NR 607 Week 6 Discussion Post

Follow these guidelines when completing each component of the assignment. Contact your course faculty if you have questions.

General instructions:

Dissociative and somatic symptom and related disorders are complex mental health problems that are often associated with trauma. These conditions can create diagnostic and therapeutic challenges. Afflicted individuals may not be aware of their condition and may not seek psychiatric care. Stigma and biases, both in society and in providers, may also hinder treatment.

Include the following sections:

I. Application of Course Knowledge

a. Explain how trauma is related to the development of dissociative and somatic symptom and related disorders.
b. Describe how clients with dissociative disorders are represented in the media. What role does media portrayal play in the public's perceptions of these disorders? What role does media portrayal play in mental health providers' perceptions of these disorders?
c. Discuss at least two (2) potential personal or professional biases providers may need to address to effectively diagnose and treat clients with dissociative and somatic symptom and related disorders.
d. Describe two (2) or more treatment challenges associated with treating clients with dissociative and somatic symptom and related disorders.

Answer

Explain how trauma is related to the development of dissociative and somatic symptom and related disorders.

Dissociative and somatic symptom related disorders are complex mental health disorders that exhibit diverse psychiatric symptoms and are more common than most people think. In general, most laypersons think that dissociative state symptoms, somatic symptoms, and dissociative disorders (DD) are rare, when in fact, they are more prevalent than schizophrenia and bipolar II disorders, affecting 1-1.5% of the general population (Bistas & Grewal, 2024). It is thought that childhood traumas including mental, physical, and sexual abuse, emotional neglect, disrupted attachment, lack of social and familial support, and boundary violations are some of the several etiological factors that contribute to the development of DD (Bistas & Grewal, 2024). Traumas stemming from familial, societal, and cultural sources play a significant role in shaping the development and phenomenology of these disorders, especially when severe long-term abuse occurs in childhood (Bistas & Grewal, 2024). Research using neuroimaging studies with fMRI/MRI technologies has underscored the neuroanatomical links between DD and trauma (Boyer et al., 2022). There are intriguing structural and functional changes in the brains of individuals with DD that are similar to those observed in individuals with PTSD, further

strengthening the belief that complex trauma literally changes the way trauma survivors respond to stress throughout their lives, survivors often continuing to experience dissociation and somatic symptoms long after the trauma has ended (Bistas & Grewal, 2024). Dissociation, which can be defined as disconnections between thoughts, feelings, behaviors, sensations, and other mental processes that would normally be connected, is a natural human phenomenon, and can be as benign as daydreaming during a boring class lecture or as damaging and problematic as the experience of rape survivors who 'check out' during the assaults and then dissociate automatically in response to any unwanted stressors in their life (Boyer et al., 2022).

Dissociation is perceived to be a protective mechanism triggered by profound trauma; the dissociative tendencies develop as a coping mechanism to navigate the ongoing trauma that a child is unable to escape from on their own. Studies have shown a robust correlation between repeated childhood trauma and dissociation, which can serve as a psychic escape in the face of overwhelming trauma when there is no chance of physical escape (Bistas & Grewal, 2024). It is thought that when children are subjected to repeated traumas and are unable to "help themselves," due to being a child without resources, dissociation serves as a survival strategy, shielding the young mind from the overwhelming emotional and psychological repercussions of trauma (Bistas & Grewal, 2024).

As a defense mechanism, dissociation involves compartmentalization, emotional numbing, detachment from traumatic experiences and amnesia or memory gaps (Bistas & Grewal, 2024). While dissociation offers short-term benefits to survive trauma, when it persists and becomes a rigid and automatic response to stress, dissociation can disrupt the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and social behavior (Boyer et al., 2022). While the dissociation may have been a protective adaptation for trauma survivors during the traumatic experiences, severe persisting dissociative and somatic symptoms can interfere with all aspects of functioning and bring increased health and social risks including chronic pain, somatic symptoms, psychogenic seizures, and a decreased ability to process cues of danger and discern threatening situations (Boyer et al., 2022).

Experts in the field propose that DD arises from the traumatized children's inability to form a cohesive sense of self, leading to development of dissociative and somatic symptoms and in the case of prolonged and intense trauma, dissociative identity disorder (DID), considered the most severe form of childhood- onset PTSD (Bistas & Grewal, 2024).

Even the physical location of DD in the DSM-5-TR shows how the complex developmental condition of DD arises from post-traumatic experiences: It is strategically positioned after the chapter on trauma and stressor-related disorders, such as PTSD, acknowledging the strong causation link between the DD spectrum and psychological trauma (Bistas & Grewal, 2024). Interestingly, the vast majority of people diagnosed with DDs also experience comorbid PTSD (Bistas & Grewal, 2024).