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EMDR Therapy as an Adjunct in the Treatment of Anorexia Nervosa: A Narrative Review of Trauma-Focused Approaches

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Abstract

Introduction: Anorexia nervosa (AN) is a severe psychiatric disorder marked by chronic calorie restriction, distorted body image, and high mortality. Despite available treatments, long-term success is limited, with frequent relapses. Evidence suggests trauma-related factors play a key role in AN development and maintenance, emphasizing the need for innovative therapies. This review evaluates Eye Movement Desensitisation and Reprocessing (EMDR) therapy as an adjunct in AN treatment, especially for patients with trauma histories, and synthesizes current research on its effectiveness.

Material and methods: A literature review from 2020-2025 was conducted using PubMed, Google Scholar, and Scopus. Selected studies include empirical research, systematic reviews, and meta-analyses on EMDR's role in treating AN and trauma. Methodological quality and relevance were assessed.

Results: Originally used for treatment of PTSD, EMDR seems promising as a complementary approach in AN, particularly for those with traumatic backgrounds. Incorporating EMDR as an alongside standard treatments (e.g., CBT-E) improves BMI, reduces dissociative and psychopathological symptoms, and aids processing of negative beliefs and body image issues. Therapy EMDR targets unprocessed traumatic memories, enhancing emotional regulation and self-perception, and may reduce trauma-related symptoms, especially in complex cases involving childhood maltreatment.

Conclusions: EMDR is a valuable adjunct in multidisciplinary AN treatment, aiding in trauma processing and symptom reduction. Further large-scale studies are needed to establish standardized protocols and integration strategies within comprehensive care.

Keywords: EMDR (Eye Movement Desensitisation and Reprocessing), anorexia nervosa (AN), trauma and PTSD in eating disorders, negative self-beliefs and body image disturbance, comprehensive multidisciplinary treatment

Streszczenie

Wstęp: Anoreksja nervosa (AN) to poważne zaburzenie psychiczne charakteryzujące się przewlekłym ograniczaniem spożycia kalorii, zniekształconym obrazem własnego ciała i wysoką śmiertelnością. Pomimo dostępnych metod leczenia długoterminowe sukcesy są ograniczone, a nawroty choroby częste. Dowody wskazują, że czynniki związane z traumą odgrywają kluczową rolę w rozwoju i utrzymywaniu się AN, co podkreśla potrzebę stosowania innowacyjnych terapii. W niniejszym przeglądzie oceniono terapię EMDR (Eye Movement Desensitisation and Reprocessing) jako środek wspomagający w leczeniu AN, zwłaszcza u pacjentów z traumatyczną przeszłością, oraz podsumowano aktualne badania dotyczące jej skuteczności.

Materiał i metody: Przegląd literatury z lat 2020–2025 przeprowadzono przy użyciu baz PubMed, Google Scholar i Scopus. Wybrane badania obejmują badania empiryczne, przeglądy systematyczne i metaanalizy dotyczące roli EMDR w leczeniu AN i traumy. Oceniono jakość metodologiczną i trafność badań.

Dyskusja: Pierwotnie stosowana w leczeniu zespołu stresu pourazowego (PTSD), terapia EMDR okazuje się obiecująca jako podejście uzupełniające w leczeniu jadłowstrętu psychicznego, szczególnie u osób z traumatyczną przeszłością. Włączenie terapii EMDR do standardowych metod leczenia (np. CBT-E) poprawia wskaźnik BMI, zmniejsza objawy dysocjacyjne i psychopatologiczne oraz pomaga w przetwarzaniu negatywnych przekonań i problemów związanych z obrazem własnego ciała. Terapia EMDR skupia się na nieprzetworzonych traumatycznych wspomnieniach, poprawiając regulację emocjonalną

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i postrzeganie własnej osoby, a także może zmniejszyć objawy związane z traumą, zwłaszcza w złożonych przypadkach związanych z maltretowaniem w dzieciństwie.
Wnioski: EMDR stanowi cenne uzupełnienie multidyscyplinarnego leczenia AN, wspomagając przetwarzanie traumy i redukcję objawów. Konieczne są dalsze badania na dużą skalę w celu ustalenia standardowych protokołów i strategii integracji w ramach kompleksowej opieki.

Słowa kluczowe: EMDR (Eye Movement Desensitisation and Reprocessing), jadłowstręt psychiczny (AN), trauma i PTSD w zaburzeniach odżywiania, negatywne przekonania na temat siebie i zaburzenia obrazu własnego ciała, kompleksowe leczenie multidyscyplinarne

1. Introduction and aim

Anorexia nervosa (AN) is a serious eating disorder that most commonly develops during adolescence, usually between the ages of 16 and 17. It is one of the most severe psychiatric disorders, with a very high mortality rate — between 15% and 20% of those diagnosed with AN die as a result of the illness [1]. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the diagnosis of anorexia is based on three key criteria: persistent restriction of energy intake resulting in significant weight loss, an intense fear of gaining weight, and a distorted perception of one's body weight and shape [2,3]. As the illness progresses, it leads to numerous serious health complications, such as osteoporosis, cardiac arrhythmias, cardiomyopathies, infertility, brain damage and other neurological changes [4-7]. In addition to physical health issues, anorexia is often accompanied by psychiatric comorbidities such as depression or obsessive-compulsive disorder (OCD), making treatment a complex challenge that requires a multidisciplinary approach [8,9].

Nutritional rehabilitation remains the cornerstone of treatment for anorexia, however, pharmacological and psychotherapeutic support are also frequently necessary. Although pharmacotherapy, including antidepressants and antipsychotics, may offer some benefit, its long-term effectiveness is limited, and relapse rates remain high. Consequently, there is a growing interest in complementary therapies to support traditional approaches and enhance treatment outcomes [9-13].

One promising adjunctive treatment is Eye Movement Desensitisation and Reprocessing (EMDR) therapy, which may be incorporated into the treatment of anorexia nervosa. EMDR is a psychotherapeutic method originally developed for trauma therapy. It has gained recognition for its effectiveness in the treatment of various psychiatric disorders, including eating disorders. Through bilateral stimulation (e.g., guided eye movements), EMDR helps patients process distressing memories and emotions that may contribute to the development and persistence of eating disorders [14,15].

In the context of anorexia, EMDR can be beneficial for patients who struggle with body acceptance, intense anxiety related to weight gain, and deeply rooted negative self-beliefs. This method enables the processing of traumatic experiences and emotions related to food, body image, and self-esteem , which may help reduce anxiety and improve overall psychological well-being [16-17]. As interest in this approach grows, further research is needed to better understand its effectiveness and how it may be integrated into comprehensive treatment plans for anorexia nervosa.

2. Research materials and methods

This literature review was conducted by searching scientific articles published from 2020 to 2025. Data was sourced from PubMed, Scopus, Google Scholar databases, using the following keywords: 'EMDR (Eye Movement Desensitisation and Reprocessing)', 'anorexia nervosa (AN)', 'trauma and PTSD in eating disorders', 'negative self-beliefs and body image disturbance', 'comprehensive multidisciplinary treatment'. Among the 1790 articles in the available database, 33 publications were included in this study after detailed analysis.

3. Research results

Eye Movement Desensitisation and Reprocessing (EMDR) is a structured, evidence-based therapeutic method developed by Francine Shapiro, originally designed for the treatment of post-traumatic stress disorder (PTSD). Currently, its application includes eating disorders, especially in cases where the symptoms are rooted in traumatic experiences or chronically stressful events. The EMDR model assumes that unprocessed memories can remain 'frozen' in a dysfunctional form and generate anxiety, shame or feelings of worthlessness, which are emotions often observed in patients with AN [14-15].

The therapy consists of eight phases. In terms of AN, those listed below play the key role: targeted identification of memories and beliefs related to feelings of control, values and body image (phases: history and assessment),

preparation for emotion regulation, which is particularly important in patients with a tendency to avoid affect and dissociation (preparation phase), and desensitisation and processing using bilateral stimulation, which reduces the emotional charge of memories and promotes the formation of more adaptive beliefs about oneself [15]. In anorexia, beliefs such as 'I am worthless' or 'the only thing I can control is my body' are among the most frequently processed therapeutic goals (Figure 1).

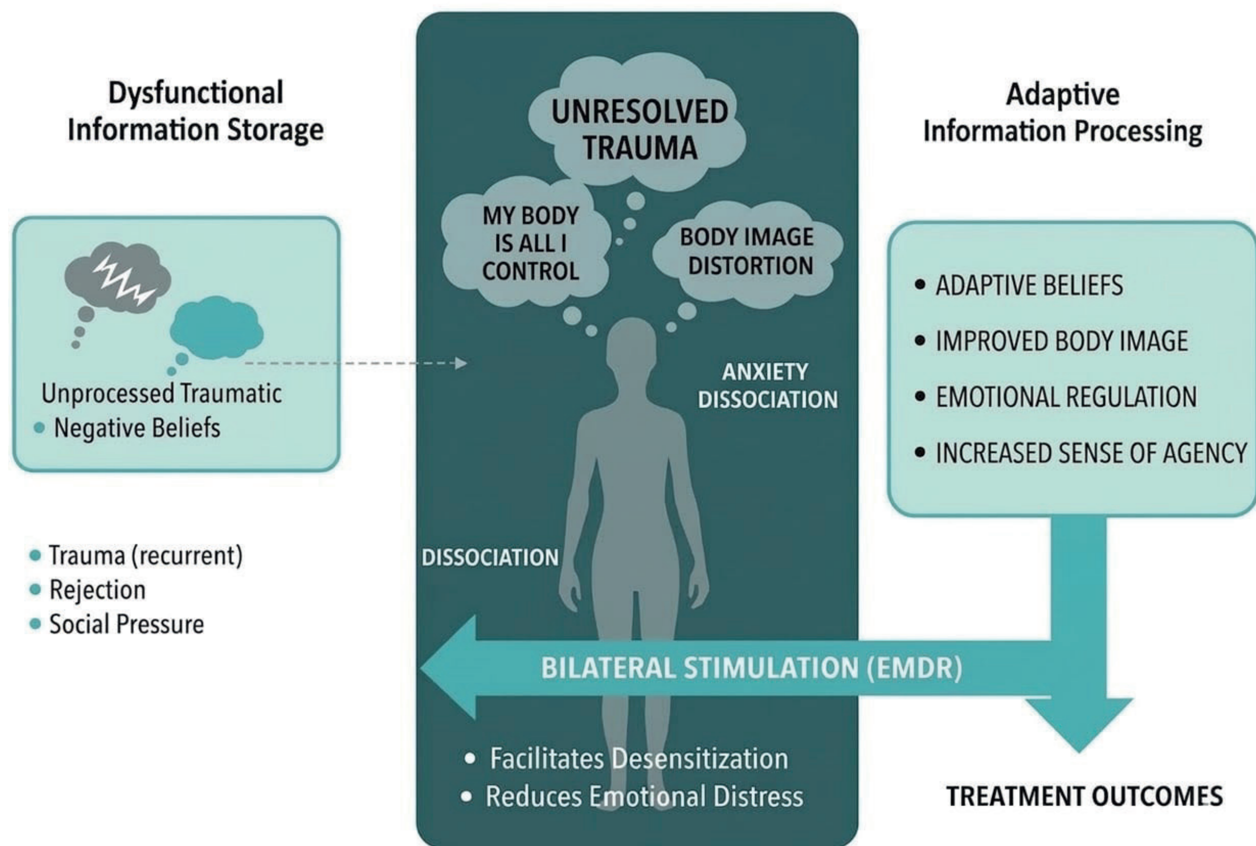

Figure 1.

The integrative, trauma-focused approach of EMDR shows promise in treating AN due to its integrative, trauma-focused approach. Many patients with anorexia have experienced rejection, emotional neglect, abuse, or social pressure. These experiences reinforced negative self-image and rigid patterns of functioning [18,19]. The EMDR allows them to be processed safely, which can lead to improved body image, increased sense of agency, and reduced symptoms. At the same time, the method does not require a detailed description of traumatic content, which is beneficial for patients who have difficulty expressing their emotions [14,15]. The use of structural tools, such as a timeline, facilitates the identification of key developmental events and the step-by-step processing of their consequences [18].

In summary, EMDR is a psychotherapeutic method that can be a great complementary method tothe standard treatment methods. Focusing not only on the underlying mechanisms of the disorder, but also addresses their sources, helping patients change the way they relate to themselves and their past.

3.2 PTSD and anorexia

Trauma and PTSD symptoms are often underestimated as components of anorexia nervosa, that should be studied more carefully in context of this complicated disease. A study by Longo et al. (2020) showed that traumatic events are very common in a group of young female patients with AN. According to PTSD symptoms, they are correlated significantly with the severity of psychopathology. It indicates that the traumatic component may worsen the course of the disease [18].

Another study conducted by Sjögren et al. (2023) involving 97 patients with moderate or severe AN showed similar results. A significant group of the study patients scored (PCL-C ≥ 44) (Posttraumatic Stress Disorder Checklist – Civilian Version). Only one person from the studied group had a formal diagnosis of PTSD. Authors noted clear differences between subtypes of anorexia: patients with AN-BP (Anorexia Nervosa Binge-Purge subtype) experienced higher trauma severity and more severe psychopathology than those with AN-R (Anorexia Nervosa Restrictive subtype). This highlights the heterogeneity of the AN population and the potential need

for differentiated therapeutic interventions. At the same time, trauma did not affect short-term weight gain. The study findings suggest that its role is primarily evident in the area of long-term psychotherapy outcomes rather than in response to nutritional interventions. However, this study has limitations like lack of formal PTSD assessment by clinicians and lack of long-term follow-up to assess the long term efficiency. That possibly limits the drawing of conclusions about causality [19].

A meta-analysis conducted by Torres-Giménez et al. (2024), in which early EMDR interventions after traumatic events were examined, confirmed the effectiveness of EMDR in reducing PTSD symptoms. The studies varied in terms of quality, timing of intervention, population, and applicability in the context of chronic developmental trauma. Methodological differences between the cited studies make it difficult to directly synthesise the results and conclude about the mechanisms linking trauma and anorexia. Significant clinical heterogeneity (AN-R vs. AN-BP, patients with vs. without trauma) is often overlooked in study design, which reduces its validity and limits the possibility of formulating recommendations for trauma-focused treatment. Despite these limitations, available evidence suggests that trauma is in fact common among patients with AN, contributing to the persistence of symptoms through emotional dysregulation and Hypothalamic-Pituitary-Adrenal axis dysfunction [9,21].

At the same time, the lack of systematic referral of patients with significant PTSD symptoms to trauma-focused treatment, as observed in the study by Sjögren et al., among others, represents a significant gap in clinical practice. These findings highlight the need for more precise studies. The study design should take into account AN subtypes, trauma history, PTSD status, and the quality and type of psychotherapeutic interventions. This approach should help accurately assess the role of trauma-based therapies in the treatment of anorexia. A quasi-experimental study conducted by Rossi et al. (2024) assessed the effect of adding EMDR in opposition to CBT-E therapy in women suffering from anorexia nervosa (AN) with a moderate or severe history of childhood maltreatment (CM). Of the 75 participants, all began treatment with 40 sessions of CBT-E. After initial CBT-E treatment, 18 women were eligible for additional EMDR intervention, while the rest continued with CBT-E alone. The study showed that during the first stage of treatment, both patients with and without CM did not achieve significant improvement in BMI. However, after CBT-E + EMDR therapy, the group achieved greater BMI increases and significant reductions in ED symptoms, compared to the group receiving only CBT-E. The original analysis indicated that the improvement in ED symptoms could be explained by a decrease in the severity of dissociation, supporting the thesis that EMDR may target key mechanisms maintaining anorexia in individuals with trauma. The quality of the evidence must be interpreted with caution due to significant methodological limitations. The study was quasi-experimental and unrandomised . This increases the risk of systematic differences between groups. Patients with CM constituted a clinically distinct population with greater psychopathology and higher dissociation severity at the start of treatment, which should be taken into consideration.

Furthermore, the sample was relatively small, and the subgroups were heterogeneous in terms of anorexia subtypes (AN-R vs. AN-BP), disease stage, and trauma profile, which may affect the generalisability of the results.

An additional limitation is that EMDR intervention was introduced after the first intensive stage of CBT-E, making it difficult to clearly separate the impact of the intervention. The authors also did not conduct long-term follow-up, making it impossible to assess the durability of EMDR effects. Despite these limitations, the study results suggest that in a heterogeneous AN population EMDR may be a valuable addiction to CBT-E therapy. The effectiveness of EMDR may be enhanced by influencing emotion regulation and trauma processing mechanisms [16].

Randomised study by Bloomgarden and Calogero showed that even a single EMDR session focused on a key negative memory led to a significant reduction of distress and an improvement in body image perception. These results support the previously discussed studies and support the thesis that EMDR may be in fact a valuable addition to standard therapy. At the same time, the study has significant methodological limitations: small sample size, heterogeneity of diagnoses, lack of active comparative therapy, and the use of a single session, which limits the possibility of generalising the results to long-term outpatient treatment. Despite these limitations, it represents an important step towards empirical confirmation of the use of EMDR in modulating negative body image and points to the need for further research with greater power and a more rigorous design [17].

4. Synthesis and Research Gap

An analysis of available studies clearly indicates that trauma and PTSD symptoms are an important but underestimated clinical component of anorexia nervosa. The work of Longo et al. (2020) and Sjögren et al. (2023) show a high prevalence of traumatic experiences and subclinical PTSD symptoms in the AN population, as well as their association with the severity of psychopathology, especially in the AN-BP subtype [18,19]. These studies highlight the significant clinical heterogeneity of AN patients, including differences between subtypes of the

disorder and between those with and without a history of trauma. In light of these data, research on trauma-focused therapies, including EMDR, takes on particular importance.

Intervention studies such as the meta-analysis by Torres-Giménez et al. (2024) on early EMDR interventions and the quasi-experimental study by Rossi et al. (2024) — suggest that EMDR can effectively reduce symptoms of PTSD and dissociation, and in the case of AN, additionally improve clinical parameters such as BMI and ED symptom severity [16,20]. However, these results should be interpreted with caution due to numerous methodological limitations: lack of randomisation, small sample sizes, significant differences between study groups, and lack of long-term data on the durability of effects. Similar limitations apply to the study by Bloomgarden and Calogero, in which, despite promising results, a single intervention was used, without comparison with active control therapy and with high heterogeneity of diagnoses [17].

Table 1.

Authors and year of publication	Population / Sample	Type of EMDR Intervention	Main Findings	Main Limitations
Rossi et al. (2024)	75 women with AN (AN-R and AN-BP); subsample of 18 patients with moderate/ severe childhood maltreatment (CM).	EMDR added to CBT-E; EMDR introduced after 40 CBT-E sessions.	- Significant BMI increase following EMDR - Reduction in ED symptoms, general psychopathology, and dissociation - Mediation analysis: reduction in dissociation partially explained improvements in ED symptoms	- Quasi-experimental design (no randomisation) - Small EMDR subgroup - Heterogeneous AN subtypes - EMDR added only after an intensive CBT-Ephase → difficult to isolate EMDR effects - No long-term follow-up
Bloomgarden & Calogero (2008)	Inpatient ED sample (AN, BN, EDNOS); small n.	Single EMDR session focused on a negative body-image-related memory.	- Significant reductions in distress and improvements in body image lasting up to 12 months - Good acceptability and safety	- Very small sample - Mixed diagnoses (not AN-specific) - No active control treatment - Single-session design limits generalizability
Hatoum & Burton (2024)	8 studies (1 RCT, 1 quasi-experimental, 6 case studies).	EMDR used alone or as adjunct to standard treatment.	- Improvements in body image, BMI, ED symptoms, and PTSD reported in most studies - High feasibility and acceptability	- Strong methodological heterogeneity - No meta-analysis possible - Many studies low quality (case reports, small samples)
Torres-Giménez et al. (2024)	Studies on early EMDR after traumatic events (not AN-specific).	Early EMDR intervention.	- EMDR effectively reduces PTSD symptoms	- Limited applicability to AN (different populations, early-intervention focus) - Substantial heterogeneity across studies
Sjögren et al. (2023)	97 patients with AN (various subtypes).	No EMDR — observational study.	- 51% met clinical threshold for PTSDsymptoms (PCL-C ≥44) - AN-BP showed greater trauma burden and more severe psychopathology - Trauma unrelated to short-term weight gain	- No clinician-confirmed PTSD diagnoses - No long-term follow-up - No trauma-focused interventions provided

In summary, the current state of knowledge indicates the potential effectiveness of EMDR in the treatment of anorexia, especially in cases of co-occurring trauma and dissociative symptoms, but at the same time reveals significant gaps in the existing literature. A key research gap concerns the lack of well-controlled, randomised controlled trials (RCTs) that take into account: subtypes of anorexia (AN-R vs. AN-BP), trauma status (with/without trauma experience), differences in the severity of PTSD and dissociation, long-term durability of EMDR effects, direct comparisons of EMDR with other trauma-focused treatments, and standardisation of EMDR protocols used in the ED population [9, 16, 20].

Future studies should take these factors into account in order to enable the development of precise clinical recommendations for the integration of EMDR into the treatment of anorexia. Current data suggest a promising direction, but a full understanding of the role of EMDR in AN therapy requires more rigorous research designs and greater attention to the heterogeneity of the patient population [9, 21, 23] (Table 1).

5. Conclusion

Therapy with EMDR should be considered as a complementary treatment method for anorexia nervosa (AN), particularly in patients with trauma histories. Research shows that AN is caused by complex biological and psychological factors. Traumatic experiences like emotional, physical, or sexual abuse, neglect and rejection play significant role in persistent negative self-perceptions and emotional dysregulation [18,19,21]. Understanding the link between trauma and anorexia is therefore crucial to developing more effective treatments.

Originally created for PTSD treatment, EMDR has shown promise in working with eating disorder patients. Its integrative nature enables the processing of painful memories and emotions that underlie negative self-beliefs [14,15]. Studies demonstrate that PTSD symptoms are prevalent among patients with AN, even when no formal diagnosis has been made [18,19]. Many people with anorexia suffer from deeply ingrained negative beliefs about themselves, often rooted in unprocessed trauma. Addressing these beliefs through EMDR can significantly reduce symptoms and improve body image and emotional functioning [16-17].

It's worth noting EMDR allows patients to process traumatic memories without discussing it in detail, a key benefit for those who find emotional expression difficult or find traumatic experiences especially painful. Bilateral stimulation during sessions supports safe and controlled emotional processing, fostering transformation of maladaptive beliefs [14,15].

However, EMDR should not be viewed as an option for monotherapy. It is most effective when integrated into a multidisciplinary treatment plan that includes psychotherapeutic and pharmacological support. For patients with conditions such as depression or OCD, a collaborative, multidisciplinary approach is essential [8,12,13,22]. A valuable role for EMDR in this context by addressing trauma-related issues that often underlie anorexia symptoms [16,17].

While early findings are promising, further research is needed to better understand when and for whom EMDR is most effective. Larger studies with diverse AN subtypes and trauma histories are necessary to determine the best ways to incorporate EMDR into standard treatment protocols [9-11, 21, 23].

Conflict of interest

The authors have declared no conflict of interest.

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