

THE BEHAVIOUR INSTITUTE
Diploma in Trauma-Informed Psychotherapy

UNIT 3 • CORE READING 3 OF 6

03

Dissociation

When the mind disconnects to survive

What This Document Covers

Unit 2 introduced freeze as one of four core trauma responses. This document extends that idea into dissociation — a broader spectrum of experiences involving disconnection from the body, emotions, memory, or surroundings, ranging from mild and common to severe and clinically significant.

Dissociation as a Spectrum

It is worth establishing early that mild dissociation is a genuinely normal, common human experience, not inherently pathological. Losing track of time while driving a familiar route, becoming so absorbed in a book that the surrounding room fades from awareness, or daydreaming through part of a conversation are all mild, everyday forms of dissociation. What distinguishes clinical dissociation is not the basic mechanism, but its frequency, intensity, and the degree to which it interferes with daily functioning and safety.

Forms of Dissociation

Depersonalisation

A sense of detachment from oneself — feeling like an outside observer of one's own thoughts, feelings, or body, or a sense that one's body does not fully belong to oneself. People often describe this as feeling unreal, or watching themselves from outside their own body.

Derealisation

A sense that the external world is unreal, dreamlike, foggy, or distant — familiar surroundings can suddenly feel strange or unfamiliar, or the world can take on a flat, artificial quality.

Dissociative Amnesia

An inability to recall important personal information, typically of a traumatic or stressful nature, beyond what would be explained by ordinary forgetting. This can involve a specific event, a period of time, or in rarer, more severe cases, significant portions of one's personal history.

Dissociative Identity Presentations

At the most severe end of the spectrum, involving a marked discontinuity in sense of identity, sometimes experienced as distinct identity states, alongside significant gaps in memory for everyday events, personal information, or traumatic events. This represents the far end of a spectrum, not a separate, unrelated phenomenon — it shares the same underlying mechanism as the milder forms covered above, differing substantially in degree and clinical significance.

Pause and Consider

Can you recall a moment of mild, everyday dissociation in your own life — losing time on a familiar drive, or feeling briefly detached during a stressful moment? What did that experience actually feel like, and does

recognising it as a mild form of the same mechanism covered in this document change how you think about more severe presentations?

Why Dissociation Happens

Dissociation functions as a protective mechanism, closely related to the freeze response covered in Unit 2. When a threat is severe, prolonged, or genuinely inescapable, and neither fighting nor fleeing is available, disconnecting from the full emotional or sensory reality of the experience can serve a genuinely protective function — reducing the immediate psychological impact of an experience that could not otherwise be survived intact.

This is precisely why dissociation is seen so often in the context of Complex PTSD, covered in Document 2 — prolonged, inescapable trauma, particularly trauma occurring in childhood, is exactly the context in which dissociation is most likely to develop as a repeated, learned response, sometimes persisting long after the original threat has ended.

A Story to Make This Real

Consider a composite scenario drawn from patterns seen repeatedly in practice. A client, “Callum,” 26, described to his therapist a recurring experience during arguments with his partner: partway through a disagreement, he would suddenly feel as though he were watching the conversation from somewhere just outside his own body, unable to fully feel what he knew he should be feeling, and struggling afterward to recall exactly what had been said.

Callum had initially assumed this meant something was fundamentally wrong with him, and had not mentioned it to previous professionals for fear of how it might be received. Exploring his history revealed a childhood home marked by frequent, unpredictable parental conflict that Callum, as a child with no ability to leave or intervene, had learned to survive partly by mentally checking out — a strategy that had genuinely helped him get through an inescapable situation at the time, and that his nervous system continued to reach for automatically, decades later, whenever conflict arose.

Understanding dissociation as a learned, protective response — not a sign of something being wrong with him — changed how Callum related to his own experience considerably. It also changed what became clinically useful: rather than needing to be told to simply stay present, Callum needed the kind of grounding and nervous-system work covered further in Units 4 and 5, aimed at gradually widening his capacity to stay embodied even under emotional stress.

Why This Matters Clinically

Dissociation is frequently under-recognised in practice, partly because it can look, from the outside, like inattention, disengagement, or even indifference — echoing the hypoarousal territory covered in Unit 2. A client who appears distracted, vague, or emotionally flat during a difficult topic may not be uninterested or resistant; they may be genuinely dissociating in that moment. Recognising this in real time changes how a practitioner responds — toward grounding and gentle reconnection, rather than pushing further into content the client is not currently able to process.

What's Next

This closes the Core Reading portion of this unit. The Materials section that follows turns to how PTSD, Complex PTSD, and dissociation are actually assessed and distinguished from one another, and from other conditions, in real clinical practice.

A Few Things to Take With You

- Mild dissociation is a normal, common human experience; clinical dissociation is distinguished by frequency, intensity, and functional impact
- Forms include depersonalisation, derealisation, dissociative amnesia, and, at the most severe end, dissociative identity presentations
- Dissociation functions as a protective mechanism, closely related to freeze, particularly under prolonged or inescapable threat
- It is seen especially often alongside Complex PTSD, given the prolonged, inescapable trauma context both share
- Dissociation can be mistaken for disengagement or indifference, when it is in fact a genuine, involuntary protective response

Before You Move On

- In Callum's story, what changed once he understood his experience as a learned protective response rather than a personal flaw?
- Why do you think dissociation is so often mistaken for disengagement, both by the people experiencing it and by those around them?
- What would a genuinely trauma-informed response look like if you noticed a client dissociating mid-session?