A GUIDE FOR FAMILY & LOVED ONES

Post-Traumatic Stress Disorder (PTSD)

Understanding trauma responses, responding to flashbacks and triggers, supporting recovery, and protecting the wellbeing of the person who is supporting too.

The starting point

PTSD is not simply remembering something upsetting. It can leave the nervous system responding as though danger is still present even when the traumatic event is over. Loved ones can help most when they understand the difference between present-day safety and a body or brain that has been pulled back into threat. Support should increase safety and choice - not turn a partner, parent or friend into the person's therapist.

What PTSD can involve

PTSD can follow exposure to traumatic events and may involve re-experiencing, avoidance, changes in mood and thinking, and a persistent sense of threat or hyperarousal. The pattern, severity and impact vary widely. Not everybody exposed to trauma develops PTSD, and distress after trauma does not automatically mean a disorder.

Re-experiencing can include intrusive memories, nightmares and flashbacks. A flashback may be a vivid visual replay, but it can also be bodily: sudden terror, nausea, pain, smells, sounds or a powerful sense that the event is happening again. The person's logical awareness that they are safe may temporarily be overwhelmed by the threat response.

Hypervigilance and the nervous system

The person may scan rooms, sit facing doors, startle sharply, struggle with crowds, monitor other people's expressions, sleep lightly or react strongly to unexpected touch and noise. This is not necessarily distrust of the family. Their nervous system may have learned that safety can change without warning.

Fight, flight, freeze and shutdown responses are automatic survival patterns, not character flaws. Anger can sometimes be the visible surface of fear. Withdrawal may be an attempt to reduce stimulation. Freezing can look like passivity. Understanding the nervous-system context can reduce blame without excusing behaviour that harms others.

Avoidance: why life can become smaller

Avoidance can bring immediate relief from trauma reminders, but over time it may shrink the person's world. They may avoid places, travel, medical care, intimacy, news, conversations, smells, clothing, particular dates or people. Families often begin avoiding these things too in order to prevent distress.

Some accommodation is humane and sensible, especially early in recovery. But if the entire household becomes organised around preventing every possible trigger, fear can become more entrenched. Treatment can help the person gradually regain choice; relatives should not attempt exposure exercises themselves unless this is part of an agreed professional plan.

Emotional numbing, guilt and shame

PTSD can involve feeling detached, unable to experience pleasure, emotionally numb or disconnected from loved ones. Partners may interpret this as loss of love. The person may also carry survivor guilt, shame about how they responded during the trauma, or responsibility for things outside their control. Trauma memories can be fragmented, which can add confusion and self-doubt.

Do not force disclosure. A person does not need to tell a family member every detail of what happened in order to deserve support. Repeated questioning can feel intrusive or recreate a sense of lost control.

Dissociation and triggers

Some people experience depersonalisation, derealisation or a sense of being absent from the present. They may stare, become slow to respond, feel unreal or lose connection with their surroundings. A trigger may be a date, smell, tone of voice, body position, location, sound, medical procedure, argument, television scene or feeling of being trapped. Sometimes the reaction appears before conscious understanding.

A useful family shift

Move from **'Why are you reacting like this?'** towards **'What is your nervous system responding to right now, and what would help you recognise that you are here, not there?'**

When a flashback happens

First assess immediate safety. Speak calmly and use the person's name if that helps. Remind them of the present without arguing with the experience: 'You are in the living room with me. It is Sunday evening. You are safe here.' Keep language short. Too many questions can increase overload.

Ask before touching. A hug that normally comforts may feel trapping during a trauma response. Offer choices: sit or stand, light on or off, door open or closed, water or no water. Choice can be regulating because trauma often involved loss of control.

Grounding can include noticing feet on the floor, naming objects in the room, holding a cool or textured object, describing the current date and place, paced breathing if breathing exercises are not triggering, or focusing on a familiar voice. The best techniques are the ones the person has chosen and practised outside crisis.

What to say - and what to avoid

Helpful phrases include: 'I am here.' 'You do not have to explain anything right now.' 'Would you like space or company?' 'Can I remind you where we are?' 'What usually helps when this happens?' Avoid 'calm down', 'it was years ago', 'you are safe so stop worrying', or demanding that the person describe the trauma while highly activated.

After a flashback, allow recovery time. The person may be exhausted, embarrassed or disorientated. Ask what was helpful and what should be different next time. A short review when calm can build an individual flashback plan without turning every episode into an interrogation.

Nightmares and sleep

Nightmares, difficulty falling asleep, waking in panic and fear of sleeping can affect both people in a household. Agree what the person wants after a nightmare: light, water, quiet company, grounding or space. Partners also need sleep. If one person's night-time symptoms mean the other is chronically sleep deprived, the support plan needs widening rather than assuming the partner must remain awake indefinitely.

Anger, irritability and startle responses

A nervous system primed for danger can react rapidly. A door slamming, unexpected approach or disagreement may trigger a disproportionately intense response. Keep your own voice steady, give physical space and postpone complex problem-solving until arousal reduces. Trauma can explain anger; it does not make threats, intimidation or violence acceptable.

Intimacy, sex and touch

Trauma can affect body safety, trust, sexual desire and tolerance of touch. A person may want closeness one day and feel overwhelmed by it another day. Consent must remain active and ongoing. Partners should not interpret a trauma response as a personal rejection, but they are also allowed their own feelings, needs and boundaries.

Agree simple communication: 'Can I hug you?' 'Would you like me beside you or further away?' 'Do you want to stop?' Never use therapy goals to pressure somebody into physical or sexual contact. Intimacy can be rebuilt through safety, choice, communication and, where needed, professional support.

Family life and children

Children can notice hypervigilance, irritability, avoidance or a parent's sudden distress even when adults try to hide it. Give age-appropriate explanations without sharing frightening detail: 'Mum's body sometimes reacts as if an old danger is happening again. Adults are helping her.' Children should not become emotional carers or be asked to manage flashbacks.

Partners, parents, siblings and friends

Partners may feel shut out or rejected; parents may feel helpless; siblings may resent family life revolving around trauma; friends may stop inviting the person after repeated cancellations. Each relationship needs realistic expectations. Support can include staying connected in smaller, safer ways rather than demanding either total participation or complete withdrawal.

Personal flashback support plan

When calm, record: **early signs; likely triggers; helpful words; touch/no touch; grounding preferences; what makes things worse; medication or clinical instructions if relevant; who to contact; what the supporter should do if they feel unsafe; and when professional or emergency help is required.**

Assessment, treatment and recovery

A professional assessment looks at the trauma history as appropriate, symptoms, duration, functioning, dissociation, depression, substance use, sleep and risk. The person should not be forced to disclose graphic details simply to prove that something happened. Assessment should also consider physical health and other explanations for symptoms.

Evidence-based treatments for PTSD include trauma-focused cognitive behavioural therapy and EMDR. NHS and NICE guidance support trauma-focused psychological treatment, with treatment selected according to the person's presentation and preferences. Trauma-focused work should be delivered by appropriately trained professionals, particularly where symptoms are severe or dissociation and risk are significant.

Trauma-focused CBT

Trauma-focused CBT helps the person understand PTSD, process trauma memories, work with meanings such as guilt or permanent danger, reduce unhelpful avoidance and reclaim areas of life that have become restricted. Family members should not try to conduct trauma processing at home. Their role is to support treatment attendance, recovery routines and agreed coping strategies.

EMDR

EMDR is another established psychological treatment for PTSD. It involves recalling aspects of traumatic memories while engaging in structured bilateral stimulation, commonly eye movements, within a therapeutic protocol. It is more than simply moving the eyes and should be delivered by a suitably trained practitioner.

Medication and additional support

Medication may be considered for some adults, particularly where psychological treatment is not preferred, is not currently possible, or where co-occurring symptoms need treatment. Prescribing and medication changes belong with qualified clinicians. Alcohol or recreational drugs may temporarily numb symptoms but can worsen sleep, mood, risk and recovery.

Recovery is not forgetting

Recovery does not require erasing the memory or pretending the event did not matter. It can mean remembering without reliving, recognising triggers earlier, sleeping better, feeling safer in the body, returning to places and relationships that matter, reducing avoidance, rebuilding trust and regaining a sense of future.

Progress can be uneven. Anniversaries, medical procedures, news events or unexpected reminders can temporarily increase symptoms without meaning that all recovery has been lost. A relapse or difficult week is information: what changed, what support is needed and which skills need strengthening?

Supporting treatment without becoming the therapist

Ask what support is wanted: transport, childcare, a quiet evening after therapy, help remembering an appointment, or simply not asking for details. Do not demand a report after every session. Therapy belongs to the person. Family support should protect autonomy and ordinary relationship roles.

When avoidance affects the whole household

A partner may stop travelling, seeing friends, using certain rooms or discussing ordinary topics because they fear triggering the person. Over-accommodation can slowly make both lives smaller. Discuss with the treating clinician how loved ones can be supportive without reinforcing avoidance. Change should be gradual, collaborative and safe.

Work and everyday functioning

PTSD can affect concentration, memory, sleep, attendance, travel and tolerance of busy environments. Practical workplace adjustments and occupational-health input may help. At home, break overwhelming tasks into smaller steps without assuming permanent responsibility for everything.

Trauma anniversaries and predictable difficult periods

Birthdays, seasons, dates, court proceedings, medical reviews or media coverage may intensify symptoms. Plan ahead: reduce unnecessary pressure, identify support, protect sleep and decide how much contact is wanted. Anticipating a difficult date is different from surrendering the entire day to fear.

Safeguarding yourself as a supporter

Living beside PTSD can affect your own nervous system. You may start scanning the person's mood, avoiding noises, changing how you move through the house or feeling responsible for preventing every trigger. Some supporters develop anxiety, sleep problems, resentment, emotional exhaustion or secondary traumatic stress.

You are allowed to be affected. You are also allowed support that is about you rather than another person's trauma. Counselling, carers' support, trusted friends and protected time can help you process fear, grief, anger and the impact on your relationship.

Boundaries are not a failure of trauma-informed care

Examples include: 'I will ask before touching you, and I need you not to shout at me.' 'I can sit with you after a nightmare for fifteen minutes, then I need sleep.' 'I will support therapy, but I cannot listen to graphic trauma details when I am not able to cope.' 'If I feel physically unsafe, I will leave and get help.'

A trauma history can explain why a behaviour occurs. It does not mean another person must accept intimidation, coercion, violence, sexual pressure, financial exploitation or repeated verbal abuse. Safety applies to everyone in the relationship.

Walking on eggshells

When supporters constantly edit every word, cancel plans or suppress their own needs to avoid a trauma response, the relationship can lose equality. The answer is not deliberate triggering. It is predictable, respectful communication and a gradual return to a life in which both people can have preferences, boundaries and ordinary disagreements.

Support versus rescue

Support asks, 'What helps you use your plan?' Rescue assumes, 'I must remove every difficult feeling.' Support can involve grounding, transport, practical help and encouragement. Rescue can become doing every task, preventing all exposure to ordinary life, monitoring constantly or making the supporter solely responsible for safety.

Secondary trauma and burnout

Listening to traumatic material, witnessing repeated flashbacks or living with chronic threat responses can affect loved ones. Signs include intrusive thoughts about what happened, nightmares, hypervigilance, irritability, numbness, poor concentration, withdrawing socially or feeling unable to switch off. These experiences deserve attention rather than shame.

Supporter wellbeing check-in

Ask: **Am I safe? Am I sleeping? Can I leave the house without feeling responsible for what happens? Do I have relationships and interests of my own? Am I hearing trauma detail that I cannot absorb? Are children affected? Am I becoming the only coping strategy? What support or boundary would make this sustainable?**

Physical, emotional and financial safety

Most people with PTSD are not dangerous. Do not stigmatise trauma survivors. At the same time, respond to actual behaviour. If there are threats, violence, dangerous substance use, reckless driving, coercive control or other concrete risks, seek appropriate professional or emergency support. Protect your finances and personal information where needed.

When family support is not enough

Seek urgent professional help when there is suicidal intent, serious self-harm, severe deterioration, inability to care for basic needs, dangerous intoxication, psychotic symptoms or another immediate risk. If there is immediate danger to life, call 999 or attend A&E.; NHS 111 can provide urgent health advice. Follow an existing crisis-team or care plan where available. Samaritans can be contacted on 116 123 in the UK and ROI.

Do not place yourself or children in danger while trying to calm another person. Calling for help when a situation exceeds what a family can safely hold is responsible support, not abandonment.

Practical family coaching tools

1. Trigger map. What happened just before the response? What sensory or relational cue may have been present? What did the person's body do? What helped? What made it worse? Which parts can be planned for without organising life around total avoidance?

2. Here-and-now grounding card. My name is ____. Today is ____. I am at ____. The traumatic event is not happening now. Helpful objects are ____. Helpful words are ____. Please ask before touching me: yes/no. The person I want contacted is ____.

3. Relationship needs. Their need during activation may be safety, space, predictability or choice. The supporter's need may be respect, sleep, reassurance, physical safety or time. Write both columns. A plan that recognises only one person's needs will eventually become unstable.

4. Boundary plan. I can... / I cannot... / I will ask before... / I need you not to... / If I feel unsafe I will... / My protected time is... / The responsibility that belongs to professionals is...

5. Reclaiming-life plan. What has PTSD taken away from the person? What has it taken away from the family? Choose one small, safe piece of ordinary life to reclaim: a walk, meal out, hobby, room, journey, friendship or shared routine. Treatment plans should guide exposure where fear is significant.

6. Supporter recovery plan. What signs tell me I am becoming hypervigilant or burnt out? Who can I talk to? What restores me? What trauma details do I need limits around? Which responsibilities can I hand back to the person, professionals or a wider support network?

Common myths

'PTSD only affects soldiers.' No. PTSD can follow many forms of trauma. **'Flashbacks are always visual movies.'** No; they may be sensory, emotional or bodily. **'Avoiding every trigger keeps the person safe.'** Avoidance can maintain difficulties over time. **'Talking about every detail with family is necessary for recovery.'** No. Trauma processing belongs in appropriate treatment and disclosure should be the person's choice. **'A trauma history excuses harmful behaviour.'** No. Context and accountability can coexist.

Recommended reading

Overcoming Traumatic Stress - Claudia Herbert and Ann Wetmore: a CBT-informed guide to understanding and working with traumatic stress. **The Body Keeps the Score** - Bessel van der Kolk: a broad trauma text that many readers find useful, but it represents one influential perspective rather than a complete clinical manual. **Trauma and Recovery** - Judith Herman: a foundational text on trauma and recovery. Readers should choose material carefully because trauma books themselves can sometimes be activating.

UK resources and sources

Useful starting points include NHS information on PTSD and treatment, NICE guideline NG116 on post-traumatic stress disorder, NHS Talking Therapies, Mind trauma/PTSD information and Samaritans for emotional support. NICE recommends trauma-focused psychological interventions, including trauma-focused CBT and EMDR in appropriate circumstances. Service availability varies locally.

Clinical note

This guide is educational and does not diagnose PTSD or replace individual medical or psychological advice. Symptoms such as dissociation, panic, sleep disturbance, pain and mood changes can have multiple causes. New, severe or rapidly changing symptoms and any significant safety concerns require appropriate professional assessment.

A message from Maggie

When somebody you love is living with PTSD, it can feel as though the traumatic event has entered the relationship too. You may find yourself watching for triggers, changing plans, lowering your voice, checking exits or wondering whether an ordinary disagreement will become overwhelming. You may desperately want to make the person feel safe and discover that love alone cannot switch off a nervous system that still expects danger.

Your calm presence can matter enormously. Asking before touching, offering choice, learning what helps during a flashback and believing the person's distress without forcing them to explain it can all create safety. But you do not need to become their therapist. The trauma does not have to become the organising centre of both of your lives.

I also want to make room for the supporter. You may be tired. You may miss spontaneity, intimacy or the person your relationship used to be. You may feel guilty for needing space. Those feelings do not make you uncaring. You are allowed sleep, boundaries, friendships, work and support of your own. You are allowed to say when something is too much.

Recovery is not about forgetting. It is about helping the past become the past - so a memory can be remembered without repeatedly taking over the present. That work belongs with the person and appropriately trained professionals, supported by relationships that are safe, respectful and sustainable.

Both people matter. The person with PTSD deserves patience, dignity and effective treatment. The person beside them deserves safety, rest and a life that still belongs to them. My hope is that understanding creates more room for both.

Maggie Learoyd
Space to Breathe Therapy

Final coaching question

If the next difficult trigger happened tomorrow, what would help both of you know: **what the person needs, what the supporter can realistically offer, what boundary protects the relationship, and when professional help takes over?**