



DOSSIER · THERAPY

EMDR (Eye Movement Desensitization and Reprocessing)

EMDR is a psychotherapeutic approach for treating trauma-associated disorders. The body of evidence is extensive. The most intriguing finding: A significant proportion of controlled studies do not evaluate **EMDR** in isolation but rather in comparison or combination with other therapeutic modalities—complicating the attribution of specific effects.

797

STUDIES IN
TOTAL

542

IN HUMANS

247

OF WHICH
CONTROLLED

7

IN ANIMALS

0

IN THE LAB

Figures from the IHR study database · Last updated 2026-10-15

How to Read This Dossier

ESTABLISHED

measured in humans, with a comparison group

PLAUSIBLE

supported by mechanism, animal studies or observation

HYPOTHESIS

a likely connection that still needs to be tested

EMDR (Eye Movement Desensitisation and Reprocessing) at a glance

ORIGIN:

EMDR (Eye Movement Desensitisation and Reprocessing) is a structured, trauma-focused psychotherapy developed in the 1980s. It combines elements of cognitive behavioural therapy with bilateral stimulation, typically through guided eye movements, and aims to process distressing memories in trauma-associated disorders such as PTSD. The procedure is conducted in eight phases, from history-taking to follow-up.

EVIDENCE BASE:

797 evaluated studies · 247 controlled human trials · 295 observational studies · 72 review articles · 7 animal studies · 0 cell culture studies

STRONGEST EVIDENCE:

- Post-traumatic stress disorder (PTSD) in adults: EMDR showed significant reductions in PTSD symptoms (CAPS, HTQ) in randomised controlled trials (RCTs), with effect sizes comparable to prolonged exposure (PE) and trauma-focused cognitive behavioural therapy (TF-CBT). Effects remain stable at 6-month follow-up, particularly for intrusion and hyperarousal symptoms.
- PTSD in children and adolescents: EMDR led to significant reductions in PTSD symptoms, depression, and anxiety, often in fewer sessions than cognitive behavioural therapy. Effects remain stable at 3- and 12-month follow-up, showing high remission rates.
- Complex PTSD (cPTSD) and comorbid disorders: EMDR showed large effect sizes for reducing PTSD symptoms in cPTSD and comorbid conditions such as psychosis or bipolar disorder. Short-term effects are evident, but long-term data are lacking.
- Anxiety disorders (non-PTSD): Meta-analyses show significant reductions in anxiety symptoms, panic symptoms, and phobias through EMDR, particularly compared to passive control conditions. However, effects are heterogeneous, and follow-up data are lacking.
- Exhaustion and stress in refugees: EMDR is safe and effective for refugees with PTSD but shows no superiority over stabilising therapy. Intensive programmes yield large effect sizes for PTSD symptoms.

LIMITATIONS:

- Non-PTSD indications: The evidence for EMDR in chronic pain, depression, or exhaustion syndromes is sparse, heterogeneous, and often shows no clear superiority over established interventions or placebo.
- Long-term effects and subgroups: Long-term data beyond the immediate post-intervention phase are lacking. Studies on specific subgroups (e.g., older patients, complex PTSD) are rare or methodologically limited.
- Theoretical foundation and mechanisms of action: Despite hypotheses (e.g., working memory taxation, REM sleep analogy), the precise mechanism of action of EMDR remains unclear. Mechanism studies are correlational and do not permit causal conclusions.

CLASSIFICATION:

EMDR is a manualised, trauma-focused psychotherapy with well-documented efficacy for PTSD, but its evidence base beyond this application is still emerging and heterogeneous.

EMDR (Eye Movement Desensitisation and Reprocessing) is a structured, trauma-focused psychotherapy developed in the 1980s. It combines elements of cognitive behavioural therapy with bilateral stimulation, typically through guided eye movements. The procedure is conducted in eight phases: history-taking, preparation, assessment, desensitisation, installation, body scan, closure, and follow-up. The goal is to process distressing memories through targeted activation and re-evaluation of traumatic experiences. **EMDR** is primarily used for post-traumatic stress disorder (PTSD) but is also applied to other stress-related disorders.

The critical factor for the evidence base is the **standardisation of delivery**. **EMDR** follows a manualised protocol but allows for individual adaptations—such as the type of bilateral stimulation (eye movements, tactile, or auditory stimuli) or session duration. This variability complicates direct comparisons between studies. Additionally, **EMDR** is often combined with other therapies, hindering the isolation of specific mechanisms of action. Most studies measure effects using standardised scales for PTSD symptoms, depression, or anxiety, and less frequently via physiological markers.

EMDR (Eye Movement Desensitisation and Reprocessing) is a structured, eight-phase psychotherapy for processing distressing memories, developed by Francine Shapiro in 1987. It aims to reduce the emotional and cognitive burden of traumatic experiences.

During therapy, the patient activates a distressing memory along with its associated sensory, cognitive, and emotional components. Simultaneously, they follow the therapist's bilateral hand movements with their eyes (or use alternative stimuli such as sounds or touches). This stimulation is conducted in sets lasting from seconds to minutes, with changes in distress and memory evaluation recorded using scales. EMDR is included in guidelines for treating post-traumatic stress disorder (PTSD) and is being tested for other conditions.

The direct evidence base for EMDR includes 466 human studies, of which 225 are controlled trials, as well as a total of 645 publications. This evidence supports the efficacy of EMDR for PTSD, though the methodological quality of studies varies, and not all controlled trials are of high quality. The data are extensive but not homogeneous.

If there are few or no studies on a procedure, this says nothing about its efficacy—only about the state of research. We therefore examine what is known about the components of the procedure: 316 studies on related procedures and mechanisms, of which 100 are controlled human trials. The references lead to the source list at the end of the page.

ESTABLISHED Bilateral stimulation in EMDR competes with working memory (WM) for limited resources, leading to a reduction in the vividness and emotional intensity of traumatic memories. This is demonstrated in studies combining EMDR with WM-taxing tasks (e.g., playing Tetris) or using functional imaging to show reduced activity in emotional and visual brain regions ²³.

PLAUSIBLE Memory reconsolidation may be influenced by EMDR, as bilateral stimulation during recall could destabilise the memory trace and enable re-evaluation. This is supported by studies showing similar mechanisms in other trauma-focused interventions (e.g., 3MDR) or combined approaches (e.g., [missing reference]). However, direct evidence for this specific mechanism in EMDR is lacking.

ESTABLISHED EMDR is comparable in efficacy to other trauma-focused interventions such as cognitive behavioural therapy (TF-CBT) for PTSD but shows advantages in efficiency in some studies (e.g., meta-analyses confirm significant effects on depressive symptoms, particularly in severe cases ²⁴).

PLAUSIBLE Integrating EMDR into multimodal approaches (e.g., VR-assisted therapies) or combining it with specific training (e.g., Memory Specificity Training) could enhance efficacy for complex trauma sequelae or comorbid disorders (e.g., [missing reference]). However, the evidence here is still limited and requires further controlled studies.

Speculative: Subjective improvements in sleep following EMDR, as described in anecdotal reports, may stem from reductions in nightmares and nocturnal intrusions. While studies show subjective improvements (e.g., PSQI scores), there are no consistent changes in objective sleep parameters (e.g., actigraphy) ²⁵. This suggests a discrepancy between subjective perception and physiological markers.

Speculative: EMDR combines multiple mechanisms of action whose interplay is not yet fully understood. Bilateral stimulation (e.g., eye movements) taxes working memory, reducing the vividness and emotional intensity of the memory. However, it remains unclear whether this mechanism alone explains the long-term processing of traumatic memories or whether additional factors (e.g., cognitive reappraisal) play a role.

Speculative: The assumption that EMDR promotes memory reconsolidation is plausible but not directly supported. Studies on other interventions (e.g., [missing reference]) suggest this possibility, but whether it is the primary mechanism of action in EMDR remains an open question. Furthermore, it is unclear whether the effects are specific to bilateral stimulation or can also be achieved through other WM-taxing tasks.

1. What EMDR (Eye Movement Desensitisation and Reprocessing) Is

It combines the activation of traumatic memories—including associated images, thoughts, feelings, and bodily sensations—with bilateral stimulation, typically through guided eye movements (alternatively auditory or tactile stimuli). The therapy aims to reduce the subjective distress and re-evaluation of the memory through repeated sets lasting from seconds to minutes, with changes recorded using scales.

The procedure follows a standardised protocol: history-taking, preparation, assessment of the target memory, desensitisation through bilateral stimulation, installation of positive cognitions, body scan, closure, and follow-up.

2. Direct Evidence Base

The evidence supports its efficacy for PTSD, though the methodological quality of studies varies. Meta-analyses show moderate to large effects compared to control conditions (e.g., waitlist, supportive therapy), though with heterogeneity in results. The evidence base for other applications (e.g., depression, anxiety disorders) is less extensive but growing.

3. Related Evidence: What Studies Show in the Same Direction

PLAUSIBLE Bilateral stimulation in EMDR competes with working memory (WM) and thereby reduces the vividness and emotional intensity of aversive memories in laboratory settings. Studies with non-clinical participants show that eye movements during the retrieval of aversive memories significantly decrease their vividness and affective charge compared with mere recall (²³, ²⁸). Similar effects have been demonstrated for other WM-taxing tasks (e.g., playing Tetris), which reduce intrusive memories following trauma exposure in experimental paradigms.

PLAUSIBLE The reconsolidation of memories plays a central role in the mechanism of action of EMDR. Neuroimaging studies show that bilateral stimulation during memory retrieval reduces activity in brain regions such as the amygdala (emotional processing) and the visual cortex (vividness), while increasing activation in prefrontal areas (e.g., dorsolateral prefrontal cortex)—a pattern associated with WM taxation and memory modulation (²³).

PLAUSIBLE Trauma-focused interventions such as EMDR, cognitive behavioural therapy (TF-CBT), or Narrative Exposure Therapy (NET) share common mechanisms of action, including exposure to traumatic memories and the reappraisal of dysfunctional cognitions. Comparative studies show that EMDR achieves effects comparable to TF-CBT, with bilateral stimulation potentially contributing to processing efficiency. However, direct comparative studies that isolate the specific contribution of bilateral stimulation in EMDR are lacking.

Hypothesised: Combining bilateral stimulation with other therapeutic elements (e.g., virtual reality, physical activity) could enhance efficacy in complex or treatment-resistant PTSD cases. Pilot studies on multimodal approaches such as 3MDR (Multimodal Motion-Assisted Memory Desensitization and Reconsolidation) show promising results, particularly in military personnel with chronic PTSD (²⁷). However, the specific role of bilateral stimulation in these combinations remains unclear and has not been isolated.

Hypothesised: The efficacy of EMDR in depression (²⁴) may be attributable to secondary effects of trauma processing, as many depressed patients exhibit comorbid trauma-related disorders. Meta-analyses show moderate effects, but the heterogeneity of studies suggests non-specific factors (e.g., therapeutic relationship) or distinct subgroups. A direct causal effect of bilateral stimulation on depressive symptoms has not been established.

4. Mechanism of Action

Hypothesised: Bilateral stimulation in EMDR taxes working memory, leading to a reduction in the vividness and emotional intensity of traumatic memories. This mechanism is supported by studies showing that WM-taxing tasks (e.g., eye movements, Tetris) decrease the vividness of aversive memories (²⁸, ²³). However, it remains unclear whether this effect is specific to EMDR or can also be achieved through other WM-taxing interventions. Furthermore, studies isolating the precise contribution of bilateral stimulation compared with mere exposure are lacking.

The reconsolidation of memories is discussed as a central mechanism of action: the combination of memory retrieval and bilateral stimulation may destabilise and reconsolidate trauma memory, leading to a reduction in affective charge. Neuroimaging studies demonstrate corresponding changes in brain activation patterns ⁽²³⁾, but the causal relationship between these neurophysiological changes and clinical symptom reduction has not been conclusively established. **Hypothesised:** It is conceivable that bilateral stimulation enhances the efficiency of exposure by selectively engaging cognitive processing capacity, thereby accelerating habituation.

5. What the Studies Show in Detail

The foundational human studies and key reviews—by application area, including population, duration, preparation, outcome measures, and results, as reported in the original publications. Numbers are only included where the study specifies them.

Distribution of **controlled human studies** by application area—the numbers are not addable, as one study may be assigned to multiple areas:

APPLICATION AREA	CONTROLLED STUDIES
Fatigue and stress	174
Cognition and mental health	160
Safety and tolerability	56
Musculoskeletal system	9
Immune system	5
Gut and microbiome	4
Oncology	4
Dermatology	2

Post-Traumatic Stress Disorder (PTSD) in Adults

In a randomised controlled trial (RCT) involving 155 outpatients with psychotic disorders and comorbid chronic PTSD (61.3% schizophrenia, 29% schizoaffective disorder), EMDR was compared with prolonged exposure (PE) and a waitlist control. Participants received eight weekly 90-minute sessions without prior stabilising psychotherapy. Primary endpoints were clinician-rated PTSD severity (Clinician-Administered PTSD Scale, CAPS), PTSD diagnosis, and full remission. Secondary outcomes included self-reported PTSD symptoms and post-traumatic cognitions. EMDR led to a significant reduction in PTSD symptoms (CAPS) post-therapy and at 6-month follow-up, with effects comparable to PE. No significant effects were found for auditory hallucinations or social functioning.

A meta-analysis of 11 RCTs (N = 424) directly compared EMDR with trauma-focused cognitive behavioural therapy (TF-CBT) in adults with PTSD. The studies comprised 6–12 sessions of 60–90 minutes each. EMDR demonstrated a slight superiority in reducing overall PTSD symptoms (effect size g = -0.43; 95% CI: -0.73 to -0.12; p = 0.006), particularly for intrusion and hyperarousal symptoms. No significant differences were observed for avoidance symptoms. However, the superiority of EMDR was no longer detectable at 3-month follow-up (g = -0.21; 95% CI: -0.50 to 0.08; p = 0.15). The included studies had methodological limitations, including small sample sizes and lack of blinding, which limit the conclusiveness of the findings.

An RCT involving 85 Syrian refugees in a Turkish refugee camp compared EMDR (n = 37) with a waitlist control (n = 33). Primary endpoints were PTSD symptomatology (Harvard Trauma Questionnaire, HTQ; Impact of Event Scale-Revised, IES-R) and depression (Beck Depression Inventory, BDI-II). Post-therapy, EMDR demonstrated a significant reduction in PTSD symptoms (HTQ: d = 1.78; 95% CI: 0.92–2.64) and depression (BDI-II: d = 1.14; 95% CI: 0.35–1.92) compared to the waitlist. The effects remained stable at the 5-week follow-up.

B. TF-CBT). TF-CBT exhibited slightly higher short-, medium-, and long-term efficacy compared to non-trauma-focused interventions. Dropout rates were comparable between EMDR and TF-CBT (14–15%). The analysis underscores the importance of trauma-focused interventions but also highlights high heterogeneity between studies and potential publication bias ¹⁴.

PTSD in Children and Adolescents

An RCT involving 52 children (aged 4–18) following an explosion disaster compared EMDR (n = 26) with cognitive behavioural therapy (CBT, n = 26). Both groups received up to four individual 60–90-minute sessions, as well as parental counselling. Primary endpoints were PTSD symptomatology (parent and self-reports), depression, anxiety, and behavioural problems. Both interventions led to significant reductions in all symptoms, with EMDR achieving treatment success in fewer sessions. The effects remained stable at the 3-month follow-up. The study shows that EMDR is effective for PTSD in children and adolescents but has limitations, including a heterogeneous sample (age, ethnicity) ⁹.

An RCT involving 103 children and adolescents (aged 8–18) with PTSD following a single-event trauma compared EMDR (n = 43) with cognitive behavioural writing therapy (CBWT, n = 42) and a waitlist (n = 18). Participants received up to six 45-minute sessions. EMDR and CBWT resulted in large effect sizes for PTSD symptoms (EMDR: d = 1.27; CBWT: d = 1.24) and high remission rates (EMDR: 92.5%; CBWT: 90.2%). Both interventions also reduced trauma-related negative cognitions and avoidance behaviours. The effects remained stable at the 3- and 12-month follow-ups. The study shows the efficacy of EMDR in children and adolescents but is limited by a small waitlist sample ¹⁵.

Complex PTSD (cPTSD) and Comorbid Disorders

EMDR ($k = 4$ studies) demonstrated a large effect size for the reduction of PTSD symptoms ($g = -1.26$; 95% CI: -2.01 to -0.51) in the evaluated controlled trials but was only evaluated in one study regarding negative self-concept. EMDR and TF-CBT ($k = 27$) were comparably effective for disturbed relationships in the included trials. Evidence for affect regulation disorders was insufficient. The analysis indicates that EMDR shows promise for cPTSD but lacks specific data on core symptoms of cPTSD ¹.

An RCT involving 20 bipolar patients with subsyndromal symptoms and a history of trauma compared EMDR ($n = 10$) with treatment as usual (TAU, $n = 10$). The EMDR group received 14–18 sessions of 60–90 minutes over 12 weeks. Primary endpoints were depressive and hypomanic symptoms, trauma symptoms, and trauma impact. EMDR led to significant improvements in all domains post-therapy, though the effects on trauma impact were only partially maintained at the 24-week follow-up. The study suggests the efficacy of EMDR in traumatised bipolar patients but is limited by the small sample size and the absence of an active control group ¹¹.

HYPOTHESIS The available pilot data suggest that EMDR may be safe and feasible for comorbid disorders such as psychoses or bipolar disorders, provided trauma processing remains the focus. Larger RCTs with longer follow-up periods are needed to assess the efficacy and sustainability of these effects.

Anxiety Disorders and Further Indications

A meta-analysis of 17 RCTs ($N = 647$) examined the efficacy of EMDR in anxiety disorders (non-PTSD). EMDR led to significant reductions in anxiety symptoms ($g = -0.71$; 95% CI: -0.96 to -0.47), panic symptoms ($g = -0.62$; 95% CI: -1.10 to -0.14), and phobias ($g = -0.45$; 95% CI: -0.81 to -0.08). No significant effects were found for trauma-related emotions. The effects were stronger when EMDR was compared with passive control conditions. The analysis indicates that EMDR may be effective for anxiety disorders but is limited by study heterogeneity and the absence of follow-up data ¹⁶.

Two RCTs ($N = 80$) demonstrated significant reductions in pain intensity scores ($g = -6.87$ and -1.12), while observational studies showed heterogeneous effects ($g = -0.24$ to -5.86). Improvements in depression and anxiety scores were also reported, though these reflect symptom assessments rather than clinical remission or functional improvement. The evidence for pain reduction is limited by small sample sizes, the absence of active control groups, and high heterogeneity, and does not yet establish clinical efficacy ¹².

HYPOTHESIS EMDR may represent a promising adjunct to established interventions for anxiety disorders and chronic pain. However, RCTs with standardised protocols and longer follow-up periods are lacking to conclusively evaluate efficacy and safety in these indications.

Exhaustion and Stress in Refugees

An RCT involving 72 refugees with PTSD compared EMDR (12 hours: 3×60 minutes preparation + 6×90 minutes desensitisation/reprocessing) with stabilising therapy (12×60 minutes). Primary endpoints were PTSD symptomatology (CAPS, HTQ). Both groups showed no significant differences in efficacy (CAPS: $d = -0.04$; HTQ: $d = 0.20$). One serious adverse event occurred in the stabilisation group. The study indicates that EMDR is safe for refugees but not more effective than stabilisation. Limitations include the small sample size and the absence of an untreated control group ¹⁰.

An observational study involving 347 patients with severe PTSD (74.4% sexual abuse, 87.5% comorbid affective disorder) examined an intensive 8-day programme combining EMDR and prolonged exposure (PE) (16 sessions of 90 minutes in total), alongside psychoeducation and physical activity. Post-therapy, large effect sizes were observed for PTSD symptoms (CAPS: $d = 1.64$), with 82.9% clinically significant responders and 54.9% no longer meeting PTSD diagnostic criteria. The study provides preliminary support for an intensive trauma-focused approach but is limited by the absence of a control group and a heterogeneous sample ²⁶.

Overall Picture

The available studies confirm the efficacy of EMDR for PTSD and comorbid disorders such as depression and anxiety. For psychoses, initial findings showed promising results but require confirmation. EMDR demonstrates comparable effects to trauma-focused cognitive behavioural therapy (TF-CBT) and prolonged exposure (PE), with partially faster treatment success, particularly for intrusion and hyperarousal symptoms. The effects are evident in both adults and children/adolescents, though the evidence for the latter group is less extensive. EMDR is safe and well-tolerated, with low dropout rates (5–15%) in most studies. Initial studies showed promising results for complex PTSD and comorbid disorders such as bipolar disorders or psychoses, but these findings require confirmation through further research with larger samples and longer follow-up periods.

The evidence for EMDR in anxiety disorders, chronic pain, or exhaustion syndromes is heterogeneous. While some controlled trials show significant effects, standardised protocols, active control groups, and follow-up data are lacking to assess the sustainability of these effects. Furthermore, it remains unclear whether EMDR is more effective than stabilising interventions for refugees with complex trauma and high levels of distress. Systematic reviews indicate potential publication bias and high heterogeneity between studies, limiting the generalisability of the findings.

Methodology of the evidence base

Most of the controlled human trials are RCTs involving 10–155 participants, comparing EMDR with waitlists, active control groups (e.g., TF-CBT, PE), or treatment as usual. Typical treatment durations range from 4–12 sessions of 60–90 minutes, though intensive programmes (e.g., 8 days with two daily sessions) have also been evaluated. Primary endpoints typically include PTSD symptomatology (CAPS, HTQ, IES-R), with secondary endpoints covering depression (BDI-II), anxiety, social functioning, and trauma-related cognitions. Follow-up periods range from 1 month to 2 years, though longer follow-ups are rare. Systematic limitations include small sample sizes, lack of rater blinding, high protocol heterogeneity, and the absence of studies on long-term effects or specific subgroups (e.g., older patients, patients with cPTSD). Additionally, data on cost-effectiveness and implementation in routine care are often lacking.

EMDR: An effective intervention – but not for everything

The broad application of
EMDR

beyond PTSD is **disproportionate to the evidence base**. While its efficacy for post-traumatic stress disorder is well-established, there are few controlled studies for other indications—such as depression, anxiety disorders, or chronic pain—which often show **no clear superiority** over other therapeutic approaches or placebo. Particularly critical is the **lack of theoretical foundation** for the intervention: despite numerous hypotheses (e.g., working memory taxation, REM sleep analogy), it remains unclear how **EMDR** precisely works. Most mechanism studies are correlational and do not permit causal conclusions.

Another issue is the
HETEROGENEITY OF STUDY POPULATIONS

. Many studies recruit specific groups, such as war refugees or patients with comorbid psychoses, which limits the transferability of the results. Furthermore, **EMDR** is frequently used in combination with other therapies, such as stabilising techniques or medication, making it difficult to isolate the **specific effects of EMDR**. The few studies examining **EMDR** as a monotherapy show positive effects but no consistent superiority over other trauma-focused interventions.

6. How Robust the Research Is

Research on **EMDR** primarily focuses on **cognitive and emotional symptoms**, particularly PTSD-associated complaints such as intrusions, avoidance behaviour, and hyperarousal. Considerably fewer studies address physical parameters, such as those involving the **musculoskeletal system** or biological markers. Many of the controlled trials conducted over the past 15 years emphasise randomised designs. Review articles and meta-analyses contribute to the theoretical foundation, though controlled trials are one part of the evidence base.

Methodologically, the field is characterised by **high comparability with established therapies**, particularly prolonged exposure and cognitive behavioural therapy. Many of the controlled trials show **no superiority of EMDR** but rather **equivalence** to these approaches. The evidence base is robust for PTSD within the available controlled trials, yet **limited or inconsistent** for other applications such as chronic pain or bipolar disorders. A central issue is the **lack of blinding**: both therapists and patients typically know which intervention is being applied, which may introduce bias. Additionally, long-term data extending beyond the immediate post-intervention phase are often lacking.

7. What Is Frequently Claimed—and What the Data Support

STATEMENT	EVIDENCE BASE
EMDR for chronic pain	The data available is still emerging. The existing studies show mixed results, often without clear superiority over other methods.
EMDR for bipolar disorders	Only one controlled pilot study involving subsyndromal patients exists. No robust conclusions can be drawn.
EMDR as a preventive measure	No controlled studies on primary prevention exist. The available research exclusively examines secondary or tertiary prevention.
EMDR in children and adolescents	The available data is limited. Most studies demonstrate equivalence to cognitive behavioural therapy, but no superiority.

Anecdotal evidence, no studies: 10 first-hand accounts from 2 public sources, evaluated by reason for treatment, outcome, duration, and side effects. Reported outcomes: 5× better, 3× partially better, 1× unclear, 1× unchanged. These accounts are uncontrolled, unrepresentative, and subject to selection bias—reflecting what individuals experience, not what the procedure achieves.

Therapists’ clients report heterogeneous experiences with EMDR, ranging from marked symptom relief to no perceptible change. Frequently cited positive effects include reductions in flashbacks, nightmares, and emotional overwhelm, particularly in cases of single-event trauma (e.g., accidents, assaults). The duration of therapy varies widely (5–30 sessions over months to years), with complex trauma-related disorders or comorbid conditions (e.g., dissociation) often requiring longer courses.

Reported side effects include emotional overwhelm, physical tension, feelings of shame, or temporary worsening of symptoms. Some individuals discontinue treatment prematurely, particularly in the absence of social support or a stable environment. Contradictions emerge in evaluations of the therapy: while some report rapid relief, others find EMDR burdensome or ineffective, especially in cases of complex trauma or dissociative symptoms.

Sources analysed: www.psychotherapiepraxis.at · www.therapie.de

DIMENSION	SCORE	RATIONALE
Direct studies on the procedure	●●● 3/3	Extensive body of research comprising 225 controlled human studies demonstrating efficacy in PTSD.
Related evidence	●●○ 2/3	Mechanisms such as working memory load and reconsolidation are plausible but not specifically proven for EMDR.
Mechanistic plausibility against known studies	●●○ 2/3	Mechanisms of action are partially supported by related evidence, but the interplay of components is not yet fully understood.
Anecdotal evidence from clients	●●○ 2/3	Heterogeneous but predominantly positive case reports suggest efficacy in specific traumas.
Safety and tolerability	●●○ 2/3	Side effects are documented but mostly transient; discontinuation rates vary depending on the complexity of the disorder.

A randomised controlled trial with three arms (EMDR vs. EMDR without bilateral stimulation vs. waitlist control) in patients with PTSD, tracking both subjective measures (e.g., PTSD Checklist) and physiological parameters (e.g., functional imaging, sleep parameters) over 12 months. The primary endpoint would be changes in symptom severity, with secondary endpoints analysing potential mechanisms of action (e.g., reconsolidation, working memory load). Findings from imaging or sleep parameters are exploratory and do not confirm clinical effects in humans.

Innovation rarely has studies—conventional wisdom then says, “It doesn’t work.” We say: This is an open question, and here is how to answer it. Universities, training institutes, and practices that have investigated or are investigating this procedure may submit their work via info@ih-research.com; we will include it in the evidence base and update this profile.

8. First-Hand Accounts from Clients (Forums and Blogs)

Anecdotal evidence, no studies: 35 first-hand accounts from 8 public sources, evaluated by reason for treatment, outcome, duration, and side effects.

Clients report heterogeneous experiences with EMDR, ranging from marked symptom relief to temporary worsening or no effect. Frequently cited positive effects include reductions in flashbacks, nightmares, and emotional distress from traumatic memories, often after multiple sessions (typically 5–20 over weeks to months). Some describe rapid improvements in daily functioning, particularly for PTSD following single-event trauma (e.g., accidents, violence). Negative effects include emotional overwhelm, physical symptoms (e.g., nausea, dizziness), sleep disturbances, or increased anxiety between sessions. For complex trauma (e.g., long-term abuse), EMDR is sometimes experienced as distressing, with feelings of shame, loss of control, or temporary symptom exacerbation.

The duration of therapy varies widely: while some patients experience improvement after just a few sessions, others require months to years of support. Contradictions emerge in evaluations of the method—some describe EMDR as “life-changing,” while others discontinue due to lack of effect or excessive burden. Preparation for sessions (e.g., stabilisation techniques) and the therapeutic relationship are cited as critical to success. Physical or dissociative reactions during sessions sometimes lead to discontinuation or adaptation of the method (e.g., tapping instead of eye movements).

Sources analysed: affablyevil.substack.com · everybodysfavoritetherapist.substack.com · forum.wildwasser.de · lorrainecladish.substack.com · posttraumatische-belastungsstoerung.com · www.psychic.de · www.psychotherapiepraxis.at · www.therapie.de

9. Plausibility Profile (FAIR)

Plausibility: high — 11 out of 15 points

This profile is not proof of efficacy. It addresses a different question:
COULD THE METHOD POTENTIALLY BE EFFECTIVE, EVEN IF STUDIES ARE LACKING?

Five dimensions, each scored from 0 to 3 points, each with justification. The profile is recalculated whenever new studies or reports are added.

Status: 12.09.2026 · direct human studies: 542 · related studies: 316 · case reports: 35

DIMENSION	POINTS	JUSTIFICATION
Direct studies on the method	●●● 3/3	Extensive body of research comprising 247 controlled studies demonstrates efficacy in PTSD, albeit with methodological limitations.
Related evidence	●●○ 2/3	Mechanistic studies support the working memory load hypothesis, yet the specificity of bilateral stimulation and its role in complex therapeutic appr
Mechanistic rationale against established studies	●●○ 2/3	Plausible hypotheses for its effects (working memory load, reconsolidation) exist, but causal evidence for the necessity of bilateral stimulation is lack
Patient experience	●●○ 2/3	Reports on symptom reduction are heterogeneous but frequently positive, with clear patterns regarding side effects and duration of therapy.
Safety and tolerability	●●○ 2/3	EMDR is considered safe, but emotional and physical strain during therapy has been documented and requires careful indication.

10. Call for Research: Who Will Investigate This?

A multicentre, randomised controlled trial with three arms (EMDR with bilateral stimulation vs. EMDR without bilateral stimulation vs. trauma-focused cognitive behavioural therapy) should be conducted in patients with PTSD. Primary endpoints would include reduction in PTSD symptoms (CAPS-5) and vividness of traumatic memories (scales), with secondary endpoints covering working memory performance (n-back test), neurophysiological markers

(fMRI), and subjective distress. Follow-up should extend to at least 12 months to capture long-term effects and relapse rates.

11. The Most Robust Studies

Ranked by evidential strength, not by prominence. The full evaluation includes significantly more studies; these are the most reliable.

Controlled Human Studies

- ¹ Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis (2019)
- ² Prolonged exposure vs eye movement desensitization and reprocessing vs waiting list for posttraumatic stress disorder in patients with a psychotic disorder (2015)
- The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: addressing the psychological and physical symptoms stemming from adverse life experiences (2014)
- ³ Prolonged exposure and EMDR for PTSD vs. a PTSD waiting-list condition: effects on symptoms of psychosis, depression and social functioning in patients with PTSD (2016)
- ⁴ The efficacy of eye movement desensitization and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: results of a randomised controlled trial (2016)
- ⁵ EMDR beyond PTSD: A Systematic Literature Review (2017)
- ⁶ Imagery rescripting and eye movement desensitisation and reprocessing as treatment for adults with post-traumatic stress disorder from childhood trauma: a randomised controlled trial (2020)
- ⁷ Eye movement desensitization and reprocessing versus cognitive-behavioral therapy for adult posttraumatic stress disorder: systematic review and meta-analysis (2015)
- ⁸ EMDR for Syrian refugees with posttraumatic stress disorder symptoms: results of a pilot randomised controlled trial (2015)
- ⁹ A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children (2011)
- ¹⁰ Eye movement desensitisation and reprocessing therapy versus stabilisation as usual for refugees: randomised controlled trial (2016)
- ¹¹ Eye movement desensitisation and reprocessing therapy in subsyndromal bipolar patients with a history of traumatic events: a randomised, controlled pilot study (2014)
- ¹² Effects of eye movement desensitisation and reprocessing (EMDR) treatment in chronic pain patients: a systematic review (2014)
- ¹³ Cognitive behavioural therapy versus eye movement desensitisation and reprocessing in patients with post-traumatic stress disorder: systematic review and meta-analysis (2018)
- ¹⁴ The efficacy and acceptability of psychological interventions for adult PTSD: a network and pairwise meta-analysis of randomised controlled trials (2023)
- Long-term outcomes of trauma-focused treatment in psychosis (2018)
- ¹⁵ Comparison of eye movement desensitisation and reprocessing therapy, cognitive behavioural writing therapy, and wait-list in paediatric post-traumatic stress disorder (2017)
- ¹⁶ The effectiveness of eye movement desensitisation and reprocessing for anxiety disorders: a meta-analysis of randomised controlled trials (2020)
- ¹⁷ An eye movement desensitisation and reprocessing (EMDR) group intervention for Syrian refugees with post-traumatic stress symptoms: results of a randomised controlled trial (2018)
- ¹⁸ A multi-site single-blind clinical study to compare the effects of prolonged exposure, eye movement desensitisation and reprocessing, and waiting list (2013)
- ¹⁹ Eye movement desensitisation and reprocessing versus treatment-as-usual for non-specific chronic back pain patients with psychological trauma: a randomised controlled trial (2016)
- ²⁰ EMDR vs. other psychological therapies for PTSD: a systematic review and individual participant data meta-analysis (2024)
- ²¹ Clinical efficacy of trauma-focused psychotherapies in treatment-resistant depression (TRD) inpatients: a randomised, controlled pilot study (2019)
- ²² A five-day inpatient EMDR treatment programme for PTSD: pilot study (2018)

EMDR is a well-established psychotherapeutic approach for the treatment of post-traumatic stress disorder (PTSD) in adults, children, and adolescents. The controlled human trials demonstrate effects comparable to established methods such as trauma-focused cognitive behavioural therapy (TF-CBT) or prolonged exposure (PE), with partially faster treatment outcomes, particularly for intrusion and hyperarousal symptoms. The safety and tolerability of EMDR are documented in numerous studies, with low dropout rates (5–15%). The evidence for complex PTSD and comorbid disorders such as psychoses or bipolar disorders is promising but less extensive, often limited to small sample sizes or short follow-up periods.

HYPOTHESIS EMDR may also represent a promising adjunct to established approaches for anxiety disorders, chronic pain, or exhaustion syndromes. The available data suggest significant effects but are limited by heterogeneity, the absence of active control groups, and short follow-up periods. In refugees with complex trauma, EMDR appears safe but not more effective than stabilising interventions. The broad application of EMDR beyond PTSD is disproportionate to the available data, suggesting a potential overestimation of its efficacy in non-traumatic indications. **Hypothesis:** A targeted combination of EMDR with other therapeutic modalities (e.g., stabilisation techniques) could enhance effects in complex trauma or comorbid disorders, though this requires further empirical investigation.

To strengthen the evidence base for EMDR, randomised controlled trials (RCTs) with larger sample sizes, longer follow-up periods (at least 12–24 months), and standardised protocols are necessary. Studies are particularly urgent in the following areas: 1) the efficacy and safety of EMDR in non-traumatic indications (e.g., chronic pain, depression), 2) the sustainability of effects in complex PTSD and comorbid disorders, 3) the identification of predictors of therapeutic success (e.g., trauma processing vs. affect regulation), 4) the clarification of mechanisms of action through experimental designs (e.g., comparison of different forms of bilateral stimulation), and 5) cost-effectiveness and implementation in routine care. Additionally, systematic reviews and meta-analyses should account for publication bias and heterogeneity in study protocols to improve the generalisability of findings.

12. Summary

EMDR is a manualised, trauma-focused psychotherapeutic approach with well-documented efficacy for PTSD. The evidence is based on controlled human studies demonstrating significant reductions in PTSD symptoms in adults, children, and adolescents. Effects are comparable to other trauma-focused approaches such as TF-CBT or prolonged exposure and remain stable in follow-up assessments. The bilateral stimulation in EMDR competes with working memory for resources, leading to a reduction in the vividness and emotional intensity of traumatic memories. This is supported by studies using functional imaging or working memory-loading tasks.

A plausible assumption is that EMDR influences memory reconsolidation by destabilising the memory trace during recall through bilateral stimulation, enabling reappraisal. This hypothesis is supported by studies on similar mechanisms in other trauma-focused therapies, though direct evidence for EMDR is still pending. **Hypothesis:** The subjective improvement in sleep following EMDR may be attributable to a reduction in nightmares and nocturnal intrusions, although objective sleep parameters do not show consistent changes. **Hypothesis:** The combination of multiple mechanisms of action (e.g., working memory load, cognitive reappraisal) may explain the long-term processing of traumatic memories, though this remains incompletely understood.

To strengthen the evidence base, studies are needed that directly investigate the specific mechanisms of action of EMDR, particularly the role of bilateral stimulation and reconsolidation. Long-term studies with larger sample sizes and extended follow-up periods are necessary to assess the sustainability of effects in complex trauma-related disorders and comorbid conditions. Furthermore, high-quality RCTs for non-PTSD indications such as chronic pain or depression are still pending, which would allow clear differentiation from established approaches or placebo.

13. Unresolved Questions

- **Mechanism of action:** It remains unclear whether bilateral stimulation is essential or whether other factors (e.g., exposure) account for the effect.
- **Long-term effects:** Data on sustainability beyond 12 months are lacking, particularly for complex trauma-related disorders.
- **Combination therapies:** Few studies systematically comparing EMDR with pharmacotherapy or other forms of psychotherapy.

Frequently Asked Questions

Is EMDR more effective than prolonged exposure for PTSD?

Most controlled studies show **no significant differences** in efficacy between EMDR and prolonged exposure. Both approaches comparably reduce PTSD symptoms, though EMDR is often perceived by patients as less distressing. Meta-analyses confirm this equivalence but highlight methodological limitations, such as the lack of blinding or short follow-up periods.

Can EMDR be conducted without eye movements?

Yes, bilateral stimulation can also be applied tactilely (e.g., through hand tapping) or auditorily. Some studies suggest that the **type of stimulation** does not critically influence efficacy. However, large-scale controlled studies directly comparing these modalities are lacking.

Is EMDR suitable for patients with complex PTSD?

The evidence base is **limited but promising**. Some controlled studies demonstrate positive effects on symptoms such as emotional regulation or dissociation, though often in combination with stabilising techniques. EMDR is frequently used as part of a multimodal approach in such cases. However, the evidence is insufficient to recommend it as a **monotherapy** for complex PTSD.

Sources

- 1 Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis
Karatzias T, Murphy P, Cloitre M, Bisson J, Roberts N, Shevlin M et al. · 2019
- 2 Prolonged exposure vs eye movement desensitization and reprocessing vs waiting list for posttraumatic stress disorder in patients with a psychotic disorder: a randomized clinical trial
van den Berg DP, de Bont PA, van der Vleugel BM, de Roos C, de Jongh A, Van Minnen A et al. · 2015
- 3 Prolonged exposure and EMDR for PTSD v. a PTSD waiting-list condition: effects on symptoms of psychosis, depression and social functioning in patients with chronic psychotic disorders
de Bont PA, van den Berg DP, van der Vleugel BM, de Roos C, de Jongh A, van der Gaag M et al. · 2016
- 4 The efficacy of eye movement desensitization and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: results of a randomized controlled trial
Acarturk C, Konuk E, Cetinkaya M, Senay I, Sijbrandij M, Gulen B et al. · 2016
- 5 EMDR beyond PTSD: A Systematic Literature Review
Valiente-Gómez A, Moreno-Alcázar A, Treen D, Cedrón C, Colom F, Pérez V et al. · 2017
- 6 Imagery rescripting and eye movement desensitisation and reprocessing as treatment for adults with post-traumatic stress disorder from childhood trauma: randomised clinical trial
Boterhoven de Haan KL, Lee CW, Fassbinder E, van Es SM, Menninga S, Meewisse ML et al. · 2020
- 7 Eye movement desensitization and reprocessing versus cognitive-behavioral therapy for adult posttraumatic stress disorder: systematic review and meta-analysis
Chen L, Zhang G, Hu M, Liang X · 2015
- 8 EMDR for Syrian refugees with posttraumatic stress disorder symptoms: results of a pilot randomized controlled trial
Acarturk C, Konuk E, Cetinkaya M, Senay I, Sijbrandij M, Cuijpers P et al. · 2015
- 9 A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children
de Roos C, Greenwald R, den Hollander-Gijsman M, Noorthoorn E, van Buuren S, de Jongh A · 2011
- 10 Eye movement desensitisation and reprocessing therapy v. stabilisation as usual for refugees: randomised controlled trial
Ter Heide FJ, Mooren TM, van de Schoot R, de Jongh A, Kleber RJ · 2016
- 11 Eye movement desensitization and reprocessing therapy in subsyndromal bipolar patients with a history of traumatic events: a randomized, controlled pilot-study
Novo P, Landin-Romero R, Radua J, Vicens V, Fernandez I, Garcia F et al. · 2014
- 12 Effects of eye movement desensitization and reprocessing (EMDR) treatment in chronic pain patients: a systematic review
Tesarz J, Leisner S, Gerhardt A, Janke S, Seidler GH, Eich W et al. · 2014
- 13 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
Khan AM, Dar S, Ahmed R, Bachu R, Adnan M, Kotapati VP · 2018
- 14 The efficacy and acceptability of psychological interventions for adult PTSD: A network and pairwise meta-analysis of randomized controlled trials
Hoppen TH, Jehn M, Holling H, Mutz J, Kip A, Morina N · 2023
- 15 Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioral writing therapy, and wait-list in pediatric posttraumatic stress disorder following single-incident trauma: a multicenter randomized clinical trial
de Roos C, van der Oord S, Zijlstra B, Lucassen S, Perrin S, Emmelkamp P et al. · 2017
- 16 The effectiveness of eye movement desensitization and reprocessing toward anxiety disorder: A meta-analysis of randomized controlled trials
Yunitri N, Kao CC, Chu H, Voss J, Chiu HL, Liu D et al. · 2020
- 17 An Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention for Syrian Refugees With Post-traumatic Stress Symptoms: Results of a Randomized Controlled Trial
Yurtsever A, Konuk E, Akyüz T, Zat Z, Tükel F, Çetinkaya M et al. · 2018
- 18 A multi-site single blind clinical study to compare the effects of prolonged exposure, eye movement desensitization and reprocessing and waiting list on patients with a current diagnosis of psychosis and co morbid post traumatic stress disorder: study protocol for the randomized controlled trial Treating Trauma in Psychosis
de Bont PA, van den Berg DP, van der Vleugel BM, de Roos C, Mulder CL, Becker ES et al. · 2013
- 19 Eye Movement Desensitization and Reprocessing vs. Treatment-as-Usual for Non-Specific Chronic Back Pain Patients with Psychological Trauma: A Randomized Controlled Pilot Study
Gerhardt A, Leisner S, Hartmann M, Janke S, Seidler GH, Eich W et al. · 2016
- 20 EMDR v. other psychological therapies for PTSD: a systematic review and individual participant data meta-analysis
Wright SL, Karyotaki E, Cuijpers P, Bisson J, Papola D, Witteveen A et al. · 2024
- 21 Clinical efficacy of trauma-focused psychotherapies in treatment-resistant depression (TRD) in-patients: A randomized, controlled pilot-study
Minelli A, Zampieri E, Sacco C, Bazzanella R, Mezzetti N, Tessari E et al. · 2019
- 22 A five-day inpatient EMDR treatment programme for PTSD: pilot study
Zepeda Méndez M, Nijdam MJ, Ter Heide FJ, van der Aa N, Olff M · 2018
- 23 Degrading traumatic memories with eye movements: a pilot functional MRI study in PTSD
Thomas K, Engelhard IM, Sijbrandij M, Cath DC, Van den Heuvel OA · 2016
- 24 The Efficacy of Eye Movement Desensitization and Reprocessing Treatment for Depression: A Meta-Analysis and Meta-Regression of Randomized Controlled Trials
Seok JW, Kim JI · 2024
- 25 Subjective and objective sleep disturbances following trauma-focused treatment
Porten S, Friedmann F, Schoofs N, Barth C, Meyer K, Santangelo P et al. · 2025
- 26 Effectiveness of an intensive treatment programme combining prolonged exposure and eye movement desensitization and reprocessing for severe post-traumatic stress disorder
Van Woudenberg C, Voorendonk EM, Bongaerts H, Zoet HA, Verhagen M, Lee CW et al. · 2018
- 27 Virtual Reality-Based Treatment for Military Members and Veterans With Combat-Related Posttraumatic Stress Disorder: Protocol for a Multimodal Motion-Assisted Memory Desensitization and Reconsolidation Randomized Controlled Trial
Jones C, Smith-MacDonald L, Miguel-Cruz A, Pike A, van Gelderen M, Lentz L et al. · 2020
- 28 The Effects of the Flash Technique Compared to Those of an Abbreviated Eye Movement Desensitization and Reprocessing Therapy Protocol on the Emotionality and Vividness of Aversive Memories
Brouwers TC, de Jongh A, Matthijsen SJMA · 2021

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