Dissociation: Understanding, Coping and Reconnecting

A practical, trauma-aware guide to understanding dissociation, recognising different experiences, grounding safely, reducing shame and knowing when professional or urgent support is needed.

What is dissociation?

Dissociation is a broad term for experiences of disconnection between thoughts, feelings, memories, identity, the body or the world around us. It can occur briefly during stress, exhaustion or overwhelm, but for some people it becomes frequent, distressing or disruptive to daily life.

People describe feeling unreal, detached, foggy, numb, far away, on autopilot, outside their body, disconnected from emotions, or as though the world is dreamlike. Memory can sometimes feel patchy. These experiences can be frightening, particularly when a person does not understand what is happening.

Different dissociative experiences

• **Depersonalisation:** feeling detached from yourself, your body, emotions or actions.

• **Derealisation:** surroundings feel unreal, distant, dreamlike, flat or strangely unfamiliar.

• **Dissociative amnesia:** gaps in memory that are more significant than ordinary forgetting.

• **Emotional numbing:** knowing something matters but feeling disconnected from the expected emotion.

• **Autopilot:** completing tasks with little sense of presence or recollection.

• **Identity-related dissociation:** some dissociative disorders involve significant disruption in identity and memory and require specialist assessment.

Why can dissociation happen?

Dissociation can be understood as one way the nervous system protects us when an experience feels too overwhelming to process normally. It is commonly associated with trauma, but can also occur alongside anxiety, panic, depression, sleep deprivation, chronic stress, some neurological or medical conditions, substance use and other mental-health difficulties. Symptoms should not automatically be assumed to have one cause.

Carl Rogers: understanding before judgement

A person-centred approach asks what the experience means for the person rather than treating them as a collection of symptoms. Dissociation may have developed as a way of surviving something that once felt unmanageable. Understanding this can reduce shame while still making room for change.

> *“The curious paradox is that when I accept myself just as I am, then I can change.” - Carl R. Rogers, On Becoming a Person (1961).*

Common early signs

• Your vision or surroundings suddenly feel distant or unreal.

• You stop feeling connected to your body or emotions.

• Conversation becomes difficult to follow.

• Time seems to jump or you cannot remember parts of an ordinary period.

• Sounds become far away or unusually intense.

• You feel frozen, numb, blank or unable to respond.

• You realise you have been functioning without feeling mentally present.

Grounding should be gentle

Grounding is intended to increase safe connection with the present. It should not be forced. For some trauma survivors, intense body-focused exercises or closing the eyes can increase distress. Use external, choice-based grounding and stop if a technique makes symptoms worse.

Grounding and Reconnection

Start outside the body if internal focus feels unsafe

• Name the date, approximate time and where you are.

• Look for five neutral objects and describe their colour or shape.

• Press your feet into the floor or feel the support of the chair.

• Hold a familiar textured object.

• Listen for one near sound and one distant sound.

• Use a familiar scent if this is soothing and safe.

• Say aloud: “I am here, in this room, now.”

A simple ORIENT plan

• **Observe:** notice that disconnection is beginning.

• **Reality:** remind yourself where and when you are.

• **Identify:** name three things you can see or hear.

• **Ease:** reduce demands, noise, conversation or stimulation if possible.

• **Next:** choose one small safe action.

• **Tell:** contact someone supportive if you need help staying oriented.

What not to demand of yourself

You do not need to instantly feel normal, remember everything, explain why it happened or force yourself through an activity. Reconnection can be gradual. Safety and orientation come before productivity.

Trauma, triggers and pacing

If dissociation is trauma-related, triggers may be obvious or subtle: conflict, tone of voice, anniversaries, touch, sensory cues, medical settings, exhaustion or feeling trapped. Trauma work should be paced carefully. Processing difficult memories too quickly can increase dissociation, so stabilisation and safety skills may be needed first.

Neurodivergence and dissociation

Autistic and ADHD people can experience dissociation too. Overload, masking, shutdown, burnout, interoceptive differences and chronic stress may complicate the picture. Autistic shutdown and dissociation are not identical, although they can overlap in how they feel or appear.

Neurodivergent-friendly support

• Reduce sensory input before asking for detailed conversation.

• Use written or visual orientation prompts.

• Allow extra processing time and fewer questions.

• Distinguish sensory overload, shutdown, fatigue and dissociation where possible.

• Build predictable recovery time after demanding environments.

• Use concrete language rather than asking someone simply to “be present”.

Driving, work and practical safety

If you feel significantly detached, confused or unable to concentrate, avoid driving, operating machinery or making high-stakes decisions until you are safely oriented. At work, practical adjustments might include quiet space, predictable breaks, written instructions and permission to step away during overload.

Substances and medication

Alcohol and recreational drugs can worsen or trigger dissociative experiences in some people. Some medication effects or medical conditions can also resemble dissociation. New, severe or unusual symptoms should be discussed with an appropriate clinician rather than assumed to be psychological.

Your Dissociation Toolkit

My early-warning map

PROMPT	YOUR NOTES
What I notice first	_____
Common situations/triggers	_____
What my body does	_____
What the world feels like	_____
What helps me orient	_____
What makes it worse	_____
Who can help	_____

Create a grounding card

- **My name: _____ Today is: _____**
- **I am currently at: _____**
- **Three things that help me: _____**
- **A person I can contact: _____**
- **A reminder I need to hear: _____**

After an episode

- Reduce immediate demands and allow recovery time.
- Have water, food or medication as appropriate to your normal needs.
- Write brief factual notes if you want to identify patterns later.
- Avoid interrogating yourself for memories while still distressed.
- Consider whether sleep, overload, conflict, substances or trauma cues contributed.
- Seek clinical advice if episodes are new, worsening, frequent or creating safety risks.

Supporting somebody who is dissociating

- Keep your voice calm and use short, clear sentences.
- Remind them where they are without arguing about their experience.
- Ask permission before touching them.
- Reduce unnecessary people, noise and questions.
- Offer simple choices rather than demanding explanations.
- Stay nearby if welcomed and safety requires support.
- Seek urgent medical help if symptoms could represent a medical emergency.

Questions for professional support

- Could these experiences fit dissociation, or should physical causes be ruled out?
- What triggers or patterns should I track?
- Would trauma-focused treatment be appropriate now, or do I need stabilisation first?
- How can we adapt treatment if grounding or body awareness makes symptoms worse?
- Could sleep, medication, substances or another condition be contributing?
- What should prompt urgent review?

When to seek assessment

Professional assessment is important when dissociation is frequent, worsening, causes memory gaps, interferes with work or relationships, creates driving or safety risks, follows significant trauma, or occurs with self-harm, suicidal thoughts, severe depression, psychosis-like experiences or substance use. A clinician can also consider neurological and physical causes where appropriate.

Emergency guidance

Call 999 or attend A&E; for immediate danger, serious injury, loss of consciousness, new severe confusion, seizure-like symptoms, stroke-like symptoms, or if you cannot keep yourself safe. Sudden new neurological symptoms should not be assumed to be dissociation.

A Message From Maggie, Books & Resources

A message from Maggie

Dissociation can be frightening because it can make you question your connection to yourself, your memories and the world around you. You may look completely fine to other people while internally you feel far away, unreal or simply absent.

I want you to remember that you do not have to fight your way back by force. Sometimes the safest route is small and practical: notice the room, feel the chair, reduce the noise, hear a familiar voice and give your nervous system time.

If dissociation developed as a way of surviving overwhelming experiences, it makes sense that your system learned to disconnect. That does not mean you have to stay disconnected forever. With the right support, safety and pacing, you can build more ways to remain connected without overwhelming yourself.

Please take new or changing symptoms seriously too. Not every episode of confusion, memory difficulty or altered awareness is psychological, and appropriate medical assessment matters.

Recommended reading

Suzette Boon, Kathy Steele & Onno van der Hart - *Coping with Trauma-Related Dissociation*. Skills and psychoeducation for trauma-related dissociation.

Janina Fisher - *Healing the Fragmented Selves of Trauma Survivors*. Trauma-informed understanding of dissociation and parts-based experiences.

Carolyn Spring - *Unshame*. Accessible trauma-informed writing on shame, survival and recovery.

Carl R. Rogers - *On Becoming a Person*. Person-centred foundations of empathy, acceptance and psychological growth.

Professional resources & clinical notes

Support may include a GP, qualified psychotherapist or clinical psychologist, trauma specialist, NHS mental-health services and specialist dissociation services where available. Treatment depends on the cause and presentation; trauma-focused work should be paced according to stability and safety.

Clinical references include DSM-5-TR dissociative disorder criteria; ICD-11 dissociative disorder classifications; NICE guidance relevant to PTSD and trauma treatment; and established phase-oriented trauma literature. Differential assessment should consider neurological, medical, sleep-related, substance-related and medication-related causes.

Important: This is a coaching and psychoeducational resource. It does not diagnose a dissociative disorder and does not replace medical assessment, trauma therapy, psychiatric care or emergency support.