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FOR EMDR CLINICIANS · NOVEMBER 2026 EDITION

EMDR 2.0 — Clinical Primer

Working-memory taxation, dual-task load, and the extension of Phase 4

A concise clinical primer on EMDR 2.0 — what it is, how it differs from standard EMDR, the taxation 'sweet spot,' safeguards, and the current evidence base.

WHAT'S INSIDE

- ✓ What EMDR 2.0 is (and is not)
- ✓ Core procedural differences vs. standard EMDR
- ✓ The taxation sweet spot (inverted-U)
- ✓ Contraindications and titration safeguards
- ✓ Evidence snapshot with references

Use this live, in session.

EMDR Assist turns protocols like this into guided, phase-by-phase session tools — SUD/VoC tracking, scripts and notes in one place.

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Clinical use notice. Educational reference material for EMDRIA-trained clinicians. EMDR 2.0 is a research-supported extension of the standard 8-phase protocol (Shapiro, 2018) and requires prior Basic Training. It does not replace supervision, consultation, or clinical judgement. EMDR Assist is not affiliated with or endorsed by the developers of EMDR 2.0 (de Jongh, Matthijssen and colleagues).

1. What EMDR 2.0 is (and is not)

EMDR 2.0 is an intensification of the standard EMDR protocol developed by Ad de Jongh, Suzy Matthijssen and colleagues (Utrecht group). It preserves the eight phases but modifies Phase 4 to maximise working-memory (WM) taxation while the client holds the target image. The theoretical basis is the Working Memory Theory of EMDR (van den Hout & Engelhard, 2012): recalled memories are vivid and emotional because they are re-stored after being loaded into limited-capacity WM; competing tasks that also load WM blur and de-emotionalise the trace during reconsolidation.

EMDR 2.0 is **not** a new modality, not a substitute for stabilisation, and not indicated for clients outside the Window of Tolerance. Sessions are typically longer (60–90 minutes) because taxation is sustained.

2. Core procedural differences

	Standard EMDR	EMDR 2.0
BLS	Single modality (usually eye movement)	Multi-modal: fast eye movements plus arithmetic, backward counting, or category naming
Set length	~24–30 saccades	~20–60 s, titrated to visible effort
Between sets	‘What do you get now?’	Brief check + titration adjustment (‘Were you still seeing the image?’)
Image	Held passively	Actively re-called each set; vividness / emotionality rated
Cadence	Client-led channel following	Therapist actively dials load up or down

3. The taxation ‘sweet spot’

Working-memory effects follow an inverted-U (Yerkes–Dodson-like) curve. Too little load and the memory retains vividness; too much and the image drops entirely (task-switching cost) — reconsolidation cannot modify a trace that is not active in WM.

- **Under-taxed:** flat SUD, image stable, ‘nothing changing’ → add a task or speed up.

- **Sweet spot:** image dims, emotionality decreases set to set, SUD drops.
- **Over-taxed:** loss of image, confusion, dissociation cues → reduce load, shorten sets, ground.

4. Contraindications and titration safeguards

- Structural dissociation (DES-II elevated, DDNOS/DID): stabilise fully; use standard EMDR with strong Phase 2.
- Acute crisis, active psychosis, uncontrolled substance use, or intolerable somatic dysregulation.
- Cognitive load ceiling: adjust for TBI, ADHD, or high fatigue — choose tasks the client can just barely sustain.
- Never introduce a new task at peak arousal; drop back to a lower rung and rebuild.

5. Evidence snapshot

- Matthijssen et al. (2021), *European Journal of Psychotraumatology* — randomized lab study (N = 62, non-clinical): EMDR 2.0 and standard EMDR reduced emotionality and vividness equally, with no difference in session time; EMDR 2.0 needed fewer sets.
- Matthijssen & Menses (2024), *Frontiers in Psychiatry* — single-patient case report of intensive online prolonged exposure plus EMDR 2.0 for severe, chronic PTSD.
- Mertens, Lund & Engelhard (2021), *Acta Psychologica* — meta-analysis of 53 lab studies: dual tasks reduce memory vividness and emotionality. Evidence that heavier tasks add benefit is mixed (Mertens et al., 2019).
- ENHANCE trial (Alting van Geusau et al., 2023, study protocol) — randomized trial of EMDR vs EMDR 2.0 vs Flash in 130 patients with PTSD; results pending.

References

Every clinical claim in this resource is traceable to the sources below. Instruments are public domain or used under their published terms.

1. Alting van Geusau, V. V. P., de Jongh, A., Nuijs, M. D., Brouwers, T. C., Moerbeek, M., & Matthijssen, S. J. M. A. (2023). Study protocol for the ENHANCE randomized controlled trial. *Frontiers in Psychiatry*, 14, 1278052.

2. Engelhard, I. M., van den Hout, M. A., & Smeets, M. A. M. (2011). Taxing working memory reduces vividness and emotional intensity of images about the Queen's Day tragedy. *Journal of Behavior Therapy and Experimental Psychiatry*, 42(1), 32–37.

3. Matthijssen, S. J. M. A., Brouwers, T., van Roozendaal, C., Vuister, T., & de Jongh, A. (2021). The effect of EMDR versus EMDR 2.0 on emotionality and vividness of aversive memories in a non-clinical sample. *European Journal of Psychotraumatology*, 12(1), 1956793.

4. Matthijssen, S. J. M. A., & Menses, S. D. F. (2024). Case report: Intensive online trauma treatment combining prolonged exposure and EMDR 2.0. *Frontiers in Psychiatry*, 15, 1370358.

5. Mertens, G., Krypotos, A.-M., van Logtestijn, A., Landkroon, E., van Veen, S. C., & Engelhard, I. M. (2019). Changing negative autobiographical memories in the lab: A comparison of three eye-movement tasks. *Memory*, 27(3), 295–305.

6. Mertens, G., Lund, M., & Engelhard, I. M. (2021). The effectiveness of dual-task interventions for modulating emotional memories in the laboratory: A meta-analysis. *Acta Psychologica*, 220, 103424.

7. Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy* (3rd ed.). Guilford.

8. van den Hout, M. A., & Engelhard, I. M. (2012). How does EMDR work? *Journal of Experimental Psychopathology*, 3(5), 724–738.