THE DRC-SENSITIVE INTAKE

Early Identification of Trauma-Related Dissociation & Pacing Support

A clinical decision-support tool for therapists

Dissociation-Responsive Care™ (DRC)

This tool supports trauma-informed, consent-based care by helping clinicians recognize dissociative adaptations early in treatment.

It is intended to complement—not replace—clinical judgment, supervision, and collaborative care.

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Developer of DRC Framework

This tool is part of the Dissociation-Responsive Care™ (DRC) framework and Clinician Guide.

Dissociation Responsive Care ™ (DRC)-Sensitive Intake (Printable Tool)

Early Identification of Trauma-Related Dissociation & Pacing Support

Purpose
This tool supplements standard intake and assessment processes by helping clinicians identify dissociative adaptations early enough to inform pacing, tool selection, and harm prevention.

This is *not a diagnostic instrument.* It is a clinical decision-support tool.

DRC-Sensitive Intake

Instructions for Clinicians:
Ask questions neutrally and without urgency. Normalize all responses as adaptive. Patterns across responses matter more than any single item. Keep in mind that being collaborative with the client throughout the therapy process remains key.

This tool is designed to be used flexibly within intake or early sessions. It may be revisited over time as insight, safety, and stability develop.

Clinical Note:
Many clients with trauma-related dissociation experience cycles of denial, disbelief, or self-doubt regarding their symptoms, trauma, or need for care. These shifts are often state-dependent and protective, not signs of malingering, resistance, or treatment failure. This tool includes prompts to help recognize and pace care around these fluctuations.

Core Screening Domains

☐ Loss of Time or Continuity
Client reports losing time, missing parts of conversations, or not remembering how tasks were completed.

☐ Internal Conflict or Pulling
Client describes feeling pulled in different directions internally or experiencing contradictory internal wants or needs.

☐ Fluctuating belief or denial about symptoms, trauma, or need for treatment
Client reports cycling between recognizing distress or trauma and later questioning it, minimizing it, or believing they "made it up," "don't belong in therapy," or are "overreacting."

Examples clients might describe:

- Feeling clear about needing help, then later believing they shouldn't be in therapy
- Questioning whether memories or symptoms are "real" or "count as trauma"
- Feeling embarrassed, fraudulent, or dramatic after disclosure
- Wanting to stop treatment because things "aren't that bad" shortly after opening up

Clinical note: These shifts often increase after progress, validation, or deeper exploration.

☐ **Disconnection or Unreality**
Client reports feeling unreal, foggy, numb, far away, or disconnected from their body or their surroundings.

☐ **Negative Reactions to Grounding or Mindfulness**
Client reports that breathwork, body focus, or mindfulness increases distress, panic, or dissociation. Standard grounding techniques are unhelpful or create more dysregulation / disconnection.

☐ **Shutdown Under Stress**
Client reports freezing, collapsing, or becoming quiet and numb rather than activated or panicked when overwhelmed.

☐ **State-Dependent Functioning**
Client notices different "sides," "modes," or ways of being that appear in different situations.

When One or More Items Are Endorsed

(Clinical stance and pacing guidance)

When one or more items are endorsed, consider the following shifts in clinical approach. These are not rules, but *guardrails* to support safety, pacing, and consent.

Clinical note:
Reports of hallucinations, internal voices, paranoia, or a prior psychotic-spectrum diagnosis do not automatically indicate active psychosis.

In trauma-related dissociation, perceptual experiences may reflect memory-based, state-dependent, or trauma-linked phenomena (e.g., flashbacks, internally perceived voices, or dissociated self-states), even when they resemble psychotic symptoms on the surface.

Careful pacing, context, and longitudinal observation are essential before assuming etiology. When in doubt, prioritize safety, stabilization, and collaborative assessment rather than immediate diagnostic conclusions.

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1. Assume dissociation is a primary organizing strategy

Rather than viewing dissociation as a symptom to eliminate, approach it as a functional adaptation that has helped the client survive or cope.

Clinician stance:

"Something about this way of responding has made sense for you at some point."

In practice:

- Hold curiosity rather than urgency
- Expect fluctuation rather than linear progress
- Anticipate that insight alone may not produce change

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2. Expect and Plan for Cycles of Doubt or Denial

Clients with dissociative adaptations may move in and out of belief about their own experiences, needs, or legitimacy in treatment. These shifts are often protective and state-dependent.

Clinical stance:

- Treat doubt as *information*, not contradiction
- Avoid pushing for narrative consistency
- Hold continuity even when the client cannot

In practice:

- Anticipate urges to cancel, withdraw, or "start over" after meaningful sessions
- Re-anchor to present-moment functioning rather than debating facts
- Avoid framing insight or acknowledgment as permanent achievements

Helpful clinician language:

- *"It's very common for clarity to come and go. We don't need you to feel sure all the time for this work to be valid."*

- *"Even if a part of you questions this later, we can just notice that shift rather than decide what it means."*

3. Avoid unmodified mindfulness or internal focus

If dissociation is active, traditional mindfulness or body-focused techniques may increase detachment or overwhelm when used without modification.

What to avoid initially:

- Prolonged eyes-closed exercises
- Breath-focused attention without external anchors
- Invitations to "go inside" without established safety

How to explain this to clients:

"Some grounding tools that help other people don't always work the same way when dissociation is present. We can figure out together what feels stabilizing for you."

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4. Begin with external orientation

Start with the external environment before shifting toward internal awareness.

Examples:

- Naming five things in the room that feel neutral or familiar
- Orienting to time, date, and location
- Brief movement with eyes open (stretching, standing, walking)

Clinician language:

"Let's help your system know where you are right now before we focus inward."

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5. Practice slower pacing than insight alone suggests

Clients may be articulate, reflective, or insightful while still becoming dysregulated beneath the surface.

Clinical reminder:
Insight ≠ readiness.

Practical pacing adjustments:

- Shorter interventions

- More check-ins during exploration
- Stopping while things still feel manageable rather than pushing through

Clinician language:

"We can pause here. We don't need to get everything today."

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6. Normalize dissociation as adaptive

Normalization reduces shame and fear while preserving agency.

Instead of:

- Framing dissociation as pathology or resistance

Offer:

"Dissociation is a common and understandable response to overwhelm. It's one way the nervous system protects itself."

This helps clients feel less "broken" and more oriented to collaborative care.

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7. Frame tools as optional and adjustable

Choice is central to safety when dissociation is present.

How to introduce tools:

"We can try this for a moment and adjust or stop if it doesn't feel right."
"There's no requirement to use any tool exactly as described."

Clinical stance:

- Permission to stop is as important as permission to try
- Client feedback guides pacing and modification

Key Reminder:
The presence of dissociation does not mean therapy cannot proceed. It also doesn't have to mean an immediate referral out or discharge of care.
It means therapy must proceed differently.

Suggested Citation

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