BEST in Mental Health
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Best Evidence Summaries of Topics in Mental Healthcare

BEST *in* MH *clinical question-answering service*

Question

"For adults with any mental health disorder other than Post-Traumatic Stress Disorder, how effective is Eye-Movement Desensitisation and Reprocessing, compared to any other intervention, for improving patient outcomes?"

Clarification of question using PICO structure

Patients:	Adults with a mental health disorder other than Post-Traumatic Stress Disorder (PTSD)
Intervention:	Eye-Movement Desensitisation and Reprocessing (EMDR)
Comparator:	Any other intervention
Outcome:	Any patient outcomes

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Clinical and research implications

The evidence on the effectiveness of Eye-Movement Desensitisation and Reprocessing (EMDR) for the treatment of mental health conditions other than Post-Traumatic Stress Disorder (PTSD) is very limited and derives from very small studies with substantial methodological weaknesses, which have been conducted in a wide variety of different populations.

There is some evidence, from one poor quality trial, that adding EMDR to standard residential treatment may reduce the distress associated with some historical negative body image memories in women with eating disorders, however, it should be noted that EMDR showed no effect on most of the body image outcomes assessed.

There is also some evidence, from two very small, poor quality trials, that EMDR may reduce anxiety symptoms in students with test anxiety.

Finally, the results of one RCT indicated that both EMDR and citalopram may improve the symptoms of obsessive compulsive disorder in the short term, with EMDR showing the greater effect, however, the high percentage of dropouts excluded from the analysis make the effect estimates from this study unreliable.

Overall, there is no high quality reliable evidence to support the effectiveness of EMDR in any of the populations considered and more research is needed to ascertain the effectiveness of this intervention in people with mental health disorders other than PTSD.

What does the evidence say?

Number of included studies/reviews (number of participants)

We identified six randomised controlled trials (RCTs) that reported results relevant to this evidence summary.[1,2,3,4,5,6] All were small studies with substantial methodological flaws. The studies assessed the effectiveness of Eye-Movement Desensitisation and Reprocessing (EMDR) in a diverse range of clinical populations, and in comparison to both control and other active treatments. One study assessed the effects on body image perception outcomes of adding EMDR to standard residential treatment for women with eating disorders.[1] Two studies assessed the effectiveness of EMDR for the treatment of test anxiety; one compared to biofeedback/stress inoculation training or no treatment,[2] and the other compared to a delayed treatment control.[3] One study compared EMDR to a similar treatment without the eye movement component or a waiting list control for the treatment of panic disorder.[4] A further RCT compared EMDR to an imaginal exposure treatment or waiting list control, for the treatment of spider phobia.[5] The final study compared EMDR to pharmacotherapy with citalopram for the treatment of obsessive compulsive disorder.[6] Four studies reported follow-up of between 1 and 3 months,[1,2,3,4] and one reported a further follow-up point at 12 months.1 The remaining studies reported only post-treatment outcome assessments.[5,6]

Main Findings

The study conducted in women with eating disorders found that adding EMDR to standard residential treatment significantly reduced the distress associated with earliest and worst negative body image memories (Negative Body Image Memory Questionnaire, NBIM). [1] These effects appeared to persist at three months follow-up, but only the effect on worst negative body image

memory persisted at twelve months follow-up.[1] It should also be noted that EMDR had no significant effect on distress associated with most recent negative body image memory, or on any of five other body image outcome measures, or other mental health outcomes (Beck Depression Inventory or Dissociative Experiences Scale).[1] The two very small studies conducted I students with test anxiety both reported that EMDR was effective in reducing anxiety (Test Anxiety Inventory, TAI) compared to control,[2,3] or biofeedback/stress inoculation training.[2] The study conducted in people with panic disorder found that EMDR was more effective than waiting list control in improving five composite measures of anxiety, however, on three of these measures, EMDR did not differ in effectiveness form a similar treatment without the eye movement component (EFER) and there were no differences between EMDR and EFER at three months follow-up.[4] A very small study conducted in people with spider phobia found no evidence to support a treatment effect for EMDR.[5] The final RCT, conducted in people with obsessive compulsive disorder (OCD) found that both EMDR and citalopram appeared to improve the symptoms of OCD in the short term (over a 12 week treatment period) and that EMDR appeared to produce greater improvements.[6] However, it should be noted approximately one third of the participants in this study did not complete treatment and were excluded from the analysis and estimates of treatment effect may therefore be exaggerated.

Authors Conclusions

The studies included in this assessment evaluated EMDR in five different clinical populations:
One RCT concluded that EMDR can reduce distress about specifically targeted negative body image memories in people with eating disorders, but that more research is needed to determine its effectiveness on broader eating disorders pathology.
Two RCTs assessed EMDR for the treatment of test anxiety; both concluded that EMDR is effective in reducing anxiety and one concluded that EMDR outperforms biofeedback/stress inoculation training.
One RCT cautiously concluded that EMDR may be effective for the treatment of panic disorder with agoraphobia, but noted that it should not be considered a first line treatment until comparable effectiveness with other treatments (e.g. exposure therapy and CBT) is shown.
One RCT concluded that there is no evidence to support the EMDR for the treatment of spider phobia.
One RCT found that both EMDR and citalopram were effective in achieving short term improvements in the symptoms of obsessive compulsive disorder, but EMDR appeared to produce greater improvements.

Reliability of conclusions/Strength of evidence

All of the studies included in this evidence summary were very small and had substantial methodological flaws. Studies assessed the use of EMDR in clinically diverse populations. There was no high quality reliable evidence to support the effectiveness of EMDR in any of the populations considered.

What do guidelines say?

Guidelines by the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) do not comment upon the use of EMDR for treatments other than PTSD.

The evidence included in this summary is not sufficient to support the expansion of guidance on the use of EMDR to conditions other than PTSD.

Date question received: 18/09/2014
Date searches conducted: 25/09/2014
Date answer completed: 03/11/2014

References

RCTs

1. Bloomgarden, A., & Calogero, R. M. (2008). A randomized experimental test of the efficacy of EMDR treatment on negative body image in eating disorder inpatients. *Eating Disorders*, *16*(5), 418-427.

2. Cook-Vienot, R., & Taylor, R. J. (2012). Comparison of Eye Movement Desensitization and Reprocessing and Biofeedback/Stress Inoculation Training in treating test anxiety. *Journal of EMDR Practice and Research*, *6*(2), 62-72.

3. Enright, M., Baldo, T. D., & Wykes, S. D. (2000). The efficacy of eye movement desensitization and reprocessing therapy technique in the treatment of test anxiety of college students. *Journal of College Counselling*, *3*(1), 36-48.

4. Feske, U., & Goldstein, A. J. (1997). Eye movement desensitization and reprocessing treatment for panic disorder: a controlled outcome and partial dismantling study. *Journal of Consulting and Clinical Psychology*, *65*(6), 1026-1035.

5. Muris, P., & Merckelbach, H. (1997). Treating spider phobics with eye movement desensitization and reprocessing: A controlled study. *Behavioural and Cognitive Psychotherapy*, *25*(01), 39-50.

6. Nazari, H., Momeni, N., Jariani, M., & Tarrahi, M. J. (2011). Comparison of eye movement desensitization and reprocessing with citalopram in treatment of obsessive-compulsive disorder. *International Journal of Psychiatry in Clinical Practice*, *15*(4), 270-274.

Results

RCTs

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Bloomgarden et al. (2008)	*Participants*: Women admitted to a residential eating disorders treatment programme, meeting DSM-IV criteria for anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified. Exclusion criteria: diagnosis of dissociative disorder or score >30 on DES; on bed rest; actively suicidal or attempted suicide in the past month; history of seizure disorder; actively psychotic. *Intervention*: EMDR, with standard residential treatment. EMDR followed standard protocols, and comprised one or two 60 minute sessions per week, during participants' stay. *Comparator*: Standard residential treatment (SRT), including individual, group, and family therapy, seven days a week. *Outcome*: Negative body image (Body Image memory Questionnaire, NBIM; Body Investment Scale, BIS; Appearance Schemas Inventory, ASI; Body	*n* = 86 (43 EMDR + SRT, 43 SRT)	This study aimed to assess the effects of EMDR on negative body image in people with eating disorders. The study included 27 women with anorexia nervosa-restricting subtype, 23 women with bulimia nervosa, and 36 women with un-specified eating disorders; there were no significant differences in the distribution of diagnoses, age of onset, history of hospitalisation, or baseline measures, between the treatment groups. For the total sample, mean BMI was 20.05 ± 5.30 and the mean age was 24.59 ± 8.48 years. Participants in the EMDR + SRT group had a slightly longer hospital stay (mean 23.25 ± 9.77 days) than those in the SRT group (19.94 ± 10.49 days). The mean number of EMDR sessions was 4.31 ± 1.96. Participants in the EMDR + SRT group reported significantly less distress (NBIM) than those in the SRT at post-treatment for earliest (effect size 0.382 (95% CI: 0.17 to 0.59)) and worst (effect size 0.362 (95% CI: 0.13 to 0.60)) memories, but not for most recent memories. These effects remained significant	Participants were assigned to treatment groups, by a research assistant who was blind to the study hypothesis, using random number tables. No information on allocation concealment was reported. The nature of the intervention precluded blinding of participants and study personnel, and outcome measures were self-reported.

	Dissatisfaction Subscale of the EDI-2, BDS; Sociocultural Attitudes toward Appearance Questionnaire-Revised, SATAQ-R), eating attitudes and behaviours (Eating Attitudes Test-26, EAT-26), depressive symptoms (Beck Depression Inventory, BDI), dissociative experiences (Dissociative Experiences Scale, DES). Outcomes were assessed pre- and post-treatment, and at 3 and 12 months follow-up		at 3-month follow-up, but only for the worst memory at 12-month follow-up. There were no significant between group differences on any other outcome measure.	All participants appear to have completed the intervention. However, 7% of the intervention group and 5% of the comparator group did not return for 3 month follow-up, and 21% of the intervention group and 26% of the comparator group did not return for 12 month follow-up; these participants were excluded from the follow-up analyses. Full results were only reported for the primary outcome measure (NBIM).
Cook-Vienot et al. (2012)	*Participants*: Adult college students, considered to have test anxiety based upon their score on the Subjective Unit of	*n* = 30	This study aimed to compare the effectiveness of EMDR to biofeedback/stress inoculation training (B/SIT) for the treatment of test anxiety.	No details of randomisation or allocation

	Disturbance Scale (SUD). Exclusion criteria: active substance abuse; dissociative disorders; psychosis; psychological problems other than test anxiety; visual problems, epilepsy, neurological impairment, pregnancy. *Intervention*: EMDR, comprising one 45-minute introduction session and three 75-minute therapy sessions. *Comparators*: (1) Biofeedback/stress inoculation training (B/SIT), which includes a cognitive restructuring component and coping skills, and comprises three 90-minute sessions; (2) no treatment. *Outcome*: Anxiety (Test Anxiety Inventory, TAI; State-Trait Anxiety Inventory, STAI) irrational beliefs (Rational Behavioural Inventory, RBI), physiological arousal (Autonomic Perception Questionnaire (APQ). Outcomes were assessed pre- and post-treatment, and at 30–45 days following the pre-test and/or completion of treatment.		Study participants were aged between 19 and 53 years, and 22 were female. Analyses indicated no significant pre-treatment differences between the three groups (EMDR, B/SIT, and no treatment), on any measure assessed. There was a significant interaction between group and pre-post score (change) for STAI-Trait, STAI-State, TAI-Total, TAI-Worry, TAI-Emotionality and APQ. There was no significant difference between groups for RBI. For all STAI measures and for APQ, participants in the EMDR and B/SIT groups showed greater improvements than those in the no treatment group, but there were no significant differences between the two active treatment groups. For all TAI measures, participants in the EMDR and B/SIT groups showed greater improvements than those in the no treatment group, and participants in the EMDR group showed greater improvements than those in the B/SIT group.	concealment procedures were reported. The nature of the intervention precluded blinding of participants and study personnel. The principal investigator remained blind to the results of the psychological testing until completion of the research, but it was not clear whether those undertaking outcome assessments were blinded to treatment group. Numbers of participants in each group and any drop-outs were not

				reported. Results were reported for all listed outcomes.
Enright et al. (2000)	*Participants*: Adult students with self-reported test anxiety (no diagnostic criteria were specified). People with a "high" (not specified) DES score were excluded. *Intervention*: EMDR, comprising two 1-hour sessions, three weeks apart. *Comparator*: Delayed treatment control group. *Outcome*: Test anxiety (Test Anxiety Inventory, TAI), distress (Subjective Units of Distress Scale (SUD), positive beliefs (Validity of Cognition Scale, VoC). TAI was completed pre-and post-treatment and at approximately one month follow-up.	*n* = 35 (18 EMDR, 17 delayed-treatment control)	This study aimed to assess the effectiveness of EMDR for the treatment of test anxiety. The mean age of study participants was 37.48 years (range 20 to 65) and 24 were female. There were no significant pre-treatment differences between the groups, on any measure assessed. Total anxiety (TAI) and the worry and emotionality subscales of the TAI were all significantly reduced, pre- to post-test in the EMDR group, whereas the control group showed no change on any measure. Effects were maintained at one month follow-up. The mean ± SD total TAI scores were 65.5 ± 8.44 pre-treatment and 51.75 ± 15.40 post-treatment, in the EMDR group, versus 68.64 ± 9.2 pre-treatment and 65.36 ± 8.22 post-treatment in the control group. The mean ± TAI (emotionality subscale) scores were 27.62 ± 3.16 pre-treatment and 21.87 ± 7.28 post-treatment, in the EMDR group, versus 28.14 ± 4.17 pre-treatment and 26.78 ± 3.90 post-treatment in the control group.	No details of randomisation or allocation concealment procedures were reported. The nature of the intervention precluded blinding of participants and study personnel, and outcome measures were self-reported. Five of the 35 participants did not complete follow-up and it was not clear whether these participants were included in the analyses.

			The mean ± SD TAI (worry subscale) scores were 24.31 ± 4.38 pre-treatment and 18.87 ± 5.85 post-treatment, in the EMDR group, versus 27.14 ± 4.18 pre-treatment and 25.71 ± 4.06 post-treatment in the control group.	Full results were reported only for TAI.
Feske et al. (1997)	*Participants*: Outpatients with a DSM-III-R diagnosis of panic disorder (including having had a panic attack in the two weeks prior to the pre-test monitoring period, and having had the disorder for at least one year. Exclusion criteria: concurrent psychotherapy; DSM diagnosis of a personality disorder or current major depressive disorder; a daily dose of more than 1.5mg alaprazolam or equivalent dosages of other benzodiazepines; current or past diagnosis of psychosis; organic mental disorder; alcohol or substance dependence; obsessive compulsive disorder. *Intervention*: EMDR, comprising 6 sessions typically 90-minutes long, over a 3 week period. *Comparator*: (1) EMDR but without eye movement (eye fixation and exposure reprocessing (EFER); (2) waiting list. *Outcome*: Anxious catastrophic thoughts (Agoraphobic Cognitions Questionnaire and Body Sensations Questionnaire, ACQ	*n* = 43	This study aimed to compare EMDR to the same desensitisation treatment, but omitting the eye movement component, and to a waiting list control, for the treatment of panic disorder. The mean age of study participants was 35.2 years (range 20 to 54) and 31 were female. Four participants were taking psychotropic medications and 15 had co-morbid diagnoses, including simple phobia (7), GAD (6), major depression (3), social phobia (2), dysthymia (1) and anxious cluster personality disorders (5). There were no significant differences between the groups in demographic or socio-economic characteristics, duration of disorder, medication use, or co-morbidities, or effect measures at baseline. Post-test comparisons indicated that EMDR was more effective than waiting list control on all five composite measures: social concerns – general anxiety composite (Cohen's d 0.68); agoraphobia – anticipated panic – coping composite (Cohen's d 1.10); physical concerns composite (Cohen's d 0.81); general anxiety – fear of panic composite (Cohen's d	No details of randomisation or allocation concealment procedures were reported. The nature of the intervention precluded blinding of participants and study personnel, and outcome measures were self-reported. Three participants dropped out prior to randomisation, one participant from each treatment group did not complete treatment, one further participant from

	and BSQ), avoidance of situations (Mobility Inventory for Agoraphobia, MI), anxiety symptoms (Beck Anxiety Inventory, BAI), panic symptoms in agoraphobic situations (Panic Appraisal Inventory, PAI), depressive symptoms (Beck depression Inventory, BDI) general mental health symptoms (brief Symptom Inventory, BSI), and adjustment (Social Adjustment Scale, Self-Report (SAS-SR). Outcomes were assessed pre- and one week post-treatment and at three month follow-up.		1.35); panic frequency (Cohen's d 0.88). Participants in the EMDR group improved more, pre- to post-test, than those in the EFER group on two of the five composite measures (anticipated panic – coping, and generalised anxiety – fear of panic). However, these differences did not persist at three months follow-up. No follow-up data were presented for the EMDR versus waiting list control comparison.	each treatment group did not provide post-treatment data and 8 further participants did not provide follow-up data. Complete data were available for 28 participants. Participants with incomplete data appear to have been excluded from the analyses. Results were reported for all listed outcomes.
Muris et al. (1997)	*Participants*: Females with a DSM diagnosis for specific phobia, animal type. *Intervention*: EMDR, comprising a one-hour session, following standard EMDR procedures. *Comparator*: (1) Imaginal exposure, comprising a one-hour session, (2) no treatment. *Outcome*: Avoidance of spiders (Behavioural Avoidance test, BAT), fear of	*n* = 24 (8 EMDR, 8 imaginal exposure, 8 control)	This study aimed to assess the effectiveness of EMDR, compared to imaginal exposure or control, for the treatment of spider phobia. There were no significant differences in age, or pre-treatment levels of spider fear between the three groups. After exposure *in vivo*, all three groups showed significant improvements in BAT score: EMDR group -	No details of randomisation or allocation concealment procedures were reported. The nature of the intervention precluded blinding

	spiders (Spider Phobia Questionnaire).		3.36, p<0.01; imaginal exposure group -4.32, p<0.01; control group -4.52, p<0.001. Similarly, all three groups showed significant improvements in SPQ scores: EMDR group -7.13, p<0.05; imaginal exposure group -5.25, p<0.01; control group -10.25, p<0.01. However, there were no significant differences in effect between the groups, on either outcome measure.	of participants and study personnel, and one outcome measure was self-reported; it was not clear whether the BAT was administered blind to treatment group. There were no drop-outs. Results were reported for both specified outcome measures.
Nazari et al. (2011)	*Participants*: Patients admitted to a psychiatric clinic with a DSM IV-IR diagnosis of Obsessive Compulsive Disorder (OCD) who were not receiving any concurrent psychotherapy or psychiatric drug. Exclusion criteria: serious medical disorders, drug misuse, or other psychiatric DSM Axis I disorders during the previous year. *Intervention*: EMDR, comprising 8 sessions. *Comparator*: Citalopram, 20mg daily, for	*n* = 90 (47 EMDR, 43 citalopram)	This study aimed to assess the effectiveness of EMDR, compared to pharmacotherapy with citalopram, for the treatment of OCD. There were no significant differences in gender, age or pre-treatment Yale-Brown obsessive compulsive scale score between the two groups. Both the EMDR and the citalopram groups showed significant reductions in the mean Yale-Brown obsessive compulsive scale score after 12 weeks of treatment; the mean change from baseline was -6.2 ±	No details of randomisation or allocation concealment procedures were reported. The nature of the intervention precluded blinding of participants and study personnel.

	12 weeks *Outcome*: OCD symptoms (Yale-Brown obsessive compulsive scale), assessed pre- and post-treatment.		2.61, p<0.001, for the citalopram group, and -11.2 ± 5.32, p<0.001, for the EMDR group. The reduction was significantly greater in the EMDR group than in the citalopram group (p<0.001, between group difference not reported).	Outcome was assessed by a psychologist who was blind to treatment group. Thirty participants (47 from the EMDR group and 13 from the citalopram group) did not complete the study and were excluded from the analysis. Results were reported for the specified outcome.

Risk of Bias:

RCTs

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Bloomgarden et al. (2008)	☺	?	☹	☹	☹	☹
Cook-Vienot et al. (2012)	?	?	☹	?	?	☺
Enright et al. (2000)	?	?	☹	☹	?	☹
Feske et al. (1997)	?	?	☹	☹	☹	☺
Muris et al. (1997)	?	?	☹	☹	☺	☺
Nazari et al. (2011)	?	?	☹	☺	☹	☺

☺ Low Risk ☹ High Risk ? Unclear Risk

Search Details

Source	Search Strategy	Number of hits	Relevant evidence identified
SRs and Guidelines			
NICE	EMDR	7	0
DARE	1 (EMDR OR (eye adj2 move*) OR desensitis* OR desensitiz* OR de-sensitiz* OR de-sensitis*) IN DARE 120 Delete 2 MeSH DESCRIPTOR Desensitization, Psychologic EXPLODE ALL TREES 29 Delete 3 MeSH DESCRIPTOR Eye Movement Desensitization Reprocessing EXPLODE ALL TREES 5 Delete 4 #1 OR #2 OR #3 136 Delete	136	0
Primary studies			
CENTRAL	#1 EMDR #2 eye movement desensiti?ation reprocessing #3 MeSH: EYE MOVEMENT DESENSITIZATION REPROCESSING #4 MeSH: Posttraumatic Stress Disorder #5 #1 or #2 or #3 #6 #5 NOT #4 = 88	88	6
PsycINFO	1. PsycINFO; EMDR.ti,ab; 960 results. 2. PsycINFO; (eye AND movement AND desensiti?ation AND reprocessing).ti,ab; 848 results. 3. PsycINFO; EYE MOVEMENT DESENSITIZATION THERAPY/; 894 results. 4. PsycINFO; 1 OR 2 OR 3; 1139 results. 14. PsycINFO; CLINICAL TRIALS/; 6943 results. 15. PsycINFO; random*.ti,ab; 121175 results. 16. PsycINFO; groups*.ti,ab; 348411 results. 17. PsycINFO; (doubl* adj3 blind*).ti,ab; 17473 results. 18. PsycINFO; (singl* adj3 blind*).ti,ab; 1526 results. 19. PsycINFO; EXPERIMENTAL DESIGN/; 8717 results.	202	0

	20. PsycINFO; controlled.ti,ab; 75517 results. 21. PsycINFO; (clinical adj3 study).ti,ab; 7408 results. 22. PsycINFO; trial.ti,ab; 63951 results. 23. PsycINFO; "treatment outcome clinical trial".md; 25074 results. 24. PsycINFO; 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23; 537971 results. 26. PsycINFO; (posttraumatic OR post-traumatic OR PTSD).ti; 13828 results. 28. PsycINFO; 4 and 24; 286 results. 29. PsycINFO; 28 NOT 26; 202 results.		
Embase	31. EMBASE; EMDR.ti,ab; 440 results. 32. EMBASE; (eye AND movement AND desensiti?ation AND reprocessing).ti,ab; 410 results. 33. EMBASE; 31 OR 32; 528 results. 34. EMBASE; (posttraumatic OR post-traumatic OR PTSD).ti; 25735 results. 35. EMBASE; random*.tw; 900118 results. 36. EMBASE; factorial*.tw; 23315 results. 37. EMBASE; placebo*.tw; 202025 results. 38. EMBASE; (crossover* OR cross-over*).tw; 69842 results. 39. EMBASE; (doubl* adj3 blind*).tw; 143636 results. 40. EMBASE; (singl* adj3 blind*).tw; 17076 results. 41. EMBASE; assign*.tw; 242053 results. 42. EMBASE; allocat*.tw; 85229 results. 43. EMBASE; volunteer*.tw; 177796 results. 44. EMBASE; CROSSOVER PROCEDURE/; 40222 results. 45. EMBASE; DOUBLE-BLIND PROCEDURE/; 115438 results. 46. EMBASE; SINGLE-BLIND PROCEDURE/; 18827 results. 47. EMBASE; RANDOMIZED CONTROLLED TRIAL/; 350056 results. 48. EMBASE; 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 OR 44 OR 45 OR 46 OR 47; 1432748 results. 49. EMBASE; 33 AND 48; 118 results. 50. EMBASE; 49 NOT 34; 57 results.	57	0

Cinahl	51. CINAHL; EMDR.ti,ab; 90 results. 52. CINAHL; (eye AND movement AND desensiti?ation AND reprocessing).ti,ab; 97 results. 53. CINAHL; 51 OR 52; 120 results. 54. CINAHL; (posttraumatic OR post-traumatic OR PTSD).ti; 4310 results. 55. CINAHL; 53 NOT 54; 84 results. 56. CINAHL; random*.ti,ab; 112569 results. 57. CINAHL; (doubl* adj3 blind*).ti,ab; 13935 results. 58. CINAHL; (singl* adj3 blind*).ti,ab; 2403 results. 59. CINAHL; controlled.ti,ab; 65091 results. 60. CINAHL; (clinical adj3 study).ti,ab; 10559 results. 61. CINAHL; trial.ti,ab; 67626 results. 62. CINAHL; 55 AND 61; 0 results.	0	0
Medline	63. MEDLINE; EMDR.ti,ab; 274 results. 64. MEDLINE; (eye AND movement AND desensiti?ation AND reprocessing).ti,ab; 272 results. 65. MEDLINE; EYE MOVEMENT DESENSITIZATION REPROCESSING/; 78 results. 66. MEDLINE; 63 OR 64 OR 65; 354 results. 67. MEDLINE; (posttraumatic OR post-traumatic OR PTSD).ti; 22816 results. 68. MEDLINE; 66 NOT 67; 224 results. 69. MEDLINE; "randomized controlled trial".pt; 389176 results. 70. MEDLINE; "controlled clinical trial".pt; 89873 results. 71. MEDLINE; placebo.ab; 159781 results. 72. MEDLINE; random*.ab; 725928 results. 73. MEDLINE; trial.ti; 133989 results. 74. MEDLINE; CLINICAL TRIALS AS TOPIC/; 173150 results. 75. MEDLINE; 69 OR 70 OR 71 OR 72 OR 73 OR 74; 1109420 results. 76. MEDLINE; exp ANIMALS/ NOT HUMANS/; 4013599 results. 77. MEDLINE; 75 NOT 76; 1014620 results. 78. MEDLINE; 68 AND 77; 48 results.	48	0
Summary	**NA**	**NA**	

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