A GUIDE FOR FAMILY & LOVED ONES

# Depersonalisation & Derealisation

Understanding what the experience can feel like, reducing fear and checking, supporting recovery, protecting relationships and safeguarding the supporter.

**Why this guide exists**

Depersonalisation and derealisation can sound impossible to understand if you have never experienced them. The person may say, 'I don't feel real', 'my hands don't feel like mine', 'you look far away', or 'everything feels like a film'. They may know logically that they and the world are real while still being unable to *feel* that reality. This guide helps loved ones respond with curiosity and practical support without turning the family into a clinical service.

## Understanding depersonalisation

Depersonalisation is a sense of being detached from yourself. It can involve feeling as though you are observing yourself from outside, functioning on automatic pilot, or moving and speaking without the usual sense of ownership. A person's face, voice, hands or reflection can seem unfamiliar. Thoughts may feel distant. Some people describe being behind glass, trapped inside their head, or present physically while their sense of self feels several steps away.

The emotional part can be especially frightening. Someone may know they love their partner, children or family but temporarily struggle to access the familiar feeling of love. They can then begin checking: 'Do I still love them? Why don't I feel anything? What if this means I've changed?' The checking increases attention to the absence of feeling, anxiety rises, and emotional connection can become even harder to access. Loved ones can easily mistake this for rejection when the person may actually be terrified by it.

Body sensations can also change. The person may feel unusually light or heavy, numb, hollow, mechanical or disconnected from movement. Their limbs may seem the wrong size or strangely distant. Their own voice can sound unfamiliar. These sensations can lead to repeated mirror checking, touching the body to see whether it feels normal, or asking others for reassurance.

## Understanding derealisation

Derealisation affects the experience of the outside world. Rooms, streets and familiar people may appear dreamlike, foggy, flat, overly sharp, too bright, visually distant or somehow artificial. Depth and distance can feel altered. Sounds may seem muffled or unusually intense. Time can feel slowed down or accelerated. A familiar place can suddenly feel emotionally unfamiliar even though the person knows exactly where they are.

Because the experience is so strange, people often fear they are developing psychosis, dementia, brain damage or another serious illness. In depersonalisation and derealisation, many people retain insight: they know the sensation of unreality is a disturbing experience rather than literally concluding that the world has stopped existing. New, severe, rapidly changing or diagnostically unclear symptoms still need professional assessment rather than assumptions.

## How the fear cycle can keep symptoms going

A common cycle begins with an odd sensation: 'My face feels unfamiliar.' The mind interprets it catastrophically: 'Something is seriously wrong.' Anxiety increases. The person checks the mirror, searches online, asks a loved one for reassurance and monitors whether the sensation has disappeared. This may bring short-term relief, but it teaches the brain that the sensation is dangerous and must be watched. Attention becomes increasingly inward and the symptom becomes more prominent.

Avoidance can then grow around the fear. The person may stop driving, shopping, socialising, working, looking in mirrors, being alone or going to visually busy places. Avoidance can be understandable in the short term, but a progressively smaller life can reinforce the message that the experience is unsafe.

**A helpful family shift**

Instead of making the main question **'Do you feel normal yet?'**, try: **'What would help you stay connected with what you are doing even while the sensation is here?'** Recovery often involves making the symptom less central rather than winning a constant battle to eliminate it.

## Possible triggers and contributing factors

Episodes may occur alongside panic, high anxiety, trauma-related responses, prolonged stress, exhaustion, sensory overload, low mood or other mental-health difficulties. Sleep loss can make concentration, visual processing and emotional regulation harder. Busy environments, fluorescent lighting, crowds, prolonged screen use, conflict or feeling trapped may be relevant for some people. Others cannot identify a clear trigger.

Substances, medication effects, migraine, seizures and other physical or neurological conditions can sometimes overlap with feelings of unreality. This is why a new presentation should be assessed rather than labelled from an online checklist. Families can help by recording factual patterns - onset, duration, context, sleep, medication or substance changes and functional impact - without trying to diagnose the cause themselves.

## What families may notice

The person may repeatedly ask, 'Do I look normal?', 'Is this really happening?', 'Do you feel real?', or 'Will I be like this forever?' They may stare at their hands, avoid mirrors, check photographs, research symptoms for hours, withdraw from conversation, appear emotionally flat, become frightened by ordinary visual sensations or struggle to concentrate because so much attention is being used to monitor their internal state.

Some people remain outwardly capable. They can work, drive, parent or hold a conversation while internally feeling detached and frightened. Do not assume that functioning means the distress is fabricated. Equally, avoid assuming that every quiet moment or change of mood is depersonalisation. Ask rather than interpret.

## Responding when the person is frightened

Start by reducing threat. Speak normally and slowly. One calm person is often more useful than several people asking questions. You might say, 'I can see this is frightening', 'You don't have to solve the feeling right now', or 'Would you like quiet, company or to do something ordinary together?' If the person is physically safe, there is usually no need to make the moment dramatic.

Try not to debate reality for long periods. If the person repeatedly asks whether they are real, answering the same question twenty times may provide seconds of relief but can strengthen reassurance dependence. A planned response can be kinder: 'I've answered that and I know the feeling is still scary. Let's not feed the checking. Shall we use your grounding plan or carry on with what we were doing?'

## Grounding: reconnecting rather than testing

Grounding directs attention towards present-time information. Useful options can include feeling both feet against the floor, noticing the weight of a mug, naming five neutral objects, describing the room out loud, listening to familiar music, walking, folding laundry, preparing food, holding a textured object, orienting to the date and place, or talking about an ordinary topic. The best grounding often feels simple rather than dramatic.

Grounding can become unhelpful if it turns into another test: 'I must do this until I feel completely real.' Repeating a technique every few seconds to measure whether the sensation has gone can maintain symptom monitoring. The aim is to help the person participate in the present, not to force a particular sensation.

Body-focused breathing and mindfulness help some people but can intensify detachment for others, especially if they become hyper-aware of breathing, heartbeat or bodily sensations. Eyes-open, externally focused grounding may be more comfortable for those people. Build an individual menu rather than assuming one technique suits everyone.

**Personal grounding menu**

Record **what helps**, **what becomes another form of checking**, **words that reassure without feeding the cycle**, **touch/no-touch preferences**, **sensory needs**, **who can be contacted**, and **what changes would mean professional or urgent help is needed**.

## What tends to make things worse

Mocking the experience, demanding that someone 'snap out of it', repeatedly testing memory, forcing eye contact, making them stare into a mirror, insisting they describe trauma, or telling them they are being ridiculous can increase shame and arousal. So can frantic reassurance, hours of symptom research and treating every unusual sensation as evidence of deterioration.

Be careful with frightening internet content. Online forums can provide connection, but repeatedly reading catastrophic recovery stories or comparing every sensation with another person's symptoms can increase hypervigilance. Families can encourage balanced, reputable information and professional assessment when needed.

## After a difficult episode

Allow the nervous system to settle. The person may feel exhausted, embarrassed, headachy, emotionally numb or frustrated. Later, review what happened without conducting an interrogation: What was happening beforehand? What was the earliest sign? What helped? What did we do that increased checking? Was there something practical - sleep, food, sensory load, conflict, medication or substance use - worth discussing with a clinician?

If you responded badly because you were frightened, repair matters. 'I kept asking you questions because I panicked. I can see that increased the pressure. Next time I'll try the plan.' Supporters do not need to be perfect; they do need to be willing to learn.

## Relationships: when disconnection feels personal

Partners can be deeply hurt when affection, intimacy or emotional warmth seems to disappear. The person experiencing depersonalisation may be equally frightened by their numbness. Both truths can coexist: the symptom may not be a deliberate rejection, and the partner may still experience loneliness. A useful conversation is, 'How can we show connection through actions when feelings are hard to access?'

Connection can be behavioural as well as emotional: sitting together, making tea, sharing a meal, walking the dog, watching a familiar programme, completing a household task, offering a hug when wanted, or keeping a small routine. These ordinary acts can reduce pressure to manufacture a particular feeling on demand.

### Parents, siblings, friends and children

Parents can become hypervigilant and begin monitoring every expression. Adult children may feel responsible for stabilising a parent. Siblings can feel that all family attention is consumed by symptoms. Friends may withdraw because they do not know what to say. Name these dynamics early. Children should receive simple, age-appropriate reassurance and should never become responsible for monitoring an adult's mental state.

## Work, study, driving and daily functioning

Concentration may become difficult because attention is divided between the task and constant internal monitoring. Visually busy environments, meetings, screens or travel can feel overwhelming. Practical adjustments might include breaks, reduced sensory load, written instructions, gradual return to avoided settings or discussion with occupational health where appropriate. The aim is to support functioning without automatically removing every challenge.

Driving needs individual judgement. If the person feels too detached, confused, visually impaired or unsafe to drive, they should not drive until the situation has been appropriately assessed. Families should avoid either minimising genuine safety concerns or assuming that the diagnosis automatically means a person can never drive.

## Professional assessment

A GP or mental-health professional may ask when the symptoms began, whether they are continuous or episodic, what the person means by 'unreal', whether insight is retained, and how the experience affects work, relationships, sleep and self-care. They may explore panic, anxiety, depression, trauma where relevant, medication, alcohol or drug use, physical health and neurological symptoms.

Good assessment also considers alternatives. Feelings of unreality can occur in several conditions and contexts. The purpose is not simply to attach a label but to understand the presentation, rule out important causes and formulate what is maintaining the distress. Families can contribute factual observations with the person's consent but should avoid speaking over them or insisting on a preferred diagnosis.

## Treatment and recovery

Psychological treatment may include psychoeducation about the fear cycle, reducing reassurance and checking, working with panic and anxiety, graded re-engagement with avoided situations, attention training, emotional regulation and addressing trauma-related difficulties when clinically appropriate. Therapy should be tailored to the individual rather than assuming every case has the same origin.

There is no single medication that reliably switches depersonalisation or derealisation off. Medication may be used for co-occurring depression, anxiety or other assessed conditions. Medication changes, side effects or substance use should be discussed with an appropriate clinician rather than managed through family experimentation.

Recovery is often uneven. A difficult day after a better week does not erase progress. Improvement may look like spending less time checking, being less frightened by the sensation, returning to work or social activities, tolerating mirrors or busy places, sleeping more reliably, reconnecting with relationships and allowing periods of normal absorption without immediately scanning for symptoms.

**Notice function as well as feeling**

Instead of asking only **'How unreal do you feel from 0-10?'**, notice: **What did you do today despite the sensation? How long did you go without checking? What did you reconnect with? What helped you remain in the situation?** These questions can make progress more visible.

## Supporting treatment without becoming the therapist

Practical support may include helping the person prepare questions for an appointment, accompanying them if requested, creating a calmer environment after a difficult day or reminding them of an agreed plan. It does not require you to analyse every sensation, provide unlimited reassurance, research for hours, manage their therapy or become available every minute.

Where safe and realistic, encourage autonomy: 'Would you like me beside you while you make the call?' rather than automatically making it; 'Which grounding option are you choosing?' rather than taking over; 'What does your plan say?' rather than becoming the plan yourself.

## Safeguarding the supporter

This deserves as much space as symptom management. Living beside persistent fear and reassurance-seeking can alter the supporter's life. You may begin sleeping lightly in case you are needed, avoiding your own plans, answering the phone immediately, researching late at night, driving everywhere, taking over responsibilities or constantly scanning the person's face for signs that another episode is starting.

The emotional load can include fear, sadness, anger, helplessness and grief for how the relationship used to feel. Supporters sometimes feel ashamed of resentment because the other person is suffering. Resentment is often a signal that needs, limits or responsibilities have become unbalanced. It deserves attention rather than secrecy.

## Boundaries are not abandonment

A boundary describes what you will do. 'I can sit with you for twenty minutes and then I need to sleep.' 'I will answer the reassurance question once, then I will help you redirect.' 'I can attend the appointment, but I cannot speak for you unless you ask.' 'I cannot cancel work every time you feel unreal.' 'I want to talk, but I will leave the room if I am being shouted at or threatened.'

A frightened person may initially experience a boundary as rejection. That does not automatically make it unsafe or unkind. Predictable boundaries can reduce uncertainty for everyone. Explain them when things are calm and keep them as consistent as possible.

## Support versus rescue

**Support** increases the person's resources: listening, encouraging skills, helping them access appropriate care and remaining alongside them while they do what they can do themselves. **Rescue** repeatedly removes every discomfort, makes all decisions, performs tasks the person can safely attempt, or makes the supporter responsible for preventing every episode. Rescue can arise from love, but over time it may increase dependence and burnout.

Reassurance can also become a form of rescue. If the person asks the same reality question repeatedly, agree a compassionate limit. This is not withholding care; it is refusing to strengthen a cycle that is keeping both people trapped.

## Carer fatigue and burnout

Watch for poor sleep, irritability, dread when the phone rings, difficulty concentrating, cancelling social contact, neglecting health appointments, feeling numb, crying unexpectedly, resentment, compulsively checking the person's whereabouts, or being unable to enjoy time away because you feel guilty. If your entire day is organised around preventing another person's distress, the support arrangement needs reviewing.

**Supporter wellbeing check-in**

Ask: **Am I safe? Am I sleeping? Do I have time that belongs to me? Can I go out without feeling responsible for what happens? Do I have someone I can be completely honest with? Am I keeping frightening secrets? Have work, finances, friendships or my health been damaged? What responsibility needs to move back to the person or to professionals?**

## Physical, emotional and financial safety

Depersonalisation and derealisation do not make somebody inherently dangerous. Most people experiencing them are frightened, not threatening. But a mental-health explanation does not require another person to accept coercion, threats, violence, destruction of property, sexual boundary violations or financial exploitation. If you are unsafe, move to safety and seek appropriate help. Children and vulnerable adults must also be safeguarded.

Maintain financial independence where possible. Be cautious about taking on debt, repeatedly covering losses or allowing unrestricted access to accounts because you feel guilty. If the relationship has become coercive or frightening, seek independent support rather than trying to manage the situation alone.

## Get support for yourself

You may benefit from counselling, family therapy, carer support, peer support or simply a trusted person outside the immediate situation. Your support can focus on your experience: fear, exhaustion, grief, anger, boundaries, practical decisions and rebuilding parts of life that have disappeared. You do not need the other person's permission to look after your own mental health.

## When urgent or emergency help is needed

Seek professional advice when symptoms are new, severe, rapidly worsening, causing major functional impairment, associated with significant confusion or memory change, or occurring alongside concerning physical or neurological symptoms. Urgent help is also needed for serious self-harm, suicidal intent or other immediate safety concerns.

If there is immediate danger to life or a serious medical or mental-health emergency, call 999 or attend A&E.; NHS 111 can provide urgent health advice. Follow an existing crisis-team or care plan where one is available. Samaritans can be contacted on 116 123 in the UK and ROI for emotional support. A family member is not a substitute for emergency or clinical services.

## Practical coaching tools for the family

**1. Map the fear-checking loop.** What sensation appeared? What did the person fear it meant? What checking, reassurance, avoidance or research followed? How long did the relief last? What could be tried next time that acknowledges the fear without feeding the checking cycle?

**2. Create a reassurance agreement.** Decide which questions need factual answers and which are repetitive reassurance. Agree a phrase such as: 'We have answered this. I know the feeling is still frightening. Let's use the plan rather than ask the question again.' Review the agreement when calm, not in the middle of an argument.

**3. Build a graded return to ordinary life.** List avoided activities from easier to harder: a short shop, ten minutes in a cafe, a drive with support, a meeting, a busy supermarket, a social event. Recovery work should be individually paced and, when symptoms are severe, discussed with a clinician. The goal is participation rather than proving fear wrong in one dramatic leap.

**4. Relationship check-in.** Each person completes: What has been hardest for me? What do I miss? What helps me feel connected? What reassurance has become unhelpful? What do I need more of? What do I need less of? What responsibility belongs to me, what belongs to you, and what belongs to professionals?

**5. Supporter's boundary plan.** I can... / I cannot... / My protected time is... / If I feel unsafe I will... / The people I can contact are... / The financial boundary I need is... / The situation that requires professional rather than family support is...

**6. Next-episode plan.** Early signs: _____. Helpful words: _____. Grounding options: _____. Touch: welcome / ask first / not helpful. Reassurance limit: _____. Things that worsen symptoms: _____. Who to contact: _____. Threshold for urgent help: _____. What the supporter needs afterwards: _____.

## Myths worth challenging

**'Feeling unreal means I am losing my mind.'** The experience can be terrifying, but many people retain insight and recognise it as a feeling of unreality. **'If I cannot feel love, the relationship must be over.'** Emotional numbing is not a reliable relationship test. **'I need to check until I feel normal.'** Repeated checking can keep attention fixed on the symptom. **'Avoiding everything will keep me safe.'** A progressively smaller life can strengthen fear. **'My family must always reassure me.'** Warm support can coexist with limits on repetitive reassurance.

## Recommended reading

**Overcoming Depersonalization and Feelings of Unreality** - Anthony David, Emma Lawrence, Dawn Baker and Elaine Hunter. A practical CBT-oriented book focused specifically on depersonalisation and derealisation. **Coping with Trauma-Related Dissociation** - Suzette Boon, Kathy Steele and Onno van der Hart. Particularly relevant where dissociation occurs in a trauma-related context. **Healing the Fragmented Selves of Trauma Survivors** - Janina Fisher. A broader trauma-focused text that can help readers understand disconnection and protective responses; it should not be treated as an explanation for every case.

## UK information and clinical sources

Useful public information includes the NHS material on dissociative disorders and on anxiety/panic, Mind's information on dissociation and dissociative disorders, and relevant NICE guidance for anxiety and trauma-related presentations. These sources support the importance of assessment, talking therapies where appropriate, treatment of co-occurring difficulties and urgent help when risk is present. Service details can change, so website information should be checked periodically.

This guide is educational and is not a diagnostic tool or a replacement for individual medical, psychological or psychiatric advice. New or unexplained symptoms should be appropriately assessed, particularly where physical or neurological causes, medication effects or substance use may be relevant.

## A message from Maggie

*When somebody you love tells you that they do not feel real, that their own face feels unfamiliar, or that the room and the people in it suddenly seem distant, it can be incredibly difficult to know what to say. You may want to find the one perfect sentence that brings them straight back. You may also feel frightened yourself - especially when the person says they cannot feel the connection or emotion that you know has always been part of your relationship.*

*Please try to remember that the experience is happening to them; it is not automatically a statement about you. You do not have to debate them into feeling real. Calm company, less pressure, ordinary routines, personalised grounding and the right professional support can be much more helpful than repeatedly trying to prove that everything is normal.*

*There is another person I want you to remember as well: you. It is very easy for a partner, parent, sibling or friend to become the person who answers every question, cancels every plan and stays permanently alert in case something happens. That may begin as love, but nobody can live indefinitely in that state.*

*You are allowed to sleep. You are allowed to work, see friends, laugh, take a break and have parts of your life that do not belong to somebody else's symptoms. You are allowed to have boundaries, and you are allowed to ask professionals to carry the responsibilities that belong to professional care. Caring deeply for somebody does not require you to disappear.*

*My hope is that understanding depersonalisation and derealisation makes the experience less frightening for everyone around it. The goal is not to build family life around the symptom. It is to understand what may be happening, reduce the fear and checking that can keep it central, strengthen safe support and gradually allow ordinary life, relationships and confidence to become bigger again.*

**Maggie Learoyd**
**Space to Breathe Therapy**

### Final coaching question

What one change could make this relationship 5% less organised around the symptom this week - while still helping both people feel understood, supported and safe?