Advanced EMDR: Complex Trauma and Specialisms

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced EMDR: Complex Trauma and Specialisms

Complex presentations, protocols and populations

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

This manual accompanies the Advanced EMDR: Complex Trauma and Specialisms course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 5. This printing was set on 9 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

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How to use this manual

This advanced programme is designed for EMDR practitioners who have already achieved competence in the standard protocol and wish to extend their clinical scope to complex trauma presentations and specialised populations. Over ten CPD hours, participants will engage deeply with the theoretical and practical modifications required for complex and dissociative presentations, including phased, resource-focused approaches that prioritise safety and stabilisation before trauma processing. The curriculum addresses structural dissociation theory, ego-state mapping, and the nuanced application of resource development and installation (RDI) within the window of tolerance, ensuring that clinicians can titrate processing intensity while maintaining therapeutic alliance.

Specialist protocols are examined in detail: the recent traumatic events protocol for early intervention, specific phobia adaptations, chronic pain protocols integrating somatic awareness, and complicated grief frameworks that incorporate meaning reconstruction. Work with children and adolescents covers developmental adaptations, storytelling, and play-based bilateral stimulation, while modules on military and emergency-services populations explore moral injury, operational stress, and the impact of organisational culture. The course also considers delivery within multidisciplinary teams and stepped-care systems, referencing outcome monitoring tools such as the PHQ-9 and GAD-7, and the importance of intersectional formulation using frameworks like Social GGRRAAACCEEESSS.

Throughout, emphasis is placed on fidelity to the EMDR model, the role of consultation in maintaining protocol integrity, and strategies for clinician sustainability in the face of vicarious trauma and burnout. Participants will leave with a comprehensive toolkit for complex case formulation, enhanced decision-making regarding protocol selection, and a strengthened capacity for reflective practice aligned with current NICE guidance and EMDR Europe standards.

This manual is the written form of a course taught in the Talking Therapies

UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Adapt EMDR for complex PTSD, including extended stabilisation and titrated processing
- Use restricted processing protocols, including EMDr, deliberately
- Work with dissociative presentations safely, including screening and fractionation
- Apply EMDR to grief, phobia, pain and addiction presentations with protocol adaptations
- Handle abreaction confidently, keeping dual attention alive
- Integrate EMDR coherently within a broader therapy rather than as a bolt-on

PART 1

EMDR for Complex Trauma and Dissociation

Covers advanced EMDR techniques for complex trauma, dissociation, stabilization, and interweaving parts.

CHAPTER 1

EMDR with complex trauma

When a client presents with the sequelae of complex trauma, the therapist must move beyond the linear eight-phase protocol that underpins standard EMDR and adopt a phased, resource-oriented stance that safeguards the client's capacity to remain within a Window of Tolerance. The Adaptive Information Processing (AIP) model, first articulated by Francine Shapiro, maintains that traumatic memories are stored in a dysfunctionally encoded state and that bilateral stimulation can facilitate adaptive integration. Yet the AIP model also acknowledges that when the nervous system is chronically dysregulated, as is typical in complex trauma, the client may lack the internal scaffolding required to tolerate the arousal that accompanies reprocessing. Consequently, the first and most critical adaptation is an extended preparation phase that is not merely a brief rapport-building exercise but a comprehensive stabilisation period that can span several weeks or even months, depending on the severity of dissociation, affect dysregulation, and the presence of comorbid conditions such as borderline personality disorder or severe anxiety.

The extended preparation phase is anchored in the principles of trauma-informed care as outlined by Judith Herman and the attachment-focused interventions described by Diana Fosha in her work on the Intensive Short-Term Dynamic Psychotherapy (ISTDP) model. In practice, the therapist begins by conducting a thorough history that includes a detailed trauma timeline, an assessment of dissociative phenomena using the Dissociative Experiences Scale (DES), and an evaluation of affect regulation through the Difficulties in Emotion Regulation Scale (DERS). The therapist also administers standard symptom measures such as the PHQ-9 and GAD-7 to establish a baseline of distress and to monitor change across the course of treatment. The purpose of these assessments is twofold: to identify the client's current level of functioning and to pinpoint the specific resources that must be cultivated before any target memory can be safely processed.

Resource-focused EMDR becomes the central intervention within this extended preparation. Rather than treating resource work as an ancillary

activity, the therapist deliberately installs cognitive, somatic, and interpersonal resources that function as a “container” or “safe haven” for the client. Cognitive resources may involve the installation of adaptive beliefs such as “I am capable of protecting myself” or “I have the inner strength to weather distress,” using the standard EMDR three-card set (image, positive cognition, and feeling). Somatic resources draw on the work of Peter Levine and the concept of pendulation, whereby the client learns to oscillate between sensations of safety and sensations of discomfort, thereby training the autonomic nervous system to self-regulate. A common somatic resource might be a grounding technique that anchors the client in the present moment through breath awareness, tactile stimulation (e.g., feeling the texture of a stone), or the sensation of the feet on the floor. Interpersonal resources are cultivated by reinforcing the therapeutic alliance and, where appropriate, by encouraging the client to identify a trusted external support person who can be mentally summoned during moments of overwhelm.

The process of installing a resource follows the same eight-phase structure as any EMDR protocol, but the therapist remains in Phase 2 (Preparation) until the client can reliably access the resource without experiencing a surge of dysregulation. The therapist uses bilateral stimulation (typically eye movements, but also tactile taps or auditory tones) while the client focuses on the chosen resource, monitoring the Subjective Units of Distress (SUDs) and the Validity of Cognition (VoC) scales after each set. When the client reports a VoC of 7 or higher and a SUDs of 0, the resource is deemed sufficiently robust to serve as a protective anchor during later desensitisation work.

Pacing with complex trauma is a nuanced art that requires the therapist to constantly assess the client’s physiological and emotional signals. The practice of beginning with “most accessible” targets, a common adaptation for complex trauma, directs the therapist to begin processing with memories that are relatively low in affective charge or that are more readily retrieved. This strategy prevents the “flooding” effect, wherein an overwhelming surge of affect can precipitate dissociation, panic, or retraumatisation. The therapist therefore conducts a meticulous target identification exercise in Phase 3 (Assessment), selecting a hierarchy of memories that progresses from the least distressing to the most entrenched. Throughout this hierarchy, the therapist remains vigilant for signs of dysregulation – a sudden drop in heart rate, a change in breathing pattern, a shift towards a dissociative

trance, or the emergence of self-critical thoughts – and is prepared to pause, return to a resource, or terminate the set if the client's Window of Tolerance is breached.

The phased structure for complex trauma can be conceptualised as three interlocking stages: Stabilisation, Trauma Processing, and Integration. Stabilisation encompasses the extended preparation and resource-focused work described above. Trauma Processing corresponds to Phases 4 through 6 (Desensitisation, Installation, and Body Scan) of the standard EMDR protocol, but it is undertaken with a heightened sensitivity to the client's physiological state, often employing shorter bilateral stimulation sets and more frequent inter-set checks. Integration, which aligns with Phases 7 and 8 (Closure and Reevaluation), focuses on consolidating the gains made during processing, reinforcing the newly installed resources, and planning for future self-regulation outside the therapy room.

To illustrate how these principles coalesce in practice, consider the case of Elena, a 34-year-old woman referred for treatment after a decade of chronic childhood neglect, intermittent physical abuse, and the subsequent development of complex post-traumatic stress disorder (C-PTSD). Elena's initial assessment revealed a DES score of 45, well above the screening cut-off of 30 (Carlson et al., 1993), a DERS score of 94, reflecting severe difficulties in emotion regulation, a PHQ-9 score of 18 (moderately severe depression), a GAD-7 score of 16 (severe anxiety), and an interview that highlighted profound interpersonal avoidance. Elena reported frequent "blanking out" during stressful situations and described a pervasive sense of internal chaos that made it impossible for her to engage in daily activities.

During the first four weeks of therapy, the clinician devoted each session to stabilisation. In the initial intake, the therapist explained the AIP model, the rationale for EMDR, and the necessity of building a safe internal container before any trauma memory could be approached. Elena was taught diaphragmatic breathing, progressive muscle relaxation, and a tactile grounding exercise involving the sensation of a smooth stone held in her hand. The therapist then guided Elena through the installation of a cognitive resource: the positive cognition "I am safe now". Using bilateral eye movements, Elena focused on the image of a warm, golden light surrounding her body while repeating the cognition. After three sets, Elena's VoC rose from 2 to 6, and her SUDs dropped from 8 to 2. The therapist reinforced the

resource by having Elena imagine the golden light whenever she felt a surge of anxiety, and she practised this in-session and as homework.

With the resource firmly installed, the therapist moved to Phase 3 (Assessment) to identify Elena's most accessible target. Elena described a recent incident at work where a colleague inadvertently omitted her name from an email, provoking a brief feeling of embarrassment. Although the incident was minor, it triggered a cascade of shame and self-blame that Elena could articulate without becoming overwhelmed. The therapist selected this memory as the initial target, noting its relatively low SUDs rating (4) and its proximity to Elena's current life context, which would facilitate generalisation of therapeutic gains.

In Phase 4 (Desensitisation), Elena was instructed to hold the image of the omitted email, to notice the associated negative cognition "I am invisible," and to rate the SUDs. Bilateral stimulation was administered in sets of eight eye movements, with the therapist pausing after each set to query Elena's level of distress. When Elena's SUDs decreased to 2, the therapist prompted her to invoke the previously installed golden-light resource, encouraging her to visualise the light expanding around the distressing image. This brief inter-set resource activation served to re-anchor Elena within her Window of Tolerance, preventing the emergence of dissociation. After six sets, Elena reported a SUDs of 0 and a VoC of 7 for the positive cognition "I am seen and valued".

Phase 5 (Installation) involved strengthening the positive cognition through further bilateral stimulation while Elena focused on the image of the golden light and the belief "I am seen and valued". The therapist monitored the VoC until it reached a stable 8, confirming that the adaptive belief had been fully integrated. In Phase 6 (Body Scan), Elena was asked to close her eyes and scan her body for any residual tension. She noted a subtle tightness in her shoulders, which she released using the grounding technique of pressing the stone in her hand while taking a slow, deep breath. The therapist concluded the session with a thorough closure, reminding Elena of the resource container she now possessed and assigning a brief daily practice of visualising the golden light.

Over the ensuing weeks, the therapist continued to follow the phased structure, gradually moving to more emotionally charged memories, such as a specific episode of physical abuse at age nine. Each time, the therapist

began with a brief resource activation, employed shorter bilateral stimulation sets, and maintained vigilant monitoring of Elena's physiological markers. By the end of the twelve-session protocol, Elena's DES score had fallen to 22, her DERS to 58, her PHQ-9 to 9, and her GAD-7 to 7, indicating a substantial reduction in dissociation, emotional dysregulation, depression, and anxiety. Moreover, Elena reported a renewed capacity to engage in social situations, describing herself as "more present" and "able to ask for help when needed".

The case of Elena exemplifies how an extended preparation, resource-focused EMDR, careful pacing, and a phased structure coalesce to produce safe and effective outcomes for clients with complex trauma. The therapist's commitment to stabilisation before processing, the systematic installation of protective resources, and the deliberate selection of the most accessible targets collectively honour the client's neurobiological limits while facilitating the adaptive re-encoding of traumatic memories. This approach aligns with the growing empirical literature that underscores the importance of phase-based treatment for complex trauma, including the findings of van der Kolk (2014) on the neurobiological underpinnings of dissociation, the meta-analytic work of Bae and Lee (2022) demonstrating superior outcomes for phased EMDR protocols, and the clinical guidelines issued by the EMDR International Association (EMDRIA) in 2023, which advocate for a flexible, resource-oriented stance when working with dissociative presentations.

In summary, the advanced application of EMDR to complex trauma demands a departure from the conventional eight-phase sequence towards a more fluid, client-centred model that foregrounds extended preparation, resource development, and meticulous pacing. By embedding these adaptations within the AIP framework, therapists can honour the intricate interplay of memory, affect, and physiology that characterises complex trauma, thereby offering clients a pathway to genuine healing and integration.

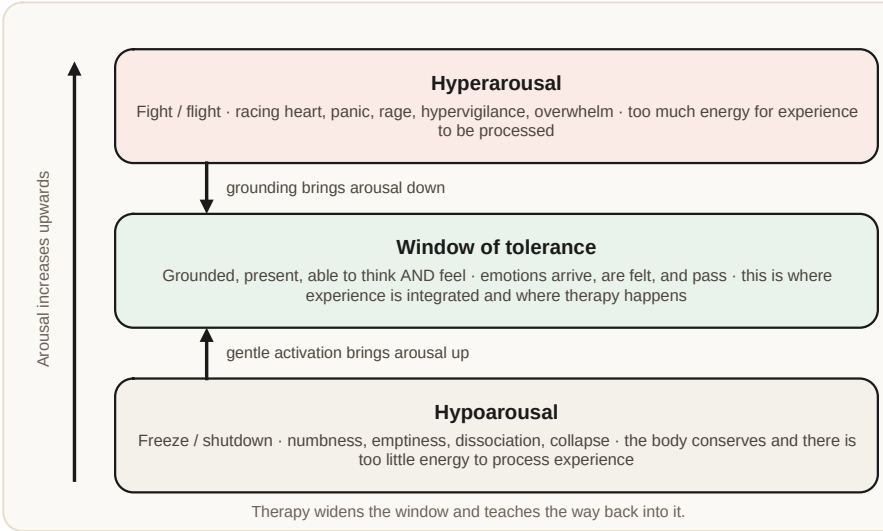


FIGURE 1.1 The window of tolerance

Siegel's window of tolerance describes the zone of arousal within which experience can be processed and integrated. Trauma narrows the window: survivors are thrown into hyperarousal (fight/flight) or hypoarousal (shutdown) by reminders. Therapy widens the window and teaches the return journey.

Points worth keeping

- Extended preparation
- Resource-focused EMDR
- Pacing with complex trauma
- A phased structure

PRACTICE TASK

Plan an extended preparation phase for a complex client.

CHAPTER 2

Dissociation and stability

Dissociation sits at the heart of the complex-trauma landscape, and for the advanced EMDR practitioner it is no longer a peripheral curiosity but a central organising principle. The shift from viewing dissociation as a hazard to be avoided to regarding it as a diagnostic and therapeutic map is underpinned by a robust evidence base that stretches from the early work of Pierre Janet to contemporary neurobiological models of compartmentalisation (van der Hart, Nijenhuis & Steele, 2006). In the context of Advanced EMDR: Complex Trauma and Specialisms, the lesson on Dissociation and Stability therefore demands a depth of understanding that integrates systematic screening, a stability-first stance, nuanced decisions about when and how to process, and a collaborative team approach that safeguards both client and therapist.

Screening for dissociation must be universal, formalised, and repeated throughout the therapeutic journey. The first line of enquiry is the Dissociative Experiences Scale (DES), which remains the most widely validated self-report instrument for identifying both trait and state dissociation (Bernstein & Putnam, 1986). A score above 30 on the DES signals the need for a structured follow-up interview, yet the DES alone cannot capture the lived phenomenology of dissociative parts, amnesic barriers, or the subtle switching that may emerge mid-session. Consequently, the clinician must complement the DES with a semi-structured clinical interview that explores the shape of the client's absences: episodes of lost time, unaccounted-for activities, internal voices, and the presence of distinct self-states that may carry names, ages, or sensory signatures. The interview should also map the temporal onset of dissociation, noting whether it began in early childhood, as is typical for Complex PTSD (C-PTSD) and Dissociative Identity Disorder (DID), or whether it is more situational, as seen in acute stress reactions.

The importance of repeated screening cannot be overstated. Dissociative symptoms can intensify under the load of EMDR desensitisation, which is why the protocol's preparation phase matters for dissociative clients (Shapiro, 2001). When this reflex is triggered, the client's attention may drift,

the eye-movement set may become empty, and the therapist may be left with an apparent “blank screen.” By administering the DES at intake, after the first three EMDR sets, and then at regular three-month intervals, the practitioner creates a longitudinal profile that can detect emergent dissociation before it destabilises the client.

Once the level of dissociation has been charted, the next imperative is to build stability before any memory processing begins. The stability-first model, articulated by van der Hart and colleagues (2006), rests on three pillars: grounding, affect regulation, and the development of a coherent internal narrative. Grounding techniques must be rehearsed until they compete with the client’s default “absence reflex.” Simple sensory anchors – feeling the weight of the therapist’s chair, listening to the hum of the air-conditioning, or noticing the texture of a held object – are taught in a paced, repetitive fashion. The therapist’s voice, delivered in a calm, rhythmic tone, becomes a retrieval instrument that can be called upon when the client’s attention begins to fragment.

Psychoeducation is a critical component of stability work. Clients often experience shame about their dissociative experiences, believing that they have “failed” to stay present. By reframing dissociation as a survival intelligence – a neurobiological adaptation that compartmentalises overwhelming affect – the therapist normalises the phenomenon and reduces self-stigma. This reframing aligns with trauma-informed care, which emphasises recognising the adaptive function of trauma responses (Herman, 1992). In practice, the therapist explains that the brain’s default mode network can “switch off” when threat exceeds capacity, and that the therapeutic goal is not to eradicate this switch but to negotiate its timing.

Internal communication within the client’s system is facilitated through parts-language when appropriate. For clients who describe distinct self-states, the therapist may invite the “adult part” to speak to the “young part” that holds the traumatic memory, establishing a co-consciousness that mirrors the “dual attention” principle of EMDR. The therapist negotiates agreements with each part, ensuring that the adult self consents to any memory work and that the younger part is aware of the safety structures in place. This negotiation respects the “earned pace” rule – no material is processed unless the client, or a part of the client, explicitly authorises it. When a part refuses, the therapist pauses, returns to grounding, and revisits

the agreement in a subsequent session.

Daily-life stability is audited with the same rigour as in-session stability. The therapist asks the client to keep a brief diary noting moments of dissociative switching, the duration of lost time, and any functional impairments such as missed appointments or relationship conflicts. The diary serves both as a monitoring tool and as a source of data for the therapist to adjust the treatment plan. If the client reports more than two episodes of significant switching per week, or if the switching results in occupational or relational loss, the therapist must re-evaluate the readiness for memory processing.

Adapting or delaying processing is the next decision point, guided by the formulation derived from the screening and stability work. For milder dissociation, for example occasional depersonalisation with a DES score below the screening cut-off of 30 (Carlson et al., 1993) and no clear structural division, the standard EMDR protocol can be employed with the complex-trauma toolkit. This includes fractionating the target into smaller “chunks,” using distance protocols, and inserting scheduled grounding pauses every three to four sets. The therapist also activates a “dissociation watch,” a mental checklist that prompts immediate grounding if the client’s eyes become empty or if the client reports feeling “spaced out.”

When the client presents with significant structural dissociation – such as the presence of two or more distinct parts that hold separate autobiographical memories, or a DES score above 45 – the therapist must adapt the protocol. The target is negotiated not only with the client but with the relevant part(s). The adult self remains the anchor throughout the session, while the part that holds the traumatic memory is invited into a co-conscious state. Processing is fractionated by part, meaning that each memory is approached only after the therapist has secured the adult part’s presence and the part’s consent. Sessions are often shorter (45-60 minutes) to reduce the risk of overwhelm, and the closure phase is extended to ensure that the client returns fully to the present before leaving the therapy room.

In some cases, the safest course is to delay processing altogether. Delay is not a passive abandonment but a strategic postponement based on explicit criteria: (1) the client lacks reliable grounding skills; (2) the client’s diary indicates frequent switching that interferes with daily functioning; (3) a part refuses consent; or (4) the therapist observes physiological signs of destabilisation (e.g., rapid heart rate, tremor, or hyperventilation) that cannot

be mitigated within the session. The therapist documents the decision, outlines the stability-building interventions that will be pursued, and sets a review date – typically four to six weeks – at which the readiness for processing will be reassessed.

Working within a team is an essential competence for advanced practitioners dealing with dissociative presentations. The team may include a senior EMDR supervisor with expertise in dissociation, a psychiatrist familiar with pharmacological adjuncts for severe dissociation, a case manager, and, where appropriate, a crisis-intervention service. Regular supervision – ideally weekly – provides a space to discuss subtle signs of fragmentation that may be missed in the moment. The therapist must also ensure that any risk of self-harm or harm to others is communicated promptly to the wider circle, with the client's consent, in accordance with the duty of care and the Mental Health Act provisions.

Boundaries around contact, session length, and between-session material are negotiated at the outset and upheld consistently. For dissociative clients, the therapeutic frame functions as a "containment container" that mirrors the safety the client's internal system craves. The therapist's own regulation is equally important; counter-transference in the context of dissociation often manifests as feelings of emptiness, frustration, or a compulsion to "fix" the client's absent parts. These feelings should be brought to supervision and, where appropriate, to the multidisciplinary team, ensuring that the therapist's wellbeing does not become a hidden source of destabilisation for the client.

A concrete worked example illustrates the integration of these principles. Sarah, a 34-year-old woman, presented with a DES score of 48, reporting frequent episodes of "blanking out" that lasted from a few seconds to several minutes, often occurring during work meetings. Her history revealed chronic emotional neglect and intermittent physical abuse in childhood, with the first dissociative episode occurring at age eight. The initial assessment involved the DES, the Structured Clinical Interview for DSM-5 (SCID-5), and a detailed clinical interview that uncovered two distinct parts: an "Adult Sarah" who managed daily life, and a "Little Girl Sarah" who held the memory of the abuse and expressed herself through a soft, child-like voice that would occasionally interject with the phrase "no, don't talk about that."

Stability work began with daily grounding exercises – Sarah was instructed

to keep a small stone in her pocket and to notice its texture whenever she felt the urge to drift. She also practised a three-minute breathing anchor, counting each inhalation and exhalation while visualising the colour blue. Over four weeks, Sarah's diary showed a reduction in switching episodes from an average of three per day to one per week, and her DES score fell to 38.

With stability established, the therapist negotiated a target with the Adult part: a memory of a school bullying incident that was less emotionally charged than the abuse memory but still linked to the part's sense of shame. The therapist used the standard EMDR protocol, inserting a grounding pause after every two sets. During the third set, Sarah's eyes became empty, and she reported a sensation of "floating." The therapist immediately activated the dissociation watch, guided Sarah through the breathing anchor, and held the retrieval set for ninety seconds. Presence returned, and the session continued with a brief closure ritual that involved Sarah naming the feeling of safety she felt after the grounding exercise.

Two weeks later, the Adult part consented to a brief exposure to the abuse memory, but only after the therapist had secured a written agreement that the Little Girl part could call a "stop" at any moment. The therapist employed a part-specific protocol, processing the memory while the Adult part remained anchored in the present. The session lasted fifty minutes, with three grounding pauses. Mid-session, the Little Girl part uttered "no," and the therapist honoured the stop, returning to a full grounding routine and scheduling a follow-up session to revisit the memory when the client felt more secure.

Throughout this process, Sarah's case was discussed weekly in a multidisciplinary team meeting that included her psychiatrist, a senior EMDR supervisor, and a crisis-intervention nurse. The team reviewed Sarah's diary, monitored her PHQ-9 and GAD-7 scores, and ensured that any escalation in self-harm risk was promptly addressed. The collaborative approach allowed the therapist to maintain a clear boundary, to receive timely feedback on counter-transference, and to keep the treatment plan aligned with Sarah's evolving stability profile.

The lesson concludes with two humility rules that anchor the practitioner's stance. First, the screen for dissociation is never a one-off event; it is repeated at regular intervals because the client's internal system reveals

itself in layers, much like sedimentary strata in an archaeological dig. Second, the referral threshold – defined by specific criteria such as frequent switching, amnesic barriers, or parts refusing all contact – should be written down in advance, serving as a safeguard against the therapist's desire to "push through" when the client's safety is at risk. By adhering to these principles, the advanced EMDR practitioner transforms dissociation from a disruptive obstacle into a map of the client's internal architecture, guiding the therapeutic journey with precision, compassion, and evidence-based rigour.

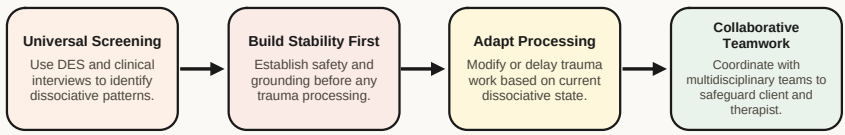


FIGURE 2.1 Managing Dissociation in Complex Trauma
This sequence outlines the essential clinical pathway for advanced EMDR practitioners. It moves from initial assessment to collaborative care, prioritising safety before trauma work.

Points worth keeping

- Screening for dissociation
- Building stability first
- Adapting or delaying processing
- Working within a team

PRACTICE TASK

Describe how screening changes your treatment plan.