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A GP guide to EMDR therapy

Australian Doctor, National

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Psychology

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This psychotherapeutic approach can be highly effective for suitably selected patients with post-traumatic stress disorder.

EYE movement desensitisation and reprocessing (EMDR) is a psychotherapy approach developed in the 1980s by American psychologist Francine Shapiro.¹ It was initially recognised as an evidence-based treatment for post-traumatic stress disorder (PTSD) and is a focused psychological strategy under Medicare's Better Access initiative.

A growing body of literature has also led to its recognition by the Australian Psychological Society as having level 1 evidence in the treatment of depression and phobias, and level 2 evidence for substance use disorders.^{2,3}

EMDR is grounded in adaptive information processing (AIP) theory. This suggests that a patient's current challenges stem from unresolved and disturbing memories that have not been adequately processed. By effectively processing these memories, EMDR aims to reduce or eliminate the associated symptoms, leading to improvement or resolution of the patient's difficulties.⁴

Memories of adverse experiences are typically associated with a maladaptive belief about the self or the world. The distress associated with such beliefs is exacerbated when the individual encounters a triggering stimulus that is related to an element in the memory.

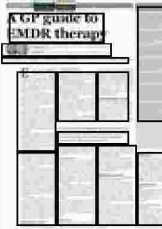
For example, a patient who presents with depressive symptoms triggered by a recent breakup may have first experienced the emotions of worthlessness and sadness, together with the belief "I am unlovable" during early childhood experiences of emotional neglect.

Processing the early memory is facilitated by pairing the key elements of the memory with another task, typically horizontal bilateral eye movements. In studies of the therapy process, it has been observed that memories linked to disturbing material are initially stored in rich and vivid details and are accompanied by a strong emotional response. After repeated pairing of the memory with another task, the memory becomes both less vivid and emotional.⁵

For example, the patient may recall the image as though it appears further away. Once the intensity of the memory is reduced, the patient's mind is no longer dominated by the negative connections to that memory and can access more positive experiences,⁶ leading them to more strongly believe an alternative, adaptive belief such as "I am worthy of love".

Mechanisms of action

Several mechanisms may underlie the effectiveness of EMDR, as outlined below.



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Working memory theory

Working memory is a limited capacity system that temporarily holds and manipulates information necessary for complex cognitive tasks, such as learning, reasoning and comprehension.

In the context of EMDR, the therapist's use of bilateral stimulation (such as eye movements or other dual-attention tasks such as tapping) taxes the working memory while simultaneously trying to access the disturbing memory.

Given the increased cognitive load, it becomes more challenging to maintain the emotional intensity and details of the associated traumatic memory. As a result, individuals are better able to reprocess these memories in a safer, less overwhelming context.⁷

This phenomenon has been highlighted by the finding that patients who play the game Tetris in the hours immediately following a motor vehicle accident reported significantly fewer and less intrusive flashbacks compared to controls.⁸

Orienting response

Eye movements may elicit an orienting response that is characterised by physiological changes such as decreased heart rate, reduced muscle tension, and a general calming effect on the nervous system. As the individual focuses on the moving stimuli, their physiological arousal diminishes, allowing for a more relaxed state that is conducive to memory processing.

By facilitating a calmer state, it allows the individual to re-evaluate and integrate memories with other experiences in their lives that are often incompatible with the negative themes associated with a trauma response.⁹

A patients' breathing rate increases during an orienting response, while heart rate does not necessarily increase. An increase in breathing rate but not heart rate has been observed in clients during EMDR as they orient to the therapist's fingers.

REM-like state

REM sleep has been found to be associated with helping individuals forget specific details of experiences and only store

the essence of a particular episode. REM sleep has been associated with improved processing of complex tasks and with consolidation of learning. PTSD produces disturbances in REM sleep. Brain imaging studies have found that both REM sleep and eye movements during wakefulness activate similar cortical areas.¹⁰ It is theorised that EMDR may induce neurobiological mechanisms similar to those during REM sleep.¹⁰

Neurophysiological evidence

Effective EMDR therapy has been demonstrated to be associated with changes in brain structure and function, such as increased hippocampal volume and normalisation of limbic structures.¹¹ These changes support the integration and processing of traumatic memories.

EMDR also has an impact on DNA methylation, the process that impacts how actively a gene is expressed without altering the genetic code itself.^{12,13} This has been demonstrated in studies of those with depression¹² or PTSD.¹³

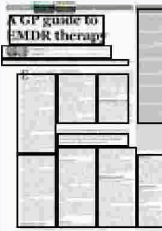
This research, while still in its infancy, may have implications that this psychological treatment influences a key epigenetic mechanism that helps regulate cell function, development, and responses to environmental factors.

EMDR therapy protocol

EMDR therapy consists of an eight-phase approach, as outlined in box 1.

The aims of reprocessing each memory are trifold. First, to create a sense of distance from the memory and reduce the vividness with which it is recalled. Second, to reduce the distress when the memory is recalled. Third, to replace a negatively held belief about oneself with a more adaptive belief pertaining to the memory.

For example, an individual who has experienced a horrifying car accident may, after EMDR, recall the memory as though further away and with minimal emotion. Following treatment, they can believe that they are now safe, and that the danger has passed. As a result, they are no longer triggered by the sound of car breaks screeching and have fewer nightmares.



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Evidence of efficacy and efficiency

EMDR has been extensively studied, with over 30 randomised controlled trials (RCTs) supporting its efficacy for PTSD in adults and children. It is recommended in various clinical practice guidelines, including those of the International Society for Traumatic Stress Studies¹⁴ and Phoenix Australia.¹⁵ Recently, EMDR has been recognised as having level 1 evidence for other disorders, including depression and phobias.¹⁶

Special populations

Children

EMDR can be adapted for children using developmentally appropriate language and techniques. There is level 1 evidence for the role of EMDR for PTSD in children and adolescents.²

Culturally and linguistically diverse groups

EMDR has been found to be highly effective with patients from a range of cultures and language groups.^{16,17} Its focus on body sensations throughout the protocol allowed clients to connect their memories with physiological experiences, making it particularly helpful for patients from more somatically focused cultures, who can struggle with cognitively based therapies.

Neurodivergent patients

EMDR is effective and well-received by many with autism spectrum disorders and ADHD.¹⁸ Its structured protocol, together with ample opportunities for patients to choose the speed and type of bilateral stimulation, offer predictability, containment and choice.

Advantages for patients

Patient preferences are an important consideration when selecting a psychological treatment to address symptoms. EMDR offers several advantages. One is that it does not require patients to complete homework. Patients may also choose to disclose as much or as little information about their memory to the therapist as they feel comfortable with. This is particularly valuable where shame or cultural considerations make verbalising or disclosing experiences difficult.

Patients' memories are treated as being aetiologically related, rather than being diagnosis specific. In this sense, it is less pathologising for patients and can be highly effective for clients with comorbid mental health conditions.

Patients also consistently report a faster reduction in symptoms when compared with other trauma-focused therapies. This anecdotal evidence is supported by a recent network meta-analysis of psychological and pharmacological treatments for PTSD, which found EMDR to have the largest effect size¹⁹ as well as being the most cost-effective of several treatments studied.²⁰⁻²¹

Limitations and future directions

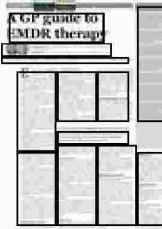
EMDR is not suitable for individuals with certain medical conditions without undertaking appropriate precautions. This is true for patients with seizure disorders or acute traumatic brain injury.

EMDR also requires that a person be willing to sit with their internal experiences with an attitude of openness or at least curiosity. Individuals who are highly avoidant of their memories, who struggle to see the relationship between adverse life experiences and their current symptoms or function, or those who lack coherent memory of the trauma, may be less well-suited to EMDR.

Initial controversies surrounding EMDR related to the impact and necessity of eye movements in therapy delivery. Current debate surrounds the degree to which patients with complex PTSD may require stabilisation and the formation of a trusting, therapeutic relationship prior to processing trauma memories. However, the vast majority of contemporary studies indicate that even for complex clients, EMDR has produced promising results.²²

Conclusion

EMDR therapy is a well-supported treatment for PTSD and trauma-related conditions. Its structured approach and evidence base make it a valuable option for GPs to consider when referring patients for psychotherapy. GPs who have already trained in focused psychological strategies are also eligible to undergo accredited training in EMDR. ●



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References on request from
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In the context of EMDR, the therapist’s use of bilateral stimulation taxes the working memory while simultaneously trying to access the disturbing memory.

NEED TO KNOW

Eye movement desensitisation and reprocessing (EMDR) is a highly effective, cost-effective psychological therapy for the treatment of post-traumatic stress disorder in suitably selected adults and children.

EMDR conceptualises patients’ adverse experiences as being aetiologically related to current symptoms, using an information processing model.

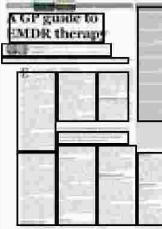
By reprocessing these memories, patients can then view events in a more historical and less vivid manner, with a much lower level of distress.

Memories are reprocessed by facilitating dual attention, where patients focus simultaneously on their memory and a bilateral stimulation, such as moving their eyes.

Neurophysiological research suggests several changes at a cortical level may occur following EMDR, underpinning patients’ symptom improvement.

Advantages of EMDR include its cross-cultural efficacy, lack of need for patients to complete homework, and opportunities to process memories without disclosing them fully, or repetitively, to a therapist.

EMDR may not be suitable for all patients, or may require additional preparations and precautions, particularly for patients who struggle to notice internal experiences, who are low in motivation to address symptoms, or who lack clear, coherent memories.



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Box 1. The eight-phase approach to EMDR

1. History-taking: Gathering background information and identifying target memories.

2. Preparation: Establishing patient readiness and teaching affect regulation techniques.

3. Assessment: Identifying the key elements of the target memory, including associated negative and positive cognitions.

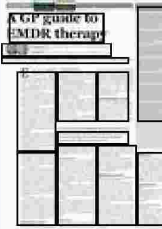
4. Desensitisation: Processing the memory with bilateral stimulation (BLS) until distress is reduced.

5. Installation: Strengthening the positive cognition associated with the memory.

6. Body scan: Checking for residual physical tension related to the memory.

7. Closure: Debriefing the patient's experience, stabilising them where required and providing education on what to expect between sessions.

8. Re-evaluation: Assessing the stability of symptom change in subsequent sessions.



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By focusing on the moving stimuli, physiological arousal may diminish, allowing for a more relaxed state conducive to memory processing.