Advanced Trauma Work and EMDR Awareness

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced Trauma Work and EMDR Awareness

Dissociation, moral injury, EMDR's mechanics at depth, and the practitioner's own nervous system.

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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

Copyright © 2026 Talking Therapies UK. All rights reserved.

The moral right of the author has been asserted. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the publisher, except for brief quotations in a review, and except that a purchaser of the accompanying course may print a single copy for their own study.

First edition, 2026.

This manual accompanies the Advanced Trauma Work and EMDR Awareness 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.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

Contents

How to use this manual 1

Part 1 Advanced EMDR for Dissociation and Moral Injury 3

1. Dissociation and parts-informed work 4
2. Moral injury and traumatic grief 10

How to use this manual

At the far end of trauma work wait the presentations that test everything: dissociative structures formed in childhood, moral injury that no exposure protocol touches, grief tangled through traumatic imagery, and the slow cost the work exacts from the clinician's own nervous system. This course meets them directly, for experienced trauma practitioners.

The first module works with the hard presentations: dissociation understood structurally rather than as an obstacle, parts-informed approaches used with clinical discipline, and moral injury and traumatic grief, where the wound is to meaning and mourning rather than to safety, and treatment must change shape accordingly. The second module examines EMDR at depth, its eight phases, its mechanism debates, what the dismantling studies actually show, so you can engage with it as an informed clinician, and closes with vicarious trauma: the realistic maintenance of the practitioner as instrument, beyond the usual self-care platitudes.

Extended written lessons with key points and supervision-level practice tasks, with a study tutor available for what this material raises. Fourteen hours of CPD, around a year of access, a final assessment, and a personalised certificate on passing.

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

- Formulate complex PTSD and developmental trauma, distinguishing them from adjacent presentations
- Sequence long-haul treatment across phases with shifting priorities and setbacks
- Describe EMDR's eight phases and adaptive information processing model, and what treatment involves, at awareness level
- Work with shame, self-attack and perpetrator introjects in relational trauma
- Manage vicarious traumatisation and your own limits as a matter of professional discipline
- Critically compare the evidenced trauma therapies and reason about matching client to approach

PART 1

Advanced EMDR for Dissociation and Moral Injury

This module covers adapting EMDR protocols for dissociative parts, moral injury, and trauma-related psychosis within a phase-oriented framework.

CHAPTER 1

Dissociation and parts-informed work

Structural dissociation theory, as articulated by van der Hart, Nijenhuis and Steele, provides a comprehensive map of how overwhelming, repeated threat—particularly in childhood—splits the personality into distinct functional parts. Under conditions of chronic danger the self that must attend school, maintain relationships and carry on daily responsibilities becomes separated from the parts that bear the unbearable affect and sensory impressions of the trauma. This division solidifies into a structural organisation that can be described along a spectrum. At the simplest end, primary structural dissociation consists of one apparently normal part that manages everyday life and a single emotional part that holds the trauma. This dyad underlies classic post-traumatic stress disorder, where intrusive memories represent eruptions of the trauma-bearing part into the conscious field of the normal part. Secondary structural dissociation involves a daily-life self that co-exists with multiple trauma-holding parts, each frozen at a particular developmental stage or defensive posture—fight, flight, freeze, submit, attach. This configuration maps onto complex PTSD and many borderline personality presentations, where the client may shift abruptly between a competent adult and a child-like exile. Tertiary structural dissociation, the most elaborate form, comprises multiple parts that organise daily life itself, a pattern that aligns with dissociative identity disorder. The lesson's focus rests on the first two levels, where the therapist must navigate a system of daily-life parts and trauma-carrying parts, recognising that each part has a purpose and a logic that must be respected before any memory work is attempted.

The first clinical imperative is to screen routinely for dissociation because it often hides in plain sight. Instruments such as the Dissociative Experiences Scale – II (DES-II) provide a quantitative index, yet the therapist must also attend to behavioural markers: unexplained time loss, gaps in autobiographical narrative, sudden skill fluctuations, inexplicable purchases or injuries, and reports of conversations that the client cannot recall. In session, the therapist may notice radical discontinuity from one meeting to the next, or a client who appears fully functional one week and markedly

impaired the next. Such observations echo the principle that unnoticed dissociation quietly voids processing; the therapist's prior rule that "if dissociation is not addressed, the work is ineffective" remains paramount. When these signs are identified, the therapist should adopt a stance of curiosity rather than alarm, inviting the client to explore the hidden parts with a tone of respect.

Working with the system's logic rather than against it is the second cornerstone. Every part, even those that seem overtly hostile or self-sabotaging, serves a protective function. The persecutory voice that repeats the abuser's words, for instance, can be understood as a protector that kept the child compliant and therefore alive in the presence of a threatening caregiver. In the language of Internal Family Systems (IFS), this would be a manager; in ego-state therapy it would be a defensive ego-state. The therapist's task is to engage the part on its own terms, acknowledging its contribution, rather than attempting to exorcise it. This approach aligns with the evidence base that shows coercive attempts to suppress parts often lead to iatrogenic reinforcement of the very fragmentation the therapist seeks to resolve (Schwartz, 2020). By validating each part's role, the therapist creates a collaborative atmosphere in which the system is more willing to negotiate the terms of further work.

The third principle, perhaps the most critical for safety, is that inner communication must be established before any memory-focused intervention. The adult part that consents to a session on Tuesday is not the frozen child part that holds the traumatic memory; premature exposure of the child part can precipitate decompensation, a phenomenon documented in both EMDR and parts-informed protocols (Shapiro, 2018). Stabilisation, therefore, involves cultivating a dialogue between parts, often through techniques such as internal meetings, journalling dialogues, or guided imagery that invites the daily-life part to ask the trauma-bearing part what it needs in the present moment. The therapist may act as a mediator, facilitating a negotiation in which the trauma-bearing part grants permission for limited, titrated exposure, while the daily-life part ensures that grounding resources are in place. Only once a consensual, cooperative internal contract is forged does the therapist move to the middle phase of processing, where the actual memory work—whether through EMDR bilateral stimulation, narrative exposure, or imaginal re-experiencing—can be undertaken safely.

The language of parts, whether drawn from IFS (managers, firefighters, exiles), ego-state therapy (protectors, executors, children), or the structural dissociation model itself (ANPs – apparently normal parts, EPs – emotional parts), provides a shared grammar that prevents miscommunication. The advanced clinician must wield this grammar with precision: avoiding dramatisation that risks re-elaborating the parts into a theatrical performance, and avoiding flattening that reduces genuine discontinuities to mere mood states. Integration, in this context, does not imply erasure of parts; rather, it denotes co-operation and co-consciousness, a single life that is jointly run by all functional self-states. The therapeutic aim is to achieve a harmonious internal system where each part can express its needs, be heard by the others, and contribute to the client's overall wellbeing.

A concrete worked example illustrates how these principles translate into practice. Maya, a 34-year-old woman, presented to a specialist trauma service after multiple unsuccessful attempts at standard EMEMDR protocols. Her history included chronic childhood emotional and physical abuse, a diagnosis of complex PTSD, and a DES-II score of 28, indicating frequent dissociative episodes. In the initial assessment, Maya reported that she often "lost time" during the day, that she would find herself in a grocery store with no recollection of how she arrived, and that her therapist's notes sometimes described her as "calm and engaged" while her own diary recorded a feeling of "being elsewhere." These signs prompted the therapist to adopt a parts-informed stance.

The first phase involved systematic screening and mapping. Using the DES-II as a quantitative anchor, the therapist invited Maya to identify the parts that seemed to dominate her experience. Maya described a "professional Maya" who was competent at work, a "little girl Maya" who felt scared and clung to a stuffed rabbit, and a "critical voice" that constantly reminded her of past failures. The therapist labelled the professional self as the apparently normal part (ANP) and the little girl as an emotional part (EP) holding the trauma. The critical voice was identified as a manager, a protector that attempted to keep Maya motivated by harsh self-criticism.

Stabilisation proceeded through a series of internal meetings. In a quiet session, the therapist guided Maya's ANP to ask the little girl what she needed in the present. The little girl responded, "I am scared. I need to feel safe before I can talk." The ANP, with the therapist's support, offered a

grounding anchor—a tactile object, a breathing rhythm, and a promise to stay present. The manager, hearing this exchange, softened its tone, acknowledging that its harshness was intended to keep Maya “on track” but that it could be moderated now that safety was being negotiated. Over the course of three weeks, Maya practised these internal dialogues in a journal, noting each part’s response and the degree of cooperation achieved. The therapist periodically assessed dissociation using the DES-II, noting a gradual decline to 15, and used the PHQ-9 and GAD-7 to monitor mood and anxiety, which also showed modest improvement.

Only after the internal contract was solidified did the therapist introduce EMDR processing. The bilateral stimulation protocol was initiated with the consent of the ANP and the little girl EP. The therapist paced the exposure, beginning with a low-intensity memory fragment—a sound of a slammed door—while continuously checking in with the ANP. The little girl’s affect was monitored through facial expression and heart-rate variability, ensuring that the activation remained within her tolerance window. After several sessions, the traumatic memory of a specific abuse incident was re-experienced, but the presence of the manager’s softened voice provided a sense of containment that prevented overwhelm. By the end of the eighth EMDR session, Maya reported a reduction in the vividness of the memory, a lower score on the Impact of Event Scale-Revised, and a renewed capacity to engage in daily life without sudden dissociative lapses.

Maya’s case exemplifies the central tenets of the lesson. Structural dissociation was mapped, daily-life parts and trauma-carrying parts were identified, routine screening highlighted the hidden fragmentation, the therapist worked within the system’s logic by respecting the manager’s protective role, and inner communication was established before any memory work was undertaken. The outcome demonstrates that, when the internal system is negotiated and stabilised, EMDR-type processing can be delivered safely and effectively, even for clients who have previously failed standard protocols.

In sum, the advanced clinician must approach dissociation with a three-fold strategy: routine screening to uncover the often-invisible splits, a respectful engagement with the system’s internal logic, and a deliberate sequencing that prioritises inner communication before memory exposure. By holding the client’s internal parts as learned, patterned self-states with specific jobs,

the therapist cultivates a therapeutic environment where integration is achieved through cooperation rather than forced amalgamation. This approach aligns with the growing evidence base that parts-informed work, when combined with EMDR protocols, yields superior outcomes for complex trauma presentations, reducing the risk of decompensation and fostering lasting resilience. The lesson's depth lies not only in theoretical exposition but in the practical, step-by-step methodology that enables clinicians to translate these concepts into safe, effective practice for the most challenging trauma cases.

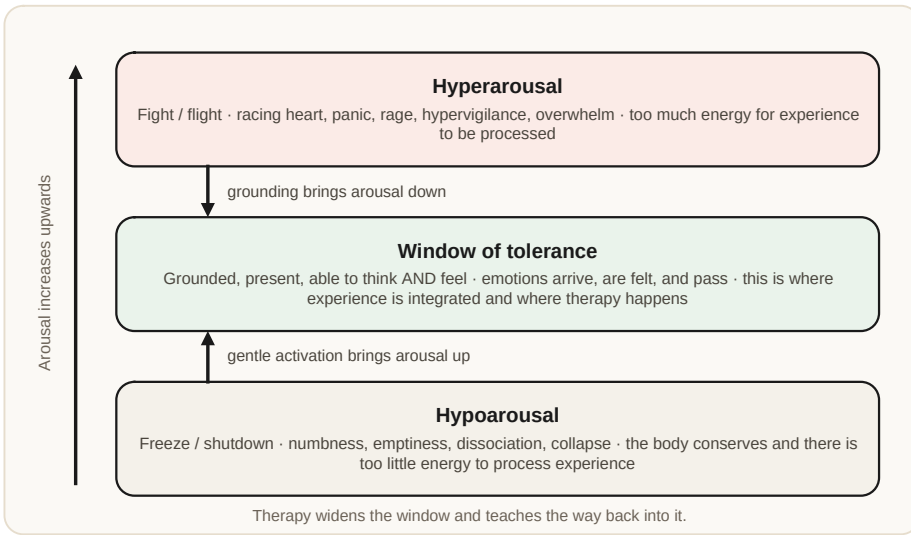


FIGURE 1.1 The window of tolerance

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

- Structural dissociation: daily-life parts and trauma-carrying parts
- Screen routinely; work with the system's logic
- Inner communication precedes memory work

PRACTICE TASK

Write the sentence you would use to introduce parts language to a sceptical client who describes "not being myself sometimes".

CHAPTER 2

Moral injury and traumatic grief

Moral injury and traumatic grief occupy a distinct niche within the broader landscape of trauma work, demanding a therapeutic stance that is both ethically attuned and technically sophisticated. In contrast to the classic fear-based trauma model, which is dominated by the threat-to-life circuitry of the amygdala and the subsequent need for extinction-type interventions, moral injury is rooted in the violation of deeply held moral schemas. The affective core of moral injury is not terror but a constellation of guilt, shame and a profound loss of meaning. This distinction is essential for the advanced practitioner, because the standard exposure-based protocols that aim to extinguish a conditioned fear response are ill-suited to a wound that is fundamentally about responsibility and value disruption.

The term moral injury was first articulated by Jonathan Shay in the context of combat veterans, and later refined by B. Litz and colleagues who identified four principal domains: transgression of personal morals, betrayal by authority, moral conflict, and loss of meaning. The Litz model emphasises that moral injury arises when an individual perceives that they have acted in a way that contravenes their own ethical code, or when they have witnessed others acting in ways that betray that code. The resulting moral emotions are not simply unpleasant; they are self-directed, often leading to a sense of being fundamentally flawed. In the clinical formulation, the therapist must distinguish between true responsibility – the portion of the event that the client can be held accountable for – and false responsibility, which is the product of hindsight bias, unrealistic standards, or the diffusion of responsibility across a system.

The therapeutic work therefore begins with a forensic-honesty stance. The practitioner adopts the role of a non-judgemental witness who holds space for the client's narrative without attempting to re-frame or minimise the moral content. This stance is echoed in the Adaptive Disclosure protocol developed by Litz and colleagues, which integrates a structured, time-limited approach to moral injury. The protocol begins with a safety and stabilisation phase, proceeds to a disclosure phase in which the client recounts the morally injurious event in vivid detail, and then moves to a reparative phase

that explores avenues for restitution, forgiveness and meaning reconstruction. Within the EMDR framework, the same principles apply: the therapist must ensure that the target memory is identified not merely as a fear memory but as a moral memory, and that the associated self-referent belief (e.g., “I am a monster”) is targeted alongside the image, affect and bodily sensations.

When employing EMDR for moral injury, the practitioner should first assess the client’s current level of distress using standard measures such as the PHQ-9 for depressive symptomatology and the GAD-7 for anxiety, while also employing the Moral Injury Symptom Scale (MISS) to capture guilt, shame and spiritual distress. The eight-phase EMDR protocol is then adapted to accommodate the moral content. In Phase 3 (assessment) the therapist elicits the most vivid image of the morally injurious act, the negative cognition (e.g., “I am a killer”), the associated positive cognition (e.g., “I am capable of repair”), the emotions (guilt, shame) and the bodily sensations (tightness in the chest). In Phase 4 (desensitisation) bilateral stimulation is used while the client holds the image and the negative cognition, but the therapist must be vigilant that the client does not become overwhelmed by self-punitiveness. If the client’s affect escalates beyond a manageable threshold, the therapist may pause the set and employ grounding techniques, thereby respecting the client’s need for safety.

The re-evaluation phase (Phase 5) is crucial for moral injury because it provides the opportunity to examine whether the client’s sense of responsibility has been refined. The therapist may ask, “Given what you now know about the context, how much of this responsibility do you truly own?” This question facilitates the sorting of real from false responsibility. When the client recognises that a portion of the guilt is attributable to systemic factors or to the impossibility of the situation, the negative cognition can be replaced with a more nuanced belief, such as “I acted within the limits of what I could control”. The subsequent installation phase (Phase 6) then strengthens this adaptive belief, and the body scan (Phase 7) ensures that any residual somatic residue is addressed.

Repair and restitution are integral to the moral injury healing journey. The therapist may guide the client in identifying concrete actions that can serve as amends, whether through community service, restitution to victims, or public testimony. For many clients, especially those with a religious or

spiritual orientation, the involvement of clergy or a trusted community leader can facilitate the reconstruction of meaning. The therapist's role is to support the client in accessing these resources, not to prescribe a particular spiritual pathway. The ultimate aim is to restore a sense of moral coherence, allowing the client to re-engage with their values without the paralysing weight of shame.

Traumatic grief, by contrast, intertwines the horror of a violent or premature loss with the natural mourning process. The literature on traumatic grief, notably the work of Prigerson and Maciejewski, highlights that the grief response becomes pathological when the bereavement is accompanied by a traumatic memory that remains unprocessed. The client's internal narrative is split: on the one hand, there is the ordinary yearning for the deceased; on the other, there is an intrusive, horror-laden recollection of the death scene that blocks access to the former. This split is often described as a "membrane" that prevents the integration of loss into the autobiographical memory.

The clinical presentation of traumatic grief includes persistent yearning, difficulty accepting the death, and a pervasive sense of emptiness, but it is distinguished by the presence of vivid, distressing imagery of the death event, hypervigilance to reminders of the loss, and avoidance of any cues that might trigger the traumatic memory. Standard grief interventions that focus solely on meaning-making or continuing bonds are insufficient because the client cannot reach the deeper layers of mourning while the horror remains locked behind the membrane.

The therapeutic sequence, therefore, mirrors that of moral injury in its emphasis on processing the traumatic component before addressing the grief work. In the EMEMDR approach, the practitioner first identifies the most distressing image of the death (for example, the moment of a car crash, the sight of a loved one's body, or the sound of a weapon discharge). This image is targeted in Phase 3 of EMDR, with the negative cognition often being "I am powerless" or "I could have saved them". The therapist then proceeds through the desensitisation and installation phases, allowing the client to experience the affect associated with the horror and to re-evaluate the belief in light of new information (e.g., "I did everything I could at the time").

Once the traumatic memory has been sufficiently processed – indicated by a reduction in the Subjective Units of Distress (SUD) to a level of 2 or lower

and a shift in the Validity of Cognition (VOC) to a positive range – the therapist can transition to grief-focused interventions. This may involve narrative work that helps the client recount the life of the deceased, the development of a continuing bond, and the undertaking of mourning tasks such as rituals, memorialisation and the expression of unsaid words. The dual-process model of coping with bereavement, articulated by Stroebe and Schut, can be employed to balance loss-oriented and restoration-oriented activities, ensuring that the client does not become re-traumatised by prematurely confronting the loss without the protective buffer of processed horror.

A concrete worked example illustrates the integration of these principles. Consider a 34-year-old former Royal Air Force pilot, James, who was involved in a drone strike that unintentionally killed a civilian family. James reports persistent guilt, shame and a sense that he has betrayed his own moral code. He also experiences intrusive images of the family's house exploding, accompanied by a profound yearning for his own brother, who died in a separate accident three years earlier. In the initial assessment, the therapist administers the PHQ-9, GAD-7, MISS and the Inventory of Complicated Grief (ICG). James scores high on guilt and shame subscales of the MISS and shows elevated ICG scores, indicating both moral injury and traumatic grief.

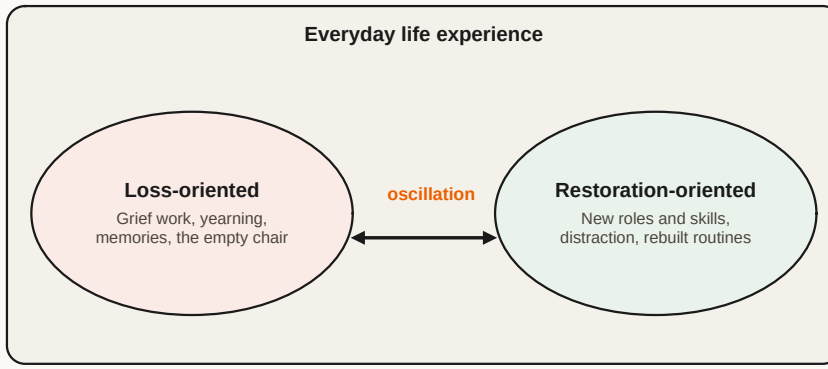
During Phase 3 of EMDR, James selects the image of the burning house as the target, with the negative cognition "I am a murderer" and the positive cognition "I can make amends". The therapist notes a SUD of 9 and a VOC of 15%. Bilateral stimulation is initiated, and after several sets James reports a shift to a SUD of 5, describing a feeling of "overwhelming responsibility". The therapist pauses the set to explore the factual context of the strike, acknowledging that James was operating under orders and that the intelligence was later shown to be flawed. In the re-evaluation phase, the therapist asks James to consider the extent of his personal control, leading to the emergence of a more balanced cognition: "I acted within the limits of the information I had". This new cognition is installed with a VOC of 80%.

Having reduced the moral injury component, the therapist then turns to the traumatic grief associated with James's brother's death. The most distressing image is the moment James found his brother's body in the hospital corridor. The negative cognition is "I could have saved him".

Through EMDR processing, James's SUD drops from 8 to 2, and he reports a sense of acceptance that the accident was beyond his control. With the horror now desensitised, the therapist introduces grief work, encouraging James to write a letter to his brother, to create a memorial garden, and to engage in a ritual with his family. Over subsequent sessions, James reports a renewed ability to feel love for his brother without being overwhelmed by the image of the accident, and his ICG scores decline to the non-clinical range.

The case of James demonstrates the necessity of sequencing: the moral injury was addressed first, allowing the client to re-evaluate responsibility, and the traumatic grief was subsequently processed once the horror memory had been thinned. This sequencing prevents the client from becoming stuck in a perpetual loop of self-punishment or from remaining immobilised by an unprocessed trauma that blocks mourning.

In summary, the advanced practitioner must cultivate a therapeutic stance that tolerates the full weight of moral and traumatic content without rushing to comfort or re-frame. The practitioner's role is to bear witness, to facilitate forensic sorting of responsibility, to guide the client through EMDR-based processing of guilt, shame and horror, and to support the reconstruction of meaning, repair and mourning. By integrating evidence-based protocols such as Adaptive Disclosure, the Litz moral injury model and the dual-process grief framework, the clinician can navigate the complex terrain where moral injury and traumatic grief intersect, ultimately restoring the client's capacity for ethical coherence and compassionate bereavement.



After Stroebe and Schut.

FIGURE 2.1 The dual process model of grief

Stroebe and Schut's model replaces fixed stages with oscillation: healthy grieving moves between loss-oriented moments (yearning, remembering, feeling the absence) and restoration-oriented ones (new roles, practical demands, respite from grief). Both are the work; the movement between them is the mechanism.

Points worth keeping

- Moral injury runs on guilt, shame and meaning, not fear
- Sort real from false responsibility; repair where real
- In traumatic grief, process the horror so mourning can begin

PRACTICE TASK

Draft one question that opens moral-injury material without absolving or judging ("what does that event say you did, in your own court?").