A GUIDE FOR FAMILY & LOVED ONES

Understanding Dissociation A detailed coaching guide to help families understand what dissociation can mean, recognise what may be happening, respond without increasing distress, and support the person while protecting their own wellbeing. The starting point Dissociation is not simply 'switching off'. It can affect awareness, memory, emotion, identity, body sensations and the sense that the world is real. The experience varies enormously. This guide is educational rather than diagnostic: new, severe, unexplained or rapidly changing symptoms need appropriate professional assessment.

What dissociation actually means Dissociation is a broad term for a disruption or disconnection between aspects of experience that usually feel integrated. A person may be physically present while feeling mentally far away. They may know where they are but feel that the room is unreal. They may hear themselves speaking while feeling detached from the voice. Emotion may suddenly become inaccessible. Time can feel distorted, and in some presentations there can be significant gaps in memory. Many people have mild experiences of absorption - for example arriving somewhere after a familiar journey and barely remembering the route. Clinical dissociation is different when it becomes recurrent, involuntary, distressing or disruptive. It may interfere with relationships, work, study, self-care or a person's confidence in their own memory and sense of self. Dissociation is not one diagnosis A person can experience dissociation without having a dissociative disorder. Dissociative symptoms can occur in several contexts, including trauma-related conditions such as PTSD, and there are specific dissociative disorders with different diagnostic features. Dissociative identity disorder is one particular diagnosis and should not be used as a general label for anyone who dissociates. Families also need to remember that not every episode of staring, confusion, memory difficulty or feeling unreal is necessarily dissociation. Panic, migraine, seizures, neurological conditions, sleep deprivation, medication effects, substances and other physical or mental-health problems can sometimes produce overlapping experiences. This is one reason professional assessment matters.

What can it feel like from the inside? Depersonalisation can involve feeling detached from yourself: as if you are observing your own actions, body or thoughts from a distance. Someone may say, 'I know this is me, but I don't feel like me.' Their body may feel unfamiliar, numb, too large, too small or somehow disconnected. Derealisation affects the experience of the outside world. Familiar rooms, people or streets can suddenly seem dreamlike, flat, foggy, artificial or far away. Importantly, the person may still intellectually know that the world is real while emotionally or perceptually feeling disconnected from it. Emotional disconnection can be particularly painful in relationships. Someone may know they love their partner, parent or child but temporarily struggle to feel the emotion. From the outside this can look cold or uncaring. Internally, it may be frightening and confusing rather than a deliberate withdrawal of affection. Memory and time can also be affected. Some people lose the thread of conversations, cannot account for periods of time, or discover that they do not remember parts of an event. Significant memory gaps go beyond ordinary forgetfulness and should be professionally explored.

Why might dissociation happen? For many people dissociation is associated with overwhelming stress or trauma. One way of understanding it is as a protective response: when an experience feels too intense to process in the usual way, the mind creates distance from sensations, emotions, memories or the immediate environment. Something that once reduced unbearable distress can later become disruptive when the response activates automatically. Triggers can include conflict, sensory overload, exhaustion, shame, feeling trapped, medical procedures, anniversaries, reminders of past experiences, particular sounds or smells, interpersonal closeness or cumulative stress. Sometimes there is no obvious trigger. Family members should avoid turning trigger-finding into an interrogation or pressuring someone to disclose trauma. A more helpful family question Move from 'Why are you doing this?' to 'What might be happening for you?' Then add a second question that matters just as much: 'What do both of us need so that this situation remains safe and manageable?'

What families may notice - and how to respond A family member may notice a distant or fixed gaze, reduced speech, delayed responses, suddenly losing the thread of a conversation, emotional flatness, confusion about time, withdrawal, seeming to function on 'autopilot', or the person saying that their body or surroundings feel unreal. Other people remain outwardly capable while internally feeling profoundly disconnected. There is no single appearance of dissociation. Try to record observations rather than interpretations. 'She stopped answering for several minutes, stared at the floor and later said the room felt unreal' is more useful than 'She ignored me'. Factual observations can help the person recognise patterns and can be useful if they choose to discuss episodes with a clinician. Why families can take it personally Dissociation can create a painful mismatch between what is happening internally and what other people see. A partner may feel rejected. A parent may feel deliberately ignored. A sibling may become angry when the person remembers one event but not another. These feelings are understandable. The challenge is to acknowledge the impact without automatically assigning intention. A symptom can explain behaviour without making every behaviour acceptable.

During an episode: begin with safety First check whether there is an immediate physical risk. Is the person driving, near traffic, water, machinery, heights or another hazard? If so, deal with the practical danger calmly. New severe confusion, unusual physical symptoms, injury, prolonged unresponsiveness or other concerning features may need urgent medical assessment rather than being assumed to be dissociation. Reduce demand rather than increasing it Use a steady voice, short sentences and fewer questions. Reduce competing noise, crowds or conflict where possible. Give the person longer to process what you say. Avoid demanding eye contact or repeatedly asking, 'Can you hear me?' A person who is already struggling to remain connected can become more overwhelmed when several people talk at once or when they feel they are being tested. Orientation and reassurance If the person finds it helpful, gently orient them to the present: 'You're at home. I'm here with you. It's Sunday morning. We can take this slowly.' Orientation

should be an offer of information, not a quiz. Do not repeatedly ask them to prove that they know the date or location. Touch and personal space Never assume touch will help. A hand on the shoulder may be reassuring for one person and frightening for another. Ask first where possible. Do not shake, grab or restrain someone simply to make them 'come back'. A support plan created in advance can record whether touch is welcome, whether the person prefers company or space, and what words they find reassuring.

Grounding - what it is and what it is not Grounding is a way of directing attention towards present-time information. It may involve noticing feet on the floor, holding a familiar textured object, naming colours or objects in the room, noticing temperature, sipping a drink, listening to familiar sounds, looking at a calendar, or using an orientation card containing the person's name, location and reassuring facts. Breathing exercises help some people but not everyone. Focusing inside the body can increase distress for some trauma survivors. Similarly, very strong sensory techniques promoted online are not automatically appropriate. Grounding should never become punishment, startling or a test of whether the person is 'trying hard enough'. Build a grounding menu when things are calm Together identify: three things that usually help, three that sometimes help, and three that make things worse. Add touch/no-touch preferences, lighting and noise preferences, helpful phrases, whether the person wants company or space, and who they want contacted if the episode does not settle.

What not to say Avoid: 'Snap out of it.' 'You're doing this for attention.' 'You remember really.' 'Look at me when I'm talking to you.' 'After everything I do for you.' 'Tell me exactly what happened right now.' These statements add shame, pressure or conflict at a time when the person's ability to process information may already be reduced. What can help instead Try: 'I'm here.' 'You are not in trouble.' 'You do not need to explain everything now.' 'Would you like quiet or company?' 'Would you like me to remind you what just happened?' 'Is there a grounding technique you want to use?' 'We can talk about the practical things when you feel more settled.'

After the episode The person may feel exhausted, embarrassed, numb, tearful, headachy or confused. Allow recovery before asking for a detailed account. Later, review the episode collaboratively: What was the earliest sign? What happened beforehand? What helped? What increased distress? What should we change next time? If memory loss is significant or recurrent, encourage professional assessment rather than trying to force recall. Repair also matters. Family members will sometimes respond badly because they are frightened. A simple acknowledgement can protect the relationship: 'I raised my voice because I panicked. I can see that made things harder. Next time I will try to slow down.'

Relationships, treatment and recovery Dissociation affects relationships as well as individuals. Partners may experience loneliness, disrupted intimacy, cancelled plans or fear of saying the wrong thing. Parents can become highly protective and begin monitoring every mood. Siblings may feel that all family attention goes to one person. Friends may want to help but have no idea what to do. These reactions deserve discussion rather than silence. Partners and families need ordinary life too A relationship cannot remain healthy if every conversation becomes about symptoms. Protect ordinary connection: shared meals, humour, television, walks, hobbies, music, pets, family rituals and plans that have nothing to do with mental health. Ask regularly, 'What do we still enjoy together that is not organised around dissociation?' Children in the family should receive simple, age-appropriate reassurance and should never become responsible for monitoring, stabilising or protecting an adult. If episodes significantly affect parenting or household safety, involve appropriate professional and practical support.

Professional assessment Assessment may begin with a GP or mental-health professional. They may ask about the nature and frequency of symptoms, memory, stress, trauma where appropriate, daily functioning, sleep, medication, substances, physical health, other mental-health symptoms and safety. The purpose is not simply to attach a label; it is to understand what is happening, consider alternative explanations and decide what kind of support is appropriate. If symptoms are complex, persistent or significantly impairing, specialist assessment may be needed. Families can help by providing factual observations if the person wants this, but should avoid speaking over them or presenting their own theory as a diagnosis. Therapy and stabilisation Psychological therapy is commonly used in the treatment of dissociative disorders. For some people, early work focuses on stabilisation: understanding symptoms, improving safety, recognising triggers, strengthening emotional regulation, developing grounding skills, improving sleep and routines, and building the capacity to remain present during distress. Trauma-focused work may be appropriate for some trauma-related presentations, but timing and pacing matter. Detailed trauma processing is not something a family member should attempt at home. A suitably trained clinician can assess whether trauma-focused CBT, EMDR or another approach is appropriate and whether adaptations are needed when dissociation is prominent. Medication and co-occurring difficulties There is no medication that specifically treats dissociation itself. Medication may sometimes be prescribed for co-occurring depression, anxiety, sleep problems or other clinically assessed difficulties. Medication decisions belong with an appropriate prescriber, particularly when symptoms are changing or side effects could be relevant. What recovery can look like Recovery does not necessarily mean never dissociating again. Progress may involve recognising early warning signs, episodes becoming shorter or less frightening, improved memory and continuity, increased ability to stay present during stress, safer coping, stronger communication, greater independence and less disruption to relationships or daily life.

How families can support treatment without becoming the therapist Ask what support is actually wanted. This might mean helping with transport, creating a calmer environment after appointments, encouraging use of agreed strategies, or helping the person organise questions for a clinician. Respect confidentiality. Do not demand to know what was discussed in therapy, insist on trauma disclosure, or use treatment as leverage in an argument. Support should

increase resources and autonomy. Where safe and realistic, encourage the person to make decisions, contact professionals, practise coping strategies and maintain ordinary responsibilities. Constantly stepping in can come from love and fear, but it may also increase dependence and exhaust the supporter. Support versus rescue Support: 'What would help you manage this?' 'Would you like me beside you while you make the call?' Rescue: automatically making every call, cancelling every commitment, speaking for the person when they can speak for themselves, or believing that nothing can happen unless you are present. The aim is not withdrawal of care; it is sustainable support.

A family support plan Create the plan when everyone is relatively settled. Include early warning signs; what the person notices internally; what others may notice; preferred words; company or space; touch preferences; grounding choices; sensory needs; things that worsen symptoms; trusted contacts; professional contacts; arrangements for children or pets if needed; and clear thresholds for urgent help. Review the plan after significant episodes or treatment changes. The plan should increase predictability and autonomy, not become a way of controlling the person. Where capacity and safety allow, the person experiencing dissociation should remain central to decisions about their own support.

How do I safeguard myself while supporting someone? This section is deliberately substantial because the wellbeing of the supporter is often overlooked. Loving someone who experiences dissociation can bring fear, interrupted sleep, repeated crises, practical responsibility, uncertainty and a strong urge to prevent anything from going wrong. Over time, the supporter can begin to organise their entire life around the other person's nervous system. Understanding does not mean accepting harm A diagnosis, trauma history or dissociative episode may help explain distress, but it does not require you to tolerate intimidation, coercive control, threats, destruction of property, financial exploitation, physical aggression, sexual boundary violations or persistent verbal abuse. Most people who dissociate are not dangerous; safeguarding is included because every person has a right to safety regardless of diagnosis. If you feel physically unsafe, move to safety and seek appropriate help. Do not put yourself in danger to prove that you are supportive. If children or vulnerable adults are affected, their safety must also be considered. Serious safeguarding concerns may require professional advice even if the person experiencing difficulties does not want the situation discussed.

Boundaries are not abandonment A healthy boundary describes what you will do rather than trying to control another person. 'I can stay with you for twenty minutes, then I need to sleep.' 'I can help you contact your therapist, but I cannot provide therapy.' 'I want to continue this conversation, but I will leave if I am being threatened.' 'I cannot lend more money.' 'If I believe there is immediate danger, I will contact emergency support.' Boundaries may initially create guilt, particularly when the other person is distressed. Guilt is not proof that the boundary is wrong. A boundary that allows you to remain rested, safe and emotionally available can make support more sustainable than repeatedly saying yes until resentment or burnout takes over.

Carer fatigue and burnout Warning signs can include poor sleep, irritability, dread when the phone rings, difficulty concentrating, cancelling your own plans, withdrawing from friends, neglecting health appointments, feeling numb or resentful, constantly checking the person, being unable to relax when away from them, or believing that their safety and emotional state are entirely your responsibility. Burnout often develops gradually. A supporter may begin by helping during occasional difficult episodes, then slowly take over appointments, household tasks, communication, finances or emotional regulation. Because each individual act feels caring, it can be difficult to notice when the overall pattern has become unsustainable. Supporter wellbeing check-in Ask yourself regularly: Am I physically safe? Am I sleeping? Do I have time that belongs to me? Can I say no without feeling terrified? Do I have somebody I can be completely honest with? Am I keeping frightening secrets? Have I stopped seeing friends or doing things that matter to me? Am I taking responsibility for work that belongs to the person or their clinical team? What needs to change this week?

Protect your emotional and practical independence Maintain friendships, work, interests, exercise, medical care, rest and private time. Protect financial independence and think carefully before taking on debts, repeatedly covering losses or giving another person unrestricted access to money. If the situation has become financially or emotionally coercive, seek independent advice rather than trying to solve it alone. Get your own support Supporters may benefit from counselling, family therapy, carer services, peer support or a trusted person outside the immediate situation. Your support does not need to focus on diagnosing the person you love; it can focus on your fear, grief, frustration, boundaries and the parts of your own life that need rebuilding.

When family support is not enough Seek professional advice when symptoms are new, worsening, causing significant memory loss or functional impairment, or creating safety concerns. If there is immediate danger to life, serious self-harm, suicidal intent, severe medical concern or another emergency, call 999 or attend A&E.; NHS 111 can provide urgent health advice. Follow an existing crisis-team or mental-health care plan where one is in place. Samaritans can be contacted on 116 123 in the UK and ROI for emotional support. You are not the emergency service. Asking professionals to take responsibility for situations that require professional care is not abandoning the person. It is recognising the limits of what a family relationship can safely hold.

Practical coaching tools for families and loved ones Use these exercises when everyone is relatively settled. They are designed to improve understanding and planning, not to analyse or interrogate the person who dissociates. 1. Separate observation from interpretation Write down exactly what you saw or heard. Then write the story your mind attached to it. Example: Observation: 'He stopped responding, looked at the floor for several minutes and later could not remember part of the conversation.' Interpretation: 'He was deliberately ignoring me.' Now ask: What other explanations are possible? What information would I need before deciding what the behaviour meant? 2. Map the episode What happened in the hours beforehand? Consider sleep, food, stress, sensory load, conflict, physical health and unusual events. What was the earliest sign? What did the person notice? What did you notice? What helped? What increased

distress? How long did recovery take? Do not use this as a search for blame; use it to identify patterns and improve the support plan. 3. Their needs and my needs Create two columns. Their needs may include quiet, orientation, choice, time, grounding, professional support, predictable communication or sensory adjustments. Your needs may include sleep, respectful communication, privacy, work, financial security, time with other family members, honest information and your own emotional support. A sustainable plan must contain both columns. 4. My boundary plan Complete these sentences: I can... / I cannot... / If this happens, I will... / I need advance notice when... / The people I can contact are... / The part that belongs to the professional team is... / One part of my own life I need to protect is... 5. The next-episode plan Early signs: _____. Helpful words: _____. Touch: welcome / ask first / not helpful. Grounding that helps: _____. Things to avoid: _____. Preferred contact: _____. When we seek urgent help: _____. What the supporter will do afterwards to recover: _____.

Myths worth challenging 'Dissociation means multiple personalities.' No. Dissociation covers a wide range of experiences; DID is one specific diagnosis. 'If someone can function normally sometimes, they must be faking.' Symptoms can fluctuate considerably. 'If I make them talk about trauma, they will get it out of their system.' Forced disclosure can increase distress; trauma processing belongs within appropriate treatment. 'I must prevent every episode.' No family member can guarantee this. 'If I set boundaries, I am abandoning them.' Boundaries can make care safer and more sustainable.

Recommended reading Coping with Trauma-Related Dissociation - Suzette Boon, Kathy Steele and Onno van der Hart. A detailed skills-based resource covering stabilisation and day-to-day coping with chronic trauma-related dissociation. It can help families understand why recovery often begins with safety and regulation rather than immediately revisiting traumatic material. Healing the Fragmented Selves of Trauma Survivors - Janina Fisher. Explores trauma-related fragmentation and helps explain how apparently contradictory reactions can coexist within the same person. Useful for readers wanting a deeper clinical understanding while remembering that no single model explains everyone. The Haunted Self - Onno van der Hart, Ellert Nijenhuis and Kathy Steele. A more technical professional text on chronic traumatisation and structural dissociation. Better suited to readers who want theory in greater depth. The Body Keeps the Score - Bessel van der Kolk. A broad trauma text rather than a dissociation-specific family guide. It can provide wider context about trauma and mind-body responses but is best treated as one perspective within a broader evidence base.

UK information and resources NHS: public information on dissociative disorders, symptoms, diagnosis and treatment, together with routes into NHS care. Mind: accessible information about dissociation and dissociative disorders, coping, treatment and supporting somebody. NICE NG116: Post-traumatic stress disorder, including information relevant to dissociative symptoms, assessment, treatment and support for families/carers. Samaritans: 116 123 for emotional support in the UK and ROI. Service details and guidance should be checked periodically because they can change. Clinical reference note This resource is educational and does not diagnose dissociation or replace individual medical or mental-health advice. Principal UK sources informing the guide include NHS information on dissociative disorders, Mind information on dissociation/dissociative disorders and helping someone, and NICE guideline NG116 on PTSD. Where symptoms are unexplained, severe or changing, professional assessment is important.

A warm message from Maggie If you love someone who dissociates, there may be times when it feels as though the person you know has suddenly moved somewhere you cannot reach. You may be sitting beside them and still feel miles away. That can be confusing, lonely and frightening. You may find yourself searching for the perfect words, watching for every change, or wondering whether you caused what is happening. You do not have to understand every part of another person's experience to meet it with respect. Sometimes the most helpful support is quieter than we imagine: staying calm, reducing pressure, learning what helps, giving choices, not assuming their disconnection is a rejection of you, and helping them reach professional support when that is what is needed. I also want you to remember yourself. Understanding another person's distress does not mean disappearing inside it. You are allowed boundaries. You are allowed sleep, work, friendships, laughter and time away. You are allowed to say that something is too much. You are allowed to feel frustrated or frightened, and you are allowed to ask for support for yourself. My hope is that this guide helps you move from fear and confusion towards greater understanding - while keeping something equally important in view: both people in the relationship matter. Supporting someone is not about becoming their therapist. It is about understanding more, judging less, responding safely and keeping enough of yourself to remain genuinely present. Maggie Learoyd Space to Breathe Therapy A final coaching question If nothing about the diagnosis changed this week, what one change in communication, expectations, boundaries or support could make life feel 5% safer or more manageable for both of you?