DISSOCIATION RESPONSIVE CARE™ · A TOOL FOR CLINICIANS

Naming It: sharing a suspected dissociative disorder

You get to choose whether, when, and how. This guide helps you decide, and find the words.

Start here: suspicion is not diagnosis

Many clinicians feel pulled between two fears: saying too much, too soon, or staying silent while the client struggles without an explanation. Both are understandable.

Sharing is a clinical intervention. It should be paced, purposeful, and collaborative.

Screening is not diagnostic, and diagnosis is iterative (DRC Guide, Appendix D). Consider consultation or structured assessment before you name anything as settled.

Check before you speak

Four questions to ask yourself first. If any answer is "not yet," keep adapting your pacing without the label (Pillar 1).

YOUR READINESS CHECK

- ✓ **Rapport:** does this client trust me enough to hear something that may feel big?
- ✓ **Capacity:** are they stable enough now? Insight is not readiness.
- ✓ **Hypothesis:** am I holding this as a possibility, with assessment or consultation in mind?
- ✓ **Purpose:** can I say how sharing will help their care?

Name the function

Share to serve the client's care, not to resolve your uncertainty.

Good reasons: it can explain experiences that carry shame (lost time, feeling pulled in different directions), it lets you set pacing together, and it supports informed consent about treatment. Why it matters: when clients are not told what you are thinking, they may feel watched or managed instead of partnered with.

Signs a client may be open to the conversation

These are clinical cues, not a validated test. Listen for the client's own language.

- *"Sometimes I lose time and I don't know why."*
- *"It feels like part of me wants this and part of me doesn't."*
- *"What is happening to me? Is something wrong?"*
- *"Could this be something like DID?"*

When to hold off

Waiting is not avoidance. It can be active protection of the alliance.

- ✓ The client is in acute crisis or recently destabilized
- ✓ Trust is still fragile, or the client is shutting down in session
- ✓ You cannot yet explain how sharing would help their care

Holding it is not hiding it. Keep working with DRC adaptations and revisit.

How to share it: five steps

Slow, collaborative, and in the client's language.

1 Ask permission and set the tone

> *"I've noticed some patterns I'd like to share with you. Is now an okay time?"*

2 Describe what you have seen, not a label

Start with observations and what they may mean. Use "parts" or diagnostic terms only if the client does. Never ask parts to show themselves; ISSTD cautions that asking before a client is ready can be destabilizing.

> *"Losing time and feeling pulled in different directions fits a pattern I see when someone's system learned to protect itself by separating experiences."*

3 Frame it as protective

> *"This is an understandable way your mind learned to keep you safe."*

4 Offer a possibility, then invite their view

Say it is not final and that understanding can change over time. Honor plural or non-clinical language.

> *"I'm not giving you a label today. What does this bring up for you?"*

5 Close gently

Keep it brief, check in on presence and body, and orient to the room before the session ends. Plan to check in at the start of the next session.

Be ready for questions

ISSTD recommends a balanced explanation at consent and notes that explanations may need repeating. Prepare answers to:

- ✓ What does this mean?
- ✓ Does it change my treatment?
- ✓ Do I have to talk about my trauma?
- ✓ Who will see this in my record?
- ✓ Do you think I have DID?
- ✓ Can I get a second opinion?

If the reaction is hard

Relief, fear, shame, denial, or going blank are all possible. ISSTD notes dissociative symptoms are commonly denied. Do not argue. If distress, self-harm thoughts, or safety concerns arise, follow your usual risk protocol.

◇ DENIAL

"We don't have to settle this today. Let's keep paying attention to what helps."

◇ FEAR OR SHAME

"A lot of people feel that way. Nothing about this means you are broken."

◇ GOING BLANK

"Let's pause. Would you like to take a moment to do some grounding?"

After the conversation

- ✓ Document your hypothesis, what you shared, and how they responded
- ✓ Consult, and refer for structured assessment when it would clarify care
- ✓ Record what the client said they wanted to know, or wanted to hold off on
- ✓ Think before you record or code a suspected diagnosis: notes may be readable by the client and may reach insurers or other providers. Mention this if they ask who will see it
- ✓ Revisit over time; diagnosis and language can change

A clinical reminder

You do not need certainty to be responsive. Rapport, stability, and a clear purpose come first. Share slowly, offer possibilities instead of verdicts, and be ready to return to the conversation.

Sources: ISSTD, Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision (J Trauma Dissociation, 2011); DRC Clinician Guide, Pillars 1, 3, 5 and Appendix D.
Scope: For licensed clinicians or those practicing under supervision. Practice within your scope, training, and state or agency rules. This guide is not a diagnostic tool and does not replace training, supervision, or clinical judgment.
Evidence note: The sharing steps reflect DRC clinical reasoning and ISSTD guidance. They are not drawn from studies on diagnostic disclosure.
Sample language is a starting point. Adapt it to the client, their culture, and the moment.
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