EMDR Therapy: Trauma Research

International Treatment Guidelines


  *EMDR is recommended as an effective treatment for trauma.*

- **Bleich, A., Kotler, M., Kutz, I., & Shalev, A. (2002).** A position paper of the (Israeli) National Council for Mental Health: *Guidelines for the assessment and professional intervention with terror victims in the hospital and in the community.* Jerusalem, Israel.

  *EMDR is one of three methods recommended for treatment of terror victims.*


  *EMDR and Trauma-focused CBT are considered “Well-Supported by Research Evidence.”*

- **Chambless, D.L. et al. (1998).** Update of empirically validated therapies, II. *The Clinical Psychologist,* 51, 3-16.

  According to a taskforce of the Clinical Division of the American Psychological Association, the only methods empirically supported (“probably efficacious”) for the treatment of any post-traumatic stress disorder population were EMDR, exposure therapy, and stress inoculation therapy. Note that this evaluation does not cover the last decade of research.


  *EMDR and CBT were stated to be the treatments of choice.*

- **Department of Veterans Affairs & Department of Defense (2010).** *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress.* Washington, DC: Veterans Health Administration, Department of Veterans Affairs and Health Affairs, Department of Defense.

  *EMDR was placed in the category of the most effective PTSD psychotherapies. This “A” category is described as “A strong recommendation that clinicians provide the intervention to eligible patients. Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.”*

EMDR and CBT both designated as treatments of choice for PTSD


  EMDR was listed as an effective and empirically supported treatment for PTSD, and was given an AHCPR “A” rating for adult PTSD. This guideline specifically rejected the findings of the previous Institute of Medicine report, which stated that more research was needed to judge EMDR effective for adult PTSD. With regard to the application of EMDR to children, an AHCPR rating of Level B was assigned. Since the time of this publication, two additional randomized studies on EMDR have been completed (see below).


  EMDR and CBT were stated to be the treatments of choice for trauma victims.


  Trauma-focused CBT and EMDR were stated to be empirically supported treatments for choice for adult PTSD.


  The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency of the U.S. Department of Health and Human Services (HHS). This national registry (NREPP) cites EMDR as evidence based practice for treatment of PTSD, anxiety, and depression symptoms. Their review of the evidence also indicated that EMDR leads to an improvement in mental health functioning.


  An NIMH sponsored website listing empirically supported methods for a variety of disorders. EMDR is one of three treatments listed for PTSD.


  Best evidence of efficacy was reported for EMDR, exposure, and stress inoculation

Trauma-focused CBT and EMDR are the only psychotherapies recommended for children, adolescents and adults with PTSD. “Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework.” (p.1)

**Meta-analyses**

EMDR therapy has been compared to numerous exposure therapy protocols, with and without CT techniques. It should be noted that exposure therapy uses one to two hours of daily homework and EMDR uses none. The most recent meta-analyses are listed here.


  Research indicates that CBT and EMDR therapy are superior to all other treatments.


  EMDR is equivalent to exposure and other cognitive behavioral treatments and all “are highly efficacious in reducing PTSD symptoms.”


  EMDR therapy is equivalent to exposure and other cognitive behavioral treatments.


  “The effect size for the additive effect of eye movements in EMDR treatment studies was moderate and significant (Cohen’s d = 0.41). For the second group of laboratory studies the effect size was large and significant (d = 0.74).”


  A comprehensive meta-analysis reported the more rigorous the study, the larger the effect.

“Results indicate efficacy of EMDR when effect sizes are based on comparisons between EMDR and non-established trauma treatment or no-treatment control groups, and incremental efficacy when effect sizes are based on comparisons between EMDR and established (CBT) trauma treatment.”


  “Results suggest that in the treatment of PTSD, both therapy methods tend to be equally efficacious.”


  “CBT and eye movement desensitization and reprocessing were the most often-studied types of psychotherapy. Both were effective.”

### Randomized Clinical Trials


  “EMDR is effective in reducing earthquake anxiety and negative emotions (e.g. PTSD, grief, fear, intrusive thoughts, depression, etc) resulting from earthquake experience. Furthermore, results show that, improvement due to EMDR was maintained at a one month follow up.”


  “Post-treatment scores of the EMDR group were significantly lower than the WLC indicating improvement in total PTSS-C scores, PTSD-related symptom scale, and the subscales re-experiencing and avoidance among subjects in the EMDR group, while untreated children improved in PTSD-non-related symptom scale.”


  “Forty-two patients undergoing cardiac rehabilitation . . . were randomized to a 4-week treatment of EMDR or imaginal exposure (IE). . . EMDR was effective in reducing PTSD, depressive, and anxiety symptoms and performed significantly better than IE for all variables. . . Because the standardized IE procedures used were those employed in-session during [prolonged exposure] the results are also instructive regarding the relative efficacy of
both treatments without the addition of homework.”

- **Capezzani et al. (2013).** EMDR and CBT for cancer patients: Comparative study of effects on PTSD, anxiety, and depression. *Journal of EMDR Practice and Research, 5, 2-13.*

  This randomized pilot study reported that after eight sessions of treatment, EMDR therapy was superior to a variety of CBT techniques. “Almost all the patients (20 out of 21, 95.2%) did not have PTSD after the EMDR treatment.”


  Twelve sessions of EMDR eliminated post-traumatic stress disorder in 77.7% of the multiply traumatized combat veterans studied. There was 100% retention in the EMDR condition. Effects were maintained at follow-up. This is the only randomized study to provide a full course of treatment with combat veterans. Other studies (e.g., Boudewyns/Devilly/Jensen/Pitman et al./Macklin et al.) evaluated treatment of only one or two memories, which, according to the International Society for Traumatic Stress Studies Practice Guidelines (2000), is inappropriate for multiple-trauma survivors. The VA/DoD Practice Guideline (2004) also indicates these studies (often with only two sessions) offered insufficient treatment doses for veterans. EMDR therapy is listed as an “A” level treatment in the VA/DoD Practice Guideline (2004, 2010).


  EMDR was found to be an effective treatment for children with disaster-related PTSD who had not responded to another intervention.

- **Cvetek, R. (2008).** EMDR treatment of distressful experiences that fail to meet the criteria for PTSD. *Journal of EMDR Practice and Research, 2, 2-14.*

  EMDR treatment of disturbing life events (small “t” trauma) was compared to active listening, and wait list. EMDR produced significantly lower scores on the Impact of Event Scale (mean reduced from “moderate” to “subclinical”) and a significantly smaller increase on the STAI after memory recall.


  “An intention-to-treat analysis of the 10 patients starting treatment showed that the PTSD treatment protocols of PE and EMDR significantly reduced PTSD symptom severity; PE and EMDR were equally effective and safe. . . . Seven of the 10 patients (70%) no longer met the diagnostic criteria for PTSD at follow-up.”

A mixed sample of full and partial PTSD was evaluated. “Both treatments are effective in children with PTSS in an outpatient setting. Results on both child and parent measures support this conclusion.”


“Children (n=52, aged 4-18) were randomly allocated to either CBT (n=26) or EMDR (n=26) in a disaster mental health after-care setting after an explosion of a fireworks factory. . . Both treatment approaches produced significant reductions on all measures and results were maintained at follow-up. Treatment gains of EMDR were reached in fewer sessions.”


EMDR treatment resulted in lower scores (fewer clinical symptoms) on all four of the outcome measures at the three-month follow-up, compared to those in the routine treatment condition. The EMDR group also improved on all standardized measures at 18 months follow up.


Combination of qualitative and quantitative analyses of treatment outcomes with important implications for future rigorous research. Survivors’ narratives indicate that EMDR produces greater trauma resolution, while within eclectic therapy, survivors more highly value their relationship with their therapist, through whom they learn effective coping strategies.


Employees who had experienced “person-under-train accident or had been assaulted at work were recruited.” Six sessions of EMDR resulted in remission of PTSD in 67% compared to 11% in the wait list control. Significant effects were documented in Global


  Both EMDR and prolonged exposure produced a significant reduction in PTSD and depression symptoms. This is the only research comparing EMDR and exposure therapy that added in vivo homework to the EMDR condition. The study found that 70% of EMDR participants achieved a good outcome in three active treatment sessions, compared to 17% of persons in the prolonged exposure condition. EMDR also had fewer dropouts (0 v 30%).


  Both EMDR and CBT produced significant reduction in PTSD and behavior problems. EMDR was significantly more efficient, using approximately half the number of sessions to achieve results.


  Participants were treated two weeks following a 7.2 earthquake in Mexico. “One session of EMDR-PRECI produced significant improvement on symptoms of posttraumatic stress for both the immediate-treatment and waitlist/delayed treatment groups, with results maintained at 12-week follow-up, even though frightening aftershocks continued to occur frequently.”


  “An effect for EMDR was identified on primary outcome and process measures including the Child Post-Traumatic Stress – Reaction Index, clinician rated diagnostic criteria for PTSD, Subjective Units of Disturbance and Validity of Cognition scales. All participants initially met two or more PTSD criteria. After EMDR treatment, this decreased to 25% in the EMDR group but remained at 100% in the wait-list group.”


  Both EMDR and stress inoculation therapy plus prolonged exposure (SITPE) produced significant improvement, with EMDR achieving greater improvement on PTSD intrusive
symptoms. Participants in the EMDR condition showed greater gains at three-month follow-up. EMDR condition used three hours of homework compared to 28 hours for SITPE.

  
  Funded by Kaiser Permanente. Results show that 100% of single-trauma and 77% of multiple-trauma survivors were no longer diagnosed with post-traumatic stress disorder after six 50-minute sessions.

  
  Funded by Kaiser Permanente, follow-up evaluation indicates that a relatively small number of EMDR sessions result in substantial benefits that are maintained over time.

  
  A comparison of “the efficacy and response pattern of a trauma-focused CBT modality, brief eclectic psychotherapy for PTSD, with EMDR . . . Although both treatments are effective, EMDR results in a faster recovery compared with the more gradual improvement with brief eclectic psychotherapy.”

  
  “Although preliminary, our findings support the utility of this treatment approach and suggest that Eye Movement Desensitization and Reprocessing therapy could be a promising and safe therapeutic strategy to reduce trauma symptoms and stabilize mood in traumatized bipolar patients with subsyndromal symptoms.”

  
  Both EMDR and exposure therapy plus cognitive restructuring (with daily homework) produced significant improvement. EMDR was more beneficial for depression, and social functioning, and required fewer treatment sessions. Subsequent reevaluation of the data indicated that “For pre- to post-treatment IES mean change score, EMDR patients also appeared to have had better treatment outcome than E+CR patients” and EMDR therapy was a predictor of positive outcome: Karatzias, A., Power, K., McGoldrick, T., Brown, K., Buchanan, R., Sharp, D. & Swanson, V. (2006). Predicting treatment outcome on three measures for post-traumatic stress disorder. Eur Arch Psychiatry Clin Neuroscience, 20, 1-7.

*Three 90-minute sessions of EMDR eliminated post-traumatic stress disorder in 90% of rape victims.*


*In this NIMH funded study both treatments were effective: “An interesting potential clinical implication is that EMDR seemed to do equally well in the main despite less exposure and no homework. It will be important for future research to explore these issues.” (p. 614)*


*Two sessions of EMDR reduced psychological distress in traumatized adolescents/ young women and brought scores within one standard deviation of the norm.*


*Seminal study appeared the same year as first controlled studies of CBT treatments. Three-month follow-up indicated substantial effects on distress and behavioral reports. Marred by lack of standardized measures and the originator serving as sole therapist.*


*The addition of three sessions of EMDR resulted in large and significant reductions of memory-related distress, and problem behaviors at 2-month follow-up.*


*The only randomized study to show exposure statistically superior to EMDR on some measures. This study used therapist assisted “in vivo” exposure, where the therapist takes the person to previously avoided areas, in addition to imaginal exposure and one hour of daily homework (@ 50 hours). The EMDR group used only standard sessions and no homework.*


*EMDR was superior to both control conditions in the amelioration of both PTSD symptoms and depression. Upon termination of therapy, the EMDR group continued to improve while Fluoxetine participants again became symptomatic.*


  All treatments led to significant decreases in PTSD symptoms for subjects in the treatment groups as compared to those on a waiting list, with a greater (albeit non-significant) reduction in the EMDR group, particularly with respect to intrusive symptoms. In the 2-3 weeks of the study, 40-60 additional minutes of daily homework were part of the treatment in the other two conditions.


  Twenty-six children (average age 10.4 years) with behavioral problems were randomly assigned to receive either 4 sessions of EMDR or CBT. Both were found to have significant positive effects on behavioral and self-esteem problems, with the EMDR group showing significantly larger changes in target behaviors.


  Three sessions of EMDR produced clinically significant change in traumatized civilians on multiple measures.


  Follow-up at 15 months showed maintenance of positive treatment effects with 84% remission of PTSD diagnosis.

A more comprehensive list of relevant research can be found at the EMDR Institute website: [http://www.emdr.com/general-information/research-overview.html](http://www.emdr.com/general-information/research-overview.html)