

# A Review of EMDR Literature

## A Clinician's Skepticism

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### Introduction

Recently, eye movement desensitization and reprocessing (EMDR) has gained traction as a transdiagnostic approach with application to mental disorders other than post-traumatic stress disorder (PTSD). Despite the broad clinical application, a look into recent meta-analyses of EMDR shows a gap between what has been substantiated in clinical studies and what is being practiced in clinical settings. Many counselors and EMDR trainers advertise that EMDR is more effective than cognitive behavioral therapy (CBT), a claim that has been challenged in clinical literature. There is also limited evidence showing that EMDR is an effective intervention for anything other than PTSD, even though counselors attempt to use it in other applications. Recent analyses also challenge the rapidity and effectiveness of EMDR compared with other interventions.

It's not my intention to invalidate the clinical experience of counselors who have had success with EMDR and believe in its application as a transdiagnostic approach. I also do not want to undermine the beliefs of any counselors whose work is rooted in the unproven theories that support EMDR and other somatic psychotherapies. I believe that if you are a counselor currently having success using EMDR to treat anxiety and complex trauma you should feel empowered to continue to do so.

I plan on continuing to use EMDR in my private practice, but only for client presentations that feature certain symptoms. I have seen results when I've used EMDR to treat symptoms such as intrusive memories, nightmares, and flashbacks. The purpose of this research was to determine if my underwhelming results using EMDR in private practice with survivors of complex trauma was normalized anywhere in clinical literature. I have confirmed that many of the common claims about EMDR's effectiveness are not substantiated by research, and study outcomes may be impossible to replicate.

### Observations When Using EMDR

Before I was trained in the intervention, misinformation about EMDR had proliferated in my circle of professional contacts. A former

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supervisor told me that she knew someone who charged three hundred dollars a session for EMDR treatment. Other colleagues reported that as clients they had paid up to two hundred a session for their own EMDR treatment. It was advertised as an intervention that directly affects neurological processes and could be used to treat people with “challenges” such as grief and loss, dissociative disorders, pain, anxiety, and chronic medical issues (EMDRIA, 2022).

Following my training, I implemented EMDR in my community mental health work to varied success. When I broached my lackluster EMDR results with my trainer, she explained that with few exceptions EMDR was an appropriate intervention for every man, woman, child, and infant who came to counseling. The training I attended included a demonstration on how to use EMDR to treat PTSD in toddlers. However, I could never duplicate the kind of success advertised in my training or endorsed by my trainers. As a counselor I take treatment cues from clients, so instead of pushing EMDR I switched to other interventions. I decided to pursue the next level of EMDR training, called certification, to see if I could achieve the kinds of results advertised in my training and supported in clinical literature, for example, symptom improvement after only two or three EMDR sessions (Marcus et al., 1997; Wilson et al., 1997; Marcus et al., 2004; De Jongh et al., 2013).

Ultimately, my greatest success in EMDR came in clinical settings that included additional supportive resources such as case managers and group counseling. For example, at the inpatient substance use rehabilitation facility where I was working while completing my certification hours, clients received a minimum of four and a half hours of group counseling daily plus weekly sessions with a

case manager and an individual counselor. I assumed that the additional supervision I was doing was responsible for my success in this setting, but it is likely that my clients would have improved regardless of what interventions I was using.

When I finally transitioned to private practice, my results with EMDR were abysmal. Not one private practice client of mine has completed an EMDR treatment plan. Two client responses predominate: 1) EMDR does not work at all, and 2) after a few successful sessions, EMDR stops working. Clients that have completed EMDR sessions have preferred switching to other treatment modalities. According to the adaptive information processing model, one reason my clients no longer respond to EMDR may be that their unprocessed memories have been processed and there is no work left to do (Shapiro, 2017). However, many of my clients continued to have symptoms of depression, anxiety, and hyperarousal.

I reached out to my trainers to consult about what might be going wrong. If you are trained in EMDR I know what you're thinking, but I keep a copy of the protocols in my office and follow them religiously. I rewatched my training videos and compared what I was doing to the counselors in the videos. In these videos, the company's trainers demonstrate EMDR on volunteers attending the workshop. The volunteers have paid more than a thousand dollars for the training, so their instant symptom reduction in the videos may indicate a placebo effect.

### EMDR as Supported by Neuroscience

It is worth noting that many clinical psychology graduate programs such as the one I attended include only a cursory introduction to neuroscience. EMDR distinguishes itself from other modalities by claiming that



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its effectiveness is based in neuroscience. Contrast this with cognitive behavioral therapy, a theory rooted in psychology. The concept of “textbook neuroscience” pervades EMDR research in a disturbing way. Although the fields of psychology and neuroscience overlap, they generally study different things. A neuroscientist studies the brain while a psychotherapist studies human behavior and measures symptomatology. Unbeknownst to me at the time of my EMDR training, many of the neuroscientific changes observed in EMDR studies also occur as a result of other treatment modalities. Landin-Romero et al. (2018) explain: “These brain functional changes are not specific of EMDR, and similar neuronal effects can be observed in other forms of anxiety-focused psychotherapy.”

The EMDR International Association (EMDRIA) website explains that by affecting the hippocampus, the amygdala, and the prefrontal cortex, “EMDR therapy helps the brain process these [traumatic] memories, and allows normal healing to resume” (EMDRIA, 2022). The theory they are quoting here is likely the orienting theory of EMDR’s mechanism of action (Bergmann, 2008). Balkin et al. (2021) summarize: “Claims of neurological changes in the brain are currently based on generalized principles of neuroscience rather than actual neuroscience.”

There are multiple theories about the mechanisms of action in EMDR, and as an EMDR counselor you can believe all of them or none of them, or you can create your own. I have experienced this in conversations with my colleagues about EMDR. As mentioned above, many counselor training programs do not include a robust neuroscience element. If you ask three different EMDR counselors to explain how EMDR works, they will likely give you three different answers, possibly because EMDR research is dense and difficult to understand without sufficient

training in neuroscience. When asked, many counselors explain EMDR by using elements of other somatic theories such as polyvagal theory, somatic experiencing, and sensorimotor psychotherapy. Many of these counselors shared with me that they also alter the protocols to accommodate these other theoretical frameworks. In a meta-analysis of 46 between-group studies, Lenz et al. (2017) discuss the problems of creating a holistic EMDR approach. They point out that study results may be hard to replicate if counselors don’t follow the EMDR protocols exactly. However, my experience suggests that innovation is common among EMDR counselors, who often incorporate a panoply of other modalities into their work.

In a paper critical of EMDR “pseudoscience,” Herbert et al. (2000) explain how the process of drawing from random sources to support clinical interventions has given eclecticism a kind of respectability. This is the same process by which folklore is created: A theory is repeated enough times that it is accepted as truth. It’s fine so long as it’s working, but I ran into trouble when EMDR stopped working for me. Some of the more commonly cited theories about EMDR’s mechanisms of action are the working memory theory and the orienting theory. These theories borrow textbook neuroscience and apply it to EMDR by citing observed brain processes and extrapolating how these processes may be affected by EMDR. Recent studies have been able to observe neurological changes during EMDR sessions (Boukezzi et al., 2017; Pagani et al., 2017; Nardo et al., 2010; Hogberg et al., 2008), and although these results support the theories behind EMDR they remain just that: theoretical.

According to the orienting theory, intrusive somatic sensations experienced by PTSD survivors are the result of unprocessed somatic memories stored in the brain. EMDR moves these sensations through the upper

levels of cortical processing, thus resolving their intrusive quality (Pagani et al., 2013; Bergmann, 2008). It sounds like real science, but it’s just a theory. As a counselor it feels problematic to me to tell clients that certain neurological changes may occur to, for example, their limbic system during counseling because I have no way of proving this will happen. I run into trouble in clinical settings when clients ask me to explain theoretical neuroscience. When I ask my colleagues, many believe this theory has been proven because they do not fully understand the science behind it either.

The same goes for working memory theory, which is even more complex and difficult to explain, especially in an outpatient setting. Landin-Romero et al. (2018) summarize that as it’s currently understood, experiencing a relaxed state in the presence of a disturbing memory constitutes something similar to a fear extinction trial, which leads to desensitization. Without measuring brain activity, it is often difficult to tell whether a client’s working memory is being taxed or they are just not paying attention to the triggering stimuli. Many EMDR counselors believe that children move through the adaptive information processing model faster than adults, although I cannot find any evidence to substantiate this claim. What may be happening is that children have a hard time paying attention during EMDR sessions and report that they cannot access the emotion attached to the traumatic memories when in actuality they are just unable to focus.

Sometimes successful EMDR can look the same as unsuccessful EMDR because without measuring brain activity both outcomes have similar presentation. If I ask a client to recall a traumatic memory and they say they feel nothing, it could be because the memory was effectively processed or because they were unable to access and process it at all. Both are reported by EMDR counselors as victories. Without the neuroscientific elements EMDR is much more believable, though it’s less special as a theory. The cognitive restructuring and exposure elements of EMDR are undoubtedly valuable, and in fact they are a part of other established trauma treatments.



### EMDR vs. CBT

As I continued looking into EMDR literature, I came across studies that validated what I was seeing in my practice, i.e., that EMDR was no more effective than CBT at treating PTSD. Cuijpers et al. (2020), Lenz et al. (2017), Erford et al. (2016), and Classen et al. (2011) found that EMDR was about as effective as other viable treatments. According to Balkin et al. (2021), the effect size difference between EMDR and other viable treatments was “small to null.” Erford et al. (2016) conducted a meta-analysis of 152 PTSD treatment clinical trials that used trauma-focused and non-trauma-focused modalities and concluded, “No theoretical approach, demographic characteristic, treatment implementation strategy, or study characteristic showed superiority over any other.”

With the exception of saccades or dual attention stimulation (depending on whether you are using eye movements, tapping, or something else), every phase of EMDR is borrowed from another modality. The vagaries surrounding EMDR’s mechanisms of action make it impossible to tell how much the cognitive-behavioral elements contribute to its efficacy. The elements of exposure and cognitive restructuring are taken from CBT, which means the claim that EMDR is more effective hinges entirely on the new elements—the dual attention stimulation—being effective.

The shift to recognizing dual attention stimulation rather than ocular saccades as the mechanism of action during desensitization occurred within the past 20 years. Dual attention stimulation, or DAS, is commonly achieved through tapping, but in my training at least, the methods of application are limitless, and providers are encouraged to get creative. Landin-Romero et al. (2018) point out that DAS can be achieved by asking clients to focus on a point in space or stare at a blank wall. Haour et al. (2019) cite mechanisms for distraction used in other studies, including focusing on breathing and playing the video game Tetris.

Prior to the introduction of diverse mechanisms for providing DAS, EMDR relied on ocular saccades, so there is a greater

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quantity of dismantling studies comparing groups that use EMDR protocols with eye movements and groups that use EMDR protocols without eye movements. Both groups followed the rest of the protocols, including repeated exposure by asking the clients to recall traumatic memories. In a meta-analysis of 13 dismantling studies, Davidson et al. (2001) found “no significant incremental benefit because of eye movements.” Cuijpers et al. (2020) advised that the difference between EMDR with eye movements and EMDR without eye movements “may not be as robust as previously mentioned.” So what does EMDR actually contribute as an intervention? Cuijpers et al. (2020) quote McNally (1999): “What is effective in EMDR is not new, and what is new is not effective.”

What about the effectiveness of dual attention stimulation over digital platforms? None of the studies I found support EMDR’s use via telehealth. If a study of the clinical effectiveness of EMDR over video chat exists, I would like to read it. My own clinical experience of attempting to provide EMDR on this platform has been poor despite booster training.

### EMDR Has Not Been Proven to Be a Transdiagnostic Approach

The biggest gap between EMDR in clinical practice and EMDR in clinical research is the theory’s transdiagnostic application, or its effectiveness for diagnoses other than PTSD. According to the adaptive information processing model, EMDR can be used to treat clients regardless of diagnosis so long as their symptoms are the result of insufficiently processed experiences (EMDRIA, 2022). These unprocessed experiences do not need to be traumatic, they can be old attachment wounds, shame, or guilt. Some EMDR interventions involve processing memories

from in utero or during infancy that the client does not consciously remember (Parnell, 2013). My EMDR training packet has instructions for its application to dissociative clients, addiction, grief, phobias/anxiety, and pain. Although these models are being implemented by EMDR counselors, recent meta-analyses have challenged EMDR’s effectiveness for disorders other than PTSD.

At this point, it’s necessary to discuss a few troubling consistencies across EMDR studies. First, the heterogeneity of EMDR studies makes comparison difficult—client demographic, type of trauma, duration and quantity of EMDR sessions, clinical setting, outcome measures, and eye movement versus tapping are just a few of the factors that vary between studies (Lenz et al., 2017; Lewis et al., 2020). Clinical trials that include single-episode trauma survivors often show significant improvement after one or two sessions, but survivors of complex trauma show a more modest symptom reduction (Van der Kolk et al., 2007). Therefore, some studies have huge effect sizes after a few sessions while others have smaller effect sizes over a greater quantity of sessions. Heterogeneity among studies means that even though EMDR appears to be beneficial, “true effect ranges from large to small” (Balkin et al., 2021).

Second, many EMDR studies include small sample sizes, as in fewer than 10 participants. Third, publication bias, by which researchers influence the outcomes of the studies, pervades EMDR literature (Cuijpers et al., 2020). Finally, many EMDR studies do not include follow-ups to measure whether treatment gains are maintained, and these findings are important for comparing the effectiveness of different modalities. For example, a meta-analysis of 14 control trials that compared EMDR and CBT initially concluded that EMDR was more effective at



treating post-traumatic symptoms. However, four of those studies included follow-up data showing that at the three-month follow up “EMDR was not better than CBT at reducing post-traumatic symptoms” (Khan et al., 2018). A meta-analysis of 61 treatment outcome trials found that “by follow-up, the differences between behaviour therapy and EMDR were nonsignificant” (Van Etten et al., 1998).

Landin-Romero et al. (2018) did a systematic review of 87 EMDR studies that examined the support behind psychological, psychophysiological, and neurobiological models of EMDR’s mechanisms of action. The study found insufficient support for all of them. Regarding the working memory theory, the systematic review found that most of the studies were performed in nonclinical populations and therefore could not address which mechanisms affect clients with PTSD, the dominant population that presents to outpatient counseling for trauma treatment. In addition, the research supporting this theory relies on conditions that are not consistent with standard EMDR protocol and at best only offers partial explanations. The systematic review also noted that the additive effects of other components, such as exposure and CBT, in EMDR’s effectiveness are unknown. The study similarly found insufficient evidence to support the theories behind the orienting theory. This undermines claims that EMDR is supported by neuroscience because the very theories that allegedly support this remain unproven.

Cuijpers et al. (2020) did a systematic review and meta-analysis of 76 randomized trials that compared EMDR to control conditions or alternative treatments for diverse mental health conditions including depression, anxiety, and substance abuse. Regarding EMDR, the paper concluded, “There is certainly not enough evidence to advise its use in clients with mental health problems other than PTSD.” They found that “the risk for selective outcome reporting and the small number of registered trials was striking” and that “only a small minority of the included studies had a low risk of bias.” The paper noted that risk of bias in these studies means their results should be interpreted cautiously and that EMDR’s success in the clinical studies may be difficult

to duplicate, which is something I have experienced in my clinical practice.


Balkin et al. (2021) did a meta-analysis of 32 effect sizes from 22 randomized control trials in which EMDR was used to treat over-arousal in anxiety and post-traumatic stress disorder. Their results were so mixed that the authors recommended, “Clinical mental health counselors who are considering training and certification in EMDR to improve treatment outcomes among their clients may wish to pause before investing in this training. EMDR may be an effective intervention, but findings in favor of EMDR may not be replicable.” They further stated, “The evidence that EMDR is a catalyst for change with clients that might otherwise not be achieved may be unsubstantiated based on this meta-analysis.” The study explains that because theories about EMDR’s mechanisms of action are unproven, client progress could be a result of anything, for example, the exposure aspect of asking the client to talk about their traumatic event.

### Implications for Practice

All of the above evidence is to say that the results of clinical studies may be hard to replicate in clinical practice. After doing this research, I feel that the phenomenon I observed of diminishing results with EMDR outside of intensive inpatient settings may be a typical one. Future research should look into the effects of EMDR on an outpatient population with complex trauma. I’d expect a longer duration of counseling with more modest therapeutic gains over time that would look a lot like the results of clinical studies of CBT treatment.

What is the line between holistic practice and clinical practice? I believe the dissemination of inaccurate information about EMDR undermines the credibility of counseling in general. The pandemic saw public opinion turn skeptical of scientists and medical experts, a trend that could extend to mental health counseling. Applying textbook neuroscience to counseling erodes its credibility because these claims cannot be substantiated.

Some of the studies mentioned above reiterate that in terms of counseling’s effectiveness,

modality remains second to the therapeutic relationship. Building relationships with clients continues to be an important, if not the *most* important, factor in counseling. 



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