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EMDR 2.0 — Clinical Science Brief

Working-memory taxation, evidence to date, and practical implications

A science-based brief on the enhanced EMDR protocol — theoretical rationale, current evidence, practical implications for clinicians, and open questions.

WHAT'S INSIDE

- ✓ What EMDR 2.0 is
- ✓ Working-memory taxation rationale
- ✓ Evidence base to date
- ✓ Practical implications and limitations

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At a glance

EMDR 2.0 is a protocol refinement developed by Ad de Jongh and Suzy Matthijssen that intentionally increases working-memory load during trauma recall. Early randomized and analog studies suggest larger per-minute reductions in memory vividness and emotionality compared with standard EMDR, with comparable safety.

1. What EMDR 2.0 is

EMDR 2.0 is not a new therapy but a set of procedural modifications layered onto standard EMDR (Shapiro, 2018). The core innovation is the deliberate escalation of concurrent cognitive load — beyond eye movements alone — while the client holds a target memory in mind. Modifications include faster and more varied bilateral stimulation (BLS), dual visual + auditory tasks, mental arithmetic, backward counting, working-memory games, and group-based delivery. Sets are typically shorter and more intensive than in the standard eight-phase protocol.

2. Theoretical rationale: working-memory taxation

The dominant mechanistic account of EMDR is the working-memory (WM) theory (Andrade, Kavanagh & Baddeley, 1997; van den Hout & Engelhard, 2012). Holding a vivid autobiographical memory in mind requires limited-capacity WM resources, particularly the visuospatial sketchpad. When a competing task taxes the same resources, the reconsolidated memory returns to storage less vivid and less emotional.

A dose–response relationship has been demonstrated: the more taxing the secondary task, the greater the reduction in memory vividness and emotionality, up to the point where the client can no longer keep the memory in mind (van den Hout & Engelhard, 2012). EMDR 2.0 raises the load on that basis; lab evidence that heavier tasks add benefit is mixed (Mertens et al., 2019).

3. Evidence base to date

Study	Design	Outcome
Matthijssen et al. (2021), Eur. J. Psychotraumatol.	Randomized lab study, N = 62, non-clinical	EMDR 2.0 and standard EMDR reduced emotionality and vividness equally; no difference in session time; EMDR 2.0 needed fewer sets.
Matthijssen & Menses (2024), Front. Psychiatry	Single-patient case report	Intensive online PE plus EMDR 2.0 for severe, chronic PTSD; remission. Proof of concept only.
Mertens, Lund & Engelhard (2021), Acta Psychologica	Meta-analysis, 53 lab studies	Dual tasks reduce memory vividness and emotionality; heavier tasks not reliably better (Mertens et al., 2019).
ENHANCE trial (Alting van Geusau et al., 2023)	RCT protocol, 130 PTSD patients	EMDR vs EMDR 2.0 vs Flash; results pending.

4. Practical implications for clinicians

- **Screen carefully:** EMDR 2.0 amplifies distress before it de-escalates and is not appropriate for clients outside the Window of Tolerance or with active structural dissociation.
- **Titrate:** aim for visible effort without loss of the image (the WM 'sweet spot'). See the Dual-Task Menu for a graded load ladder.
- **Longer sessions:** plan 60–90 minutes to reach and consolidate high-load reprocessing.
- **Document load:** recording task and load per set enables consultation review and treatment fidelity.

5. Limitations

The only randomized comparison so far is a lab study in non-clinical adults. Clinical reports have no comparison group and combine EMDR 2.0 with other treatments; the first randomized trial in PTSD (ENHANCE) is under way. Adverse-event reporting is limited but no serious safety signals have been reported when screening and titration guidance are followed.

References

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

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