EMDR Beyond Trauma Reprocessing

Clinical Applications and What Sets It Apart

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Disclosures and learning objectives

Disclosure: I have no relevant financial relationships with ineligible companies to disclose.

1. Identify patients who may benefit by a referral to a clinician well-versed in EMDR.

2. Describe the research base supporting EMDR, including key randomized controlled trials, meta-analyses, and guideline endorsements.

3. Describe key similarities and differences between EMDR and CBT-based approaches, including basic considerations for treatment matching and contraindications, as an introduction to informed referral decision-making.

4. Describe the phases of EMDR treatment based on a case example and brief demonstration.

Four questions this talk answers

1 What does the evidence support?

Obj 2

2 How does EMDR differ from PE and CPT?

Obj 3

3 What does treatment look like?

Obj 4

4 Who should I refer?

Obj 1

What EMDR is, beyond "the eye movement therapy"

A structured psychotherapy

Eight phases, developed by Francine Shapiro in the late 1980s, from history and preparation through reprocessing and reevaluation

Targets what drives symptoms now

Past memories, present triggers, and feared future situations linked to the current problem

How reprocessing works

The client briefly holds a memory (image, belief, emotion, body sensation) while doing a dual attention task: eye movements, taps, or tones. Then they notice what comes up, and the cycle repeats

What clients notice

Less talking through details, no formal homework, and associations the client follows rather than the therapist directs

Would you refer this patient?

SHOW OF HANDS

- 30-year-old with major depressive disorder superimposed on several years of persistent depressive disorder
- Prior CBT; two adequate antidepressant trials; ongoing medication management
- No trauma history or PTSD
- Reminders of past embarrassing experiences bring up shame and harsh self-criticism

A) Refer for EMDR

A) Refer for another CBT-based therapy

A) Not sure yet

OBJECTIVE 2

What does the evidence support?

PTSD trials · head-to-head comparisons · guideline ratings · comorbid conditions with PTSD and the more limited evidence beyond PTSD

PTSD: a trial base comparable to PE and CPT

49	38	34
Prolonged exposure (PE)	EMDR	Cognitive processing therapy (CPT)

Randomized controlled trials involving each treatment, VA PTSD Trials Repository (accessed Sept 2026)

Trial count shows scope of study, not quality. Head-to-head trials are counted twice (once for each modality)

VA National Center for PTSD, PTSD Trials Repository (accessed Sept 2026)

Most trials are small, so certainty is moderate

- Most EMDR trials are small; in a 2025 review, only 1 of 16 newer adult trials was rated low risk of bias
- Common limitations: allocation concealment, assessor blinding, waitlist comparators, short follow-up
- These problems run across psychotherapy research; they explain cautious grading, not ineffectiveness

Agency for Healthcare Research and Quality (2018), PTSD trials vs inactive controls

Treatment	Strength of evidence
Exposure-based CBT (13 RCTs)	High
CPT (5 RCTs)	Moderate
EMDR (8 RCTs)	Moderate

Simpson et al., 2025; Forman-Hoffman et al., 2018 (AHRQ)

SHOW OF HANDS

Q: In head-to-head trials, which came out ahead?

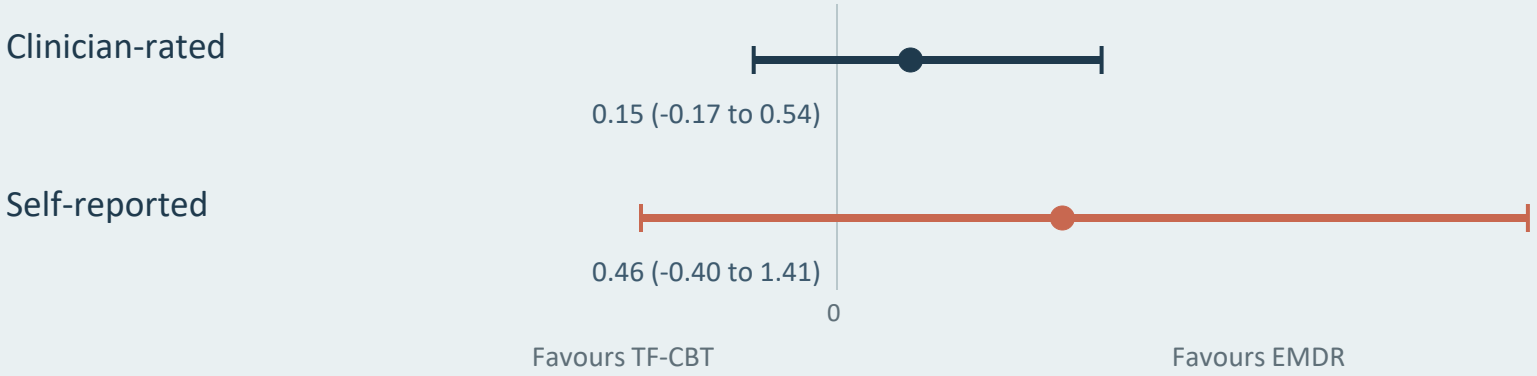
EMDR

Trauma-focused CBT

No clear difference

A: No clear difference detected

EMDR vs. trauma-focused CBT: post-treatment PTSD symptoms



Simpson et al., 2025. Standardized mean differences with 95% credible intervals.

Head-to-head trials: no clear winner

Comparison	What it found
Wright 2024: **EMDR vs other therapies**, individual data from 8 trials (n = 346). Comparators: trauma-focused CBT, relaxation, EFT, REM desensitization	No difference in symptoms, response, remission, or dropout, including vs trauma-focused CBT alone
Simpson 2025: **EMDR vs trauma-focused CBT**	Wide intervals; no clear difference
McGuire Stanbury 2020: **EMDR vs PE** (n = 20 pilot)	Both improved; no significant difference
Contrast: Schnurr 2022, **PE vs CPT** (n = 916)	PE better by 2.4 points on the CAPS-5: statistically significant, but below clinical significance

No clear difference isn't the same as proven equivalence. EMDR, PE, and CPT all work with traumatic memories; they differ in protocol, theory, and client experience, which can make one a better fit for a particular client.

Wright et al., 2024; Simpson et al., 2025; McGuire Stanbury et al., 2020; Schnurr et al., 2022

How guidelines rate EMDR for adult PTSD

Organization	Rating for EMDR, adult PTSD
U.S. Department of Veterans Affairs and Department of Defense (VA/DoD, 2023)	Strong
International Society for Traumatic Stress Studies (ISTSS, 2018)	Strong
American Psychological Association (2025)	Conditional, second tier; evidence vs. other active treatments insufficient to compare. CPT, PE, and trauma-focused CBT rated strong, first tier.
World Health Organization (2023)	Conditional, moderate-quality evidence
National Institute for Health and Care Excellence, UK (NICE, 2018)	Offer for non-combat trauma after 3 months
American Psychiatric Association	No current rating. Its 2004 guideline called EMDR effective; that guideline is no longer considered current

'Insufficient evidence to compare' isn't the same as inferior. A conditional rating is still a recommendation
NICE found the combat-trauma evidence for EMDR weak and restricted its recommendation; the VA/DoD guideline recommends EMDR for veterans alongside CPT and PE.

VA/DoD, 2023; ISTSS, 2018; APA, 2025; WHO, 2023; NICE, 2018; American Psychiatric Association, 2004

EMDR for youth PTSD

World Health Organization (2023)	Strong recommendation for children and adolescents
International Society for Traumatic Stress Studies (2018)	Strong, for clinically relevant posttraumatic stress symptoms
National Institute for Health and Care Excellence, UK (2018)	Consider at ages 7–17, more than 3 months after trauma, if the patient does not respond to or engage with TF-CBT
Direct comparisons with TF-CBT	3 trials (n = 185): no significant difference, limited precision

WHO, 2023; ISTSS, 2018; NICE, 2018; Hoppen et al., 2025

EMDR for PTSD with comorbid conditions

Substance use disorder	Added to SUD treatment, EMDR and PE both reduced PTSD more than SUD treatment alone, without worsening substance use (Lortye 2025, n = 209)
Psychotic disorder	EMDR and PE were safe and effective in outpatients, including those with current psychotic symptoms (van den Berg 2015, n = 155)
Mild TBI	PE and CPT have positive studies; EMDR is considered promising but not yet adequately tested (DoD TBI Center of Excellence, 2025)
Intellectual disability	Case series from mild to severe ID and a small feasibility RCT: feasible and well tolerated; a full RCT (Trauma-AID) is underway

These support treating PTSD in patients with comorbid conditions, not EMDR as a treatment for the comorbid condition itself.

Lortye et al., 2025; van den Berg et al., 2015; TBICoE, 2025; Karatzias et al., 2019; Mevissen et al., 2012; Willner et al., 2025

Beyond PTSD: depression



- **EMDR targets memories that anchor depressive beliefs like "I'm a failure," not the episode itself**
- 8 RCTs, 320 adults with major depression
- Added to medication or therapy: larger symptom reduction than that treatment alone
- Remission, EMDR vs. control conditions: 59% vs. 48%, no significant difference
- Vs. CBT, 3 small trials (n = 118) favored EMDR, too limited to say it outperforms CBT
- Certainty: low to very low; **all 8 trials at high risk of bias**

Yan et al., 2021

Beyond PTSD: chronic pain

- **EMDR targets distressing pain-related memories and the fear that can amplify pain**
- 7 RCTs plus 2 observational studies, mostly compared with usual care or waitlist
- Studies generally reported pain improvement. Long-term effects varied, including small or nonsignificant effects
- Small, varied trials with different protocols and pain measures; not formally graded
- Small trials and inconsistent findings limit confidence in durable comparative benefit
- **Bottom line: an adjunct to multidisciplinary pain care, not a replacement**



Singla et al., 2025

Beyond PTSD: specific phobia



- **EMDR targets memories of frightening encounters and the imagined worst-case outcome**
- Dental phobia (n = 31): EMDR outperformed waitlist
- Child spider phobia (n = 26): in vivo exposure did better; EMDR reduced self-reported fear but not avoidance
- Fear of childbirth: no gain over usual care
- **Exposure remains first-line. If declined, consider EMDR through shared decision-making, with limited evidence explained**

Doering et al., 2013; Muris et al., 1998; Baas et al., 2022

Beyond PTSD: panic disorder

- **EMDR targets the memories and images that maintain the fear (e.g., first or worst panic attack)**, rather than the bodily sensations themselves
- One RCT (n = 84): 13 sessions of EMDR vs. CBT
- EMDR met the study's noninferiority criteria for panic-related thoughts and bodily sensations at 3 months; findings for agoraphobic avoidance were inconclusive
- Limits: underpowered (84 of 128 planned), unbalanced groups, audio tones instead of eye movements, 3-month follow-up
- **CBT with interoceptive exposure remains first-line. If declined, consider EMDR through shared decision-making, with limited evidence explained**



Horst et al., 2017

When a client isn't ready for exposure

25–30%

of patients refuse to start exposure because it feels too aversive; 10–20% drop out

- Case studies and series (phobia n = 3; OCD n = 4): good tolerance; some reluctant patients went on to engage with exposure
- Controlled evidence: in children with spider phobia (n = 26), EMDR before exposure added nothing beyond exposure alone
- IMPROVE RCT (panic): testing whether EMDR increases willingness to start exposure. Results pending
- In the developers' flashforward protocol, EMDR is followed by mental rehearsal, then in vivo exposure
- **Bottom line:** EMDR may be a bridge to exposure for some clients, but this role is not yet established by controlled research

Endhoven et al., 2023; Muris et al., 1998; Logie & de Jongh, 2014; Scelles & Bulnes, 2021; Marr, 2012

Beyond PTSD: personality disorder



- EMDR for personality disorders **targets the memories behind the patient's core negative beliefs**
- Two RCTs, both vs. waitlist (n = 159 and n = 97)
- Larger trial, 10 sessions over 5 weeks: greater reduction in PD symptoms; 44% remission; 5% dropout; no adverse events
- Mostly avoidant, borderline, and obsessive-compulsive PD. Larger trial allowed PTSD. Smaller trial excluded PTSD
- Limits: no active comparison, with overlapping investigators
- **Bottom line: promising, best offered in specialist settings**

Hofman et al., 2025; Hafkemeijer et al., 2020

EMDR-adjacent protocols you may hear about

EMDR 2.0

Standard phases with stacked, modality-matched tasks

No difference detected in a nonclinical laboratory study

Flash Technique

Brief 'flash' of the memory while attention stays elsewhere

No difference detected vs. abbreviated EMDR in a nonclinical study

Flashforward

Targets the imagined worst-case future image

Lab support, clinical evidence limited

Blind to therapist

Memory processed without disclosing details

One non-randomized study

EMD Bomb

Stacked tasks for avoidant or overwhelmed clients

Not studied on its own

Apps, devices, ART, and ketamine pairing are distinct or untested and don't inherit EMDR's evidence. The goal: informed, not sold.

Matthijssen et al., 2021; Brouwers et al., 2021; Farrell et al., 2020; Engelhard et al., 2011; Logie & de Jongh, 2014

OBJECTIVE 3

How does EMDR differ from CBT-based options?

Procedures, mechanisms, matching, and cautions

What's different for the client in the room

	EMDR	PE	CPT
Memory activation	Brief, repeated activation in sets with a concurrent task	Prolonged, continuous imaginal recounting	Examines the meaning of the event; written account optional
Homework	None formal	Imaginal and in vivo practice	Worksheets
Spoken detail	Less required	Full recounting	Varies
Body focus	Part of target activation; tracked during reprocessing; body scan	Distress ratings	—
Therapist direction	Sets structure; brief interweaves	Plans exposure hierarchy	Socratic questioning

Shapiro, 2001

Two explanations for how EMDR works

Adaptive Information Processing (AIP)

The AIP model proposes that some memories remain stored with the emotions, body sensations, and beliefs of the original experience. EMDR aims to process these memories so they feel like past events rather than present threats.

Shapiro, 2001

A clinical framework, not a proven biological mechanism

Working memory account

Working memory has limited capacity. Recalling a distressing memory while doing a demanding task makes the two compete for mental resources, which can reduce the memory's vividness and emotional intensity.

Andrade, Kavanagh & Baddeley, 1997; van den Hout & Engelhard, 2012

Supported in the lab; laboratory findings don't prove the clinical mechanism

Shapiro, 2001; Andrade et al., 1997; van den Hout & Engelhard, 2012

SHOW OF HANDS

Are the eye movements necessary?

Yes	No	Not sure

Eye movements and dual attention: what is established?

Recall + task beats recall alone

The memory must be held in mind and emotionally charged

Laboratory task effects

In lab studies, vertical eye movements and other demanding tasks can reduce memory vividness or emotionality

Matching task to memory

A PTSD sample (n = 36) found no clear benefit of matching visual or auditory tasks to the memory modality

Clinical dismantling

Reviews differ: Lee & Cuijpers (2013) found added benefit. Cuijpers et al. (2020) found no pooled advantage

Gunter & Bodner, 2008; Matthijssen et al., 2017; Lee & Cuijpers, 2013; Cuijpers et al., 2020

Dual attention tasks used in EMDR



Light bar with alternating tones
Visual tracking plus auditory input



Therapist-guided eye movements
The original and most studied format

Handheld tappers

Alternating vibration in each hand; useful when eye movements are uncomfortable

Butterfly hug

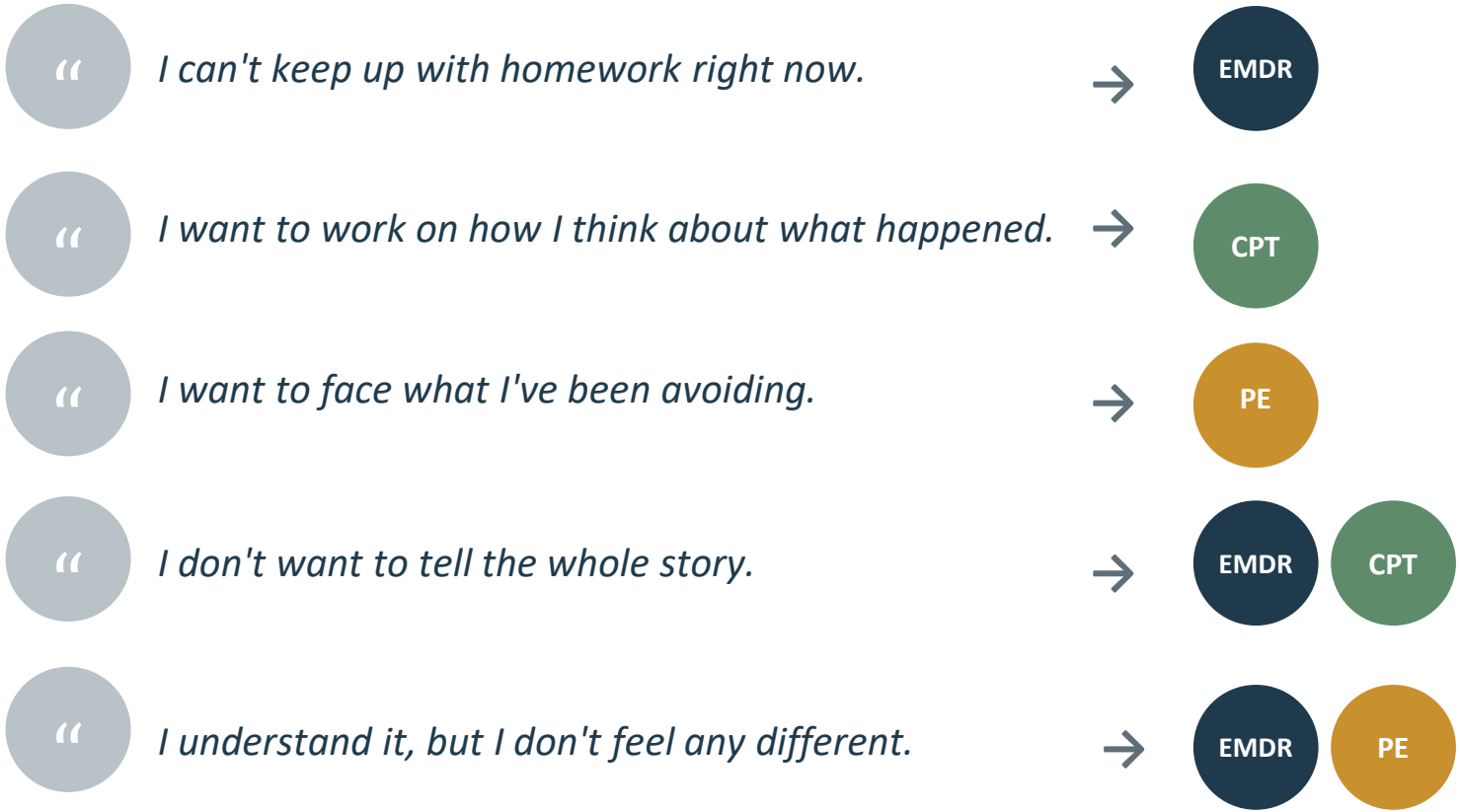
Arms crossed, alternately tapping each shoulder; also taught as a self-soothing skill

Spelling or counting

Spelling a word or counting backward while holding the image (EMDR 2.0)

Shapiro, 2001; de Jongh et al., 2024; Matthijssen et al., 2021

Matching on fit and preference



Preference and feasibility considerations, not validated predictors that one therapy will work better.

VA/DoD, 2023; Shapiro, 2001 (preference examples are clinical considerations)

Safety and readiness



Imminent suicide risk

Stabilize first

A history isn't an exclusion



Acute psychosis or mania

Stabilize first

Stable outpatients with ongoing symptoms did well



Severe dissociative disorder

Specialist assessment

Dissociative symptoms in PTSD don't reduce response



Active substance use

Integrated care

Doesn't automatically rule out PTSD treatment



Active legal proceedings

Talk with client and attorney first

EMDR reduces memory vividness

van den Berg et al., 2015; Hoeboer et al., 2020; VA/DoD, 2023; Otgaar et al., 2021

Dissociation across EMDR, PE, and CPT

Across all three, dissociation generally didn't reduce outcomes.

Dissociative patients improved in trials of PE (n = 71), CPT (n = 150), and intensive PE + EMDR (n = 168). A meta-analysis of 21 studies agreed, though most participants had low dissociation.

How each therapy manages it in session

- **PE:** grounding, eyes open during imaginal exposure, adjusting how long the memory is held
- **CPT:** grounding; the written account, which highly dissociative patients benefited from
- **EMDR:** make dual attention more difficult or use physical movement; shorter sets; preparation as needed

Hagenaars et al., 2010; Resick et al., 2012; Zoet et al., 2018; Hoeboer et al., 2020

OBJECTIVE 4

What does treatment look like?

The eight phases, a case example, and a brief demonstration

How EMDR treatment is organized

Prepare

Phases 1–2

History, evaluate dissociation, treatment plan, psychoeducation, and coping resources

→

Reprocess

Phases 3–8

Past memories, then present triggers

→

Rehearse the future

Future templates

Imagined future situations, handled with new skills

Shapiro, 2001; de Jongh et al., 2024

The eight phases

1

History

Target selection and treatment plan

2

Preparation

Psychoeducation and resources

3

Assessment

Image, beliefs, emotion, SUD, VOC, body location

4

Desensitization

Sets with a dual attention task

5

Installation

Strengthen the positive belief

6

Body scan

Check for residual disturbance

7

Closure

Return to equilibrium

8

Reevaluation

Check the target next session

SUD: Subjective Units of Disturbance (0–10)
VOC: Validity of Cognition, rating how true the positive belief feels (1–7)

Shapiro, 2001

Preparation: building resources first



Container

Imagining distressing material placed in a container until the next session

CBT parallel: Like scheduled worry time: set it aside on purpose, return to it later



Calm place

Visualizing a calm, safe place, often paired with a cue word

CBT parallel: Like guided imagery and cue-controlled relaxation



Butterfly hug

Self-tapping with crossed arms (short, slow sets) to strengthen the calm place and cue word

CBT parallel: A self-administered coping skill clients can use between sessions



Then vs. now

Mapping current supports and differences between then and now

CBT parallel: Like the orienting and safety planning used across trauma therapies

Shapiro, 2001; van Vliet et al., 2021 (preparation is individualized)

Case example: long-standing depression with shame-linked memories

- 30-year-old adult with major depressive disorder superimposed on several years of persistent depressive disorder ("double depression"), with co-occurring generalized anxiety disorder and sleep difficulties
- Prior CBT; two adequate antidepressant trials (an SSRI, then an SNRI); continuing medication management
- No trauma history or PTSD diagnosis
- Reminders of past embarrassing experiences triggered shame, self-criticism, and emotional reactivity
- Plan, developed collaboratively with the client, included EMDR for shame-linked memories

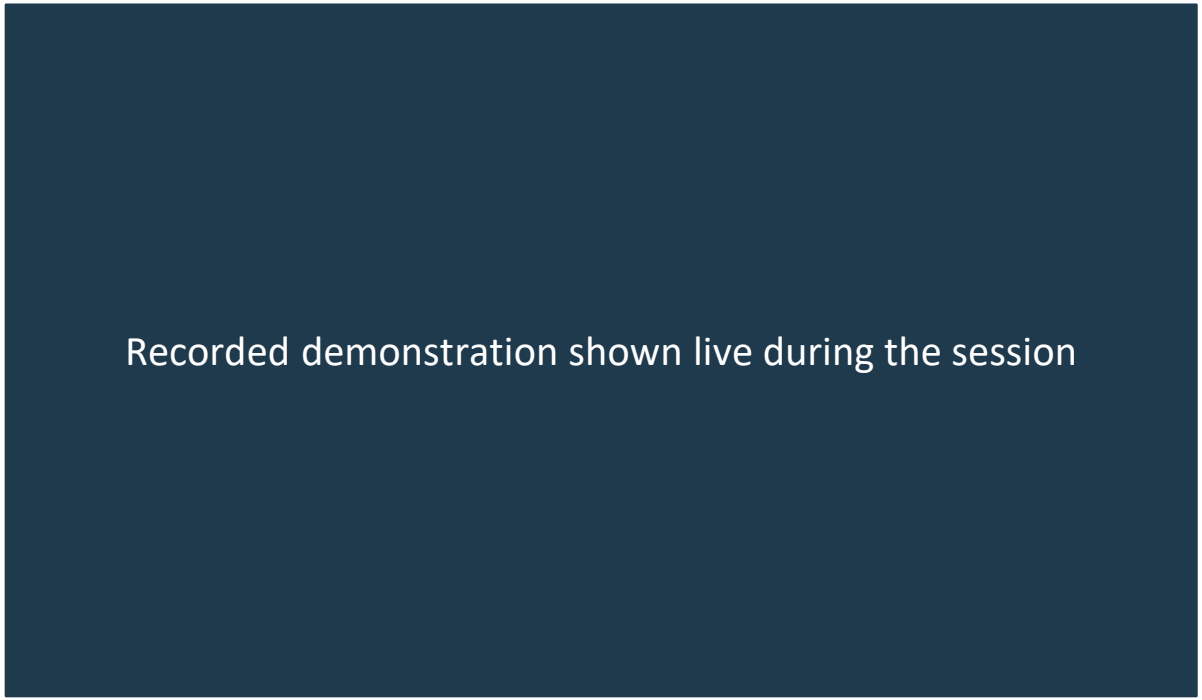
Note: Identifying details changed to protect confidentiality.

Case example: each target repeats phases 3–8

Phase	This target: a socially embarrassing experience from early adulthood
1–2. History, preparation	Collaborative formulation; current stressors, sleep, and coping first
3. Assessment	Belief: "I'm out of control." Emotions: shame and embarrassment. SUD 6. VOC 2.5. Body: sensations in chest and throat
4. Desensitization	Sets until SUD 0 out of 10
5. Installation	"It was a mistake; I'm in control now." VOC increased to 7 out of 7
6. Body scan	Clear
7. Closure	Container, grounding, and then vs. now
8. Reevaluation	SUD remains 0; if not, return to phase 4

Note: One target was typically completed in one session

Demonstration: reprocessing a target, a compilation video



- Target identification: image, belief, emotion, SUD, body location
- Two or three sets with reports between them
- SUD check later in the session

Video not included in distributed slides to protect client confidentiality.

Case example: client-reported outcomes

PHQ-9 (self-report)

$11 \rightarrow 5$

Moderate → mild

GAD-7 (self-report)

$17 \rightarrow 4$

Severe → minimal

18 sessions total, initially weekly. Final two visits every 3 weeks for relapse prevention.

Client-reported changes in daily life

- Memories felt further in the past, with less shame and reactivity
- More self-compassion and acceptance of past mistakes
- Less pressure to be perfect; more flexible standards
- Better boundaries and more openness in close relationships
- More present, less anxious during meaningful experiences

Note: Anxiety improved first; depression improved after several targets. One case can't establish how much change is attributable to EMDR.

OBJECTIVE 1

Who should I refer?

Where EMDR can be offered with confidence, where to discuss it with caution, and how to coordinate care

Where can I offer EMDR with confidence?

Offer alongside PE and CPT for

- Adult PTSD
- Youth PTSD (alongside TF-CBT)
- PTSD with complex trauma, dissociation, or psychosis (with specialist care)

Discuss as an option, evidence stated

- Depression (adjunct)
- Chronic pain (adjunct)
- Phobia or panic: if first-line care is declined, use shared decision-making and explain limited evidence
- Personality disorder (specialist settings)

Mention with caution

- Performance anxiety
- Sexual pain
- OCD (alongside ERP)
- Cravings and addictions
- Grief, eating and body image, tinnitus, migraine

VA/DoD, 2023; WHO, 2023; Yan et al., 2021; Singla et al., 2025; Horst et al., 2017; Scelles & Bulnes, 2021

Referring and coordinating care

Ask the clinician	EMDRIA-approved training (certification optional); experience with cases like this one; how progress is measured
Medications	No guideline I found recommends pausing medications for EMDR. VA/DoD recommends against benzodiazepines for PTSD; coordinate PRN timing rather than stopping medications unilaterally
Share the plan	Agree on target symptoms and how you'll exchange updates

VA/DoD, 2023

Back to our patient

Long-standing depression · prior CBT and two antidepressant trials · no PTSD · shame-linked memories

Evidence	Strong for PTSD; limited but real for depression, where EMDR targets the memories anchoring self-critical beliefs
Differences	A different protocol, theory, and client experience than CBT: a fit or preference, not a guaranteed advantage
Referral	EMDR is a reasonable adjunct to discuss, with the evidence level stated and outcomes tracked

Yan et al., 2021; VA/DoD, 2023

Questions and discussion

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