survivors*. Philipsburg, NJ: P & R, 2023.

Struthers, William, Kerryn Ansell, and Adam Wilson. “The Neurobiology of Stress and Trauma.” In *Treating Trauma in Christian Counseling*, edited by Heather Davediuk Gingrich and Fred C. Gingrich, 55-77. Christian Association for Psychological Studies Books. Downers Grove, IL: IVP Academic, 2017.

Thoma, Nathan, Brian Pilecki, and Dean McKay. “Contemporary Cognitive Behavior Therapy: A Review of Theory, History and Evidence.” *Psychodynamic Psychiatry* 43, no. 3 (2015): 423-62.

Tripp, Paul David. *Suffering: Gospel Hope for When Life Doesn’t Make Sense*. Wheaton, IL: Crossway, 2018.

US Department of Veterans Affairs. “Epidemiology and Impact of PTSD,” Accessed March 17, 2024. https://www.ptsd.va.gov/professional/treat/essentials/epidemiology.asp.

———. “How Common is PTSD in Adults?” Accessed March 17, 2024. https://www.ptsd.va.gov/understand/common/common_adults.asp.

———. “How Common is PTSD in Veterans?” Accessed March 17, 2024. https://www.ptsd.va.gov/understand/common/common_veterans.asp.

———. “Prolonged Exposure for PTSD.” Accessed March 17, 2024. https://www.ptsd.va.gov/professional/treat/txessentials/prolonged_exposure_pro.asp.

———. “PTSD and *DSM-V*.” Accessed March 17, 2024. https://www.ptsd.va.gov/professional/treat/essentials/dsm5_ptsd.asp.

———. “PTSD History and Overview.” Accessed March 17, 2024. https://www.ptsd.va.gov/professional/treat/essentials/history_ptsd.asp.

———. “Sexual Assault Experienced as an Adult.” Accessed March 17, 2024. https://www.ptsd.va.gov/professional/treat/type/sexual_assault_adult.asp.

Van den Hout, Marcel, and Iris Engelhard. “How Does EMDR Work?” *Journal of Experimental Psychopathology* 3, no. 5 (2012): 724-38.

Van den Hout, Marcel, Nicola Bartelski, and Iris Engelhard. “On EMDR: Eye Movements during Retrieval Reduce Subjective Vividness and Objective Memory Accessibility during Future Recall.” *Cognition and Emotion* 27, no. 1 (2013): 177-83.

Van der Kolk, Bessel. “Beyond the Talking Cure: Somatic Experience and Subcortical Imprints in the Treatment of Trauma.” In *EMDR as an Integrative Psychotherapy Approach*, edited by Francine Shapiro, 57-84. 3rd ed. Washington, DC: American Psychological Association, 2007.

———. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma.* New York: Penguin Books, 2014.

Van der Kolk, Bessel, Joseph Spinazzola, Margaret E. Blaustein, James W. Hopper, Elizabeth K. Hopper, Deborah L. Korn, and William B. Simpson. “A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder: Treatment Effects and Long‐Term Maintenance.” *Journal of Clinical Psychiatry* 68, no. 1 (2007): 37‐46.

Van Veen, Suzanne, Sahaj Kang, and Kevin van Schie. “On EMDR: Measuring the Working Memory Taxation of Various Types of Eye (Non-)Movement Conditions.” *Journal of Behavioral Therapy and Experimental Psychiatry* 65 (2019): 1-5.

Viars, Steve. *Putting Your Past in Its Place: Moving Forward in Freedom and Forgiveness*. Eugene, OR: Harvest House, 2011.

Wadji, Dany Laure, C. Martin-Soelch, and V. Camos. “Can Working Memory Account for EMDR Efficacy in PTSD?” *BMC Psychology* 10, no. 1 (2022): 1-12.

Wartik, Nancy. “The Amazingly Simple, Inexplicable Therapy That Just Might Work: Is EMDR Psychology’s Magic Wand or Just Some Hocus Pocus?” *Los Angeles Times*, August 7, 1994.

Watkins, Laura, Kelsey R. Spring, Barbara O. Rothbaum. “Treating PTSD: A Review of Evidence-Based Psychotherapy Interventions.” *Frontiers in Beahvioral Neuroscience* 12 (2018): 1-9.

Weathers, Frank, and Terence Keane. “The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma.” *Journal of Traumatic Stress* 20, no. 2 (2007): 107-21.

Weinrach, Stephen G. “Cognitive Therapist: A Dialogue with Aaron Beck.” *Journal of Counseling and Development* 67, no. 3 (November 1988): 159-63.

Welch, Ed. “Trauma and the Body: An Introduction to Three Books.” *Journal of Biblical Counseling* 33, no. 2 (2019): 61-83.

Wetherford, Ruth. “Francine Shapiro on the Evolution of EMDR Therapy.” Psychotherapy. Accessed September 13, 2021. http://www.psychotherapy.net/interview/francine-shapiro-emdr.

Williams, Amy, Tara E. Galovski, and Patricia Resick. “Cognitive Processing Theory.” In *Treating PTSD in Military Personnel*, edited by Bret A Moore and Walter E. Penck, 63-77. 2nd ed. New York: Guilford Press, 2019.

Williams, Sam. “What About the Body?” In *Scripture and Counseling: God’s Word for Life in a Broken World*, edited by Bob Kellemen, 144-58. Grand Rapids: Zondervan, 2014.

Wilson, Sandra, Lee Becker, and Robert Tinker. “Eye Movement Desensitization and Reprocessing (EMDR) Treatment for Psychologically Traumatized Individuals.” *Journal of Consulting and Clinical Psychology* 63, no.6 (1995): 928-37.

Winfrey, Oprah, and Bruce D. Perry. *What Happened to You?* New York: Flatiron Books, 2021. Kindle.

Wolpe, Joseph, and David Wolpe. *Life without Fear*. 2nd ed. Oakland, CA: New Harbinger, 1988.

Wolpe, Joseph, and Janet Abrams. “Post-Traumatic Stress Overcome by Eye-Movement Desensitization: A Case Report.” *Journal of Behavior Therapy and Experimental Psychiatry* 22, no. 1 (1991): 39-43.

World Health Organization. *Guidelines for the Management of Conditions Specifically Related to Stress*. Geneva: World Health Organization, 2013.

Young, Allan. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton, NJ: Princeton University Press, 1995.

ABSTRACT

A BIBLICAL ANALYSIS OF EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) THERAPY AND ITS USE IN BIBLICAL COUNSELING

Matthew Claude Higgins, DMin
The Southern Baptist Theological Seminary, May 2024
Chair: Dr. John M. Henderson

This thesis argues that Eye Movement Desensitization and Reprocessing (EMDR) therapy is incompatible with Scripture and the precepts of biblical counseling." The first chapter is an introduction to the topic of EMDR therapy and the void in biblical counseling literature surrounding EMDR. The second chapter shows how Dr. Francine Shapiro developed EMDR and then how the psychiatric community came to accept EMDR as a trauma treatment. The third chapter analyzes the adaptive information processing model, which is the leading theory regarding how EMDR works. The fourth chapter presents an overview of why Scripture is incompatible with the premises of EMDR. The fifth chapter presents some implications for how the biblical counseling movement should engage with EMDR.

VITA

Matthew Claude Higgins

EDUCATION

BS, James Madison University, 1995
MPA, Virginia Commonwealth University, 1997
MDiv, Southwestern Baptist Theological Seminary, 2010

ORGANIZATIONS

Association of Certified Biblical Counselors

MINISTERIAL EMPLOYMENT

Youth Minister, Urbanna Baptist Church, Urbanna, Virginia, 2002-2007
Youth Minister, Fellowship Family Church, Grand Prairie, Texas, 2007-2009
Lead Pastor, Calvary Heights Baptist Church, Martinsville, Indiana, 2010-2015
Pastor of Family Ministries, NorthWoods Church, Evansville, Indiana, 2015-2021
Pastor of Worship, NorthWoods Church, Evansville, Indiana, 2022-