WALKING WITH GRIEF & TRAUMA: A DEVELOPING COUNSELLING PRACTICE

by

Thea Megas

A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Counselling (MC)

City University of Seattle
Vancouver BC, Canada site

October 21, 2017

APPROVED BY

Christopher Kinman, M.Sc.; M.Div. Thesis Supervisor.
Maria Stella, PhD, RCC, Faculty Reader

Division of Arts and Science

Abstract

Background: A counselling practice involving walking with clients during counselling sessions seems to be gaining popularity across North America. There is a prevalence of practice of using this modality in working with people critically impacted by grief and/or trauma. However, there is no research supporting this practice. The research on walking with clients for any therapeutic purpose is skewed, limited, and rare. **Method**: An ethnographical epistemological literature review unpacks grief, trauma, and the idea of walking with counselling clients. **Results**: Grief and trauma are understood via an academic, historical, and etiological context as interrelated aspects of loss. Clues from historical and current literature demonstrate grief and trauma can be serious conditions impacting the mind, heart, and body and therefore potentially benefiting from mind-body treatments. Evidence for this is found in the way grief and trauma are languaged, historically documented, and colloquially understood, as well as in a precedent setting prevalence of practice of walking with clients. **Conclusion**: Walking with clients is understood as a practice validated as potentially impactful for counselling in general, and specifically for grief and trauma work.

Keywords: grief, trauma, loss, melancholy, sorrow, anxiety, depression, somatic, soma, mind-body, body-mind, counselling, counsel, counsellor, psychotherapy, psychology, Walk & Talk Counselling, Walking Therapy, Running Therapy, Dynamic Running Therapy, Runtalk, PTSD, Mindful Walking, Labyrinth Walking, Walking Group, mental health, treadmill

Acknowledgements

I would like to express my sincere gratitude and appreciation to:

My thesis advisor, Christopher Kinman, for his positive reassurance and support, and for encouraging me to look at things in a way I hadn't before and acknowledge, as he calls it, the lineage of psychology. Additionally, the faculty, staff, and students at CityU – thank you for the partnership and learning that has led to this end! Particularly, to Maria Stella, who acted as my second reader for this thesis, and whose incredible attention to detail, heartening feedback, and curious questioning allowed me to hone in on finer points in this work. Moreover, the CityU librarians, Theresa Gehrig and Miriam Wnuk, who processed countless requests for obscure, obsolete, and ancient texts for me with a zest and collaborative attitude I will never forget! Without their hard work, the historical aspects of my thesis would not exist.

My husband, Craig Rawlyk, who has let me chase my dreams and laughed his way through the more challenging times with me. And, to our children Blake and Kaida, who have been bright spots in hard times, and have shown an incredible degree of patience with me as I have had to spend time with school rather than with them so frequently over the last years. Additionally, our dog, Chili, who is my own special trauma-rescue project, who has barely shaken at all since I started walking with her. The rest of my incredible family; for all of the support, laughter, walks, and food! Most especially, my mother, Carol Megas, who has carried on our long standing tradition of supporting me by editing my work page by page, word by word, comma by comma.

My dear friends who have encouraged me and listened to me endlessly, taken me for walks, hugged me, laughed with me, shared wine and Zumba with me, worked on my energy with me, helped with my children, read over my papers for me, and just been there. A special

thank you to Maryam who inspired me to start this program and who has cheered me on and kept me enthused, even from a great distance in the end! And to Erika and Monika, who have lent me an ear time and again through the process, as well as read some of my work and provided feedback.

My colleagues, especially my Director, Alison Grauer, who first supported my application to this Master's program, and has stood with me through all the ensuing chaos and learning.

Finally, to everyone I have ever known who has shared their experience of grief or trauma with me. I am honoured to have learned from your lives, and I hope that in this thesis I do some justice to what I think I have seen.

Table of Contents

List of Tables

List of Figures

List of Acronyms

3MDR: Military Motion Memory Desensitization and Reprocessing

APA: American Psychiatric Association

BCPMHPC: British Columbia Provincial Mental Health & Practice Counsel

CBT: Cognitive Behavioural Therapy

CNS: Central Nervous System

DSM: Diagnostic and Statistical Manual of Mental Disorders

PCBD: Persistent Complex Bereavement Disorder

PTSD: Post Traumatic Stress Disorder

WT: Walking Therapy/ Walk & Talk Therapy (interchangeable)

VT: Vicarious Trauma

Chapter I Introduction

All people experience loss (Archer, 1999). Furthermore, the impact of loss is different for everyone, to some degree (Archer, 1999). This is so much so that some have proposed the psychology of loss be designated a fully separate field of psychology (Harvey & Miller, 1998). However, common reactions to loss include experiencing grief and trauma as well as depression, anxiety, and disruption in identity, self-efficacy, attachment and self-esteem (Archer, 1999; Harvey & Miller, 1998; King et al., 2014; Pillai-Friedman & Ashline, 2014; Boss, 2010; Papa & Maitoza, 2013; American Psychiatric Association [APA], 2013). Further, loss provokes conditions that have a tendency to ease with time and naturally resolve for most people (Winokuer & Harris, 2012; Zhang, El-Jawahri, & Prigerson, 2006; Harvey & Miller, 1998). For most, loss will not be a condition requiring clinical intervention (Winokuer & Harris, 2012; Parkes, 2011; Zhang et al., 2006). For a select few, however, psychotherapy will be recommended as crucial, particularly around grief and trauma (Winokuer & Harris, 2012; Parkes, 2011). It is my opinion that clinicians working with these clients have a simple and historically validated tool at their disposal. This tool does something important in regards to loss: it supports the movement through loss-provoked conditions by invoking physicality into counselling. This tool is Walking Therapy or Walk & Talk Therapy (WT); walking with clients while conducting counselling sessions.

Background

Years ago, I came across what I now understand to be a well-known poem written by Andy Raine (2000) which reads:

> Do not hurry as you walk with grief; it does not help the journey.
>
> Walk slowly, pausing often: do not hurry as you walk with grief.

Be not disturbed by memories that come unbidden.

Swiftly forgive; and let Christ speak for you unspoken words.

Unfinished conversation will be resolved in Him.

Be not disturbed.

Be gentle with the one who walks with grief.

If it is you, be gentle with yourself.

Swiftly forgive; walk slowly, pausing often.

Take time, be gentle as you walk with grief. (p. 225-226) [1]

This is a piece I have heard referenced at countless funerals and memorial services. For me, it has always seemed incredibly full of wisdom, if lacking a bit in poetic style. The poem is found nestled within a collection of much older prayers and devotions, placed there by the publisher of the book with no indication of where it is from or that it is his own work. And yet, this poem is greatly responsible for igniting this thesis topic in me. The piece has been a companion and guide in my own experience of grief as well as in this thesis, so I must pause a moment to recognize it as an inspiration: It is largely the basis for my hypothesis that walking with a person who is caught in grief or trauma could be a helpful clinical counselling intervention.

For me, the wisdom within the poem is pronounced. Accordingly, grief is not meant to be hurried, harried, or dealt with alone. It is a process involving acceptance, forgiveness, and support in speaking and finding meaning. There is a need for gentleness, kindness, slowness, and most of all, time and movement in meeting grief. Most notably, this poem explicitly draws

[1] This poem is found in a daily prayer book produced by a religious community, the Northumbria Community. It was written by one of the founders of the community, Andy Raine and first published in 2000. However, the writing is often mis-attributed to George MacDonald who lived and wrote in the early 19th century, as is easily evidenced when by searching the poem online. While the piece is not old as it is widely believed to be, the prevalence of hits online associated with grief advice and support does establish that the poem has been widely accepted as useful over the past 17 years.

attention to walking with grief; it links the physical movement with emotional, spiritual, and cognitive adjustment in a way that aligns with the ideals of grief/ trauma counselling.

Specifically, it seems to me that people occasionally become stuck or caught in grief or trauma when processing a loss. Furthermore, sometimes, despite a great deal of support and/or traditional talk therapy, the *stuckness* seems to stick, perhaps even being associated with a mental health diagnosis allied with depression, anxiety, grief, or trauma. Indeed, in the 17th century, psychological philosopher, Robert Burton (1867), in an exploration of the state of melancholy writes:

> The idea of restraint is vexatious and tormenting to the human mind; and a life confined to any precise and particular boundary, still passing round and round in the same circle, like a dog in a wheel, or a horse in a mill, without novelty or change, is so odiously adverse to all the feelings of nature, that it can only be endured in melancholy sufferance. (p. 108)

Notably, Burton published the original *Anatomy of Melancholy* sometime in the mid-1600s, however, there are many edited/ annotated versions of the work in print, such as the 1867 version cited above. Thus, it is certain that the experience of a cognitive-emotional *stuckness* is no new phenomenon.

Additionally, traditional therapeutic counselling sessions, and even specialized interventions specifically targeting grief or trauma seem to not always impact said *stuckness.* I cannot count the number of people I have known who have refused talk therapy, or have become entirely silent on the subject of their grief. In these cases, I have been hard pressed to see how talk therapy could be helpful.

Encountering this in my therapeutic work and personal life, I often resort to one practice;

moving collaboratively with people who seem caught in grief or trauma. Namely, I walk with the person affected while talking with them. My observation is that for some reason, there is often a change during a walk that moves things forward, creates a new meaning, or shifts a perception. Some of the *stuckness* simply evaporates. With this in mind, and reflecting on some familiar idioms such as: *movement through trauma*, *walk with grief, stuck in trauma, Widow's Walk,* and *Grief's Journey*, there is a sense that perhaps moving with a counselling client impacted by loss has a deeper history and truth to it than the lack of research in this area would suggest. Hence, my interest in using walking with clients as a therapeutic intervention to assist in moving through grief and trauma. Indeed, on working with loss, Winokuer and Harris (2012) state "…the most important aspect of your work will be your ability to "walk alongside" your clients as they share their experiences with you" (p. 22). While this may be figurative, the sentiment links precisely to the practice of using WT with clients presenting with grief/ trauma.

What exactly is WT? To begin, it is important to recall and summarize what WT is. WT, also termed *Dynamic Running Therapy, Running Therapy,* and *RunTalk*, is the process of walking or running with a client while conducting a counselling session (McKinney, 2011; Hays, 1994; Doucette, 2004; Nguyen, 2008; Revell & McLeod, 2016; Jung, 2011). It generally takes place outdoors, but can involve indoor/ treadmill walking, is highly accessible (no special training required, and one can walk anywhere), and integrates physical activity and the surrounding environment (McKinney, 2011; Hays, 1994; Doucette, 2004; Nguyen, 2008; Revell & McLeod, 2016; Jung, 2011). WT is the only body-based therapy I have heard of which does not require specialized training or equipment; just reasonable shoes. WT is commonly practiced across North America in a variety of settings such as hospices and by many psychotherapists (see Appendix A and B). It is so simple, that therapists who practice it say they "make it up as they

go" (McKinney, 2011).

Despite this prevalence of practice and history of use, there is little research supporting WT as a clinical practice. However, there is a great deal of knowledge from several relevant though less obvious sources. For example, Burton (1867) states:

> The heavens themselves are in constant motion; the sun rises and sets, the moon increases and decreases, the stars and planets have their regular revolutions, the air is agitated by windes, the waters ebb and flow, and man also should ever be in action. (p. 13) [2]

This quote, which originates sometime in the late 17th century, speaks to the idea that being in motion is intrinsic to human well-being: we must move, inasmuch as our universe does, to really live. Walking, as one of the simplest forms of movement, begs to be explored as a therapeutic enterprise.

Therefore, the question that interests me for this thesis is: Understanding that talk-therapy alone is not always an impactful or opportune intervention for trauma or grief as related to loss; is the collaborative and natural movement of walking with a client as part of therapy sessions a useful way of involving the body as well as the mind in moving people through loss? To answer this question, I juxtapose use of Walking Therapy (WT) with understandings of grief and trauma as conditions of the mind, heart, and body to encourage the idea that WT is an impactful therapeutic intervention for grief and trauma.

Subject of Thesis

The subject of this thesis is exploring the idea of walking with clients through grief and

[2] An alternate, less flowery and likely more accurate translation of this same passage is "The heavens themselves run continually round, the sun riseth and sets, the moon increaseth and decreaseth, stars and planets keep their constant motions, the air is still tossed by the winds, the waters ebb and flow to their conservation no doubt, to teach us that we should ever be in action." (Burton, 2004, Kindle Locations 8773-8775).

trauma as a clinical intervention. My theory is that in using the physical movement of walking with counselling clients, clinicians can support psychological movement through the realms of grief and trauma as related to loss. In fact, I hypothesize that walking with clients is a historically validated intervention that counsellors should turn to more frequently when working with grief and trauma.

Statement of Problem

There are three problems I tend to in this paper. First, grief and trauma are not consistently or well understood or explained in the world of psychology. Second, there is a research gap: Although WT is prevalently practiced, there is limited research on it. It is not well conceptualized or validated as a therapeutic approach in general. Third, despite WT being commonly used to work with grief and trauma, there is little empirical support for this practice.

Statement of Purpose

My overall purpose in this thesis is to provide a foundation for doing WT with clinical counselling clients presenting with grief/ trauma. To address the three problems above, I need to explore and clarify the conditions of grief and trauma, bridge the research gap around WT in general, and demonstrate that WT can be a viable and useful tool to address grief and trauma. Therefore, I intend to establish an operational understanding of grief, trauma, and WT through historical/ epistemological/ ethnographical literature reviews. I also plan to substantiate WT as a practice with particular relevance to loss counselling. I aim to demonstrate that grief and trauma are two related areas of loss that are best treated holistically by involving the mind and the body simultaneously. I intend to validate WT as a viable alternative to traditional talk therapy in working with grief and trauma, largely due to the experiential/ symptomatic make-up of grief and trauma and the manners in which WT is found to interrelate. I mean to further show that

despite a research gap around use of WT in general, there are other manners of knowing that WT does have a strong validity as a therapeutic tool, and that it is a modality more therapists should employ. In the end, I aim to establish a best-practice conceptualization of doing WT with grief/ loss.

Relevance

This topic and question should concern and appeal to those who work with clients who have been impacted by a traumatic event, and/or appear caught in grief or loss. Psychotherapists, counsellors, hospices, people caught and held by loss, as well as those interested in or using WT and other movement therapies are among those who this thesis should intrigue. Doctors and professionals who are encouraging people to walk to improve mental/emotional wellness, particularly in cases where patients are not taking action on walking on their own may find this information useful in connecting clients to WT as a way to get started (ie. overcoming sedentary lifestyles). The reviews I offer on grief and trauma may be of special interest to anyone wondering about how to understand, explain, normalize, or work with grief/ trauma.

Method

My method, while generally a literature review, takes a nuanced approach to the topics of grief, trauma, and WT by utilizing an epistemological/ethnographical lens. Epistemology "is the study of knowledge and the process of knowing… the operating premises that underlie… actions and cognitions" (Gehart, 2014, p. 43). In other words, an epistemological study involves expanding knowledge by relying on a process involving more than one method of inquiry. It is done by looking at the interrelation between the big picture and the small pieces, including the processes surrounding actions and cognition in the investigation, and coming from many different angles to best understand. Ethnography can be understood as a logic-in-use

philosophical mode of epistemology that relies on logical inference based on observation of insider meanings evidenced by recurrent patterning (Green, Skukauskaite, & Baker, 2011). Looking at the etymology of grief/ trauma and exploring the documented historical experiencing of each condition, for example, is an ethnographical epistemological exploration of grief/trauma. Studying grief, trauma, and WT in this manner creates the opportunity to bridge the research gap in regards to using WT with clients held by loss.

Consequently, each section of this thesis involves examining the etiology of each concept; looking far back in human experience to better understand trauma, grief, and the practice of using walking as a therapeutic tool. I utilize a strong historical and colloquial element throughout, building on peer-reviewed and evidence-based practice by drawing in traditional, instinctive, and immersive ways of knowing. For example, I bring in discourse from historical philosophers and poets, as well as from modern psychotherapy experts. I include reference to many aged documents, as well as current interviews and training videos, practitioner websites, newspaper stories, and other informal sources. I offer evidence of how WT practice has established a precedence that is not fully acknowledged in peer-reviewed and classic literature, and give weight to how this prevalence of practice can be seen as validation of the technique. This is to establish a fuller knowing of the concepts, to better support the links between using WT to address grief and/or trauma related to loss. It is key to my thesis that I rely on other ways of knowing outside of academia; the research gap is too significant and insurmountable otherwise.

Through this historical lens, I am able to add credence to the current research in a manner often ignored in the field of psychology. My purpose is to explore the evolution and current practice of WT, generally as well as specifically around grief, loss and trauma, and to create

validity for the practice based on historical context. In this, I address the current lack of an evidence-base showing that WT is data-driven when one takes into consideration the vast history of use. Therefore, for each of the main concepts; grief, trauma, and WT, I devote significant space to a historical study. Overall, I demonstrate that the body should logically be linked to grief and trauma work because of the way the symptoms of grief and loss sit in the body as well as the mind/ heart, and that WT is one simple way therapists can do this.

Organization, structure and progression of thesis. To begin, I explore the concepts of grief and trauma in Chapters II through V. Generally, I clarify that grief and trauma are two aspects of loss with distinct and often overlooked or dismissed symptomology. I demonstrate how grief and trauma can be understood more clearly through examining historical documentation and that they have a relationship to one another and to loss as diagramed in Figure 1.1. For example, although grief is a term often reserved exclusively for the experience of loss related to death, grief demonstrably overlaps and interrelates with the experience of any loss. Further, as will be discussed in the following chapters, trauma can sometimes arise when a person's sense of control, self-determination, or autonomy is significantly interrupted; experiences that can be understood more simply as loss. It is because of this sentiment that I choose to introduce grief prior to trauma in this paper: Grief is the natural reaction to loss, whereas trauma is a condition that only sometimes emerges. Therefore, grief becomes the overarching response under which trauma sometimes exists.

It is important to note that I am not dedicating space to exploring the predominant concept of loss, or other conditions such as anxiety/ depression which are commonly referenced as related to loss and do connect to grief and trauma. I am choosing to focus on loss as related to grief and trauma. Depression, anxiety, disruptions in identity, etc. are equally intriguing aspects

of loss, however, I am limited in how much I can encompass in one thesis. Furthermore, it is my opinion that in examining grief and trauma we cover aspects of these other states. Ideally, I would propose that WT could be helpful in treating all of these pieces, but, for now, grief and trauma shall suffice out of necessity.

Figure 1.1. A Conceptualization of Loss with Related Reactions. Grief is always a part of loss, trauma sometimes is a part of loss, so sometimes is a part of grief. Depression and anxiety can exist separate to the experience of loss, but can also be present in loss, as well as overlap with grief and trauma.

Concretely, I have chosen to focus on grief and trauma as two pieces of loss, with some connection to one another, and have felt a need to dissect and understand these pieces as if viewing them microscopically. In fact, grief and trauma both come across to me as so multidimensional and particular all at once, that it became crucial to my presentation of WT as a viable therapy intervention to unpack grief and trauma exhaustively. There is a great need to source and refine operational definitions for these terms for the sake of clarity, congruency, and

relatedness in this paper and in the field overall, as well as in considering treatment approaches. Consequently, after unpacking grief and trauma as distinct concepts, I will connect them together around the relationship to loss, their symptomology, and the need to find therapeutic approaches that work for both; namely approaches incorporating the body as well as the cognitive and emotional realms typically addressed in talk therapy.

Following this, in Chapters VI through IX, I cover research and publications referencing many different aspects of WT. I begin by looking at walking as therapeutic in and of itself, progress to discussing individual then group walking therapy, and end by covering Mindful Walking and Labyrinth Walking as related. Along the way, I connect this data to therapeutic practices recommended for grief and trauma work.

In Chapter X, I conclude with summative implications for best practice approaches in using WT for grief and trauma, including limitations.

Limitations

WT is not well studied, and I acknowledge that much of my thesis requires drawing connections and inference in ways that are not aligned with traditional literature review methods. In some senses, this may appear to weaken the links I propose. However, the dearth of knowledge I pull in deserves attention. If the perspective I draw from this material is not all-encompassing, I suggest future discussion and research focus on addressing areas of weakness by doing more empirically recognized studies of the same literary sources I offer. Furthermore, as expressed above, I have a personal connection with and bias toward the idea of walking with grief and trauma clients.

Results

Grief, trauma, and WT become known in a manner deeper and fuller than what is

typically covered in a literature review. Grief and trauma grow to be understood as common and natural reactions to loss with a long history of documentation as conditions affecting the mind, body, heart, and soul in various capacities. Talk therapy is found lacking in some regards as it may forget to include the body, and grief and trauma are understood to be conditions where the body is significantly involved. WT is understood as a useful modality to consider for use in clinical work with grief and trauma, and best-practice approaches are summarized. Overall, in this thesis, I clarify that WT is historically a significant therapeutic tool which can be relevant to grief and trauma work due to the physical/ emotional/ mental moving forward that co-occurs.

Chapter II Grief

Before I can go into an academic discussion of grief, I must take a moment and express something of my individual relationship with grief as grief has always felt, to me, such a subjective and personal experience. Indeed, I am sure I am not alone in being able to call to mind no shortage of times in life when grief has manifested. From minute losses to violent and unexpected deaths, grief has made her way into my world time and again. I expect no less of grief; grief will always show up with loss. This is simply the way of it. Still, there is a comfort in knowing that grief is natural and human. Further, although grief has always come to me, I have felt an equal comfort in knowing that the grief will ease, bit by bit, and gradually become a smaller and less influential presence in my heart, soul, and body. The passage of time has felt the most crucial to me in this process, and my grief has to this point always moved naturally through. However, this is not the case for everyone. Sometimes, grief does not seem to be processing, or to be moving along, but instead seems to be holding captive the person impacted. I have seen it before; I am sure you have too. This is the aspect of grief with which I am intrigued; the part that traps some people and holds them in grief long past natural tendency and where the grief is not integrated.

Have you ever been asked how long grief is supposed to last, for example? I have asked this. Many people have asked me. We ask not always for ourselves, but often for a loved one who we perceive to be lost in grief; trapped, stuck, held, or caught. There is a sense that the person is stuck in a way that makes it nearly impossible for them to move forward in life, much less in seeking therapy. Certainly, grief has a way of capturing us, of holding us, and of keeping us in every way. There is no part of a person not impacted by grief. The mind, the body, the heart, the soul; the very energy in the room around a person who is held by grief is markedly

changed. This *stuckness* is, in fact, why I am so invested in working with grief. I have been the one on the outside so many times, simply wishing there was a way other than traditional talk therapy or the passage of time to help someone move through grief.

It is not the stuckness alone which intrigues me, but also the balance between privacy and connection. Personally, the emotional experiencing of any loss in my life has felt wholly my own; something which no one else can quite understand, measure, empathize with, or share, even as I have sought solace in the company of others. So, there is solitude in grief which I acknowledge. However, I have found that few people move through grief entirely alone. Instead, there is an awareness of a need for companionship on the journey, to some degree. Indeed, it is my experience that many share this sense of self-contained processing combined with seeking support. When grief moves through naturally, this seems to work well. However, at times where grief is present for an extended period, social supports dwindle and the equilibrium between solitude and engagement in processing is disrupted. I wonder then, if this is not a role for a counsellor in working with grief; to be a companion on the journey and holding space without infringing on the private experience?

For these reasons (the idea that grief can get stuck, and that stuck grief may need companionship outside of one's natural supports), grief and grief counselling are fascinating to me. However, before I can address the issue of how clinicians can use WT to move through the stuckness with clients, I have to establish, in great detail, what exactly grief entails.

Grief: A Somewhat Epistemological, Etymological, and Ethnographical Exploration

Having stepped away from academics above, I must now return to indicating, by way of an introduction, the purpose of the following chapter: A short epistemological study on grief infused with reflection. My purpose is to explore grief, in the realm of psychology, as a concept

requiring an operational understanding best sourced through a historical lens. Yes, grief, at the base, is an emotional experiencing of loss. However, it is also a thing of many layers. For example, poet Robert Browning Hamilton (1936) writes the poem 'Along the Road' on a dichotomy of pleasure and sorrow which can both be intrinsic to grief:

> I walked a mile with Pleasure;
> She chatted all the way;
> But left me none the wiser
> For all she had to say.
>
> ~
>
> I walked a mile with Sorrow;
> And ne'er a word said she;
> But, oh! The things I learned from her,
> When Sorrow walked with me. (p. 101)

As such, grief lacks a concise, scientific, or measurable definition. This is noticeable in the etymology, or evolution of the language, and the dichotomous universality/uniqueness of experiencing. Therefore, in this section, I study grief through epistemology; looking for knowledge by exploring the use and experiencing of grief as documented in historical and current literature. I believe this is the best way to reach an understanding of grief; examining grief as evidenced in language origins, historical literature references, and psychological literature. By the end of this chapter, we will have journeyed through varying perceptions of grief, followed the psychological conception of grief through centuries of literature, thumbed through the symptoms associated with grief, determined what grief does and does not encompass, and gathered everything together to contextualize and manage the subject of grief for

this thesis. Overall, I use ethnographical observation encompassing etymology, auto-ethnography, symptomology, categorization, and literature reviews to establish how Western society has historically interacted with grief. I also clarify why this knowing of grief is essential to understand in terms of modern clinical intervention.

Etymology of grief. To begin, it is advantageous to unpack the languaging of the word *grief* and explore the origins and usage. For example, Hunt (2004) examines the Greek lexography of *grief r*eferring to the work of Hesychius (1861) who composed a lexicon of Greek words. Hunt states that in Hesychius' lexography, the Greek word for grief is defined as, "distress of mind or body" (p. 9). As such, grief seems simple and straightforward: the mind or body must simply be distressed, and therein, is grief. However, I find this understanding too basic; it is just one piece, and there is much in the way grief has been languaged over the centuries to contextualize it, and show it is more than simply distress, or demonstrate how the mind and body are linked in the experiencing and languaging.

Oxford English Dictionary (OED) (2017a). One highly useful source in working through language development is the *OED*. The *OED* is considered the ultimate source on etymology as it tracks the evolution of language according to usage and meaning throughout history. All tracking of the word *grief* in this section relies on the *OED* unless otherwise referenced.

To begin, the word *grief* itself, spelled *gref* at the time, first appears in English literature as early as c1225 in *Ancrene Riwle*, a guide for female anchorites (women who have retired from society for a spiritual life) (definition 1). In this instance, *gref* is mentioned just once and is not given much context. However, the use of words related to *grief*, or use of *grief* in other languages predates this significantly, such as in the Bible and epics such as *Beowulf*, *Iliad*, and *Odyssey* (Zachary, 2011; Hunt, 2004; Archer, 1999). Obviously, there is a verbal tradition that would

come even before this. Thus, we can surmise that grief has a longstanding place in the English (and pre-English) language and therefore is easily a term defined by use as much as anything.

Building on this, in the early 13th century, *grief* (also spelled *gref/ greeus/ greues* and a plethora of similar ways) is understood as hardship or suffering. This definitive usage does not appear in the literature past 1861. The current definition of grief, per the *OED* (2017a) is:

> Mental pain, distress, or sorrow… Use in a more limited sense: deep or violent sorrow, caused by loss or trouble; a keen or bitter feeling of regret for something lost, remorse for something done, or sorrow for mishap to oneself or others. (definition 7)

Were I able to write an entire thesis on the etymology of grief, I would look also at the words within this definition: *pain, distress, sorrow, regret, remorse*. Exploring these words would build the understanding of the word *grief*. However, due to the etymology of *grief* being just a small part of this paper, I will resign myself to focussing on just *grief* and move on.

Grief is further derived from the Middle English and Old French, *grief*, which is from *grever*, meaning *to burden*. The related term, *grieve*, comes from Middle English for *harm or oppress*, and is based on the Latin word *gravare*. *Gravare* is from *gravis* for *heavy* or *grave*. Going one step further, *grave* comes from the Old English *graef* which is Germanic in origin and relates to the German word for *grab*. *Grave* can not only refer to a burial plot but also can mean *serious.* Finally, in music, *grave* means *slowly; with solemnity.*

Common use. One final point on languaging grief comes just from considering common phrases invoking the word, as follows:

Grief-stricken. This term calls to the mind the notion of being impacted, perhaps even struck down, much as the connection to *grab* above does. The idea of grief striking also speaks to the concept that grief has a life of its own. Being struck is about being hit unexpectedly,

knocked about, stunned; a burst of pain.

Heartbroken. If it were possible for a heart to actually burst from emotion, the loss-provoked sentiment of grief would surely be the cause. Breaking; shattering, falling apart, never to be repaired without cracks, torn in two: This is the infliction of grief.

To be marked, wild, sick, consumed, or beside oneself with grief. To be marked with grief is to be observably different due to the impact of a loss. Think of posture and physical markings like red eyes or dramatic changes in weight. To be wild with grief is to be beyond reason, to move, think, and feel with an abandon not generally encouraged outside of immediate loss. Sick with grief implies the body suffering, wasting away, the feeling of being unable to rise up and move forward. Consumed with grief provokes the image of being lost in a world of grief, of seeing nothing beyond or outside of the loss. How is there hope when one is consumed by grief? How is there anything? Being beside oneself with grief encourages discussion of dissociation and of being with and without oneself at once. The body acting on its own, while the mind restlessly wanders nearby.

These expressions are just a small selection, from the top of my head, attesting again to how the language we use around grief captures so much of the experiencing of grief. This reflection on the language encourages the understanding of grief in a way that must be considered in how we acknowledge and work with grief clinically.

Conclusions on etymology. Taking the above into consideration, in saying *grief* we are not just referencing a feeling of pain and sorrow related to loss, but encompassing the notion of a heavy burden, slowness of process, solemnity, a harm or oppression, and something serious that grabs or strikes. It is necessary to think of grief this way; it is normal, yes, and it is also immense and foreboding with almost a life of its own.

Overall, we cannot understand grief at present if we completely dismiss the past use; it all ties together. What comes before shows up in what we speak of and experience now. Therefore, the evolutionary and now obsolete definitions of *grief* have added depth to our current understandings, as have phrases and idioms incorporating the notion of grief. Grief is just grief, and yet in examining the languaging of it, we can see it is vastly deeper in every way. In the next sections, digging further into the ethnography of grief, going beyond the language and into the experience, moreso clarifies what grief is.

Experiencing grief. As noted above, grief is dichotomous: straightforward and nuanced. This is demonstrated not only in language but also in experience. In this section, I explore both sides of the experiencing of grief; what is simple, and what is complex. This generates a perspective on grief that adds to the ethnology.

What is simple, is that grief is a universal human experience (Shand, 1914; Archer, 1999; Prieto, 2001; Parkes, 2011; Zhang et al., 2006), and has been recognized as such in psychological literature for some time. Indeed, British psychologist, A. F. Shand (1914) undertook what could be considered the first study on grief in an ethnological study on sorrow via writing about the instincts and emotions of grief as documented in poetry and literature (Archer, 1999). Therein, Shand posits that all emotions and impulses will relate back to the innate and primary conditions of fear, disgust, curiosity, anger, joy, or sorrow as provoked by environmental stimulation. Archer (1999) remarks that grief can be observed in babies, children, and animals, particularly around the absence of a cared for being or object. Crucially, as a natural human condition, grief is typically moved through instinctively with no need for clinical intervention (Parkes, 2011; Zhang et al., 2006; Winokuer & Harris, 2012). In this manner, grief can even be thought of as entirely simple, universal, and as the most natural and expected experience in the case of loss.

At the same time, there are layers to grief, and it is a nuanced concept. For example, Archer (1999) points out that how each person manages and addresses grief can be influenced by personality, culture, society, and even profession in diverse and complex ways. Prieto (2001) echoes this, finding grief to be unique in impact, though generally considered unpleasant and painful. As the famous poet, Alfred Lord Tennyson (1849), writes:

> One writes, that `Other friends remain,'
> That `Loss is common to the race'—
> And common is the commonplace,
> And vacant chaff well meant for grain.
>
> ~
>
> That loss is common would not make
> My own less bitter, rather more:
> Too common! Never morning wore
> To evening, but some heart did break. (p. 8)

In other words, per Tennyson, though loss is common, it does not soften the encounter or erase the peerless experiencing of grief. Grief will be met differently despite prevalence. In fact, we know that for a small population, the experience can become difficult and even traumatic when grief does not move through on its own, and counselling or support services are recommended (Parkes, 2011). Undeniably, “Grief can ruin or mature us” (Park & Halifax, 2011, p. 359), and in this, we see the complexity of experiencing grief.

Accepting that grief is mutually simple and complex, the next step in extrapolating a logical understanding of grief is to look at historical literature. The concept of grief has been vastly explored and contextualized in Western literature. There are numerous works examining

the portrayal of grief. As Archer (1999) states "Long before modern psychologists and psychiatrists began to study grief, novelists, poets, and playwrights described many of the features that would be recognized by contemporary researchers" (p. 35). Consequently, Archer lists the following historical sources as referencing grief: *The Old Testament*, Homer's *Iliad* and *Odyssey*, poetry, Shakespeare, works written by clergymen and ministers, including "mourning manuals", several novels, films, visual arts such as paintings and ornaments, and music. Goodland (2006) draws from several similar sources in exploring the history of grief. Archer and Goodland go into detail on each of these sources in a way I cannot. They wrote books; I, a thesis. What is telling from their chronicling is the certainty that the history of noticing grief is long and enduring. I will look more closely only at a brief sampling here, examining analysis of *Beowulf,* historical records, current research on the Widowhood Effect, and tidbits from well-known writer's auto-ethnographies.

Beowulf. Zachary (2011) in a Master's thesis explores the male expressing/ experiencing of grief in three medieval pieces: *Beowulf, The Song of Roland, and Sir Orfeo*. I studied *Beowulf* in my undergrad; it is regarded as the earliest European epic composed by an unknown author around the start of the 11th century. It follows the quest of the hero, Beowulf, to avenge the deaths of innocents at the hands of monsters. As such, it is an excellent source to examine how grief has been historically documented or observed. I am unfamiliar with the other two works, and so shall focus on *Beowulf* here.

Zachery (2011) finds grief in *Beowulf* in how characters indulge in public weeping and mourning, leaders take on a greater societal grief than their subjects, the heroes are stoic and seek only revenge and glory, but learn through their quests the need for grief, sympathy, loyalty, and

mourning[3]. Zachery's interest is in the male expression of grief, but what is relevant to me is that grief figures so prominently in these early writings.

To elaborate on the prominence of grief in early literature, I share some of Zachary's (2011) findings. To begin, in *Beowulf,* Zachary (2011) counts 46 uses of Anglo-Saxon words relating to grief. S*orgian/ sorh* (sorrow/ grief) appears 19 times in the epic. *Murnan* (to mourn) appears five times. *Meornan* (to care) appears four times, and *mænan* (to lament) twice. Finally, *geómrian* (the vocal expression of grief) is used 11 times. Words relating to crying, tears, and weeping account for the remainder. Notably, Zachary examines the language in the other two pieces as carefully with similar findings.

In entirety, Zachery's (2011) analysis clearly demonstrates how the experiencing of grief is documented in English literature as a normal or expected experience related to loss. From this exploration, it is clear that grief has historical relation to sorrow, mourning and lamenting (the public and private rituals and expressions associated with death), emotional investment (care), and the bodily expression of loss (tears, weeping, crying). At the same time, that different figures in the tale experience and express grief inconsistently captures again the complexity and individuality of the experience. Furthermore, Zachary's examination of the language alone easily showcases the long-standing relationship humans have with grief as an obvious and explicit state full of ritual, deep sadness, and unthinking bodily and emotional expression. An obvious caveat here is to recall that literature has a tendency to portray life/ death in a theatrical manner; this epic can provide some insight into historical relationships with grief, but should not be

[3] The use of Old English or Anglo-Saxon English in the writing of *Beowulf* makes it impossible for me to offer my own interpretation of the work. While doing my undergrad I developed a rudimentary skill in reading and interpreting Old English and Middle English, the task of translating on my own would take me too far off course here, so I am relying on the work of another.

considered as an absolute or accurate depiction. However, it is not solely to ancient epics that one can turn to build, observe, and infer a knowing of grief, and for ethnographical and epistemological purposes, it is necessary to bring in other sources.

Historical records. One of the most intriguing pieces of evidence I uncovered about our evolved understanding of grief comes from how grief is documented historically via official records. MacDonald's (1981) exploration of clinical notes from 1597 – 1634 taken by Richard Napier, a clergyman and physician, are a fascinating example of this. Reviewing 60 volumes of these 17th-century notes, Macdonald finds:

> …sorrowful occasions were so common that the causes of such misery and the mood they provoked were both described by the single word, *grief*. The supple phrase, *to take a grief* meant more than to have felt some sudden sadness; it also implied that one had been assailed by a sickness or a loss, a *grief*. (p. 159)

This excerpt uniquely clarifies that historically, grief is more than just mourning the passing of a loved one. Instead, grief is a sickness, or existence in a state beyond sadness. This use of the word carries with it a sense that grief is entirely serious, insatiable in its own way, and hostile. It also demonstrates that the state of grief may not be simply cured.

In fact, during this period, there is more evidence that grief surpasses the simplicity of an emotional state. As shown in Figure 2.1, grief is officially recorded in *London's General Bill* for the year 1665 as a cause of death in 46 cases. It was that serious and significant; it was a legitimate cause of death (McDonald, 1981). Keep in mind, this was the year of the plague: 63,596 people died of the plague that year. It is assumable that there would be more people grieving than usual because of the higher numbers of death due to the plague, and that most years not this many people would die of grief. Still, it is imperative to keep this in mind; there is

historical evidence that encourages the notion that grief can kill. It can impact the mind, body,

A generall Bill for this present year, ending the 19 of *December* 1665. according to the Report made to the KINGS most Excellent Majesty.

By the Company of Parish Clerks of *London*, &c.

The Total of all the Christnings — 9967
The Total of all the Burials this year — 97306
Whereof, of the Plague — 68596

The Diseases and Casualties this year.

Abortive and Stillborne	617	Executed	21	Palsie	30
Aged	1545	Flox and Small Pox	655	Plague	68596
Ague and Feaver	5257	Found dead in streets, fields, &c.	20	Planet	6
Appoplex and Suddenly	116	French Pox	86	Plurisie	15
Bedrid	10	Frighted	23	Poysoned	1
Blasted	5	Gout and Sciatica	27	Quinsie	35
Bleeding	16	Grief	46	Rickets	557
Bloody Flux, Scowring & Flux	185	Griping in the Guts	1288	Rising of the Lights	397
Burnt and Scalded	8	Hangd & made away themselves	7	Rupture	34
Calenture	3	Headmouldshot & Mouldfallen	14	Scurvy	105
Cancer, Gangrene and Fistula	56	Jaundies	110	Shingles and Swine pox	2
Canker, and Thrush	111	Imposture	227	Sores, Ulcers, broken and bruised Limbs	82
Childbed	625	Kild by severall accidents	46	Spleen	14
Chrisomes and Infants	1258	Kings Evill	86	Spotted Feaver and Purples	1929
Cold and Cough	68	Leprosie	2	Stopping of the stomack	332
Collick and Winde	134	Lethargy	14	Stone and Strangury	98
Consumption and Tisick	4808	Livergrown	26	Surfet	1251
Convulsion and Mother	2036	Meagrom and Headach	12	Teeth and Worms	2614
Distracted	5	Measles	7	Vomiting	51
Dropsie and Timpany	1478	Murthered and Shot	9	VVenn	8
Drowned	50	Overlaid & Starved	45		

Christned: Males 5114, Females 4853, In all 9967
Buried: Males 48569, Females 48737, In all 97306, Of the Plague 68596

Increased in the Burials in the 130 Parishes and at the Pest-house this year — 79009
Increased of the Plague in the 130 Parishes and at the Pest-house this year — 68559

Figure 2.2. London Mortality Statistics Circa 1665. A general bill from 1665 tracking mortality statistics in London. Notice that 46 deaths that year are the result of grief. There are several other Bills easily viewable online; most of them show much lower numbers for death related to grief, but 1665 was the year of the plague, and the numbers for death were higher all around. From *The Great Plague: The Story of London's Most Deadly Year* by Moote & Moote, 2008, p. 260.

and soul to such an extent that it can account for death. Of course, in the 21st century, we have generally dismissed this idea, but not entirely, as we now consider a phenomenon known as the Widowhood Effect.

Widowhood Effect. To my knowledge, grief is no longer considered a cause of death in Western society. However, research continues to support that the impact of grief can be

incredible, particularly around the notion of the Widowhood Effect (the increased risk of dying following the loss of a spouse). Per Vable, Subramanian, Rist, and Glymour (2015), the Widowhood Effect is well documented. For example, Carey et al. (2014) conducted a study of over 30, 000 people who

were recently bereaved (with 83,588 non-bereaved subjects for control). Carey et al. determine there is an increased risk of experiencing a cardiovascular event in the month following the death of a partner, though this risk becomes null within a year. Specifically, Carey et al. find:

- 16% of bereaved people had a fatal or nonfatal myocardial infarction (MI) or stroke within 30 days of losing their partner (compared to 8% of non-bereaved controls).
- 2.25% of bereaved people died in the six months following their partner's death (compared to 1.6% of non-bereaved controls).

This would also indicate there is a higher chance of dying within one month of losing a partner, or, as Carey et al. posit, the adverse physiological symptoms allied with acute grief are more likely to provoke a cardiac event in that first 30 days. Therefore, this study perpetuates the concept that death by grief is possible, even in our modern world. However, it is certain that in statistics today, any such deaths would be attributed to heart conditions or strokes rather than grief.

There are many more studies which demonstrate a link between grief and increased risk of death and/or physical ailments. For example, Parkes, Benhamin, and Fitzgerald (1969) study 4,486 widowers over nine years. 213 of these men died within 6 months of losing their spouse; 40% more than married men of the same age who were not widowed. Further, Elwert and Christakis (2008) analyse nine years of data from 373,189 elderly married couples in the United States and find that the so-called Widowhood Effect not only increased the all-cause mortality of

the bereaved partner, but also the specific type of mortality.

Overall, these historical records and modern study allow for questioning around the impact of the experience of grief: Can it be deadly? Is it potentially that impactful that it can disrupt, deregulate, and destroy a body? What is it about grief that it turns from an emotional experience to a deadly one? Are we backward in looking at the physiological causes of death rather than the emotional/ mental/ psychological connection with grief? At the same time that we ask these questions, it is critical to acknowledge that grief has been linked to illness and death in many capacities, but the statistics demonstrate that just a small percentage of people actually die, even when grief does seem conclusively linked.

Auto-ethnographical accounts. Beyond epics and statistics, personal accounts of grief in literature offer another historical clue around experiencing. It is valuable to seek personal accounts because there is a *lived-ness* that comes across therein which is never quite captured in records or studies; there is something about how individuals capture their encounters with grief that goes beyond the data or the literature. Furthermore, as this section focusses on the dichotomy of grief as simple and compounded, and much of the discussion to this point has demonstrated how it is the individual experiencing of grief at the source of the complexity, it seems crucial to at least sample individual accounts.

De Quincey. In 1845, English essayist Thomas De Quincey, in chronicling his opium addiction, wrote of the experience of loss related to the deaths of several siblings. In this auto-ethnographical work, De Quincey (2001)[4] rawly illustrates the experiencing of grief:

> The sentiment which attends the sudden revelation that all is lost ! silently is gathered up into the heart; it is too deep for gestures or for words; and no part of it passes to the

[4] Note that although the date here is 2001, this is not the original date of publication; this work is from 1845.

> outside. Were the ruin conditional, or were it at any point doubtful, it would be natural to utter ejaculations, and to seek sympathy. But where the ruin is understood to be absolute, where sympathy cannot be consolation, and counsel cannot be hope, this is otherwise. The voice perishes; the gestures are frozen; and the spirit of man flies back upon its own centre. (p. 3)

What can we take from this? First, the sentiment of loss. The loss De Quincey describes is so intense that no gestures or words can take it from the internal experiencing and move it outward. It is too much to process, too much to share, too much to hope, even. De Quincey also acknowledges that were the loss less in some manner, there would be an opportunity to speak of it or to look for support. However, in such an overwhelming experience of loss and grief, De Quincey makes a case for freezing and internalizing. From De Quincey, we can understand how different events, or even the internalizing of events, can impact ability to process grief.

C. S. Lewis & Madeline L'Engle. Lewis and L'Engle were two of my favourite authors when I was young. Lewis wrote the famous *Narnia* series, and L'Engle *The Wrinkle in Time* series. I read both these series aloud to my younger sister, and entirely associate the authors with the sense of comfort and security I found cuddled up with my little sister night after night reading these stories. Even now, I feel a great sense of whimsy as I remember the feeling of delving into fantastic fictional worlds through their writing. Thus, in researching for this thesis, it was a surprise to me to come upon a much different work by Lewis (1994), *A Grief Observed*[5], which has a foreword written by L'Engle.

A Grief Observed is a reflective book by Lewis around his own bereavement upon losing

[5] The book was originally published in 1961 under the pseudonym N. W. Clerk, per the copyright notice in the book. This is important to note as Lewis wrote the book in the year following his wife's death.

his spouse. L'Engle's foreword captures some of her experience of bereavement after losing her husband, as well as how she differentiates between her experience and Lewis'. It seems to me a great stroke of luck to be able to bring the work of these two authors into my thesis to elaborate on the experience of grief. I will highlight just two passages though, for the sake of space.

The most poignant section from Lewis (1994) for me is in the opening lines of Chapter One:

> No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing. At other times it feels like being mildly drunk, or concussed. There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps, hard to want to take it in. It is so uninteresting. Yet I want the others to be about me. I dread the moments when the house is empty. If only they would talk to one another and not to me. There are moments, most unexpectedly, when something inside me tries to assure me that I don't really mind so much, not so very much, after all. (p. 3-4)

Much like in De Quincey's work, one can easily see how impactful grief is for Lewis; it hits the emotions (fear-like), the body (the stomach, the restlessness, the swallowing), the mind (confusion), and the balance between aloneness and seeking others. For me, all of these characteristics are easily associated with grief. However, L'Engle's foreword brings a different perspective.

In the foreword, L'Engle, writes "The death of a beloved is an amputation." (Lewis, 1994, p. vi). In this, L'Engle and Lewis seem onside with one another; for both of them, grief strikes hard, is absolute, and inspires aloneness. However, L'Engle then specifies that although

the circumstances of her own grief are similar to Lewis' in some manners (ie. loss of a spouse), their experiences of grief are quite unique and separate. In a sense, L'Engle cautions the reader not to define grief by someone else's experience. Again, the relative balance is palpable: simple and complex, universal and individual; always present.

Conclusion on ethnography of grief. Grief is a well-explored concept in Western literature through fiction, historical records, research, and auto-ethnography. From public displays of mourning and lamenting, to tears, to being overwhelmed and unable to move, speak, or tolerate companionship, to needing others; grief has been known and captured. Most striking is the weight given to the connection between the mind and body as evidenced by the Widowhood Effect and the *General Bills* (that grief can provoke death), as well as in the auto-ethnographic accounts referencing mental, emotional, and bodily disruption. Overall, although the experience of grief maintains complexity though individuality, there is simplicity in the universality of it.

Symptoms & Evolution of Psychological Pathology: What *Is/ Is not* Grief & Why it Matters

Beyond languaging and documenting the experiencing of grief, humans (and particularly those invested in psychology) have dedicated a great deal of time and energy to defining grief by type and symptomology in order to simplify or clarify what exactly is and isn't grief. Thus, in this section, I will discuss what historical, classic, and current psychological literature has divined as grief, as well as clarify why it matters to be able to recognize grief in terms of clinical intervention.

Recall, to begin, that grief is widely understood as an emotional response to loss, most often associated with a reaction to death, with some cognitive interaction. A predominant conception of grief, for example, involves an individualized experience of moving through and

between five stages of cognitive-emotional processing: denial, anger, bargaining, depression, and acceptance (known by the acronym DABDA) in response to death (Kübler-Ross, 2005). However, as alluded to above, the acknowledged symptomology of grief clearly demonstrates that grief is not limited to the emotional-cognitive realm, nor is it linked simply to death, but to loss overall. Indeed, grief can manifest symptoms that traverse the mind, body, and heart. For example, Archer (1999), from an ethnographical standpoint, suggests that grief can be understood "in terms of mental suffering, harmful physical effects, and as a natural reaction to the loss of a relationship" (p. 247). Furthermore, Archer indicates that grief, as a natural human state, is "in the province of biology and psychology, rather than psychiatry and counselling" (p. 247). Archer also finds distress, protest, and despair in grief, as well as the possibility of painful or intrusive thoughts. Several other sources provide a similar depiction, as follows.

In a textbook focussed on grief and loss, symptoms associated with grief "can include shock, denial, numbness, anger, longing, yearning, searching, disorganization, despair, and potential reorganization" (Park & Halifax, 2011, p. 355). Shapiro and Forrest (2016), in a text on the treatment of trauma, associate grief with guilt and a sense of personal failure. In making a case for the notion of *complicated grief,* Attig, (2010), Moody and Arcangel (2001) and Worden (2008) cite symptoms such as depression, mood swings, mental fatigue, stress, exaggerated worry, and sleep disruptions. Grief as psychosomatic, or as a physical feeling in the body, is noted by Neiyemer and Sands (2011), Hays (1994), Tripp (2007), Callahan (2011), Gudmundsdottir (2009) and Devereaux (2008). Gudmundsdottir provides these details, which sum up the symptoms of grief per psychological literature rather succinctly:

> Lindemann (1944) described grief as a syndrome including both psychological and somatic symptomatology. He identified the physical symptoms of grief as a feeling of

> tightness in the throat, choking with shortness of breath, the need for sighing, an empty feeling in the abdomen, and fatigue. Engel (1964) emphasized that the bereaved person becomes increasingly aware of various sensations of, or pains in the body during the time that the person attempts to deal with the painful void left by the dead loved one…. Parkes (1970, 1972) also described episodes of "pangs" experienced in the first few weeks after a major loss during which the person sobs or cries aloud sorely missing the lost loved one. He explained these pangs of grief as 'an episode of severe anxiety and psychological pain' (Parkes, 1972, p. 39). (p. 254)

Through the above sources, it is clear that recognized symptoms of grief far surpass the emotional domain. In fact, this same overlay of symptoms impacting mind, body, and emotions is reflected in writings throughout history as well as in the *DSM-5*. Therefore, I offer a small sampling of the works of a 16th century scholar, Robert Burton, and psychologists, Shand (1914) and Freud (1917), as well as a summary of how grief is depicted in the *DSM-5* (APA, 2013) to clarify symptoms and types of grief. I then conclude this section by exploring why it matters how grief is recognized and pathologized currently and asking whether the current pathology works.

Burton. In the 1600s, scholar Robert Burton produced *The Anatomy of Melancholy* in which he explores what we could now cite as clinical depression. In this work, it seems to me that what Burton terms sorrow is synonymous with what I am calling grief. Burton (2004) [6] says of sorrow:

> An inseparable companion, [1637]" The mother and daughter of melancholy, her epitome, symptom, and chief cause:" as Hippocrates hath it, they beget one another, and

[6] Robert Burton is known as a scholar who wrote about depression in an attempt to counter depression in himself. He originally published under the pseudonym Democritus Junior sometime in the 1600s. The edition I am referencing is a 2004 kindle which was edited and checked against a 1638 version by the publisher. The age of the document is crucial to recall in juxtaposition with the citations from it.

> tread in a ring, for sorrow is both cause and symptom of this disease… a cause of madness, a cause of many other diseases, a sole cause of this mischief… And if it take root once, it ends in despair.. Chrysostom, in his seventeenth epistle to Olympia, describes it to be "a cruel torture of the soul, a most inexplicable grief, poisoned worm, consuming body and soul, and gnawing the very heart, a perpetual executioner, continual night, profound darkness, a whirlwind, a tempest, an ague not appearing, heating worse than any fire, and a battle that hath no end. It crucifies worse than any tyrant; no torture, no strappado, no bodily punishment is like unto it."… Eccles. xxv. 15, 16. [1643]" Every perturbation is a misery, but grief a cruel torment," a domineering passion…when grief appears, all other passions vanish. "It dries up the bones," saith Solomon… makes them hollow-eyed, pale, and lean, furrow-faced, to have dead looks, wrinkled brows, shrivelled cheeks, dry bodies, and quite perverts their temperature that are misaffected with it.… It hinders concoction, refrigerates the heart, takes away stomach, colour, and sleep, thickens the blood," ([1646] Fernelius,l. 1. c. 18. de morb. causis,) "contaminates the spirits." ([1647] Piso.) Overthrows the natural heat, perverts the good estate of body and mind, and makes them weary of their lives, cry out, howl and roar for very anguish of their souls… Antiochus complained that he could not sleep, and that his heart fainted for grief, [1648] Christ himself, vir dolorum, out of an apprehension of grief, did sweat blood… (Kindle Locations 4535-4557).

Is this not a remarkable depiction? All those symptoms of sorrow, conceptualized as a type of grief, captured and digested in literature 400 years ago based on works even older. Is there any part of this encapsulation of grief which goes against what one might see, feel, or otherwise know today in response to a loss? In my opinion, this bit of writing is as valid today as when it

was produced, and I encourage the reader to keep this in mind. Particularly, I draw attention to how Burton's description places all of the experiencing of sorrow as a natural reaction to loss. It is significant how this natural knowing of grief shifts over time in regards to pathology, which can be seen in examining more recent and classic works.

Shand & Freud. The works produced by psychologists Alexander Shand and Sigmund Freud in the early 20th century are the first to psychologically unpack grief (Archer, 1999). As such, these works are arguably classic works on grief. Distinguishingly, Shand's (1914) work is ethnographical in nature, while Freud (1917) uses a more scientifically accepted method of presenting case studies (Archer, 1999).[7] Overall, the psychological writings by Shand and Freud on emotions associated with loss, offer beautiful examples of how variations in grief start to become something less naturally accepted and instead more diagnosable with treatment connotations as we move forward in time.

Shand. In a book dedicated to ethnographically studying human emotions and sentiments in terms of expression and function, Shand (1914) deeply explores sorrow as one of several innate and interconnected emotions. Sorrow, Shand (1914) proposes, is the only emotion explicitly linked to loss. Therefore, sorrow is understood as most closely tied to grief for my purposes. Thus, I will limit my discussion to Shand's exploration of sorrow, which Shand explores in terms of type and function.

Types of sorrow. Shand (1914) suggests that there are different types of sorrow. One is full of abandonment; loud and obvious. Another, "tearless and mute, and concentrated within the mind" (Shand, 1914, p. 302), Shand describes as worse, with links to being stuck and frozen, and

[7] Archer (1999) suggests that Shand's work, *Foundations in Character*, has been overlooked due to the ethnographic nature of it; thus, Freud's case-study based work, *Mourning and Melancholia,* is better known.

yet connected to self-control and concentration. A third type of sorrow is rooted in loss of energy and fatigue engendering depression and paralysis (Shand, 1914). Herein, the body experiences a depressed condition which encourages a depressed mood. The final type of sorrow, Shand categorizes as frenzied and links to potential for suicide.

Functions of sorrow. All types of sorrow, Shand (1914) suggests, are purposeful. For example, Shand states:

> Sorrow, as an emotion of weakness caused by frustration of impulse has, as its innately determined end, to obtain from others the help of which it stands in need: the instinctive behaviour of its system is the cry for help. The appeal for relief, distraction and sympathy, a development of this primitive cry. (p. xxiii)

In other words, for Shand, a purpose of sorrow is to solicit help from others. Furthermore, Shand suggests that sorrow helps to maintain a connection with what has been lost, to elicit hopes around better future connections, and to increase self-love. In short, sorrow reminds us to be joyful and connected.

Conversely, Shand (1914) states that sorrow, when frustrated, "tends to destroy all hope, courage, and energy of resistance" (p. xxiv). Shand suggests that sorrow is increased when kept secret, or if its cause is sudden, unexpected, or "caused by our own folly" (p. xxiv), or if there is a loss of control. Contrariwise, it lessens with the knowledge that others share the sorrow and with self-control.

Reflections on Shand's work. Personally, I can presently relate to each of Shand's (1914) four types of sorrow. Furthermore, I find all four types connect well to all I have presented on grief to this point; the ups and downs, the variations in experiencing, the linking of mind, body, and emotion. At the same time, it can be seen here, that just by type-casting sorrow, there is a

push toward pathology. In this sense, it is easy to accept and incorporate Shand's exploration of sorrow into the knowing of grief. At the same time, it is wise to question Shand's stance to some degree. For example, I propose that these questions are useful to reflect upon:

- Are there only four types of sorrow?
- Are they truly so separate and distinguishable from one another?
- Does sorrow, as Shand describes it, capture the notion of grief?
- What is the purpose in distinguishing sorrow as Shand does?

It is beyond the scope of this thesis to delve into these questions, but it is my hope that the reader will give due consideration here.

Beyond the categorization of sorrow, Shand's exploration of the functions of sorrow is intriguing. This is because Shand pays such attention to the idea of the benefits of sorrow, and offers clues to what is helpful in treatment approaches. Reading Shand's work clarifies that it is important to remember that grief is not only universal and natural but highly functional regardless of type. Whether Shand is correct in exactly what the functions of sorrow are is questionable, but the relevant piece is that there is a function, or purpose, to grief. In fact, Shand proclaims that anger arises only when sorrow is frustrated or held back in some manner. This, along with the ideas around the need to speak of one's sorrow, build connection, alert others to a need for help, and highlight joy, give insight into potential treatment approaches which could reflect these ideas.

Freud. Offering perhaps the most well-known classic psychological text on grief, *Mourning and Melancholia,* Freud (1917) explores the loss of a loved object, state, or person by examining grief (mourning) and depression (melancholy) as interrelated and distinct reactions to loss. Per Freud (1917), *mourning* is the affect and outward manifestation of grief. Of *melancholy,*

Freud states:

> The distinguishing mental features of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. (p. 244)

Furthermore, Freud stipulates the mourning exactly mirrors melancholy with the exception that mourning does not include disruptions in self-regard[8]. Another distinction Freud makes is that in melancholy, the sense of loss may be unconscious, while in mourning, it is explicit. Generally, Freud distinguishes between mourning and melancholia in a very similar fashion to the current *DSM-5* distinctions between normal bereavement and major depressive episodes as I discuss in the next section.

Overall, Freud (1917) recognizes mourning (or grief) as a fundamentally natural process that neither could nor should be treated clinically unless it gives rise to melancholy. Undoubtedly, Freud's work adds to the notion that some expression of grief is normal, and conversely, that grief which develops into melancholy is abnormal and needs clinical attention. However, a significant consequence of his work has been the positioning of grief as an object for psychological and psychiatric research and intervention (Granek, 2010). One product of this is arguably the *DSM*.

DSM-5. Despite the above-noted shifts in philosophy around the natural/unnatural categorizing in grief, it is well known that no prior edition of the *DSM* specified grief alone as a

[8] Interestingly, Shand (1914) also explores melancholy (depression) and melancholia (depression with mania) in relation to sorrow. Shand finds that sorrow can lead to melancholy, and stipulates that this connection suggests they spring from the same root.

diagnosable condition. However, the *DSM-5* references grief repeatedly, has a diagnosis related specifically to bereavement, and in the *DSM-5* we can see a strong clinical interpretation of bereavement as divisible between normal and needing clinical intervention.

To begin, note that the *DSM-5* includes exactly two options which rely on experiencing the death of a person, and as such relate particularly to grief. They are Persistent Complex Bereavement Disorder (PCBD) and a category for Uncomplicated Bereavement (APA, 2013). Comparing the criteria on both sides is useful.

The category of Uncomplicated Bereavement is used to specify whether reaction to a death is normal or persistent in nature (APA, 2013). Normal grief (as the *DSM*-5 terms it) is said to last less than 12 months (or less than six months in children), following a death (APA, 2013)[9]. In other words, grief which lasts more than a year is seen as abnormal and in need of intervention. In Uncomplicated Bereavement, there is a chance for insomnia, anorexia, and depression, for example, but these are seen as normal reactions to loss (APA, 2013). Further, the experience of normal grief can occur in waves and be felt as pangs (APA, 3013). In normal grief, one can still experience happiness and humour (APA, 2013). In fact, the overall theme of "normal grief" and the Uncomplicated Bereavement category is just to look at what is considered normal for culture and setting and consider grief to be normal, or as Uncomplicated Bereavement, unless it is quite abnormal by meeting criteria to establish PCBD (APA, 2013).

The PCBD diagnosis is much more stringent. It requires the loss of a close person, with symptoms lasting more than 12 months (or more than six months for children) (APA, 2013). The symptoms include a combination of:

[9] Note: Under Depressive Disorders in this version of the *DSM* it is considered critical to acknowledge that doctors and grief counsellors consider normal bereavement to last 1-2 years; in previous versions, the inference was that normal bereavement only lasts 2 months (APA, 2013).

- Emotional: Yearning or longing, intense sorrow or emotional pain, reactive distress, emotional numbness, bitterness or anger, feeling distrust/ loneliness/ detachment/ meaningless/ empty.
- Cognitive: Preoccupation with the deceased or with circumstances of the death, difficulty accepting the death, disbelief, self-blame, difficulty with positive reminiscing, a desire to die to reunite, belief that one is unable to function, possible hallucinations.
- Behavioural: Excessive avoidance of reminders (ie. people, places, situations), difficulty or reluctance pursuing things such as friendships/ activities, out of proportion bereavement reactions (or inconsistent with cultural, religious, or age-appropriate norms).
- Social/ Occupational/ Relational: Social/identity disruption, role-confusion, diminished sense of identity, impairment in social/ occupational functioning.
- Somatic: Diverse somatic complaints such as digestive, pain, fatigue, and symptoms experienced by the deceased, associated with marked increases in risk for medical conditions such as cardiac disease, hypertension, cancer, immunological deficiency. (APA, 2013)

Note how the symptoms encompass all realms; the impact of loss related to death is recognized as being more than emotional-cognitive. Compare the list of symptoms here with those presented by Burton, Shand, and Freud; it is clear the diagnostic criteria are long reflected in psychological literature around grief. At the same time, consider the implication that these symptoms might be considered normal for the first year following a death, but then suddenly are considered problematic. What does this say about the cultural expectations of grief? That grief is permissible

for just one year, perhaps? That the purpose of grief is to get through these symptoms rather than be stuck with them? Further, consider how the diagnosis excludes a sense of normality were these responses to manifest for losses not specific to a beloved's death. These are simply points of interest to sit with in terms of understanding grief as we move forward. At the same time, it is requisite to note that prior editions of the *DSM* did not include a category accounting for what experts previously referred to as complicated grief, traumatic grief, complicated grief disorder, and prolonged grief (Shear et al., 2011). In other words, prior to the inclusion of PCBD, grief which lasted longer than 2 months and included any of the above symptoms did not have a place in diagnostics, except as unrelated to grief.

Beyond these two categories related explicitly to grief, the *DSM-5* mentions grief in relation to: Major Depressive Disorder (MDE), Post-Traumatic Stress Disorder (PTSD), Acute Stress Disorder (ASD), Adjustment Disorders, Stressor-Related Disorder, Nightmare Disorder, Bipolar I/II Disorder (BPD), Persistent Complex Bereavement Disorder (APA, 2013). In these cases, grief is addressed as a state to rule out and is ongoingly associated with a reaction to death. In other words, grief is distinct from these conditions, although there is some overlap. For example, if thoughts of death are intrusive, in MDE, it is thoughts about taking one's life due to feelings of worthlessness, hopelessness, self-loathing, or undeservedness, whereas in PCBD, thoughts are around what one could have/ should have done differently while the deceased was alive, and potentially about joining the deceased via suicide (APA, 2013). Thus, we can see that in grief, suicidal thinking is related to reconnection and reworking the past. Furthermore, in distinguishing grief from MDE, the *DSM-5* notes that in grief the feelings of emptiness and loss predominate, while for MDE, the focus is the inability to hope for happiness or pleasure (APA,

2013). Each of the other disorders referencing grief carry similar distinctions[10].

Comprehensively, discussion of grief in the *DSM-5* is important for several reasons. First, it is a clear demonstration of how far toward pathologizing grief Western society has moved. Note that there is a notation in the *DSM-5* which specifies that a mental disorder is not possible in the case of an expected or culturally normed response to a stressor or loss, such as a death (APA, 2013). However, we are effectively at a point where instead of instinctively registering whether grief is normal or problematic, we are encouraged to clinically categorize it as such based on severity and duration and intervene from there. The pathology functions to potentially open doors to some in terms of seeking treatment. At the same time, it also brings forward the notion of stigma associated with any *DSM* diagnosis, and one has to wonder if it is needed. Second, there is certainly a possibility of comfort to some in finding a way to label their ongoing experiences as a death-induced outcome, as compared to believing that the experiencing of death is separate to conditions such as anxiety and depression. Third, it is important to recognize that all literature to this point does include elements of body, mind, and cognition in the experiencing of grief. This is crucial to acknowledge in formulating treatment plans when intervention is deemed worthwhile. Overall, the references to grief in the *DSM-5* as well as the inclusion of PCBD as distinct from other diagnoses establishes that grief can be as impactful and life-altering (across all realms of life) as any diagnosable mental illness might be. In a sense, this is the current norm in Western culture, and one must wonder whether it captures the notion of grief in entirety as it certainly excludes reaction to losses unrelated to the death of a loved one.

---

[10] One outstanding note of interest is that in cases where a death has been sudden or violent, there is a possibility of PTSD and PCBD being concurrently diagnosed. This alludes to a distinction and connection between traumatization and grief as reactions to loss which is explored further in later chapters.

Other grief. Each of the examples above has related specifically to grief based on the death of a loved one. Simply, this is where the most documentation around the experiencing of grief focusses. Frankly, this is also where my interest directly lies. However, as noted previously, grief is not exclusively experienced as a reaction to the death of a loved one. Grief is associated with all loss, to some degree (Archer, 1999, Harvey & Miller, 1998; Papa & Maitoza, 2013; Boss, 2010; Clifton, 2014). Therefore, to fully explore grief, it is important to consider how grief as a reaction to other losses can add to the knowing of grief for clinical purposes.

Disenfranchised grief, ambiguous grief, and traumatic grief are examples of alternate experiences of grief and are often related to non-finite loss (Winokuer & Harris, 2012; Boss, 2010; Clifton, 2014). Non-finite loss is long-lasting or enduring, where ongoing accommodation and adjustment is required (Winokuer & Harris, 2012). According to Doka (1989, 2002), disenfranchised grief applies:

> to situations where the loss is not recognized as valid, the griever is not recognized as a valid person to mourn the loss, the grief response of the individual falls outside of social norms, or where the loss itself has a social stigma attached. (as cited by Winokuer & Harris, 2012, p. 39)

Ambiguous grief is when a something is physically present, but psychologically gone or vice-versa (Boss, 2007; Boss, 2010; Ford, Linde, Gigliotti, & Kim, 2012; Winokuer & Harris, 2012; Fernandez-Alicant, Garcia-Caro, Montoro, and Cruz-Quintana, 2016). Traumatic grief is when the nature of the grief is related to a traumatic experience; this type of grief is identified in the *DSM-5* in a note suggesting that at times a person may be diagnosed with PTSD and PCBD concurrently if the nature of death was sudden or violent (APA, 2013). Some examples of these types of grief might be related to ending a relationship, losing a pet, losing a job, giving up a

child for adoption, loss of a sense of personal safety, loss of physical health or ability, or exposure to a natural disaster.

Clifton (2014), for example, provides an auto-ethnographic account of grieving a spinal cord injury sustained in a helicopter accident. Clifton states, "prevailing literature has lost sight of the fact that SCI [spinal cord injury] constitutes a loss that is analogously equivalent to the loss of a loved one – precisely because losing one's own body is to lose an intimate companion" (p. 1825). This loss in non-finite and ambiguous because despite the injury, one keeps living, so the loss is felt ongoingly. The loss is disenfranchised due to a sense that one is lucky to be alive, despite the injury, and should not grieve. The loss is traumatic because it came on suddenly and violently and was unstoppable. The sense of grief associated with this loss is palpable.

Another example is in Fernandez-Alicant et al.'s (2016) exploration of the experience of parents who have children diagnosed with autism. The parents in this study expressed that their emotions fluctuated widely between happiness, sadness, and distress. A parent speaks to the news of the diagnosis saying:

> …completely transforms you, it's like as if all the supports beneath your feet have collapsed and you have to construct them again. With all this comes grief. . . it's that you break down, you know? You go through a terrible emotional stage in which on top of that, not even one foundation remains standing to carry on, because nothing of what you have learned will be useful, nothing of what you have… (a mother as cited by Fernandez-Alicant et al., 2016, p. 317)

This excerpt highlights the traumatic sense of the grief despite the lack of a death. Simply, the parent's world is blown apart in one moment, and there is no other word for this experience than grief. Further, the grief continues ongoingly; it exists even as the child and parent live, but in a

way that many will not understand or support.

Despite the ambiguity and disenfranchisement of grief in these types of loss, there is some evidence that these losses provoke similar grief responses to death. For example, Winokuer and Harris (2012) state, “The implications for disenfranchised grief usually involve inadequate to no social support to the bereaved individual, or social stigma or shunning becomes attached to the individuals identified with this loss” (p. 39). In regards to ambiguous grief, symptoms manifest in the physical, emotional, cognitive, and behavioural realms in the same manner as described in relation to grief due to death (Winokuer & Harris, 2012). Papa, Lancaster, and Kahler (2014) study the grief experience relating to divorce and job loss as compared to death and find that the symptoms experienced can be just as intense and significant in the cases of non-finite loss.

Reflections and conclusions on symptoms of grief and pathology. Grief certainly has a long history of being examined, picked apart, dissected, contrasted, and wrapped back up in a package meant to be not just palatable, but clear and straightforward. However, it is clear that although there is an acceptance of grief as natural and universal, there is an ongoing debate about what is acceptable or normal, when, and for how long in terms of associated symptoms. For example, juxtapose, for a moment, the *DSM-5* classification of PCBD and the ethnographic review of grief offered by Burton (2004). Notice the overlap (all the same symptoms), and consider that while Burton explores these symptoms as the natural conclusions of grief or sorrow, in the *DSM-5* these same symptoms are connected with a disorder associated with grief. Consider also Freud and Shand’s discourse on melancholy as related to and yet distinct from grief. Is this not reflected in the *DMS-5* in the way MDE is distinguished from grief? Finally, notice how challenging it is to conceptualize grief as related to all loss. On one hand, it is

common sense to notice that grief is attached to all losses, and on the other hand, there is an element of judgment around how appropriate or acceptable a grief reaction is, particularly in the case of non-finite loss. In the end, it is back to the question of whether there is any sense to pathologizing grief, or, if in fact, all of the experiences currently under the *DSM-5* criteria for diagnosis might just be normal reactions to loss. Thus, a key point in exploring the notion of grief is to wonder why, if grief is a natural human condition, the idea of pathologizing grief would be considered crucial to working with grief.

Pathologizing grief: why it matters. In answering to the pathology of grief, I have found only one source offering clarity. Kofod (2015) conducted 20 interviews with 13 parents who had lost an infant. Conclusively, Kofod suggests that labeling people who have experienced a loss via *DSM* criteria is something many people are uncertain about. Participants consistently indicate the experience of grief is individual and should not be prescribed, while at the same time acknowledging that for some a diagnosis could help with interventions/ support and with understanding/ explaining what grief can be (Kofod, 2015). At the same time, Kofod identifies one universal aspect in the participants' experience:

> In my interviews with the parents participating in this study, grief is repeatedly referred to simply as love. However painful, grief is also in some way appreciated as recognition of their dead children's continuing significance in their lives. When asked whether they would appreciate it, if there were a "pill that could make the pain of grief go away," all of them object. Nevertheless, although some of the parents are critical toward the idea of a grief diagnosis, several of them immediately support it. (para. 29)

In other words, although people have a sense of needing grief to be unique and unconditional, there is a desire to have some expectation of what is and is not grief to help in moving through

grief, and to connect grief with the feeling of love, at least in working with death. This means that it is key to cover what Western society currently acknowledges and dismisses as symptomatic and characteristic of grief, because although the experience may vary person-to-person, simple awareness of the potential norms, processes, and connections could be helpful to people experiencing grief or supporting someone who is grieving.

Conclusions on symptomology. This small collection of the symptoms of grief, coupled with the above discussion on the etymology and ethnography of grief leaves no doubt: grief is experienced emotionally, mentally, behaviourally, socially, and physically whether it is pathologized or not. The trending toward pathologizing has done nothing to change the structure, function, or process of grief, at least as it is observed and explored symptomatically. However, in examining the symptoms, we see again that grief is not simply an emotion, and it is not confined to death-related loss. Thus, we can acknowledge that talk-therapy is not likely to produce the best results with grief, as it ignores the body in processing by being so reliant on verbal integration. Furthermore, in exploring symptoms and pathology, we can notice that there is some usefulness in building awareness of typical/atypical reactions to grief, while leaving room for subjective experiencing, to help in establishing when counselling may or may not be helpful.

What does it all mean?

Overall, my purpose has been to explore grief from many angles and rely on numerous alternate sources to create an operational understanding for this paper. Distinctly, I wanted a fuller knowing or awareness of grief than is simply found in recent psychological literature. I wanted something to really digest so that in working with grief, myself, and others in the field of psychology, could have a substantial underlying of meaning in our work and interventions. This desire is in response to an observation that grief is a term bandied about in the field with limited

consistency, and often oversimplified to merely relate to the emotional experiencing of loss of a loved one to death.

Only now, can I sum up grief.

Grief is the uniquely complex and enduring individual emotional, cognitive, behavioural, spiritual, biological, bodily, physical, and mental reaction to the universal human experience of loss. Simply, grieving a loss is universal, as is experiencing grief across many domains. Still, the extent of the grief, the way it is expressed and experienced, the length of time in which grief is dominant varies from one person to another.

I hope this explanation of grief will remain present with the reader throughout the remainder of this paper. In particular, it is important for my purposes to notice the bodily experiencing of grief and to question how traditional talk therapy interacts with any of the realms beyond the cognitive-emotional pieces. This is useful in moving toward clinical interventions and working with grief.

Conclusion

Grief is so much more than modern psychological literature suggests, and using an epistemological method of investigation has proven so. Following an inquiry into grief relying on etymology, ethnography, symptomology, and pathology has provided an understanding of grief well beyond the simplified notion of grief generally referenced (the emotional reaction to loss by death). Reflection on each of these areas has allowed a further opportunity for a rounded and grounded understanding of grief to come forth. Through exploring the languaging of grief, both in examining the origins, the use of the word in epics, and referencing common idioms involving grief, we can see how much deeper grief has always been. From encompassing suffering, to being grave, to being more than about death, the etymology of the word grief

establishes how powerful, pervasive, and serious grief has long been known to be.

In ethnographically exploring the dichotomy of grief, the simple and complex, universal and individual, influenced and instinctive, it has been clarified that this *is* grief: being both/and rather than either/or. Studying historical poems and epics provides evidence of grief as an observable phenomenon throughout human history with varying degrees of commonality and severity. Historical records demonstrate that grief has a history of being considered powerful enough to influence death and illness in others. Current studies show this is a trend still observed in modern times as the Widowhood Effect despite a downplaying of the seriousness of normal grief. Auto-ethnographies add a live-ness that reveals the potentially overwhelming and disruptive power of grief, while at the same time speaking to the quality of personal experience and ability to survive.

Exploring the evolution of the pathologizing of grief through historical and current studies and catalogs on the symptoms and functions of grief provides further awareness. This probing captures grief as not just emotional or cognitive, but as encompassing all parts of a person. The inquiry into symptomology and pathology also elicits knowledge around the function of grief, such as enhancing the experience of joy or love. Comparing the historical and current studies on grief confounds the movement toward defining normal/ abnormal based on the symptoms. The same symptoms have always been noticed, and therefore must be normal (and indeed were once considered normal). Yet, in modern society, when evaluated around duration, intensity, and cultural fit, these symptoms become diagnosable as a grief-based condition only connected to loss by death. While this pathology can be important to people wanting to know that they are not alone in their experience, and to helping clinicians understand the many ways in which grief can manifest, it has become clear that grief is not just related to death. Grief is just as

significantly observed in related types of loss (ie. ambiguous, disenfranchised, traumatic). Furthermore, pathology stigmatizes and discredits the personal and subjective experience of grief to some degree.

Overall this chapter demonstrates that no matter where we look, grief is not just emotional or emotional-cognitive behavioural; it breaks across all realms and relates to all experiences of loss. This diversified sourcing of information provides a stronger knowing of grief than could otherwise be created. It is through exploration of these points that we are able to better conceptualize grief and to understand how to work with it clinically.

Chapter III Trauma

In the previous chapter, I sought to define and clarify the concept of grief. I connected to grief through etymology, ethnology, and a discussion of current symptomology and classification. In this chapter, I will follow a similar pattern in exploring the concept of psychological trauma, for comparable reasons: an operational understanding of trauma, in and of itself and as an arm of grief, is necessary for this paper.

While I believe that most psychotherapists will engage in discourse about the importance of understanding and working with trauma, I am not certain everyone is speaking about the same entity. Overall, my impression of trauma, in the clinical world, is that of an ill-defined, multifaceted, and sometimes confusing buzzword. On this, Van der Kolk, Weisaeth, and Van der Hart (1996) say:

> From the earliest involvement of psychiatry with traumatized patients, there have been vehement arguments about trauma's etiology. Is it organic or psychological? Is trauma the event itself or its subjective interpretation? Does the trauma itself cause the disorder, or do preexisting vulnerabilities cause it? Are these patients malingering and suffer from moral weakness, or do they suffer from an involuntary disintegration of the capacity to take charge of their lives? (p. xii)

With the above in mind, my intention in this chapter is to answer this: What is psychological trauma, for the purpose of this paper, in relation to the modern world of psychology and carrying forward the conversation on working with trauma? To link trauma counselling to the practice of WT, we need to be clear on how the concept of trauma has evolved and how it relates to the mind and body, what psychological trauma currently means, what distinguishes it, and what the impacts or symptoms are. This understanding must take into account expert opinions, historical

nuances and constructs, current diagnostic criteria, and practice to meet the pattern of epistemological study. By the end of this chapter, I will clarify exactly what trauma means for this paper based on interpreting knowledge from a variety of sources.

Evolution of Psychological Trauma: From Ancient Literature to Modern Expert Discourse

The concept of psychological trauma is not new. According to the *OED* (2017b), the term *trauma,* deriving from the Greek word τραῦμα for *wound,* has been used since 1894 in psychological literature to describe an unhealed psychic injury related to emotional shock, which may include repression in memory. Van der Kolk and McFarlane (1996) state "Experiencing trauma is an essential part of being human; history is written in blood" (p. 3). Take note; this statement is over 20 years old at this point and is written by two still well-known experts in the field of psychological trauma. In fact, the condition of trauma, as a collection of psychologically based symptoms which develop in response to a traumatic experience, has been depicted in Western literature since at least around 720BC when Homer's epic, *Iliad* was produced (Sheth, Gandhi, and Vankar, 2010; Sauve, 2013; Zepinic, 2011). However, Sheth et al. (2010) stipulate that these same trauma symptoms are first documented in Indian literature around 5000BC in the epic *Ramayana* wherein a character displays all the symptoms of Post-Traumatic Stress Disorder (PTSD) after being shot by an arrow and almost killed. We can also assume a prior oral tradition of some sort. Furthermore, there are examples offered by Burton (1867), in *Melancholy Anatomized: Showing Its Causes, Consequences, and Cure,* of terror-inducing events such as a massacre at Lyons in 1572, and an earthquake in Italy in 1504, as leading to cases where the terror "imprints itself so strongly on the brain that, if the whole mass of the blood were extracted from the body the patient could not be effectually relieved" (p. 99). Burton writes:

For when the mind with violent terror shakes,

Of that disturbance too the soul partakes;

Cold sweats bedew the limbs, the face looks pale,

The tongue begins to falter, speech to fail,

The ears are fill'd with noise, the eyes grow dim,

And deadly shakings seiz on every limb" (p. 99)

Notably, Burton only lived until 1640, so although this edition was published in 1867, the writing itself is significantly older.

However, acknowledging the history in written literature alone certainly attests to the ever-present and long-observed condition of trauma as experienced by humankind for thousands of years. Indeed, Van der Kolk et al. (1996) stipulate "People have always known that exposure to overwhelming terror can lead to troubling memories, arousal, and avoidance" (p. 47). In other words, psychological trauma is not a new concept, but something which humans have a long history experiencing, documenting, and processing. I find that the challenge in bringing this record forward is the manner in which the experience of psychological trauma is viewed, explored, and labeled in recent history. However, if indeed "the study of trauma has become the soul of psychiatry" (Van der Kolk & McFarlane, 1996, p. 4), it is crucial to understand what our modern narrative on trauma is.

Historically, and to varying degrees, terms such as *neuroses*, *shell shock*, *combat fatigue*, *soldier's heart*, and *hysteria* have been used to capture the notion of trauma (Van der Kolk et al., 1996; Ringel, 2012; Sauve, 2013). The nature of these conditions is generally understood as either solely one of the body or one of the mind; the more colourful concept of a mind-body connection is more recent (Van der Kolk et al., 1996). The conception of trauma as a mental concern originated in the late 19th century in the work of neurologist, Jean Charcot, who worked

with women recovering from rape, sexual abuse, and violence who exhibited physical, emotional, and mental reactions to their experience (Ringel, 2012). Charcot referred to the women's condition as *hysteria* (Ringel, 2012). Charcot was the first to consider a mental base rather than a physical one (Ringel, 2012). Prior to Charcot's work, the symptoms of trauma were understood as *hysteria* and treated with a hysterectomy, as the condition was assumed to be organic in origin (Ringel, 2012). Other early work in the same period by people such as surgeon, John Eric Erichsen, and neurologist, Herman Oppenheim, revolved around further understanding the relationship between the central nervous system and the condition, particularly in soldiers (Van der Kolk et al., 1996).

Presently, the British Columbia Provincial Mental Health & Practice Counsel (BCPMHPC) (2013) states that 76% of Canadians "report some form of trauma exposure in their lifetime" (p. 9). Furthermore, Elliot (1997) surveyed 505 respondents across the United States by mail; 72% of them reported some form of trauma experience (ie. motor vehicle accident, death of a child, witnessing violence, natural disasters, imprisonment during war, combat experiences, adult physical or sexual assault, child abuse, murder/ suicide of a family member,) in their life. In other words, the exposure to traumatic events is certainly more common than not. Furthermore, it is important to recognize that in each of these events, there is a certainty of loss, and because of this, an association with grief. For example, loss of control or loss of security could easily relate to most of these events. Regardless of loss and grief, however, the experience of a traumatic event (and the associated grief and loss) does not absolutely lead into the experience of psychological trauma (BCPMHPC, 2013). According to Janina Fisher, a PhD clinician self-identifying as having 34 years of experience in clinical trauma work:

Trauma is the term we use for events… It is really important that we don't confuse

> traumatic impact with traumatic events. So when we talk about trauma, we're referring to a series of events, but we're also referring to the legacy of those events which can differ person to person. (PESI Publishing & Media, 2016, 6:30:00)

Clearly, the conversations and studies related to traumatic experiences and the resulting symptoms continue to this day, and still, there is no consensus on what shifts a traumatic event into psychological trauma. However, there is more of an understanding that the mind and body both play a part. Furthermore, there is a section in the *DSM-5* of disorders stemming from a traumatic event (APA, 2013). This *DSM-5* inclusion alone demonstrates how deeply entwined the concern around trauma has become within psychology.

The entire evolution of the concept of psychological trauma is much more complicated and complex than I am able to capture in a paper of this dearth. However, it is sufficient to note that trauma is not a new concept, and the understanding of trauma has been formally studied since the 19th century and documented in literature for thousands of years prior. Furthermore, the concept is one that has been confounding for some time, and discussion is ongoing academically and colloquially.

Defining Psychological Trauma

Having explored the historical base for psychological trauma, it is now ideal to examine the current definitions of trauma in the world of psychology. According to the Klinic Community Health Centre's (2013) *Trauma-Informed: The Trauma Toolkit*, trauma is the result of these three elements:

- An event was unforeseen.
- The person was not prepared.
- There was nothing the person could do to stop the event from happening. (p. 9)

Van der Kolk (1996), a well-recognized expert in clinical trauma work, offers a definition of trauma as "an inescapably stressful event that overwhelms people's existing coping mechanisms" (p. 279). BCPHMPC (2013) echoes Van der Kolk, explaining trauma as "experiences that overwhelm an individual's capacity to cope" (p. 5).

Pause a moment and note the difference here: these latter two definitions do not speak to ability to foresee or control experiences; only a person's coping capacity. There is unity in the above definitions, however, in that all three require an *experiencing*.

Building on this, Allen (1995), author of the book, *Coping with Trauma: A Guide to Self-Understanding*, states "It is the subjective experience of the objective events that constitutes the trauma…The more you believe you are endangered, the more traumatized you will be…Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness" (p.14). Here again, the idea of *experiencing* is prominent, however, the inclusion of subjectivity bridges these first two understandings; if one's coping capacity is overwhelmed due to subjectively feeling unprepared and helpless despite any foreshadowing of an event, trauma can result.

Furthermore, Bessel Van der Kolk explains in an interview:

> Trauma is an event that overwhelms the central nervous system and changes the way you remember and react and… Yeah, remember and react, basically, to things that remind you of it. But, trauma is.. is a trauma. Something very bad that happens to your central nervous system, to your mind that you are incapable of assimilating, of taking in and integrating into your life. So, it's about a very bad event... (Psychotherapy Networker, 2014, 6:30)

In this description, trauma is the symptomatic result (changes in memory and reaction due to

impact on the Central Nervous System (CNS) and mind) of undergoing a dreadful experience which the mind is not able to handle. Again, *experiencing* is at the forefront, but this definition is the first to draw in the CNS, the physical body, as well as the mind. Furthermore, it is important to note the mind's place as the agent of cognition, which is indirectly addressed above through the ideas of subjectivity, coping capacity, and cognitive awareness, for example. Van der Kolk's definition concretely links the mind and body's processing capacities to the understanding of trauma, which draws attention to the mind-body connection.

Also relating to mind-body connection, Solomon, Solomon, and Heide (2009) speak of *traumatic stress,* or the symptomatic result of "experiencing an event that overwhelms the brain's information processing system" (p.391) linking to "psychological, emotional, and physiological distress" (p. 391). Fisher specifies that trauma is the event(s), and psychological trauma is the legacy that comes with the experiencing of said event(s) (PESI Publishing & Media, 2016). Fisher clarifies that the legacy can differ person to person, and involves mental, emotional, and bodily symptoms. Heart rate, breathing, and full body movement (ie. via yoga) are some interventions Van der Kolk (2014) discusses. The interventions, according to Van der Kolk, link to better therapeutic outcomes when working with trauma, adding further credence to the notion that trauma is not just a matter of the mind. In short, as Van der Kolk states, "the troubles of our patients and ourselves are not in our heads, they're in our entire organism and trauma certainly is part of our entire organism" (PESI Publishing & Media , 2011, 17:66:00). Another trauma expert, Pat Ogden, simplifies this, saying "Well trauma, first of, first and foremost infects the body and the nervous system" (Psychotherapy Networker , 2012, 4:30).

Overall, to this point, the psychological concept of trauma can be understood as the subjective response to an experience which impacts both the mind and the body in a manner

which overwhelms personal coping systems and can produce psychological and somatic changes. Understanding this, it is crucial to examine how trauma is understood from a diagnostic perspective, as well as what neuropsychology has to offer around defining trauma and then to look at ways of understanding it all together for practical clinical use.

Diagnosing Trauma. Along with robust discussion among trauma-experts, there is a need to consider what the de facto authority on diagnosis has to offer around trauma. The diagnosis of PTSD was added to the *DSM-III* in 1980 as the first specific diagnosis to rely on the experience of a traumatic event (Van der Kolk & McFarlane, 1996; Sheth, Gandhi, and Vankar, 2010; Ringel, 2012; Klinic Community Health Centre, 2013). Currently, in the *DSM-5*, there is a *Trauma- and Stressor- Related Disorders* section. Herein, diagnosis possibilities specific to the experience of a traumatic event are: reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders (APA, 2013). PTSD is the most commonly diagnosed of these disorders with prevalence rates up to 30% - 50% in people in cases of rape, military combat/ captivity, and genocide, for example (APA, 2013). Acute Stress Disorder (ASD) is slightly lower with a 20%-50% prevalence for similar interpersonal criteria (ie. rape, assault, witnessing a mass shooting), but ASD can only be diagnosed 3 days post-trauma and cannot last beyond the period of one month (APA, 2013). Gordon (2012) explains ASD is the *DSM-5* diagnosis for the transient and symptomatic response that immediately follows witnessing or experiencing a traumatic event; if the response exceeds four weeks, the diagnosis changes to PTSD. Not experiencing the symptoms of ASD immediately following a trauma does not preclude the eventual diagnosis of PTSD (Gordon, 2012; APA, 2013). Only around 50% of people who develop PTSD have ASD prior (APA, 2013). The remaining disorders in this category have much lower prevalence (ie. 1.5% for

Dissociative Identity Disorder, 5%- 20% for Adjustment Disorder, and under 10% for Reactive Attachment Disorder) (APA, 2013). I find that the pervasiveness of the PTSD diagnosis, as well as the longer period which the diagnosis covers may explain why PTSD is the focus of many studies investigating trauma. Due to the awareness that PTSD is the main diagnosis trauma studies look to (Shapiro & Forrest, 2016; Vereniging EMDR Nederland [VEN EMDR], 2014; DePrince & Freyd, 2002), it is important to compare what the *DSM* includes in the diagnostic criteria, particularly in contrast with how experts mentioned above describe trauma.

PTSD. PTSD is defined as developing characteristic symptoms after exposure to a traumatic event (APA, 2013). Alternatively, Tan et al. (2013) say it is a "persistent and constant mental disorder caused by psychological trauma" (p. 3). Overall, the diagnosis can be arrived at by meeting one or two of the criteria in each of five areas (exposure, symptoms, stimuli avoidance, negative alterations in cognition and mood, and altered levels of arousal and reactivity) for a period of over a month in a manner which impairs social, occupational, and other significant areas of functioning and is not attributable to physiological effects of a substance or medication (APA, 2013). Note that the criteria vary somewhat in children under six, however, I will only be including the over-six criteria in this paper.

Criteria A: exposure. To be diagnosed with PTSD, a person must be exposed (by witnessing, experiencing, or learning about) to a traumatic event (APA, 2013). The possible events include, but are not limited to: violent, unnatural, or accidental death or suicide of a family member or friend, work-related collection of human remains or ongoing exposure to child abuse, exposure to war, assault (physical and sexual, including the threat of), being kidnapped or taken hostage, terrorist attack, torture, prisoner of war, disasters, motor vehicle accidents, and sudden and catastrophic medical incidents like anaphylactic shock, and serious accident (APA,

2013). Not all life-threatening illnesses or debilitating conditions are considered traumatic events, and exposure cannot be through media, television, pictures, or movies unless work-related (APA, 2013). Also, in the *DSM-IV*, unexpected death from natural causes was included; it no longer is (Kilkpatrick et al., 2013).

Remember, per the prevalence numbers above, statistically up to 50% of people who experience one of the previously mentioned explicit traumatic events, will develop PTSD. Kilkpatrick et al. (2013) state that 89.7% of 2,953 adults sampled had experienced one or more of these events. Of these, the number of people eligible for a PTSD diagnosis under the *DMS-5* was significantly lower than under the *DSM-IV* (Kilkpatrick et al., 2013). Kilkpatrick et al. suggest that the biggest factor in this difference is the exclusion of unexpected death by natural cause, which accounts for 50% of the difference.

Another point to note; in the previous version of the *DSM*, subjective response to the event was included via the experience of fear, helplessness, or horror in conjunction with the event (APA, 2013). In other words, prior to the *DSM-5*, the event had to provoke the feelings of fear, helplessness, or horror to meet the criteria for PTSD. This requirement is removed in the *DSM-5* (APA, 2013). The removal is due to variations in clinical presentation, as not all individuals indicate fear-based reactions (APA, 2013). In a sense, this broadens the potential definition of trauma. Consider this: If PTSD, as *the* trauma-based disorder, does not require an experience of fear, helplessness, or horror, does *any* definition of trauma demand it?

Criteria B: symptoms. The list of intrusive symptoms associated with the traumatic event includes: distressing memories or dreams of the event, dissociative reactions, intense/ prolonged distress due to related triggers, and physiological reactions resembling or symbolizing the event (ie. rapid heartbeat) (APA, 2013). Note that the symptoms cover the conscious and unconscious

mind, emotions, and the body. Thus, we can see there is agreement within the *DSM-5* that trauma impacts all of these areas as suggested in the previous section. However, only one symptom in one area is required for diagnosis of PTSD; the true key to diagnosis is the intrusive nature of the symptom.

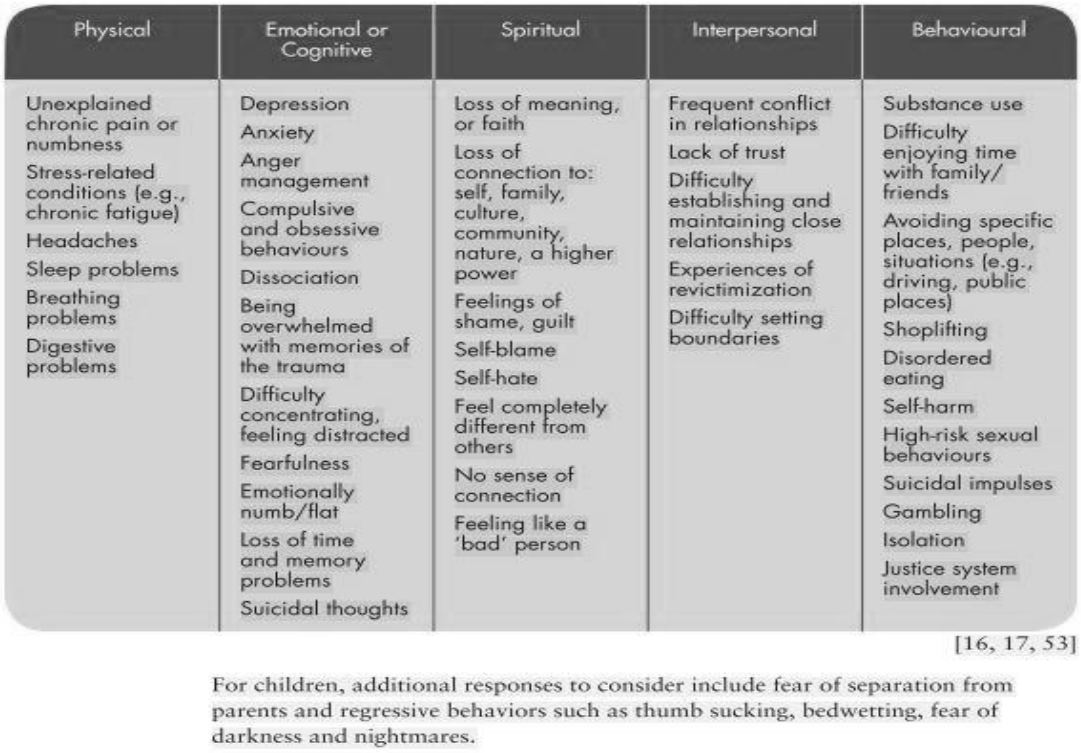
Criteria C: stimuli avoidance. This category is essentially about avoiding triggers. The stimuli can be in the form of memories, thoughts, or feelings directly or closely associated with the event (internal cues) (APA, 2013). Alternatively, avoidance can focus on external reminders such as people, places, activities, or objects, for example, which can bring up upsetting memories, thoughts, or feelings directly or closely related (APA, 2013).

Interestingly, stimuli avoidance was not a criterion in the *DSM-IV* (Kilkpatrick et al, 2013). Kilkpatrick et al. (2013) indicate the change in this criteria results in a significant discrepancy between the possibility of diagnosis for PTSD, with a negative trend between the *DSM-IV* and *DSM-5*. Furthermore, I note that in the non-*DSM*-based definitions of trauma I provide above, stimuli avoidance is not mentioned once. This stands out to me as an interesting observation. As mentioned, trauma is usually studied via the diagnosis of PTSD. However, in the very few examples I could find outside the *DSM-5* of a definition of trauma, the avoidance of stimuli is not obviously noted. To me, this is what makes it difficult to accept the notion of PTSD as representative of trauma; the question of whether the diagnosis rules out the legitimacy of being traumatized for a number of people. However, as Kilkpatrick et al. observe, "most would agree that avoidance is a key part of the PTSD construct and clinical picture, and most would agree that PTSD without active avoidance is not PTSD as we know it" (p. 544). In other words; avoidance is crucial to understanding PTSD; I simply question whether it is necessary to consider in the broader definition of psychological trauma.

Criteria D: negative alterations in cognition and mood. Two or more of the criteria in the category are required for diagnosis. The criteria in this category are: dissociative amnesia, persistent and exaggerated negative beliefs/ expectations, persistent, distorted, and blaming cognitions about the cause or consequence of the event, persistent negative emotional state, significantly lowered interest/ participation in usual activities, feelings of detachment or estrangement, and persistent inability to feel positive emotions (APA, 2013).

Criteria E: altered arousal and activity. In this category, irritable, reckless, and/or hypervigilant behaviour, angry outbursts (with low provocation), exaggerated startle response, concentration problems, and sleep issues are considered (APA, 2013). At least two of the criteria must be met for diagnosis (APA, 2013).

Relating criteria B, D, and E to non-DSM based understandings of trauma. In exploring the criteria attached to a diagnosis of PTSD, it is interesting to consider how the symptoms described therein relate to a non-DSM identification of psychological trauma. Figure 3.1 is an example of how psychological trauma is being observed, symptomatically, outside of a *DSM* diagnosis. Note that the symptoms listed significantly reflect those described in the *DSM-5*, though they are categorized differently. It is vital to understand that Figure 3.1 is sourced from the *Trauma Informed Practice (TIP) Guide* created by the British Columbia Provincial Practice Council on Mental Health. This guide, in my experience, is distributed widely to social service agencies/ workers and counsellors in BC. There is a sense, for me, that this guide is the way trauma is being understood in BC at present. What truly distinguishes the *TIP Guide* from the *DSM-5* in relating to trauma is the idea that a person can be psychologically traumatized without meeting the criteria for a diagnosis.



Physical	Emotional or Cognitive	Spiritual	Interpersonal	Behavioural
Unexplained chronic pain or numbness	Depression	Loss of meaning, or faith	Frequent conflict in relationships	Substance use
Stress-related conditions (e.g., chronic fatigue)	Anxiety	Loss of connection to: self, family, culture, community, nature, a higher power	Lack of trust	Difficulty enjoying time with family/ friends
Headaches	Anger management	Feelings of shame, guilt	Difficulty establishing and maintaining close relationships	Avoiding specific places, people, situations (e.g., driving, public places)
Sleep problems	Compulsive and obsessive behaviours	Self-blame	Experiences of revictimization	Shoplifting
Breathing problems	Dissociation	Self-hate	Difficulty setting boundaries	Disordered eating
Digestive problems	Being overwhelmed with memories of the trauma	Feel completely different from others		Self-harm
	Difficulty concentrating, feeling distracted	No sense of connection		High-risk sexual behaviours
	Fearfulness	Feeling like a 'bad' person		Suicidal impulses
	Emotionally numb/flat			Gambling
	Loss of time and memory problems			Isolation
	Suicidal thoughts			Justice system involvement

[16, 17, 53]

For children, additional responses to consider include fear of separation from parents and regressive behaviors such as thumb sucking, bedwetting, fear of darkness and nightmares.

Figure 3.1. Symptoms of Trauma. Reporting and experience of these criteria are unique to each individual who has experienced a traumatic event. From the British Columbia Provincial Mental Health & Practice Counsel (BCPMHPC) (2013) *Trauma-informed Practice Guide* (p. 21).

Conclusive understanding of trauma as related to the DSM-5. PTSD can be understood as one type of trauma-based diagnosis among several in the *Trauma- and Stressor- Related Disorders* section of the *DSM-5*. Still, it is important to recall that PTSD is not a diagnosis of trauma, it is simply the most commonly diagnosed trauma-based disorder. Although the research focus on PTSD as the way to understand trauma is prominent, there is a feeling of needing to understand psychological trauma as a broader category overall.

I find that although the *DSM-5* is the authority on diagnosis for PTSD and other trauma-based disorders, and certainly this impacts the understanding of and working with psychological trauma in general, the human experience of psychological trauma is more nuanced than the *DSM-5* captures. This is evidenced by comparison between the *DSM-5* criteria and

expert opinion. In fact, there are some who suggest that PTSD would be better conceptualized as part of a spectrum or syndrome of trauma-related disorders (Bovin & Marx, 2011; Payne, Levine, & Crane-Godreau, 2015). Furthermore, as I will discuss next, there are those who suggest there is no need to pathologize trauma to begin with; instead, they say, we need to work with the subjective nature of trauma.

Conversely; not diagnosing trauma. Relating back to the idea of subjectivity in experiencing trauma, it is important to consider that many people would likely suggest trauma should not be pathologized at all. For example, Francine Shapiro, another trauma-work expert who discovered and developed a process called Eye Movement Desensitization and Reprocessing (EMDR), takes this stance (Shapiro & Forrest, 2016).

On the surface, Shapiro seems strongly connected to the idea of pathologizing trauma. Shapiro first practiced EMDR with people who were experiencing troublesome thoughts (VEN EMDR, 2014). However, in order to research EMDR effectiveness more thoroughly, Shapiro required a homogenous population to investigate the impact of trauma (VEN EMDR, 2014; Shapiro & Forrest, 2016). Shapiro found this population in people with a PTSD diagnosis (VEN EMDR, 2014). Thus, EMDR was initially studied and examined for efficacy in trauma by working with individuals who had a PTSD diagnosis (VEN EMDR, 2014). Shapiro indicates that she relied on the PTSD diagnosis as it was a recent addition to the *DSM* at the time of EMDR discovery, and allowed for the isolation of a particular group in studying efficacy (VEN EMDR, 2014).

Intriguingly, despite the bulk of her research focussing on PTSD, Shapiro does not see PTSD as the definition of trauma (VEN EMDR, 2014). Instead, Shapiro & Forrest, (2016) suggest:

> When psychotherapists talk about trauma, they are generally referring to events that would be upsetting to nearly everyone and that involve a reaction of fear, helplessness, or terror. Unfortunately, many people (and some psychotherapists!) mistakenly believe that events are somehow unimportant if they do not meet this standard. But many events can be disturbing because of their personal significance, such as overhearing a passing remark that you are unattractive, getting a failing grade in school, or having a pet run away. (p. 25)

Furthermore, Shapiro & Forrest, (2016) state:

> Most of us are used to thinking of trauma only as those big events that appear in the newspapers. War veterans, survivors of natural catastrophes and terrorist attacks, these are the sufferers of trauma in the popular imagination. But, in fact, by dictionary definition, trauma is *any event that has had a lasting negative effect*. We all know people who have lost jobs, loved ones, even possessions and who have truly suffered as a result. When you lose your peace of mind, or if you never had it, there can be serious physical and psychological consequences no matter what the cause. Regardless of the "triggers," the causes are generally found in earlier life experiences. We call these experiences *traumas*. (first page of introduction)

In fact, Shapiro and Forrest indicate that it is not what a diagnostic criterion or a therapist considers trauma to be, but the personal experience of the client that matters. According to this mentality, if the client perceives herself to be psychologically traumatized, irrelevant of any diagnosis potential, this is what clinicians need to work with.

Inconclusive conclusivity on need for pathology. So, if trauma can be either studied or understood as related to current *DSM* criteria, or as an independent subjective experience (non-

pathologized and self-identified) how can we be clearer, as clinicians and for clients, about what trauma is and is not? There is no clear answer to this, but one area of exploration which might help is in looking at typology of trauma.

Types of Trauma. As mentioned above, the *DSM-5* references several diagnosable conditions relating to trauma. However, outside of the *DSM-5,* there are many types of trauma commonly discussed in the field. It is important to have a brief overview of these types of trauma because the very invention of these categories aids in understanding trauma overall.

BCPHMPC (2013) divides trauma into five types based on "dimensions of trauma, including magnitude, complexity, frequency, duration, and whether it occurs from an interpersonal or external source" (p. 5). These dimensions are: single incident trauma (ie. a sudden loss), complex or repetitive trauma (ie. ongoing abuse), developmental trauma (ie. early childhood neglect), intergenerational trauma (ie. living with a trauma survivor and picking up their coping and adaptation patterns), and historical trauma (ie. residential schools) (BCPMHPC, 2013).

Vicarious Trauma (VT) is another widely discussed type of trauma (Pearlman, 2012; Boulanger, 2016; Klinic Community Health Centre, 2013). There is widespread acknowledgment that the term VT is used interchangeably with compassion fatigue, secondary traumatic stress disorder, burnout, work-related stress, and secondary trauma (Pearlman, 2012; Boulanger, 2016; Klinic Community Health Centre, 2013). On this, Boulanger (2016) writes, "Trauma is contagious; its powerful affect and frequently unformulated memories can be transmitted – sometimes nonverbally and often mysteriously – within families, across generations, and from patient to clinician" (p. 1).

From this categorizing of trauma, we can surmise that the sentience of trauma is not

homogenously provoked: people can feel traumatized due to a variety of experiences. Accordingly, trauma can be the result of a single incident, or several, and can relate to direct or vicarious experiences. However, there is some research that shows that there is a distinction between the subjective experience of trauma and the impact that traumatic events can have on the human brain.

Science and the Mind-Body Connection with Psychological Trauma. The final area I will explore, in attempting to answer, "What is trauma?" is neuropsychology. Specifically, I look at the way neuroscience connects with current understanding of trauma. This clarifies the mind-body connection with trauma.

There is a plethora of research showing that the human brain undergoes physical alterations post-exposure to a traumatic event. However, as mentioned above, most of the research on trauma revolves around the diagnosis of PTSD, and this is certainly true within neuropsychology. Thus, bear in mind that trauma, as discussed in this section, relies on the diagnosis of PTSD. In other words, although this section is meant to inform and expand on the definition of trauma, the discussion here is not so easily generalized beyond the diagnosis. A further caveat is that the field of neuropsychology is vast and explicit; I will be offering only a broad and general overview. My purpose is simply to assist with conceptualizing trauma, and observations from neuropsychology are helpful in this.

Van der Kolk explains the neuropsychology in the brains of people who have been diagnosed with PTSD:

> there's many different areas of the brain that get impacted by trauma. One is the lowest part of the brain, way back here, our brain stem. The brain stem gets stuck in this fight, flight or freeze mode so that traumatized people continue to always be on the attack,

> always on the defense and at some very core areas of their work. The second piece is that the limbic system, which is in the middle of your brain, which is in charge of how your brain organizes and perceive experience, gets changed. And so you see the world differently. The next piece of brain that gets messed up is your prefrontal cortex. Your prefrontal cortex is in charge of understanding, of having perspective, of saying; no this would not be that I think to do right now because people will get hurt or offended, they will have bad consequences, all of that gets very messed up by trauma also. And so trauma affects many different brain levels and what people have known for at least 150 years now is that when people get upset the brain shuts down from the front to the back. (PESI Publishing & Media, 2011, 1:22:00)

Van der Kolk explains that other areas of the brain show up as completely altered in people who have trauma, including the part of the brain which is responsible for a person's sense of self (PESI Publishing & Media, 2011). Van der Kolk further suggests:

> The only therapy that counts is limbic system therapy because the problem is not in your frontal lobes. And most of our patients are not mentally retarded. They know what the right thing to do is. But their limbic system continues to propel them into feeling what they feel and experiencing what they experience, has nothing to do with reason, nothing to do with understanding. (PESI Publishing & Media, 2011, 1:27:00)

In other words, the presence of trauma in the brain's limbic system is so strong that logic and reason are overwhelmed, at least in cases where PTSD has been diagnosed.

Another example of how trauma impacts the brain is provided by Tan et al. (2013). Tan et al. compared the brain scans of 26 people who survived a mine disaster, 12 of whom had been diagnosed with PTSD. In the participants with a PTSD diagnosis, physical changes in the brain

structure were observed in areas which relate to muscle control and sensory perception. This shows a clear difference between the brain overwhelmed by trauma and the brain which has adapted to or accommodated trauma. There were also differences between participants whose PTSD symptoms had been improving versus those with a PTSD diagnosis and no symptom improvement.

Overall, it is clear that the changes that take place in the brain, as evidenced by brain scans, are measurable and clear changes in physiology related to the diagnosis of PTSD. It is not clear whether or not the diagnosis in entirety is linked to these changes, however, which is a curiosity. Still, there is a definite link between cognition and the physical body; trauma exists in and impacts the mind and the body simultaneously.

This mind-body connection is further clarified by Van der Kolk in examining the vagus nerve system; a nerve which essentially connects the brain and the rest of the body (PESI Publishing & Media, 2011). Van der Kolk links to Darwin's research to explain this connection as follows:

> He [Darwin] says that is a nerve, he calls it the pneumogastric nerve. Today we call it the vagus nerve… He says, heart, guts and brain communicate intimately via the pneumogastric nerve, the critical nerve involved in expression and management of emotions in both humans and animals. When the mind is strongly excited, it instantly affects the state of the viscera… I mean, knowing from our own experience is that when you're really upset you feel it in the course of your vagus nerve. You feel it in your chest. You feel it in your gut and you have heart wrenching or gut-wrenching and heart-breaking feelings… As long as your feelings are in your head, you can manage them. As long as I say that person really makes me very mad, don't worry about it. But when I

> have a gut-wrenching feeling I have got to do something… Let's say it's all about the management of unbearable physical sensations. And that's what Darwin pointed out. My teachers didn't teach me that and I think your teachers didn't teach you that. But that's what it's about. It's about your management of unbearable sensations in your body… And so this is the course of the vagus nerve. In the last 25 years or so the research have show that 80% of the fibers of the vagus nerve are efferent fibers, fibers that run from the body into the brain. What this Darwin's prescient capacity showed us is that if you can change the state of your body, then you can change the state of your mind. Okay, and then it shows that if you can breathe slowly and deeply, it can send signals to your brain to calm yourself down more effectively than valium. And if you can twist yourself and move yourself, you can actually change your brain. (PESI Publishing & Media, 2011, 3:36:00)

Through this explanation, the mind-body connection is evident again, and it is not just in the brain that the physical body, emotion, and cognition are linked, but through the CNS as well via conduits such as the vagus nerve. This means that trauma is definitively a concept which must involve the entirety of a person; mind (as the source of cognition and emotion), and body (the physiological base and physical connection to the mind in experiencing and expressing the impact of trauma). Therefore, to update my definition of trauma: the psychological concept of the subjective and somatic response to an intense and loss-related experience which overwhelms personal coping systems and impacts cognition, emotion, and the CNS, and may cause changes in the structure of the human brain.

Conclusion

In short, despite the inclusion of trauma-based disorders in the *DSM-5*, the conversation

on trauma's constitution is an ongoing one, and there are many who argue that defined disorders do not truly capture the lived experience of trauma that clinicians and clients will deal with in psychotherapy. At the same time, trauma is a concept with a well-documented history, with references to symptomatology in historical literature thousands of years old. Overall, the link between the experience of an event subjectively defined as traumatic and the development of an array of symptoms related to mind, body, heart, and soul is certain, which begs the question of how to address trauma using simply talk-therapy and encourages the idea of using a mind-body approach.

Chapter IV Connecting Grief and Psychological Trauma

In the previous chapters, I individually defined and contextualized the concepts of grief and trauma under the umbrella of loss. However, I remain hard-pressed to clarify the relationship between grief and trauma. I have been able to demonstrate a longstanding acknowledgement of each of these concepts distinctly, but it remains unclear how the two overlap. Take, for example, this snippet of spoken word artist Andrea Gibson's (2014) *The Madness Vase:*

> The trauma said, "Don't write these poems.
>
> Nobody wants to hear you cry
>
> about the grief inside your bones."
>
> ~~~
>
> But my bones said, "Tyler Clementi jumped
>
> from the George Washington Bridge
>
> into the Hudson River convinced
>
> he was entirely alone.
>
> ~~~
>
> My bones said, "Write the poems." (Kindle Locations 73-78)

In this poem, trauma seeks to control the response of the speaker, while grief is held in the body. And who is to say which is more prevalent, obvious, or relevant; the grief, or the trauma? This ill-defined distinction between these concepts is problematic in regards to including both grief and trauma as conditions for which WT might be helpful.

We need to better understand the relationship between grief and trauma to be able to discuss using WT to treat these conditions. Thus, in this chapter, my purpose is to connect these two concepts. I do this by showcasing how trauma and grief are linked and differentiated. I rely

on conceptualization and treatment approaches in psychological literature and an examination of the overlay in symptoms. Therefore, in this chapter I argue:

- that grief is the fundamental reaction to loss,
- that therefore trauma can only exist where grief is present,
- that all grief has the potential to induce trauma,
- that when trauma is present it hijacks grief and becomes the focus for therapy as well as increases the likelihood that therapy would be helpful,
- that most cases of grief which therapists are likely to see will in fact be cases where trauma is apparent and has complicated the grief process, and therefore;
- the clinical approach to treating grief and/or trauma is to first establish safety and then to support the creation of meaning.

Overall, in this chapter, I establish the connection between grief and trauma which therapists need to understand in planning treatment approaches.

Fluidity between Grief and Trauma

As discussed in Chapter I, the main bond between grief and trauma is that they both stem from loss (see Figure 1.1). In review, by following the reasoning that all loss invokes grief, we can surmise that grief must be the broader condition. Trauma, which also stems from loss, but is less predictable, must therefore be directly fused with grief. In short, trauma cannot exist without grief because loss always leads to grief, and only sometimes to trauma. Therefore, it becomes most important to examine how trauma arising in tandem with grief impacts.

To begin, recall that most often grief and trauma move through naturally without any need for therapy. Grief that does not tend to move naturally, or as cultural norms would predicate, is generally treated as a distinctive type of grief, much as trauma that sticks is

pathologized as PTSD. This type of grief is interchangeably referred to as complicated grief (Zisook & Shear, 2009; Papa & Maitoza, 2013, Boss, 2010; Callahan, 2011), traumatic grief (Salloum & Overstreet, 2008), persistent complex bereavement (APA, 2013), or prolonged grief (Papa et al., 2014). As the names suggest, the persistent nature or length of time the grief overtakes a person is longer than normal in these cases. Also from the names, we can see that the grief is considered to be complicated somehow, indicating that there may be more than just grief at play. The idea of traumatic grief suggests that one type of complication could be in the inclusion of trauma in the experience. Indeed, this type of grief, by any of these names, tends to relate to events associated with a traumatic experience (Winokuer & Harris, 2012). Intriguingly, Neiyemer and Sands (2011) stipulate that all grief contains some elements of trauma due to the manner in which grief shatters world assumptions. This begs the question of whether there is any de facto difference between grief and trauma.

Adding to the notion that trauma and grief are in many ways the same presenting condition, it is crucial to note that the symptoms provoked and documented for grief and for trauma are incredibly similar, as shown in Table 4.1. This table lists symptoms and details sources which have cited the listed symptoms as those of grief, trauma, or both. As can be seen, when the symptoms and sources are cross-compared, there is almost no difference in the symptoms of grief versus trauma. Of course, where there are differences, it is entirely likely that many people could dispute omissions/ inclusions of certain symptoms from either grief or trauma based upon personal/ professional experience, or even by how the symptom is named. For example, I have grouped Cognitive Disruption, Mental Fatigue, and Madness together as one category due my perception that there is a high degree of correlation between each of these titles. It is important to also note that this list is not exhaustive. Conversely, recall that part of the

uniquity of grief and trauma reactions is in the experiencing: everyone experiences an individualized collection of symptoms. Overall, this table is provided simply to highlight the general similarities between grief and trauma symptoms as noted via a multitude of sources.

Table 4.1
Symptom Overlap Between Grief and Trauma

Symptom	Source(s) Connecting the Symptom to Grief	Source(s) Connecting the Symptom to Trauma
Anger	Park & Halifax (2011)	BCPMHPC (2013), APA (2013)
Anxiety/ Exaggerated Worry/ Startle Response	Parkes (1972) as cited by Gudmundsdottir (2009), Attig (2010), Moody & Arcangel, (2001), Worden (2009)	APA (2013)
Avoidance	Lewis (1994)	BCPMHPC (2013), Van der Kolk et al. (1996), APA (2013)
Cognitive Disruption/ Mental Fatigue/ Madness	Attig (2010), Moody & Arcangel (2001), Worden (2009), Burton (2004), Shand (1914)	BCPMHPC (2013), Solomon, Solomon, and Heide (2009), APA (2013)
Compulsive Behaviour	Darwin (1872)	BCPMHPC (2013), APA (2013)
Denial/ Protest	Park & Halifax (2011), Archer (1999)	-----
Depression	BCPMHPC (2013), Attig (2010), Moody & Arcangel (2001), Worden (2008), Shand (1914), Freud (1917)	BCPMHPC (2013)
Despair	Park et al. (2011), Burton (2004)	APA (2013)
Difficulty Concentrating	Shand (1914), Lewis (1994)	BCPMHPC (2013), APA (2013)
Disordered eating	Johnson (2002), Clayton, Desmarais, & Winokur (1968), Clayton & Darvish (1979), APA (2013)	BCPMHPC (2013)
Disorganization	Park & Halifax (2011), Shand (1914)	Van der Kolk (as interviewed by PESI Publishing & Media, 2011)
Dissociation	Winokeur et al. (2012)	BCPMHPC (2013), APA (2013)
Distress	Archer (1999)	APA (2013)
Emotional Disturbances/ Mood Swings	Attig (2010), Worden (2008), Burton (2004)	Solomon, Solomon, and Heide (2009), APA (2013)
Fear	Lewis (1994), Zisook & Shear (2009)	BCPMHPC (2013), Burton (1867)
Isolation	Lewis (1994)	BCPMHPC (2013), APA (2013)

Table 4.1 ***(cont)***

Symptom	Grief	Trauma
Hallucinations	Clayton, Desmarais, & Winokur (1968), Clayton & Darvish (1979), Zisook & Shear (2009)	APA (2013)
Longing	Park & Halifax (2011)	-----
Intrusive or Painful Thoughts	Archer (1999), APA (2013)	APA (2013), BCPMHPC (2013), Van der Kolk et al. (1996)
Loss of Connection	Clayton & Darvish (1979)	BCPMHPC (2013)
Loss of Faith	Clayton & Darvish (1979)	BCPMHPC (2013)
Loss of meaning/ Loss of assumptive world	Winokuer & Harris. (2012), David (2002)	BCPMHPC (2013)
Numbness	Park & Halifax (2011)	BCPMHPC (2013)
Physical Ailments (ie. headaches, sleep problems, digestive problems)	Attig (2010), Moody & Arcangel (2001), Worden (2008), Lindemann (1944) as cited by Gudmundsdottir (2009), Burton (2004), Clayton, Desmarais, & Winokur (1968), Clayton & Darvish (1979), Zisook & Shear (2009)	BCPMHPC (2013), APA (2013)
Psychosomatic	Neimeyer et al. (2012), Hays (1994), Tripp (2007), Callahan (2011), Gudmundsdottir (2009), Devereaux, (2008), Lindemann (1944) as cited by Gudmundsdottir (2009), APA (2013). Parkes (1970) and Parkes (1972) as cited by Gudmundsdottir (2009)	Ringel, (2012), Bessel Van der Kolk as interviewed in Psychotherapy Networker (2014)
Relationship Disruptions	Winokuer & Harris (2012)	BCPMHPC (2013)
Searching	Park & Halifax (2011)	-----
Self-Blame/ Guilt	Shapiro & Forrest (2016), Clayton & Darvish (1979)	BCPMHPC (2013), APA (2013)
Self-harm/ Risk-taking	-----	BCPMHPC (2013)
Shame/ Self-Hate	Zisook & Shear (2009)	BCPMHPC (2013)
Shock	Park & Halifax (2011)	-----
Stress-Related Conditions	Attig (2010), Moody & Arcangel (2001), Worden (2008)	BCPMHPC (2013)
Substance Use	Szanto, Shear, Houck, et al. (2006) as	BCPMHPC (2013)

cited by Zisook & Shear (2009)

Table 4.1 ***(cont)***

Symptom	Grief	Trauma
Suicidal thoughts	APA (2013), Shand (1914)	APA (2013)
Yearning	Park & Halifax (2011)	-----

Note. This table was created by pulling out symptoms from sources discussing the concepts of grief and/or trauma to demonstrate the overlap between the symptomology of the two conditions. Most of the sources used in this table are cited extensively in Chapters II & III of this thesis.

Alternatively, Papa et al. (2014), provide Figure 4.1: a visual mapping of the comorbidity of grief (referred to as PGD in figure 4.1), trauma (PTSD in figure 4.1), and depression (MDD in figure 4.1)[11] in relation to bereavement, job-loss, and divorce samples. Note that in this representation, grief, trauma, and depression are all considered distinct experiences with individual symptomology. The overlap for Papa et al. is that participants experience aspects of each of these conditions in relation to loss. Overall, Papa et al. show that type of loss correlates with variations in the experiencing of grief, trauma, and depression. However, experiencing bereavement, job-loss, and divorce all include elements of grief, depression, and trauma. Therefore, the notion of a relationship and interplay between these conditions in the face of loss is validated.

Between the comparison of symptoms in Table 4.1 and Papa, Lancaster, and Kahler's (2014) research, the argument for a strong connection with indeterminate distinction between grief and trauma is obvious. Indeed, per Winokuer & Harris (2012):

> The common thread between traumatic grief and a traumatic response to an event is found in the propensity for psychological overload that is demonstrated in the similarities

[11] Papa, Lancaster, and Kahler (2014) and I use different terms for the same concepts. They refer to grief as Prolonged Grief Disorder (PGD), to depression as Major Depressive Disorder (MDD), and to trauma as Posttraumatic Stress Disorder (PTSD).

> between the two responses. This distinction can be very confusing, but for the practicalities sake, if your client describes feeling highly anxious or unsafe, or tends to focus on the events surrounding the loss rather than the person, you are probably dealing with traumatic overlay of some sort. What mainly separates PTSD from complicated/ traumatic grief is the presence of separation distress, including yearning for the deceased person and intrusive thoughts of, or pangs for the lost person (Horowitz et al., 1997; Prigerson et al., 2009). (p. 139)

In other words, although there have been attempts made to connect or disconnect trauma and grief, the common-sense approach of tuning in to what the client is presenting with (a grief reaction and/or a trauma reaction) is recommended. Distinguishing whether one is dealing with trauma or grief might relate to feelings of safety and fixation on the event (trauma) versus feelings of loss and focus on separation (grief).

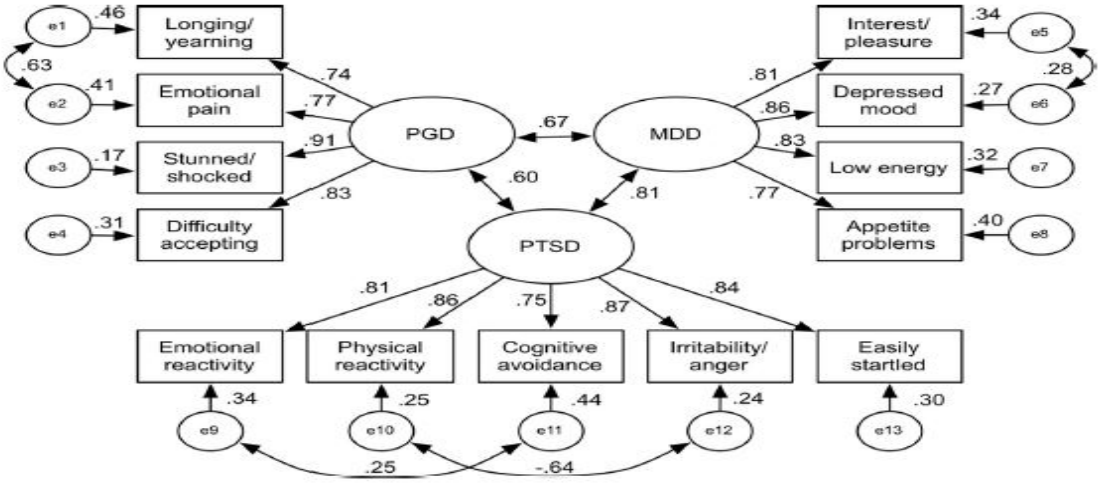


Figure 4.1. Interaction of Grief, Trauma, & MDD Symptoms Related to Loss. This figure is copied from a study by Papa, Lancaster, and Kabler (2014) exploring what the authors identify as the three most common responses to bereavement: Prolonged Grief Disorder (PGD), Major Depressive Disorder (MDD), and Posttraumatic Stress Disorder (PTSD). This figure captures how the participants experienced the interrelation of these three reactions to the death of a loved one. Reprinted from: Papa A, Lancaster N, Kahler J. (2014). Commonalities in grief responding across bereavement and non-bereavement losses. *Journal of Affective Disorders, 161*, pp. 136–143.

According to Winokuer and Harris (2012) this is important as trauma can hijack therapy

by overshadowing grief and making grief work impossible if the trauma is not addressed. In fact, per Winokuer and Harris, trauma can stunt the grieving process. Thus, grief cannot be addressed unless safety is created to deal with the trauma (Winokuer & Haris, 2012). Resultantly, the question of how to best proceed in clinical practice with grief and trauma overlapping becomes the focus.

Treatment Approaches to Grief & Trauma

Winokuer and Harris (2012) cite Prakes (2002) and Stroed and Schut (2001) in determining that the groups of people who benefit from grief counselling are:

> …older men who lose spouses, mothers who lose children… survivors of sudden or violent losses with traumatic features… those with preexisting psychological disturbances such as depression, substance abuse, posttraumatic stress disorder, and a history of psychosis… individuals with high levels of distress early in their bereavement experience… (p. 21)

In short, the people most likely to benefit from grief counselling are identified as the people who have actually had a traumatic experience and/or who have pre-existing conditions (and one must question whether these conditions might have originated in response to one or more traumatic events). Thus, I posit that most clients seeking therapy for grief are likely to actually be working through trauma as well, and therefore trauma must be centrally addressed in therapeutic interventions targeting grief.

Consequently, having established that trauma can appropriate the grief process, Winokuer and Harris (2012) suggest that this is where counsellors must be attentive, slow down the process, notice when clients may become flooded, focus on breathing, and use limited dosing or exposure therapy, CBT, and meaning reconstruction therapy. The process is to create safety

and subsequently rework cognitions and meaning around loss (Winokuer & Haris, 2012). Unsurprisingly, establishing safety and the creation of new meanings are at the forefront of both grief therapy recommendations (Winokuer & Harris, 2012; Neiyemer & Sands, 2011; Walter & McCoyd, 2009) and trauma therapy recommendations (Shapiro & Forrest, 2016). Accordingly, Neiyemer and Sands (2011) write:

> When losses are more objectively traumatic, data suggest that a search for sense or significance in the loss is more common, characterizing the majority of those bereaved by the sudden death of a family member, or parents who lose a child (Davis et al., 2000). Evidence demonstrates that a crisis of meaning is especially acute for those bereaved by suicide, homicide, or fatal accident, who report a far more intense struggle to make sense of the loss than do those whose loved ones died natural deaths. Moreover, the role of sense making – a key form of meaning making – is so prominent in accounting for the complicated grief symptomatology experienced by the former group that it functions as a nearly perfect mediator of the impact of violent death, accounting for virtually all the difference between those bereaved by the traumatic as opposed to natural deaths of their loved ones (Currier, Holland, & Neimeyer, 2006). (p. 12)

Neiyemer and Sands also suggest that reworking meanings can alleviate symptoms of grief and provide hope and autonomy going forward. Prieto (2011) also speaks to meaning making:

> Walking the rest of one's days on earth as a woman who lost a breast to cancer, as the victim of a rape, as a husband and father who has lost his family to a tragedy, as a child who has lost a parent - none of these is an exceptionally good life path. So while it would of course be easier to teach those who suffer from grief how to numb the pain, how to divert themselves from it, how to partition the pain into some past event that currently

> means nothing to them or that they "have gotten over," it is infinitely more difficult, for client and clinician alike, to really come to terms with the intense, sometimes inconsolable, nature of loss and grief. To take the time to absorb the terrible experiences of life, painful as they are, and make them our own. To make loss and grief a literal part of who we are, just as surely as we carry the scars of physical injuries. (Prieto, 2011)

Altogether, it is clear that meaning making, accepting, and processing emotional response are paramount when thinking about clinical interventions for grief and trauma.

Indeed, various authors in the book *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*, edited by Neimeyer, Harris, Winokuer and Thornton (2011), suggest several ways to clinically address loss such as: naming and validating the loss, finding meaning, addressing trauma when present, tempering mastery, reconstructing identity, normalizing ambivalence, revising attachment, and discovering new hope. In fact, CBT, cognitive processing therapy and prolonged exposure therapy are particularly helpful and validated approaches to working with trauma (Sauve, 2014) as they all involve reworking cognitions/ emotions and making meaning.

So, what is missing from these treatment approaches? Despite the focus on reworking meanings, creating safety, and so forth, one point stands out as hugely dismissed in working with grief and trauma. Referring again to Table 4.1, and Figure 4.1 note the prevalence of somatic or bodily symptoms. Recall also the somatic experiencing of grief and trauma as discussed in Chapter II and Chapter III. It is a major omission in current practice in addressing grief and trauma that there are so many symptoms held within the body, and yet therapy focusses on cognitive/ emotional interventions via traditional talk therapy. One has to wonder if this is by chance, or if there is a reason why the involvement of the body is not commonly referred to in

treatment approaches. I will be exploring this area in further chapters.

Conclusion

Certainly, it is debatable how closely linked or distinctly separate grief and trauma are. There is no simple way to resolve their relationship. Therefore, the reasonable approach is to not ruminate about finding clarity, but to find approaches which work for both grief and trauma and/or work with what a client presents (a grief-response or a trauma-response). Indeed, the treatment approaches most likely to benefit trauma are also those most likely to impact grief: the creation of safety, use of exposure, and work on meaning-making. Beyond the use of these interventions, the question we are left with is why, how, and if the body should be included in counselling when working with trauma and/or grief. This is the subject of the following chapter.

Chapter V The Body in Grief and Trauma

At this point, it is clear that, for me, grief and trauma are two conditions almost unequivocally co-occurring for people seeking counselling related to a loss. In previous chapters, I broke down grief and trauma as individual concepts and showed a relation between them. Consequently, we know that one aspect where grief and trauma overlap is in the manifestation of bodily symptoms. In this chapter, I will start by delving more deeply into my perception of the naturally occurring bodily experience of loss. I highlight discourse in the field which suggests movement as an adjunct to therapy and/or during therapy could be particularly useful for moving through grief and trauma. This demonstrates the problem we have in the field with omitting a mind-body treatment that incorporates movement as part of therapy.

How the Body is Naturally Involved in Grief & Trauma

A character in Sarah Noffke's (2014) sci-fi fantasy novel, *Awoken*, captures the impact that grief and trauma can have on the body:

> No one ever told me how sorrow traumatizes your heart, making you think it will never beat exactly the same way again. No one ever told me how grief feels like a wet sock in my mouth. One I'm forced to breathe through, thinking that with each breath I'll come up short and suffocate. (p. 287)

Indeed, there are several easily sourced examples of how grief and trauma hit at a bodily level. For example, consider for a moment the simple clarity within the following quote from Danish psychologist and physicist, Carl Lange's (1895) book *Les émotions; étude psychophysiologique* (translated as: *The Emotions: Psychophysiological Study*). Lange says "The sorrowful man moves slowly, staggers, creeps along swinging his arms, his voice is weak, without brilliancy…

he remains inert, prostrate, and silent" (Shand, 1914, p. 38) [12]. A further example comes from Hunt (2004). Hunt considers the historically philosophical relation between tears and the emotion of grief. Hunt points out that tears are widely recommended, biblically, as a way of bodily expressing the experience of the soul in the face of loss. Building on this, Kalaga (2013) in an introductory chapter to a book on grieving suggests:

> There seems to be no greater unity of the soma and the psyche, but in grief. The grieving body is a body of pain. In the visual images of grieving, that pain is pain/ted into the contortion or blankness of the face, emblazoned in the arched torso, limp and excruciatingly tense at the same time, in the twisting of hands and the hollowness or infinite depth of the eyes. Sometimes the hands cover the face to safeguard the loneliness, to keep away the compassionate gaze from the outside, to beg off sympathy – because true grief is a lonely affair, not something to be shared with those who do not grieve. (p. 2)

Furthermore, trauma specialist Pat Ogden speaks about how when trauma stimulates the CNS; sympathetic arousal and anxiety consecutively increase and the feeling of panic and heart rate do not recede immediately (Psychotherapy Networker, 2012). Instead, the feeling of trauma lives on in the body in movement, posture, and in fight-, flight-, freeze-, and faint-death- responses (Psychotherapy Networker, 2012, 7:46:00). Moreover, Darwin[13] (1872) writes "When a mother suddenly loses her child, sometimes she is frantic with grief, and must be considered to be in an

[12] This is the translation provided by Shand, 1914. The original text reads "Aussi, l'homme triste est-il souvent reconnaissable à son aspect extérieur; il va lentement, il chancelle, il se traîne les bras ballants, sa voix est faible, sand éclat, par suite de la faiblesse des muscles expirateurs et du larynx; voluntiers, il reste inerte, affaissé, muet. (Lange, 1895, p. 38)

[13] This quote is from the infamous Charles Darwin, a naturalist, geologist, and biologist who wrote *The Expression of the Emotions in Man and Animals* which links human behaviour to genetics following evolutionary theory.

excited state; she walks wildly about, tears her hair or clothes, and wrings her hand" (p.80).

Between these examples, we can understand very clearly a relationship between grief/ trauma and the body. Whether through posture, emotive gestures, CNS, or instinctive movement, loss can cause the body to change. While perhaps this is not a complete and universal picture of how grief or trauma might manifest physically, the imagery is powerful and clear. Indeed, it is relatable and showcases easily how loss and devastation might become deeply entrenched within the body. For an entertaining visual of this, see Figure 5.1 which shows a cartoon linking posture with emotional state. It is partially through imagery like this that we can really envision the impact that grief and trauma can have upon the body. Further, we can know that this has clinical

Figure 5.1 Charlie Brown & Posture. This *Peanuts* cartoon by Charles Schultz (1960) shows the link between posture and emotion. Retrieved from http://www.mysaltlakecitycounselor.com/standing-up-for-good-posture/

relevance to the counselling field. Consequently, Kalaga (2013) states:

> First, the body aches even though no pain has been inflicted to the body itself; grieving brings about corporeal suffering without corporeal cause: no wound or fracture of bodily tissue, no impact on the skull or chest apart from the inside. The body aches from within, and even though the griever's corporeal pain may not be as acutely intense as the pain

> caused by physical injury, it is by no means less severe…. Compassion and sympathy are external impositions, they have no access to the body; the body rejects them as intruders obliterating the pain. No cure is desired because it would spoil grieving; if there is cure, as one rabbi insists, it is to continue: "The only cure for grief is to grieve." (p. 2)

In sum, there is a knowing that grief and trauma cannot be targeted without involving the body. There is a sense that to access and change the grief/ trauma reactions, the body is key. The body holds and expresses the emotions in a manner which words alone have little success altering. Understanding this deep connection between the body and the conditions of grief and trauma, it is now crucial to consider what is known about this need to involve the body in moving forward.

Why the Body Must be Involved in Grief and Trauma Counselling

Having noted that loss is held within the body, it becomes highly relevant to consider how that loss is to be moved forward within the body. To understand this, we need to understand how clinical counselling interacts with the body.

According to Shelley (2015), therapy can be understood as composed of three separate registers. The first register, that of the conscious mind, utilizes techniques such as cognitive behavioral therapy (CBT), mindful walking, talk therapy, and mindfulness approach to work in the *here and now* (Shelly, 2015). The second register, that of the unconscious, relies working symbolically (Shelly, 2015). This register is that of the *there and then* (Shelly, 2015). Here, symptoms are often produced and trauma is often linked (Shelly, 2015). In the second register, tools such as art therapy, sand tables, Emotional Focussed Therapy (EFT), tracking early recollection, and metaphors are used to raise items to the first register; to move the unconscious to the conscious mind (Shelly, 2015). The third register is that of *Soma*, the body, or *what is physical* (Shelly, 2015). In the third register, the mind-body link can be understood. Shelley

indicates that interventions such as massage, floating, yoga, dancing, swimming, hiking, sports, stretching, martial arts, gardening, and sex play can be accompanying interventions to therapy. Shelley suggests asking clients what comes up for them during their use of these activities and does not specify these are therapeutic interventions which a therapist might employ. What Shelley highlights best is how important it is to tune into the body in therapy across all treatment realms, regardless of whether it is within the therapy room (as in sand table therapy and art therapy) or without (as in yoga and walking, for example). However, Shelley's arguments are not specific to trauma work, and do not account specifically for how including moving the body within therapy sessions rather than as an adjunctive activity relate.

Shelley is not alone in noticing therapeutic differences across the biopsychosocial domains. Pasquariello (2011), in a Master's thesis on connecting physical movement to improved mental health treatment in suggests:

> The biopsychosocial model embodies the holistic perspective necessary to understand the individual needs of the client. Instead of perpetuating the theory of mind-body dualism from past centuries, it is important to recognize and acknowledge the connection, independence, and overlap of the biological, psychological, and the social aspects of an individual. As mental health practitioners, it is imperative to not fall prey to the strong pull in the field to only focus on the mind (Hays, 1999). Instead, it is the role of mental health clinicians to address the mind, the body, and the social world of our clients in accordance with the biopsychosocial model (Smits & Otto, 2009). (p. 7)

In essence, there is a call to therapists to think bigger than traditional talking therapy and move toward approaches that make more sense in the face of conditions which traverse mind, body, heart, and soul. At the same time, this is not a new subject within psychotherapy, and, much as I

did in the first several chapters, it is important to again refer back to much older material in exploring this topic.

Specifically, recall again the work of Robert Burton (2004) who dedicates pages and pages to the relationship between exercising both the body and mind to combat sorrow. Burton suggests many well-known thinkers/ writers from all manner of medical, philosophical, and religious backgrounds, and from places such as Rome, Greece, Egypt, and Turkey, value exercise of the body greatly. These people, according to Burton, require exercise so that the mind (and emotions) might function properly as a result. Burton provides sources citing exercise from hawking/ hunting, to working up a sweat, to playing a ball game, walking, fishing, bowling, wrestling, running, swimming, riding, rowing, gardening, dancing, playing with children or animals, card playing, board games, shuttlecock, billiards, singing, discoursing, jesting, labour/ work, and cooking as types of exercise which benefit mind and body. Burton specifically targets sorrow/ depression in his discourse; these exercises are meant to turn one's body and mind from melancholy. As discussed previously, depression is noted in both grief and trauma symptomology. By occupying the mind and the body, Burton proposes, the brain cannot sink into sorrow. Furthermore, should the mind and body be idle then so shall anxiety creep in (Burton, 2004). Accordingly, with idleness a person can never be entirely well, as:

> …they are continually offended with the world and its concerns, and disgusted with every object in it. Their lives are painful to themselves, and burdensome to others; for their bodies are doomed to endure the miseries of ill health, and their minds to be tortured by every foolish fancy. (Burton, 1867, p. 44-45)[14]

[14] This same section in the more recent and more carefully translated version reads:

> they shall never be pleased, never well in body and mind, but weary still, sickly still, vexed still, loathing still, weeping, sighing, grieving, suspecting, offended with the world, with every object, wishing

Alternatively, Burton (2004) suggests that cures for melancholy are tied into the very air we breathe, the food and drink we take, the movement we do or do not push our bodies to, a solitude engaging the mind in intentional and purposeful practices, moderate and restful sleep, cleanliness of the body, and a control and strengthening of mind, particularly the imagination (thoughts) and emotions. Music, mirth and merry company, and healthy friendship are also recommended (Burton, 2004). In sum, the inclusion of movement and the exclusion of idleness are imperative to mental health and specifically useful in targeting depression or grief.

In fact, according to Pasquariello (2011), the idea of mind-body dualism has been developing for centuries. Pasquariello states:

> According to Homer, "mens sano in corpore sano," a healthy mind in a healthy body was ideal for Grecians who spent most of their day engaged in physical activity (Hays, 1999). It is said that Hippocrates prescribed physical activity for patients with mental illness centuries ago (Hays, 2002), Sigmund Freud worked with some of his patients while walking or hiking (Jones, 1967), and traditional Eastern practices of yoga have been connecting the mind to the body for thousands of years (Yuasa, 1987). (p. 6)

Overall, we can surmise that exercise as a remedy for mental health has been recommended for centuries by people relevant to the field. Indeed, to this day, there is no shortage of research on the psychological effects of exercise (Stanton & Reaburn, 2014), and many clinicians prescribe exercise to address mental health outside of therapy.

In fact, there is research indicating that just by incorporating intense and regular exercise into lifestyle, there is potential for significant improvement in depressive symptoms (Stanton et al., 2014). For example, Stanton et al. (2014) conducted a systematic review of five recent

---

themselves gone or dead, or else earned away with some foolish phantasy or other. (Burton, 2004, Kindle Locations 4271-4272).

randomized controlled trials and reported exercise as influential in treating depression. Stanton et al. screen 2696 potential studies for this review and eliminate duplicates, studies with participants who had multiple diagnoses, studies that did not include structured exercise interventions or showed no treatment effect of exercise, and studies older than 2007. Stanton et al. conclude that the use of supervised exercise (ie. walking, running, and/or cycling; indoor and/or outdoor) three times a week for at least nine weeks is effective in treating depression. The high number of excluded studies demonstrates a vast amount of literature studying the psychological effects of exercise.

Overall, there is strong evidence connecting healthy amounts of exercise to a wellness in mind and heart. This seems instinctively clear as well if we consider the notion that physical movement is a basic human need. It is no secret that when a body is made stagnant, by injury, for example, bed sores, muscle atrophy, and numerous other bodily conditions arise and spirits seem to sink. Likewise, children need to go through various stages of movement to develop their brains and bodies; from building their neck muscles to support their heads so they don't suffocate while lying face down, to learning to roll, crawl, walk, jump, clap, and so on to develop sequencing skills, for example. In my experience, most parents in North America will have been inundated with information on the importance of reaching these kinds of physical developmental milestones. Simply put, the body needs movement for physical well-being, and it is not hard to imagine the interplay between emotional well-being and physical when thinking of how debilitating the lack of movement is for most people. Knowing this, it is important to consider how incorporating physical movement into therapy sessions might relate to grief/ trauma counselling.

Incorporating body-work into counselling practice: Movement in session. Recalling

Shelley's (2015) model of the three levels of therapy, note that this theory breaks different therapeutic interventions into understandable levels. However, what Shelly does not explore well is the use of the body within therapy sessions. Indeed, this is something not well explored by any of the sources cited above. In the second register, for example, Shelley mentions art therapy and sand table work. It is important to note that these are two examples of therapeutic interventions which utilize the mind and the body within the therapy session. For example, Jung (1966) suggests of sand table therapy "Often the hands will solve a mystery that the intellect has struggled with in vain" (para. 181). Shelley does not explore either the second or third level around the potential of connecting the mind and body within the therapy room. This omission is problematic; there are several therapies which require extensive training and then focus on combining bodily movement with therapy including EMDR, Dance/Movement Therapy, Adventure/ Wilderness Therapy, and Nature Therapy.

In regards to working with the body in trauma therapy, two somatic trauma experts, Pat Ogden, and Bessel Van der Kolk have some insight on specifically including body-work within counselling sessions. Van der Kolk suggests:

> …befriending your body, being involved in your body has become a very important cornerstone of all trauma treatment and it doesn't mean you have to go to yoga, you can do taichi, you can do chi kung, you can do something else but as long as you don't have a body, your chances to ever recover from trauma are zilch. You cannot recover from trauma until you have a loving relationship to your body, bottom line and quote me on it, if you want to argue with me, if you want to disprove me, do it, do it." (PESI Publishing & Media, 2011, 2:19:00)

Ogden further suggests that trauma must be addressed on the level where it impacts the most,

which Ogden submits is in the CNS and movement of the body (Psychotherapy Networker , 2012, 4:30:00). Connectedly, Northcut and Kienow (2014), in a case study on working with military survivors of sexual trauma find that treatments for trauma must attempt to "include the survivor's mind and body as part of the treatment to integrate the disconnected aspects of the self" (p. 249). In sum, within the current psychology/ trauma field, there is an understanding that the body must be remembered in clinical intervention to most benefit clients[15]. Furthermore, there are several types of therapy available which do include the body in therapy sessions; this is the content of the following chapter.

Conclusion

It is relatively well accepted that physical movement is important to the body and mind together. Furthermore, there are centuries of wisdom suggesting that movement can help in moving through grief/ trauma or improve mental health in general. However, there is little empirical research demonstrating how including movement in therapy might be helpful in processing loss. At the same time, it is useful to explore how a natural movement such as walking can potentially interact with counselling to process grief and trauma.

Therefore, in the next several chapters, I explore how WT is based on the idea that walking is a therapeutic practice unto itself. I present literature specific to individual and group WT. I include material covering Mindful Walking and Labyrinth Walking as two specific types

[15] Bessel van der Kolk has an interesting theory on how trauma is naturally mitigated which he discusses in a video presentation (PESI Publishing & Media , 2011). Herein, van der Kolk suggests that physical movement toward safety in the face of catastrophic events significantly decreased the development of trauma-reactions in the people impacted (PESI Publishing & Media , 2011). Van der Kolk compares the experiences of people in the 9/11 terrorist attacks with other populations who experienced an event highly likely to invoke a trauma-response (PESI Publishing & Media , 2011). Van der Kolk suggests that there was almost no resultant trauma following 9/11 and suggests that because people were able to keep moving toward a place of safety and were not trapped in the event, that this greatly diminished trauma-reactions (PESI Publishing & Media , 2011). This is curiosity provoking: can moving the body toward safety in some manner benefit people impacted by trauma?

of walking which are associated with therapy. In exploring each of these areas, I include data from a multitude of sources: peer-reviewed articles, historical accounts, current philosophical works, newspapers, magazines, and online articles. This provides a comprehensive record relating to the practice of walking with clients impacted by grief and/or trauma and stays true to the ethnographical and epistemological method I employ through this paper.

Chapter VI Walking as a Therapy unto Itself

Solnit (2014) draws attention to the physicality and constitution of walking in this passage from *Wanderlust: A History of Walking*:

> Where does it start? Muscles tense. One leg a pillar, holding the body upright between the earth and sky. The other a pendulum, swinging from behind. Heel touches down. The whole weight of the body rolls forward onto the ball of the foot. The big toe pushes off, and the delicately balanced weight of the body shifts again. The legs reverse position. It starts with a step and then another step and then another that add up like taps on a drum to a rhythm, the rhythm of walking.
>
> The most obvious and the most obscure thing in the world, this walking.... (p. 3)

Consequently, regardless of any mindset, emotional sense, or introspection, there is a rhythm and a sense that walking is the baseline underscoring humanity's very ability to think, feel, and grow. Accordingly, the research I present in this chapter is specific to walking as a stand-alone therapeutic practice and as an adjunct to therapy. As discussed previously, there are very few studies on WT, so practitioners instead rely on connections to other research and/or an instinctive inclination toward including the body easily in therapy. Personally, it is studies linking movement to mental and emotional health that first compelled my belief that including walking during therapy would be more effective for grief/ trauma work. Thus, in this section, I am including a small sample of studies demonstrating how walking, simply walking, can be therapeutic. Furthermore, I provide some documentation demonstrating how walking seems instinctively related to grief or trauma processing.

This review is to create awareness that walking just for the sake of walking can be an intervention convergent with mental health and wellness development, which we understand as

being foundational in WT philosophy and important in grief/ trauma processing. Providing this review continues to build the groundwork for WT as we go beyond studies specific to individual and group WT and to the very root of the practice; walking. Exploring the idea of walking as an adjunctive and/or stand-alone therapy is crucial: not only does it enhance the stance that WT can be more helpful than therapy alone, but it keeps WT practitioners humble, and deepens the connection for a grief/ trauma modality.

Research on Walking as a Stand Alone Intervention

Napier (1967) in *The Antiquity of Walking,* an essay on the origins of walking (one of the first works insisting on the formative importance of walking in terms of evolution according to Solnit (2014)), writes:

> Human walking is a unique activity during which the body, step by step, teeters on the edge of catastrophe…. Man's bipedal mode of walking seems potentially catastrophic because only the rhythmic forward movement of first one leg and then the other keeps him from falling flat on his face. (p.98)

This quote describes how close to the sense of a fall walking constantly holds a person. If we pause to think about this, each step taken without a fall reinforces the sense of accomplishment, endurance, trust, and ability. Conversely, were we to stumble or fall, it is the opportunity to recall slowing down, going back to the basics, problem solving, looking at the world from a new perspective, and to re-evaluate our interaction with the surrounding world. In this manner, every successful and unsuccessful step can teach us something, whether we are deeply aware of it or not. This understanding shows walking as therapeutic at the core. Thus, in this section, I provide research on walking first as a stand-alone intervention and then as adjective to other therapy. I relate the findings to the idea of grief/ trauma work.

Walking/ exercise to address mental health. There is a dearth of literature covering the impact of walking/ exercising on mood. For example, Robertson, Robertson, Jepson, & Maxwell (2012) provide a systemic review and meta-analysis in searching 11 databases for randomised controlled trials of walking to treat depression; they find 14,672 articles initially. This is an incredible quantity of studies associating exercise and depression. However, only eight of the articles originally retrieved are analysed by Robertson et al.. These eight studies are included because they are randomised, controlled, have adult participants with depression of any kind, but no other mental illnesses or serious health condition, and are treated with any kind of walking but no other physical movement except for warm-up/ cool-down stretches and activities.

Robertson et al. (2012) find walking has a significant effect in decreasing depression. However, Robertson et al. caution that the results only show that within trial settings walking can be an effective intervention; there is no clarity on how this could carry over into recommending that people with depression should walk. Still, as depression is a commonly associated symptom of grief and trauma, and loss overall, this is a key finding; walking, with no other therapeutic intervention, can cautiously be recommended for grief/ trauma.

Additionally, Rahman, El-Werfalli, & Lehmann-Waldau (2017) provide a literature review including 574 articles published 2011 to 2016 referencing physical exercise and mental health. (Notice the large sample size of articles this review covers; the literature review is extensive!) Only activities designed to strengthen muscles or the cardiovascular system and consistent in their aerobic or anaerobic qualities were included (Eastern modalities such as Yoga, Qigong, and Tai chi were excluded). Rahman et al.'s review indicates:

- Exercise as an adjunct to therapy is impactful in reducing depressive symptoms (as effective as counselling and medication per Conney et al. (2013).

- Exercise has been beneficial to populations of pregnant women, elderly people, and adolescents specifically.
- Exercise impacts psychiatric symptoms (including in relation to schizophrenia and ADHD), anxiety (a small but significant effect when a meta-meta-analysis of 306 studies covering a total of 10,755 participants), and PTSD symptoms.
- Exercise improves concentration.

More concisely, Table 6.1 provides a summary of Rahman et al.'s research on physical activity in the treatment of mental health. This table is a helpful reference point for visually capturing the complexity of the above-listed results. Moreover, Rahman et al. draw attention to research showing biological factors such as changes in norepinephrine, dopamine, serotonin, beta-endorphin, opioids, endocannabinoids, changes in brain resource use, area of stimulation, and/or neural pathways as possible factors related to improvement in mental health (citing Matta Mello et al., 2013; Agawa Yamada et al., 2008; Ströhle Stoy et al., 2010; Dietrich, 2006).

Overall, Rahmen et al.'s (2017) broad literature review leaves little doubt that exercise, including walking, can significantly impact many of the symptoms associated with grief and trauma. The benefits of exercising are important to be aware of in recommending walking as an activity separate from and adjunctive to counselling, as well as in promoting the potential of WT itself, as hypothetically these benefits can arise as part of a WT session.

Walking settings: less relevant than you might expect. The interaction between setting/ environment and walking as effective in adjusting mood/ thought is an interesting area to consider. As the below studies show, walking stands out as the likely catalyst for changes in mental health, wellness, and cognitive/emotional processing; the setting of walks becomes a secondary consideration.

Table 6.1
Summary of Research on Physical Activity in the Treatment of Mental Health.

Summary of Research for Mental Illness Clusters. PANSS=Positive and Negative Syndrome Scale; SOFS=Social Occupational Functioning Scale; ISFS=Item Short Form Survey; BBS=Bergs Balance Scale; SMD=Standardized Mean Difference; CI=Confidence Interval; RR=Relative Risk; MD=Mean Difference, *p<.05; **p<.01; ***p<.001.

AUTHORS	YEAR	INTERVENTION	STUDY TYPE	OUTCOME/MEASURE	RESULT
Depression					
De Souza et al.	2015	Aerobic Exercise	Lit. Review	Depressive Symptoms	70% of studies showed a significant improvement in depressive symptoms.
Cooney et al.	2013	Physical Activity (not specified)	Sys. Review (39 studies)	Depressive symptoms	Significant reduction of depressive symptoms, SMD=-0.62, CI [-0.81, -0.42].
Schizophrenia					
Vera-Garcia et al.	2015	Aerobic exercise & strength training	Sys. Review (13 studies)	PANSS	↓ in PANSS.
Firth et al.	2015	90 min. moderate-vigorous intensity exercise per week	Sys. Review (20 studies)	Psychiatric symptoms (physical & mental health)	Psychiatric symptoms were significantly reduced, SMD=0.72, 95% CI [-1.14, -0.29]. Improved functioning, co-morbid disorders and neurocognition.
Anxiety					
Rebar et al.	2015	Physical activity (varying types)	Meta-meta-analysis (306 studies)	Anxiety	↓ in anxiety, SMD = -0.38, 95% CI [-0.66, -0.11].
ADHD					
Silva et al.	2015	Intense physical activity (relay race; 5 min. run with no breaks)	Experimental	Concentration levels (measured using computer game)	30% improvement in concentration after intense physical activity
PTSD					
Rosenbaum et al.	2015	Physical activity	Sys. Review (4 studies)	PTSD & depressive symptoms	Improvement in PTSD*, 95% CI [-0.63, -0.07], and depressive symptoms*, 95% CI [-0.69, -0.05].

Note: This table is copied from the literature review "Physical activity in the treatment of mental illness" by Rahman, El Werfalli, & Lehmann-Waldau (2017).

For example, Aspinall, Mavros, Coyne, and Roe (2013) use portable EEG machines to track how frustration, engagement, excitement, and meditation changed for people walking for about 30 minutes through three different urban environments: an urban shopping street, a green space, and a busy commercial district. They find that moving from a shopping street to a green space increases meditation while frustration, engagement, and excitement lower. Furthermore, engagement increases when moving out of the green space into the commercial area. This indicates that just by walking in different settings, people can expect changes in their self-regulation and ability to process information. It further indicates, that although different settings correlate with particular changes, each setting offers a potential emotional/ cognitive fluctuation which can relate back to grief/ trauma work. For example, moving through the modes of frustration, excitement, and engagement is reflective of processing grief in stages. The idea of a meditative experience is useful to consider regarding invasive thoughts that often arise with grief

and trauma.

Furthermore, Berman, Jonides, and Kaplan (2008) compare the restorative effects of walking for about 50-55 minutes in natural and urban environments on cognitive functioning. They find that natural settings correlate with an increase in function. As discussed in previous chapters, grief and trauma can lead to the mind, body, heart, and soul feeling incredibly taxed and depleted. Walking, as a restorative activity regardless of environment, is crucial to consider as a stand-alone grief/ trauma processing option for this reason.

Additionally, Oppezzo and Schwartz (2014) demonstrate that walking increases creative ideation during the activity and for a short time after. Walking outside had the strongest impact (over inside on a treadmill, or being pushed on a wheelchair outside) in terms of forming novel and high quality analogies. Oppezzo and Schwartz theorize that walking gets ideas to flow freely. Even walking on a treadmill facing a blank wall correlates with higher creativity (otherwise known as divergent thinking). Convergent thinking simultaneously decreases. Oppezzo and Schwartz state "While research indicates that being outdoors has many cognitive benefits, walking has a very specific benefit—the improvement of creativity" (p. 1148).

Oppezzo and Schwartz's (2014) research is highly relevant to the idea of WT for grief/ trauma work. Think of this: just by walking on a treadmill facing a blank wall, creativity increases! For a person weighted down by the oppression of loss, creativity is stifled in many senses. If a treadmill and a blank wall can address this, counsellors can consider recommending this as an adjunct to therapy, an activity to attempt instead of therapy, or even consider putting treadmills in the counselling room to use in session. Furthermore, it is important to note that even being pushed in a wheelchair has an impact; this may be important to consider in working with people who have physical limitations precluding the option of on-foot WT. Moreover, setting

becomes the less important aspect; walking indoors or out still increases creativity. Finally, concerns around confidentiality can be addressed by having a private indoor setting (just walking around an office, or using treadmills, for example); there will still be benefits, although perhaps not quite as great as being outdoors.

On top of this, Moules, Simonson, Fleiszer, Prins, and Glasgow (2007), in a hermeneutic study[16] on providing grief and trauma therapy to families, suggest that walking, in and of itself, can create a *groundedness* for people:

> We know, however, that to walk at all requires a connection to something, to the ground. If we cannot feel the ground beneath us, we cannot walk. We need to trust that there is firm ground to walk on; we prefer it when others have gone before us, posted signs, and perhaps even left vague footprints that guide the way and tell us we are not alone on the journey. Perhaps it is not the ground that changes at all, but it is our location to the ground, our appreciation of it, and that it is sometimes the group that paves a grounding that allows new travelers to tentatively step down. (p. 133)

This idea of grounding a person is hugely important for grief and trauma work. Think of the language in the phrase, "Out of her mind with grief," for example; grief can be such a strong force it can create the feeling of being outside of reality. So can trauma. In these cases, there is a need to metaphorically find the ground, and if walking can support this, then again, there is support for the idea of using WT, or encouraging walking regardless of interest in therapy.

---

[16] The term "Hermeneutic Study" is described by Moules et al. (2007):

> Philosophical hermeneutics begins with the premise that the world is interpretable, we are always in the process of interpretation, interpretation is inseparable from understanding, and truth in hermeneutics is a meaningful account that corresponds to experience (Gadamer, 1989). Therefore, hermeneutics may be seen as the tradition, theory, and practice of interpretation and understanding in human contexts. Hermeneutic inquiry involves the selection of participants or exemplars of practice that can best illuminate the topic and invite an extended understanding of it. (p. 120)

The benefits of walking with company… or alone. Plante et al. (2007) look at whether type of exercise and differences in the amount of company one has while exercising can impact wellness. Plante et al. (2007) conduct two experiments using 128 female participants:

1) Participants bike alone, bike with a friend, or bike with a stranger.
2) Participants walk with a friend (indoor and outdoor trials) or alone (indoor and outdoor trials).

The results show that generally, exercise positively correlates with mood, outdoor walking is preferred, and participants experience more calmness after biking alone. Regardless of company/ aloneness, post-biking all bike groups trend away from calmness with no main effects on energy, tension, or tiredness (Plante et al., 2007). For participants who walk, those who exercise outdoors express greater satisfaction with their workout, regardless of company variations (Plante et al., 2007).

WT practitioners interested in grief/ trauma work can think about these results with regard to how exercising with clients can actually decrease calmness, and may not effect energy, tension, or tiredness. Often, with loss comes anxiety and depression, and I perceive calmness as an oppositional emotion to anxiety, a state between anxiety and depression, and related to acceptance. Thus, it is mildly concerning to consider that exercising with clients could trigger a reaction seemingly at odds with processing loss. Counsellors need to be aware of this possibility, and consider a way of including assessment and/ or feedback from clients on how WT does interact with calmness, how desirable calmness is, and how a decrease in calmness can be managed at the conclusion of a session, for example. Also, it is interesting that calmness outcomes are highest when participants exercise alone. This suggests that if calmness is the desired outcome, having the client walk alone at the end of a WT session could be helpful, for

example. At the same time, it is useful to note that despite the calmness conundrum here, Plante et al.'s (2007) research also finds positive mood does correlate with exercise, and outdoor exercise, though preferred, does not seem to change outcomes.

Walking to increase productivity and social life. Ben-Ner, Hamann, Koepp, Manohar, and Levine (2014) find that having access to treadmills at work increases work performance in terms of quality and quantity as well as social connections at work. In this study, treadmills are built into workstations. Results are limited as just one company's employees are studied and only 10% of employees volunteer for the experiment (suggesting that only a certain "type" of employee/ person is interested). However, it is useful to note that having easy access to walking, even on a treadmill, could address aspects of grief/ trauma relating to disruptions in generativity, possibly in areas of life other than just work, and including in connecting socially.

Summary. Overall, this sample of research shows that walking anywhere correlates with decreasing depression and increasing positive enhancement, creativity, and productivity. Furthermore, walking outside seems to increase the effects and be preferable, and walking alone may be more calming than walking with a friend or stranger (and thus, theoretically, a WT practitioner). These findings tie in well with ideal grief/ trauma intervention outcomes and the practice of WT overall. At the same time, WT clinicians need to remember that findings are limited in terms of ability to generalize beyond trial populations.

Walking as an Adjunct to Therapy

Gros (2014) philosophically explores the idea that walking can be therapeutic in and of itself saying "When one has walked a long way to reach the turning in the path that discloses an anticipated view, and that view appears, there is always a vibration of the landscape. It is repeated in the walker's body" (p. 24). In other words, the body, mind,

and heart intrinsically echo one another in reactions to every step, sight, and perspective found in the movement of walking. Therefore, we can acknowledge that there is a powerful opportunity for prescribing walking as an adjunctive activity to therapy. Indeed, on top of being recognized as therapeutically significant in and of itself, walking, among other physical activities/ exercises, is often recommended to clients by psychotherapists as an activity to engage in outside of therapy to enhance effects sought in therapy (Pasquariello, 2011). Relatedly, 19th century philosopher, Fredrich Nietzsche writes:

> Sit as little as possible; do not believe any idea that was not born in the open air and of free movement – in which the muscles do not also revel. All prejudices emanate from the bowels. – Sitting still (I said it once already) – is the real sin… (as quoted in Gros, 2014, p. 11)

It appears Nietzsche is on to something, for there is some evidence demonstrating that including exercise/ walking as an adjunct to therapy does improve outcomes. I cover a couple examples here.

Firstly, Hutchenson, Fergunson, Nish, and Gill (2010) identify that when hospitals offer structured and accessible physical activities to promote physical and mental wellness on top of regular hospital programs, the groups are well attended and feedback from staff and patients is highly positive and consistent with acknowledging improvement in mental health conditions. Hutchenson et al. create and evaluate participation in 15 different 6-month groups for in-patients from adult continuing care wards, elderly inpatient wards, and adult acute wards. The groups Hutchenson et al. develop and offer are: Karaoke, Name that Tune, a Supper/ Lunch/ Breakfast Group, Crafts, Clay Modelling, Bowling, Workshop Taster, Dance, Art, Music, Walking, and Badminton. The activities provide “meaningful occupation, distraction from thoughts of illness,

the development of a positive identity and the extension of social networks" (Hutchenson et al., 2010). Only three of 63 participants joined the walking group. However, the ratings for the group are positive. (As a comparison, 19 participants attended Karaoke, and one attended Music; reasons why participants picked particular activities are not included.) There is a lack of clarity on the mental health conditions addressed in Hutchenson et al.'s study. However, relevant here is that there is a demand in hospital settings for activity groups, feedback from participants supports the idea that having activities and groups in wards is beneficial to mental health, and that even a group as generic as walking is likely to attract some participants. WT practitioners may find that partnering with hospitals during hospitalization and when transitioning out could be a viable business opportunity. Further, it is important to again note that, by walking being among the interventions explored as beneficial to mental health, there is further merit to the idea that WT could be useful for the mental health disruptions often brought on with grief/ trauma.

Secondly, White et al. (2011) find that participating in regular and controlled walking in addition to specialized medical care is moderately effective in treating chronic fatigue with similar results to CBT in addition to medical care. Including walking or CBT is more impactful than just medical care.

Thirdly, Merom et al. (2008) find that adding a home-based walking program to group CBT for outpatients diagnosed with panic disorder, generalized anxiety disorder, or social phobia has a significant positive effect on self-reports of depression, anxiety, and stress as compared to a CBT group which did not have a home-based walking program attached.

Summary and implications. Altogether, these studies do offer some precedence for the idea of walking as an adjunct to therapy. However, the research is quite limited, both in amount of research and in terms of generalizing results beyond the trial populations. In short, physical

exercise is well known to relate to positive psychological outcomes. These effects link well to treating grief and trauma due to the overlap in symptomology. Overall, walking/ exercise on its own, or as an adjunct to therapy, can be impactful in many areas which would correlate with grief/ loss symptomology as criteria associated with depression, schizophrenia, ADHD, and PTSD decreases when adjunctive exercise is added to therapy. Furthermore, chronic fatigue, depressive symptoms, symptoms associated with panic disorder, generalized anxiety disorder, social phobia, anxiety, and stress are found to decrease. Again, the symptoms of grief and trauma, as discussed in previous chapters, overlap with all of these.

Prevalence of Practice: Real Life Examples of how Walking is encountered as Therapeutic.

Consider this quote from Nietzsche (1882) who writes:

> We do not belong to those who only get their thoughts from books, or at the prompting of books, it is our custom to think in the open air, walking, leaping, climbing, or dancing on lonesome mountains by preference, or close to the sea, where even the paths become thoughtful. Our first question concerning the value of a book, a man, or a piece of music is: Can it walk? (kindle location 3733)

In other words, walking is the baseline, the root, the harbinger to creativity. The historical and commonplace value of walking to mankind's ability to think is recognized here. Considering walking as the catalyst for creativity (a term synonymous with originality, inspiration, imagination, resourcefulness, and vision), it is easy to think of walking as therapeutic. Therefore, in this section, I build on this idea and, as in previous chapters, I am including literature from non-academic sources to broaden my agenda and demonstrate some run-of-the-mill examples of the therapeutic power of walking, particularly as related to grief and trauma work.

Instinctively walking through grief: examples from people in history. As has been

another theme in my thesis, I once again have pulled from historical literature examples of bygone thinkers who have moved instinctively through grief/ trauma via walking, or used walking for therapeutic purpose. For example, De Quincey (featured in Chapter II as having a deep and enduring relationship with grief), was an avid walker who believed that his walking would ease his opium addiction and depression and support his health overall (Coverley, 2012). Charles Dickens, who walked 20 – 30 miles at a time on a very regular basis, used walking in his early years just for exercise, and in his later years for depression and anxiety (Coverley, 2012). Darwin (1872) observes that often people who are entering grief throw themselves into violent or frantic movements such as pacing, wringing hands, and rocking, and suggests that the tendency toward movement slows a part of the grief/ trauma reaction; people become motionless or passive with feeble breathe and deep sighs. Kierkegaard (1813-1855), a Danish philosopher and avid walker of city streets (who coincidently died while walking after a life of depression and trauma, having lost 5 of his six siblings, according to Hayden (2016)) writes:

> Above all, do not lose your desire to walk: every day I walk myself into a state of well-being and walk away from every illness. I have walked myself into my best thoughts, and I know of no thought so burdensome that one cannot walk away from it. Even if one were to walk for one's health and it were constantly one section ahead – I would still say walk! Besides, it is also apparent that in walking one constantly gets as close to well-being as possible, even if one does not quite reach it – but by sitting still, and the more one sits still, the closer one feels to feeling ill. Health and salvation can only be found in motion. If any denies that motion exists, I do as Diogenes did, I walk. If anyone denies that health resides in motion, then I walk away from all morbid objections. Thus if one keeps on walking, everything will be all right. (as cited by Coverley, 2012, p. 29-30)

In sum, walking as a way to manage mental health and wellness and as a natural tendency in the human body when impacted by a traumatic event, has a long lineage in literature and is given extensive credit by many influential writers/ philosophers. Thus, it is not surprising that the idea of walking to improve mental/ emotional/ bodily states has endured and broadened over time. At present, walking as an instinctive way to manage trauma and grief is not easily observable, but I offer a few examples.

Instinctively walking through grief: examples from real people. In this section, I provide quotes from several individuals sourced from online sites. The quotes explore these people's use of walking to move through their grief/ trauma experiences.

First, in an online *Psychology Today* article, Andrews (2016) quotes widow, Christine Baumgartner's, experience of the healing power of walking following the sudden death of her husband:

> I walk almost every day now, and I walked almost every day before my husband died. But I tell you, for a little while after he passed away, I just couldn't do that… So I would tell myself, 'Let's do five minutes and see how that feels.' And sometimes, that's all I did, and then I would turn back while my neighbor continued on. She understood completely. I never felt like I had to do something that I wasn't capable of doing… It has been three-and-a-half years since my husband's death, and I believe my regular walks are definitely part of the reason I feel as good as I do today. (para 15)

This article is recognizably an independent opinion on the power of walking, and may or may not be reflective of how others might experience walking through grief. However, it is vital to acknowledge how potent walking is for this person in her grieving experience. It is feasible as well that due to the sudden nature of her husband's death, Baumgartner may be experiencing a

degree of trauma with her grief, so there is a suggestion that walking may link to trauma intervention here as well. In this case, it is not possible to distinguish what it is about the walking that is helpful; is it the habit of it, the holding onto the activity as a reminder of normality, the sense of accomplishment or purpose? Or something else? It is, once again, unclear.

Meanwhile, freelance writer, Harriet Hodgeson (2013), who has encountered a great degree of personal grief and consequently has written copiously on grief, shares this insight from her life about walking through grief:

> I thought about how walking helped me cope with grief. Walking was an antidote to grief, changing my body and mind. Today I am a walking advocate… Grief is a solitary journey and, though people help you, nobody can grieve for you. How can you cope with grief? I recommend walking. Keep walking day after day and you'll notice a change in mood. Life won't seem as bleak and your spirits will lift. You may think of all the things your loved one brought to your life and treasure every one. With persistence, healthy eating, and grief work, you can walk out of the darkness to the bright life that awaits you. Life can be good again. (para 3-12)

Hodgeson highlights the solitary processing that comes with walking alone and coincides with the individuality and subjective nature of grieving. She also draws attention to how walking can help by lifting spirits, improving mood, and finding a way to move forward.

Furthermore, there is an amazon.com review written by a customer, Pamela (2014), who, after the death of her dog, Harley, purchased and read *Grief-Walking: Four Prayerful Steps to Healing After Loss* by Linus Mundy. Her review reads:

> At a time when all I could do was cry, the simple suggestions in "Grief-Walking" helped me to move through (not over) the most acute pain. Each day, I took out walking on some

> of the many routes that Harley and I explored for 10 years. Yes, I still wept, but I also moved, and I breathed. For those who regard their fur children as family, you'll understand. Recently, I lost my mom, my best friend, and I pull out my little book again - a gentle reminder that in time, allowing oneself to grieve, to breathe and to move, will help the heart begin to heal.

Pamela's review does at least three things. First, it spotlights a commonly available resource for grief, a book, which suggests walking as a way to grieve. Second, this review shows how walking a route shared by a lost person or pet can be especially helpful. Third, it displays how Pamela desires to move figuratively as well as literally to process her grief reaction.

Finally, Moules, Simonson, Prins, Angus, and Bell (2004) cite an online advice column, "Ask Ayi" in suggesting that in Eastern culture, walking, particularly walking backward, is spiritually helpful. Indeed, this column does recommend walking barefoot and walking backward for health benefits, as well as for using muscles not normally used, and metaphorically to rework one's past (Bejing Scene, n.d.). Moules et al. suggest that walking (frontward and backward) might be useful in moving through grief. Moules et al. postulate that perhaps walking backward is as good a fit metaphorically as it is literally, stating:

> Walking backwards seems to fit in the movement associated with grief. The art of grieving requires the use of different muscles than we are used to using in our lives, and grief appears as perversely different from what is expected as does an old man walking backwards. Walking backwards allows the strengthening of part of ourselves that we were not aware of or did not have to use. It allows one the ability to look to the past and recall what was, and yet continue to move along…. Walking backwards implies moving backwards but paradoxically, this is not the case. We are always, already moving forward

> in life, and walking backwards requires that one move ahead, periodically faced to the past. (p. 103)

I am unable to verify if backward walking as a healing/ spiritual practice is common in Eastern culture or not; I could find no substantiation of this. However, I recently tried walking backward with this idea in mind (the idea of moving forward while looking back). I would strongly recommend trying this practice to anyone interested in walking for a therapeutic purpose or practicing WT. It felt entirely different to me, and my thoughts came repeatedly to the idea of watching things fade in the distance, even as the only thing really moving was me. I thought about holding on and letting go, and about how differently a moment seems when moving in the slower more careful manner demanded by moving in reverse. (Of course, for anyone who does try this, common sense must prevail: walk slowly and carefully, choose an area free of obstacles, check over the shoulder as often as reasonable to ensure safety, and so forth.)

Summary. Overall, these examples give insight into how people impacted by grief or trauma may instinctively turn to walking as a therapeutic opportunity. This gives further credence to the idea that walking is therapeutic on its own and thereby potentially even moreso as an adjunct to counselling. This is useful for WT practitioners to contemplate, as considering demand and efficacy are important to determining what might be useful to offer. Also, the idea of walking backward may relate particularly well to grief/ trauma work, and may be an interesting and useful experience for people to try on their own or with a WT therapist.

Conclusion

To review, walking as a stand-alone intervention and/or as adjunctive is associated with many psychological benefits. As discussed, advantages associated with walking include decreasing frustration, depression, chronic fatigue, anxiety, and stress while increasing

restorative effects, positive mood, creative ideation, divergent thinking, engagement, excitement, calmness, and meditation. Further, conditions such as depression, schizophrenia, ADHD, PTSD, panic disorder, anxiety disorder, and social phobia have improved with the introduction of walking. Additionally, no effects on energy, tension, or tiredness are noted. Finally, these changes happen regardless of environment (though outdoor less-urban spaces tend to be the best), company kept, and whether walking on a treadmill or not.

Thinking back to the symptoms of trauma and grief as discussed previously, it is easy to see how these changes again directly address many of the symptoms. Decreasing frustration and depression, for example, would directly link to the experiences of sorrow, melancholy, and anxiety associated. Divergent thinking, meditation, and calmness can arguably impact the ability of a person to make meaning of a loss. It is these reasons, among others, which have likely led to walking being prescribed as an adjunct to therapy.

However, WT clinicians must use caution in drawing upon this research. Although the research points to walking being impactful in and of itself, as noted above, the results may not be easily generalized outside of the trials. Also, the conditions researched are specific to different durations, intervals, and intensity levels that might not occur in WT. However, providing the above information as a form of psycho-education is possible, and cautiously generalizing the benefits of walking to WT is reasonable.

Finally, as alluded to previously, the idea that WT could be impactful seems based on an understanding of walking as a therapeutic activity on its own. However, it is not sufficient to rely solely on studies of the therapeutic impact of walking to validate the practice of WT. For example, Marselle, Irvine, and Warber (2013) provide this summary on literature specific to the impact walking may have:

> Previous results have found that walking per se was associated with improvements in well-being, irrespective of the type of environment or the social condition for walking [24,25]. Johansson et al. [24] found that walking increased positive affect, irrespective of whether it occurred in a park or in urban public space. Mood improved irrespective of whether one was walking alone or with a friend in either a university campus or indoors [25]. Pretty et al. [98] found that all types of physical activity outdoors—irrespective of the environment, duration or intensity—increased self-esteem and mood. Barton and Pretty [60] found there were "no great differences" (p. 3949) in self-esteem and mood between exercise in urban space, countryside and woodland environments, suggesting physical activity outdoors was the main cause for change in these measures. Issacs et al. [101] found there were no significant differences for anxiety and depression between participants randomly assigned to a walking group, gym exercise or an advice-only control group. (p. 5619)

Although this paints the picture that walking is therapeutically useful, when broken down, this research is confounding: What benefits mentioned are attributable to walking, to type of walking, to environment, to other physical activity, to the social aspects of walking in groups, to the level of facilitation and supervision involved? And furthermore, how well does this research actually relate to the idea of WT? It is clear that there is a need to go more deeply into this type of summation. Therefore, in the following chapter, I move into documentation relating specifically to individual WT.

Chapter VII Evidence for Individual Walking Therapy - A Literature Review

Despite a philosophical awareness of the beneficial influence of walking, and the research and practical use of therapeutic walking discussed in the previous chapter, there is very little research specific to combining walking with counselling into WT. Essentially, academic writing explicitly including or focussing on individual WT is summed up in just 13 documents (Revell & McLeod, 2016; King, 2015; Hays & Sime, 2014; Nguyen et al., 2014; Jung, 2011; McKinney, 2011; Nguyen, 2008; Beauchemin & Manns, 2008; Pasquariello, 2011; Berger & McLeod, 2006; Doucette, 2004; Dench, 2002; Hays, 1994). At the same time, the number of clinicians who are using individual WT in some capacity, including with grief/ trauma in some cases, is remarkable (see Appendix A). The resultant research gap is immense and problematic. Truly, it appears that support for the use of WT is often speculative and tends to draw on research that bears some or minimal resemblance to the idea of WT. Furthermore, there is no research specifically linking WT to working with loss. Thus, my purpose in this chapter is to continue using ethnographical and epistemological methodology to weave together a variety of literature to explore individual WT with grief and trauma.

The Research

To begin, Hays (1994) provides a peer-reviewed anecdotal case study of running with a client prior to the talking portion of therapy sessions. Hays suggests that WT results in mood improvement and cognitive restructuring helpful to therapy clients. Hays submits that cognitive clarity post-run is a phenomenon most runners will know. Hays hypothesizes this is related to right-brain (integrative, intuitive, holistic) problem solving. She concludes that WT allows a deeper, more effective, and faster progression through therapy than traditional therapy.

Subsequently, years later, Dench (2002) uses WT sessions on top of games with

movement, construction of genograms charting exercise/ activity in the family, and partner interviews on activities, exercise, and movement as a 16 week intervention for three women targeting increasing exercise to improve mental health. Two of the three women committed to the WT and are observed to make progress in regards to their mental health, although specific measures are not used.

Next, Doucette (2004) offers a peer-reviewed phenomenological qualitative study of eight Canadian teenagers (with no control). These teens receive 30-45 minute weekly WT sessions for six weeks (Doucette, 2004.) Doucette subjectively argues that all the youth in the study benefit in some manner from the intervention. Doucette finds that all youth improve in self-awareness as well as in self-esteem. Observably, this study and the two previous rely on very small sample sizes, subjective interpretation of changes in symptomology, and although peer-reviewed, lack the ability to demonstrate a great deal of significance. They can, however, be understood as the study of WT in infancy, providing the initial foundation for future research.

Associatedly, Berger and McLeod (2006) deliver a collection of case studies, three of which use what would be considered WT, but where WT is not the focus. The first of these cases covers the case of a 12 year old boy who, due to his inability to tolerate traditional therapy, begins walking first indoors, then out with his therapist. In this case, Berger and McLeod draw attention to the use of nature and rituals in therapy once outside, but it is impossible to say whether the walking with the client, which started before the outdoor option was included and is a ritual in itself, is not perhaps the more influential aspect. The second case is that of a man who took a private walk as part of group therapy. The third case refers to a woman who while walking with a therapy group is metaphorically connected to her grief through an encounter with a bridge. Specifically, she repeatedly returns to the same spot and relates to how the passage of

time (just three days) changes the scene. This is metaphorically connected to her grief experience; the passage of time alters the experience even if nothing else seems to be shifting (Berger & McLeod, 2006). This study shows how WT is naturally included by some therapists, even if it is not intended or named WT, and calls into questions whether WT might be responsible for more therapeutic outcomes than is known because of this tendency.

Relatedly, Pasquariello (2011) surveys 287 graduate students who are practicing clinically. Participants, when asked about their thoughts/ practices around exercise and clients, reveal that:

> 80% of participants reported that they do not exercise with their clients during treatment, while 20% endorsed that they do exercise with their clients (N = 287). For participants that endorsed exercising with the clients during treatment, 64% reported that they use physical activity as a method of helping the client open up more fully in subsequent therapy and 59% reported that they use exercising with their clients to help start the physical activity habit (N = 58). Moreover, for those that exercise with their clients during treatment, 64% reported treating their clients during walk-talk therapy; 53% reported that they engage in non-competitive exercise (e.g., throwing softball, shooting hoops); and 7% reported runtalk therapy with their clients (N = 58). (p. 45)

In other words, only about 20% of these 287 therapists are exercising with clients during therapy, but 64% of those are doing it with WT (perhaps 71% if the runtalk group is counted). This would be about 36-40 participants. Pasquariello further finds 86% of all participants would like to have training in physical activity included in graduate school. Overall, this adds to the evidence that WT is being practiced (regardless of clear research) by a large number of therapists, including those new to the field, and there is an interest in learning more about options such as WT.

Building on this, Beauchemin and Manns (2008) submit a speculative piece focussing on a WT practitioner who advocates the use of WT with young people in particular. The case synopsis and quotes from a teenage client in this article illustrate that WT can be seen to positively impact energy level, overall health, youth work, and client engagement. Beauchemin et al. also offer ideas on how to engage clients in WT.

Shortly thereafter, Nguyen (2008) provides a doctoral dissertation; a randomized experiment with controls in an inpatient setting measuring changes in depressive symptoms for patients who do WT. Despite this being the first study to measure quantitatively the impact of WT on participants, only the abstract for this study is available. Thus, it is difficult to properly review. Still, according to the abstract, Nguyen finds WT is beneficial in decreasing anxiety, stress, and depression and increasing clarity and mental functioning.

Following this, McKinney (2011) collects qualitative information from 11 WT therapists in North America to draw out "characteristics, a procedure, reasons walk and talk therapy evolved, limitations, outcomes, and a framework for practice for walk and talk therapy" (p. xii) for her doctoral thesis. Information gathered is from the perspective of WT therapists with a very small sample. This grounded study offers support for the efficacy of WT as perceived by therapists who practice WT, clarifies the processes associated with WT, and lends support for best practice of WT. McKinney proposes that in offering WT, counsellors could support increased physical activity lifestyle changes in a society where obesity and sedentary lifestyles are on the rise. Comprehensively, what practitioners believe about WT is summarized by McKinney as:

1. Walk and talk therapy is therapy conducted walking outdoors.
2. Physical activity, nature, and casualness are the central components of walk and talk

therapy**.**

3. The setting of walk and talk therapy includes the location and a walking path.
4. No training is required to participate in walk and talk therapy.
5. Interventions utilized in walk and talk therapy are traditional therapeutic interventions.
6. The procedure of walk and talk therapy includes an initial intake session indoors then walking outdoors for following sessions.
7. Research, a need for options, lack of physical activity, and a nature deficit caused walk and talk therapy to emerge as an approach.
8. Personal experiences, other therapists, desire to get out of the office, and a need for options motivated therapists to utilize walk and talk therapy in their practices.
9. Clay Cockrell, LCSW was instrumental in the evolution of walk and talk therapy.
10. General limitations of walk and talk therapy include a lack of support, difficulty in obtaining clients, and population concerns.
11. Session limitations of walk and talk therapy consisted of weather, confidentiality, safety, and conceptualization.
12. Therapeutic benefits of walk and talk therapy included getting to issues faster, building therapeutic rapport faster, processing differently, and assessment expanded.
13. Benefits for clients include: physical health benefits, mental health benefits, nature benefits, increased body awareness, and self-care.
14. Benefits for therapists include: physical health benefits, mental health benefits, nature benefits, and self-care. (p. 111)

Around the same time, Jung (2011) provides a master's thesis speculating that WT could

be used as a positive, creativity-enhancing, and accessible on-campus career counselling option. Jung does not trial this proposal. However, Jung's thesis draws attention to related research that associates walking with positivity and creativity in particular. This paper is relevant because it shows the manner in which WT is being considered for certain types of intervention despite the lack of supporting research.

At this point, Nguyen's (2008) previously mentioned doctoral thesis appears to have paved the way for a peer-reviewed study by Nguyen et al. (2014). Nguyen et al.'s study seems to be a collaborative effort to review and bulk up Nguyen's initial findings (it does not appear to me to repeat the research, but this is not certain). Nguyen et al. compare two control groups (a traditional therapy group and a mixed-mode cohort receiving traditional group and individual therapy), and an intervention group (a mixed-mode group combining 30 minutes of individual WT with traditional group therapy). Nguyen et al. find the WT involved intervention is significantly more impactful on depression symptoms as measured on two validated scales. The research is conducted with 78 inpatients, all 50 years and older, in a hospital setting. This is the only research I found in which participants did WT, and there was a control group. This establishes that the addition of the individual WT to the group sessions was more effective than CBT and group therapy and/or just group therapy alone. This is the first and only peer reviewed study on a larger body of participants where WT has been the focus of the research.

Additionally, Hays and Sime (2014) report that in an online survey of 200 psychotherapists interested in or practicing WT or exercising with clients, Hays (2010) finds:

> Exercise with clients can break an emotional impasse, and 40% described it as an opportunity to "bypass an impasse." Nearly half described exercise as a synergistic medium for psychotherapy that can help manage agitation, anxiety, or interpersonal

> tension; facilitate catharsis; or (especially with children or adolescents) develop rapport via a different relational mode. Anecdotal reports suggest that the combination of exercise and psychotherapy can lead to exploration of less conscious issues and increase the availability of affect expression, creativity, or insight…. More than half of psychotherapists surveyed reported that exercise during therapy helped clients become more open in subsequent therapy. The predominant mode (80%) of exercise was walk–talk therapy. Run–talk therapy was conducted by 10%, and 40% used noncompetitive exercise, such as throwing a softball or shooting basketball hoops.

Although I have not been able to obtain a copy of Hays' (2010) research, this second-hand account reinforces the idea that therapists feel WT helps move through issues, engage clients, and support self-regulation. Hays (2010) research does not appear to be a peer-reviewed publication, so I have not included this study in the tally of WT research, but I am including the information here because it speaks to and reinforces the conclusions and observations included in the other studies listed.

Next, King (2015) offers a qualitative dissertation examining eight participants experience of counselling in nature, some of which involve WT. Results related to the idea of using WT for grief/ trauma surface as relationship, trust, and openness are increased in natural environments and mood and interpersonal skills are improved with spending time in nature. The participants also highlight concerns about ethical practice, in particular, confidentiality and competence. Competence remains a problem because as these participants identify, there is not a good body of research or training to establish good practice in nature therapy, and there is not regulation around using titles such as "adventure therapist" so there is risk of doing harm that is not well-mitigated. Although this study is not entirely focussed on WT, due to the idea of

walking in natural settings being included in the research, it is important to include the results.

Finally, Revell and McLeod (2016) provide the most recent peer-reviewed study related to WT. This study focusses on practitioners perceptions of WT on clients as well as on how therapists experience WT. The results indicate that practitioners perceive shifts in *stuckness* for clients and feel that WT increases collaboration between therapist and client. In particular, participants identify that walking side-by-side with clients "helped clients to open up, enhancing overall well-being, and that walk and talk promoted a holistic approach for client self-discovery" (Revell & McLeod, 2016, p. 38). Table 7.1 summarizes the results around how clinicians perceive WT as helpful or hindering for clients as well as how practitioners experience the practice. Per Table 7.1, at the high end, most therapists perceive WT helps clients get unstuck and that it strengthens the connection between body and mind (a mean of 4.1/5 was found in both cases). At the low end, participants do not feel that WT leads to faster resolution for clients (a mean of 2.9/5).

Research in progress. On top of the above-noted studies, there is some research currently being conducted which includes WT. Firstly, the Canadian Broadcasting Corporation (2015) ran a news story reporting that in Ottawa a trial collaboration between the Ottawa hospital and the Canadian Military was underway examining how having veterans with PTSD walk on a treadmill in a virtual reality environment, Military Motion Memory Desensitization and Reprocessing (3MDR), with the support of a therapist, could impact the PTSD symptoms. (See Appendix C for more information on 3MDR) At that point, the researcher being interviewed, Col. Rakesh Jetly, a Canadian Forces Senior Psychologist, states that 20-25 participants have trialed the system. Conversely, in an occupational therapy network blog, Brown (2016) indicates that this same research is set to begin in early 2016. I have been unable to find any indication that

the research has gone ahead.

Table 7.1
Perceived Benefits & Therapists Experience of WT

Perceived benefits of walk and talk	Mean	SD
Walking and talking during a therapy session helps clients to get 'unstuck'	4.1	.6
Walk and talk therapy strengthens clients connection between body and mind	4.1	.9
Walking side by side with a clients helps them to open up	4.0	.8
Clients achieve a greater sense of overall well-being through walk and talk therapy	4.0	.8
The process of clients self-discovery is promoted in a more holistic way through walk and talk therapy	4.0	.9
Walking together during walk and talk therapy promotes equality in the therapeutic relationship	3.9	.8
Being outdoors during a therapy session enhances the therapeutic process	3.9	.9
Walk and talk therapy encourages deeper ways of thinking	3.9	.9
Walk and talk therapy is less intimidating for clients compared to indoor seated therapy	3.8	.8
Through walk and talk therapy, the overall counselling process is enhanced	3.7	.8
Lack of eye contact is more comfortable for the client	3.7	.8
Walk and talk therapy improves physical fitness of the client	3.6	.8
Clients resolve issues quicker through walk and talk therapy compared to indoor seated therapy	2.9	.8

Therapists experiences of walk and talk	Mean	SD
I believe that offering a variety of therapeutic experiences (such as walk and talk) is useful to clients	4.5	.6
I generally feel invigorated when doing walk and talk therapy sessions	4.3	.5
I generally have no trouble being focused on my client during walk and talk therapy sessions	4.3	.8
I generally have clear thought processes during walk and talk sessions	4.1	.8
Offering walk and talk therapy has been beneficial for my professional development	4.1	.7
I believe that walk and talk therapy offers mutual benefits to both client and therapist	4.1	.8
Offering walk and talk therapy has reduced my own stress levels	3.8	1.0
I do some of the best therapeutic work during walk and talk sessions	3.6	.8
I am physically fitter since starting walk and talk sessions with clients	3.4	1.0
I sometimes get distracted by things happening in the environment during walk and talk sessions	2.9	1.0
I find walk and talk mentally demanding to do with my clients	2.7	1.1

Note. This table is from a study by Revell and McLeod (2016) exploring how clinicians who practice WT perceive benefits and experience the practice themselves. The mean ratings are based on a scale 1 – 5 showing strongest disagreement to strongest agreement. Reprinted from: Revell, S., & McLeod, J. (2016). Experiences of therapists who integrate walk and talk into their professional practice. *Counselling and Psychotherapy Research, 16*(1), 35-43. doi:10.1002/capr.12042

However, currently underway at Cardiff University in the United Kingdom is a two-year study where military veterans with a PTSD diagnosis immerse in a 3MDR environment where they walk on a treadmill to interact with images related to their trauma-experience while monitored by a therapeutic support (NewsRx Health & Science, 2017; Forces in Mind Trust [FIMT], 2017). According to FIMT, "Researchers hope that exposure to trauma-related images, enhanced with walking and music will eliminate cognitive avoidance – a coping strategy that can

contribute to the worsening of PTSD symptoms" (para 5). Although this research includes WT, there are no results at present. Thus, including this research is about showing an interest in WT and expanding thinking on how WT can be done, no more.

Summary. The research above, overall, shows limited but consistent evidence that WT can improve mood, clarity, creativity, right-left brain interaction, cognitive restructuring, self-awareness, self-esteem, decrease depression and anxiety, increase mental functioning, increase energy level, overall health, overall mental health, increased potential for self-discovery, strengthening of the mind-body connection, and possible use for populations with PTSD. Indeed, the studies above demonstrate WT is of interest in the academic community. This is shown by the numbers of practitioners using it and who are interested in learning about it, the military interest in it, and the small but growing body of research. The main limits for the studies are small sample sizes and lack of validated measure for how WT clients are impacted, as the focus thus far is mainly on WT therapist subjective interpretation.

The Precedence and Prevalence of WT

Historical use of WT. The research above is highly limited in scope and number and creates (at least for me) the impression that WT is not widely used. However, there is a litany of evidence from non-academic sources speaking to a prevalence of practice, as well as rumours of an extensive history of walking with patrons for educational or therapeutic purposes (Solnit, 2014; Gros, 2014; McKinney, 2011; Hayes & Sime, 2004; Gontang, 2009). For example, Solnit (2014) lists The Stoics, Jeremy Bentham, John Stuart Mill, and Thomas Hobbes as examples of philosophers who certainly did walk while philosophizing. Gros additionally references The Cynics. Coverley (2012) quotes Haultain's (1914) *Of Walks and Walking Tours: An Attempt to find a Philosophy and a Creed* as containing a list of "notable walkers" including Plato, Virgin,

Horas, Jesus, Mohammed, and De Quincey. Coverley also discusses Charles Dickens, who he quotes as saying "If I couldn't walk fast and far, I should explode and perish" (p. 136) and "My only comfort is in Motion" (p. 136). Other prominent people who are anecdotally said to have walked while talking to improve their thinking, teaching, or as an aspect of therapy include Aristotle, Plato, Socrates, Freud, and Glasser, although factual information supporting this is debatable (Solnit, 2014; Bartlett & Collins, 2011; Gros, 2014) (see Appendix D for more detailed information). Indeed, to this point, there is no validated history of using walking and talking toward any of the more commonly touted ideals of WT, despite anecdotal accounts commonly shared as true (see Appendix D). Thus, WT practitioners need to be aware that what they are building a practice on does not involve as much observable or documented history of walking and talking with clients for therapeutic or educational purposes as is commonly believed. The lack of a background does not predicate that WT should or should not be used, only limits the argument that there is a long history of known use, and suggests more research would be helpful.

Current use of WT. More presently, there are several sources providing insight directly into prevalence of WT practice. For example, Gontang (2009) shares the following names and information about seven clinicians Gontang is aware of who do WT:

> Psychologist Ray Fowler, former CEO of the American Psychological Association. Mark Shipman, MD psychiatrist, who died several years ago, was medical director of the San Diego Center for Children for 30 years. Mark has done some extremely good research on the benefits of walking and running (especially running) on emotionally disturbed children. It greatly lowered or did away with the need for medications. Rosalie Chapman, Ph.D., adjunct professor of Psychiatry, UCSD had walked with many of her patients. Jim Hornsby who has conducted running groups for recovering alcoholics. Isaac McLemore,

> LCSW has conducted walking and running groups for polydrug users and recovering alcoholics. Ron Lawrence, MD founder of the American Medical Athletics Association (formerly the American Medical Joggers Association). John Griest, MD. psychiatrist. John was one of the early researchers back in the late 70's who did research on the effects of running on depression. Again, all of these individuals used walking and running with their patients or groups. (bullet 6)

Even the invention of EMDR is linked to walking by EMDR creator, Francine Shapiro (see an account of this in Appendix E). Further, using internet searches, Revell and McLeod (2016) find 32 therapists in the UK who offered WT as part of their practice; McKinney (2011) finds 28 in North America. By conducting another internet search, I easily found 10 psychotherapists across North America advertising WT as part of their professional services for a variety of psychological issues (see Appendix B). Hayes and Sime (2004) cite Hays' (2010) research showing that of 200 clinicians, one fifth (around 40) were using exercise with clients in some manner.

Colloquial documentation: media coverage. Additionally, I have found that since 2008, WT has been covered in the media numerous times, and this coverage seems to be increasing yearly (see Appendix F). Explicitly, when I started researching this topic in 2015, there was very little press/ online coverage available. However, just two years later, I easily find several non-academic online articles written in 2017 alone. Interestingly, it appears that practitioners, reporters/ writers who trial WT, as well as clients interviewed, are highly positive about the process (see Appendix F). For example, WT practitioners quoted in media sources promote that WT can be especially helpful for: anxiety, depression, schizophrenia, PTSD, autism, trauma, ADHD, grief, domestic violence, males, and relationship work (see Appendix F). These same

practitioners are highlighting benefits such as: stronger connection, collaboration, sense of ease/ comfort (lack of eye contact, fresh air, side-by-side stance), getting clients unstuck, being less formal, ability to incorporate mindfulness, sense of release, clarity, and shifts for clients, creating a sense of accomplishment, comfort, active, marketable/ practical aspects, increased rapport, use of natural world for metaphor and symbolism, feeling alive and connected, feeling accomplished, and aspects that are refreshing, enhancing, meditative, and therapeutic (see Appendix F). Reporters trialing WT sessions are commenting on experiencing: quick insight and outcome, feeling more comfortable being in a side-by-side position, enjoying mindfulness components, having a higher sense of ease expressing feelings and sharing details, feeling happier and lighter, connecting physical movement during session with a sense of moving through mental problems, symbolically moving forward, option to include pets, and feeling less anxious or trapped (see Appendix F). Clients interviewed bring up: appreciating being outdoors and connecting with nature, being natural, coming away with a sense of accomplishment, feeling WT is cathartic which engenders sharing, feeling WT normalizes therapy, helps with collaboration and conversation, helpful with grief and trauma, and feeling the therapy is less invasive (see Appendix F).

Overall, this ongoing media attention suggests potential public interest in the notion of WT, as well as provides colloquial documentation of how therapists, clients, and other bodies are experiencing and conceptualizing WT. In fact, despite the small amount of academic research on WT, through media reports, online magazines, and popular articles it can be seen that there may be an increasing trend in using WT. Notably, the subjective media-based accounts are taken from articles meant to promote the image of WT, and are rather one-sided. At the same time, the comments line up remarkably well with the information from the research above (though, again,

that may be biased too). Furthermore, these narratives offer practical support for the idea of using WT with grief and trauma not found in the academic research. Specifically, there are clients/ therapists touting WT for usefulness with grief and trauma work (see Appendix F).

Furthermore, media accounts inform ethical practice. The WT therapists cited in academic articles are backed up by those in colloquial documents in speaking to ethical practice. For example, media reports include therapists offering tips like: adjusting pace to maximize confidentiality (stay away from groups), monitor the client's tolerance for the activity, have an alternate private space available, be prepared to stop and hold a client's eyes as needed to process heavier topics, ensure informed consent regarding being out in public (confidentiality), offer clients tips like wearing sunglasses if they are worried about crying in public, carry tissue and have places to stop and sit if clients cry or are anxious, have ways to deal with boundaries, plan for running into people the therapist or client know, and ensure WT is working toward treatment goals (see Appendix F). The practical insight around ethical and responsive practice is highly useful for anyone planning to do WT, and this includes the idea of grief/trauma specific WT.

Moreover, through media documentation, attention is drawn to certain populations for whom WT may not be a good fit. This includes people with eating disorders, addiction concerns, those in a major crisis, and people with boundary issues (see Appendix F). Notably, these are highly specialized areas to begin with, but they can tend to overlap with grief/ trauma work. However, it is worth mentioning that Kostrubala (2013) (a WT practitioner who has been largely responsible for the development of WT as a practice in North America) in his landmark book, *The Joy of Running,* suggests that, for people who have eating disorders, WT may not seem logical, but it has actually worked for clients. Kostrubala suggests this is because the client can

work on their relationship with their body by attending to what is happening in the body during walking and staying with that in a way that cannot happen in therapy. Kostrubala also reports using WT with addiction. Furthermore, as much as some therapists find these conditions unfit for WT, other clinicians identify success. In the end, Kostrubala's account and the concerns or promotions of the practitioners interviewed should all be taken with a grain of salt; what is and is not a good fit for WT treatment is still not well known. Therapists must, therefore, remain mindful of practicing within competence and noticing how therapy does or does not seem to fit with ethical practice overall.

Conclusion

Walking alongside a counseling client, or doing individual walking therapy, is a simple practice, likely gaining popularity. When thinking of philosophy and walking, WT seems instinctively validated, particularly for grief and trauma work. However, there is limited research on the practice of WT, and none specific to grief/ trauma work, despite a prevalence of practice. This chapter explores academic research, historical accounts, current philosophical work, media reports, and popular literature to demonstrate how individual WT works, is effective, and can be used with grief and trauma.

The academic research consistently shows that WT efficacy relates directly to the symptomology of grief and trauma. However, this research is highly limited by the small number of studies, small sample sizes, and reliance on subjective accounts from therapists (bias). By incorporating discussion of popularized historical accounts of walking with clients for educational or therapeutic purposes, it becomes apparent that the rumoured precedence of practice is not a documented one, although there may be some truth to it. This does not clarify whether WT should or should not be practiced. Further, in reviewing documentation from

colloquial media sources, the evidence of the efficacy, popularity, prevalence of practice, and use with grief and trauma expands. Ethical issues around confidentiality and suitability are considered in both the academic and non-academic sources, with WT practitioners suggesting the benefits outweigh the risks, and that the risks can be mitigated by informed consent, monitoring the environment and the client's experience of WT, ensuring competence for specialized conditions, and having a plan.

Overall, combining academic research with idiomatic literature expands awareness and knowledge of how individual WT works and how it can relate to grief/ trauma work. To build on this understanding, it is important to move into a discussion of the research and prevalence of practice of group WT, which is the subject of the next chapter.

Chapter VIII Group Walking Therapy

The differences between walking alone or with others can be profound. For example, Solnit (2014) suggests:

> A solitary walker, however short his or her route, is unsettled, between places, drawn forth into action by desire and lack, having the detachment of the traveler rather than the ties of the worker, the dweller, the member of a group. (p. 26)

This quote indicates a belief, a suggestion, an argument. It is neither founded nor unfounded; it simply is. The benefits of walking with company or walking alone cannot truly be assessed, and yet there are some attempts to do just this. Indeed, I am attempting this here; to show that walking with a therapist (which in a very strict sense is a group setting, for there is more than one person), and/or with a larger group, has some benefits for grief and trauma work.

Indeed, group counselling is recommended for grief therapy (Connor & Monroe, 2012; Yalom, 2005). Therefore, to further understand how WT can be used with grief and trauma, it is useful to explore group WT. Thus, in this chapter, I discuss therapeutic walking groups, which, though not defined in the literature as WT, appear to function as WT groups. In this light, research on these groups may give some of the best evidence of the potential efficacy and impact of WT as a general practice with aspects that translate incredibly well to the idea of working with loss. The purpose here to expand on the idea of using WT with grief and trauma. Therefore, to begin, I will review what I believe to be the only five peer-reviewed studies involving walking in therapeutic groups. Then, I will include examples of the prevalent practice of therapeutic walking groups.

The Research

As it stands, I have found only five articles which reference walking in facilitated groups

as an intervention meant to target mental health outcomes; only one relating to grief and trauma specifically. Therefore, in this section, I will provide a review of each of these studies. I privilege the client voices in the research, as, per Crone (2007) "To make sense of the effect that participation in a walking programme can have on a person's health, it is critical to discuss participants' perceptions and experiences" (p. 170). Overall, I summarize and draw inferences from these studies for the use of group WT with grief and trauma.

First, Marselle et al. (2013) use a cross-sectional design to study the psychological and emotional changes in 708 people who participate frequently in a United Kingdom public health initiative, a group called *Walking for Health*. This is a free, organized, and led walking group (Marselle et. al, 2013) (see Appendix C for more information about this program). Marselle et al. find that group walks in both urban and farmland settings impact mental well-being, depression, and positive and negative affect attributable moreso to the group setting and physical exercise than to the environment people walk in. Furthermore, depression decreases as group walk time increases, and stress decreases with frequency of group walks.

In these groups, there is no therapist, but the group is led by a trained facilitator. Additionally, the intervention targets mental wellness/ mental illness components that are generally therapeutically addressed. In this sense, it can almost be categorized as group WT, specifically as the aim is to target health as a holistic concept involving body, mind, and heart. Moreover, for WT, it is useful to think about group work, and how to increase the session length and frequency to best support a client. Noting that there are changes in depression, affect, and well-being, and recalling how grief and trauma can impact these areas so strongly, there is a clear link. It is also useful to note that setting does not seem to limit the impact. Thus, theoretically, walking with a therapist anywhere could be helpful, as human connection is more relevant than

the setting.

Second, McDevitt, Wilbur, Kogan, and Briller (2005) find that a walking group appears rehabilitative due to the combined effects of cardiovascular risk-reduction benefits and improvements in mood and skills around psychosocial functioning. In this study, 15 psychiatric outpatient participants participate in a 12 week group meeting three times a week. 13 participants completed the study. The intervention includes individual sessions to goal set and plan as well as walking in a group led by a psychosocial case manager trained in supporting, educating, and motivating the participants during the walks. Although the group walks are not defined as therapeutic, but were about exercising specifically, I include this research here due to the fact that this is an outpatient program where walking was led by a therapeutic professional in a group setting to target mental health. The walking group is, in essence, WT.

The impact of mood and psychosocial functioning is promising when thinking of grief and trauma work. It is uncertain how therapeutic the conversation between the walking facilitator and the group members is, but this is worth paying attention to. Note that the group meets three times a week, and keep in mind that this is likely more than most clinicians would see a client for any condition. This is key to thinking about efficacy; is it the high number of meetings that help, or some other aspect of this program? Or, is the walking what is responsible for the difference? This is an area where future research could be of use.

Third, Priest (2007) conducts a six week qualitative study of participants' experience post-psychiatric hospitalization in an out-patient walking group. Priest (2007) finds that the walking group is healing and soothing. Specifically, Priest finds participating in the group alleviates emotional pain, withdrawal, oppression, feelings of insecurity, experiences of isolation, rejection, and fragmentation, feelings of hopelessness, purposelessness, and

worthlessness. Priest (2007) provides quotes from participants on their experience to demonstrate how a walking group impacts their wellness. For example, Priest shares these direct quotes:

- 'when I'm walking, I do feel less tension . . . there's less stress. Because you're walking . . . you're doing something enjoyable . . . so you might not necessarily be focusing on things that are bothering you at the minute.'
- 'I benefit more if the walk is out in the wilds. Less houses or society and more wandering through fields and over styles means less anxiety and more mental freeness. Less self-consciousness.'…
- 'Being away from all the hustle and bustle re-sets your mind . . . you come out into the countryside and there's nothing . . . nothing complex . . . it just calms you down… there is a certain good feeling you get . . . being out in the sort of really …primitive sort of . . . I don't know what it is . . . really . . . it's really the higher up you go the mountains, the bigger buzz you get, sort of . . . of being back to nature.'
- 'when I'm psychotic I do do quite a lot of walking into gorse bushes . . . y'know, things like that . . . but, in some ways that's quite good because I get pricked, or I fall over, and that gives me a bit of a jolt and a bit more of a focus . . . It does literally ground me, yeah!
- 'when you're doing something . . . y'know, using energy . . . it sort of takes your mind off things.'
- it really helps not having to decide where to go, which way to turn . . . To just trudge and put one foot in front of the other takes away decision making and responsibility which is great if your mind is so full you can't take any more'
- 'It's like I can leave the intensity of my problems, mental illness stigma, or

whatever's on my mind and be more reflective and feel a physical freeness.' (p. 43 - 47)

Priest suggests that, based on participants' responses, walking outdoors in a group is impactful because of the interaction with nature, the feeling of safety (being away from others as well as being within the group), and the feelings of striving, getting away, self-acceptance/ vulnerability/ openness, simplicity, and meaning-making for clients. The examples Priest provides also highlight that social connection, shared experience of distress, opportunity to strategize, positive memory association, and use of metaphor are impactful. Table 8.1 captures some of the participant responses and demonstrates how Priest codes them into categories. Table 8.2 shows how participants perceive a walking group to be beneficial and healing.

Table 8.1
Examples of Statements made by Participants in a Walking Group and Subsequent Coding.

In-vivo codes	*Line by line codes*	*Focused codes*	*Category*
'You feel like you've achieved something'	Achieving something	Achieving	*Striving* 'You strive to your own sort of limits and goals'
'My aerobic fitness is improved'	Improving fitness		
'At least I'm always moving forwards'	Always moving forwards	Getting there	
'Just to get to the end of the walk'	Getting to a location		
'You're actually making yourself do it'	Making yourself do it	Using effort	
'I'm trying to get over my problems'	Trying to overcome problems		

Note: From Priest, P. (2007). The healing balm effect: Using a walking group to feel better. *Journal of Health Psychology, 12*(1), p. 36.

Pointedly, although Priest (2007) does not identify this intervention as group WT, it can be argued that it meets the criteria. Specifically, this is because the population is drawn from mental health outpatient programming, the process hinges on walking and talking with Priest, a psychotherapist, and each other about their mental health concerns, thoughts, and feelings, and the intention of the group is to target mental health. This, coupled with the mirroring of many of

the impressions of WT offered by clinicians (as noted in the previous chapter), builds support for the potential impact of WT overall. Of particular relevance to grief and trauma work are participant comments relating to the idea of having movement toward something (striving) as well as feeling safe and finding meaning.

Table 8.2
Summary of Participant Identified Effects of Being in a Walking Group

Category name	*The walking group experience*	*The Healing Balm Effect*
Closer to What Is More Natural	Enables people to feel soothed, calmed, refreshed, free and able to breathe	Alleviates emotional pain, withdrawal, oppression
Feeling Safe	Feels safer for people than in other contexts, other groups, other environments	Alleviates feelings of insecurity
Being Part	Offers people a sense of belonging, as opposed to isolation, and integrates people's bodies and minds	Alleviates experiences of isolation, rejection, fragmentation
Striving	Shows how people are trying to help themselves and each other	Alleviates feelings of hopelessness, purposelessness, worthlessness
Getting Away	Helps people to escape from things which are difficult, such as identities, people and environments	Alleviates oppression, emotional pain
Being Me	Allows people to feel okay about themselves through being accepted	Alleviates feelings of worthlessness, rejection, insecurity
Finding Meaning	Connects people with themselves, each other and the world	Alleviates feelings of isolation, purposelessness

Note: From Priest, P. (2007). The healing balm effect: Using a walking group to feel better. Journal of Health Psychology, 12(1), 36.p. 49

Fourth, Crone (2007) offers a qualitative study of a monthly walking program designed to target mental health by encouraging walking to improve overall quality of life. The four participants express some anxiety about going to new places and affording/ finding appropriate footwear, and also gladness for having something to do and trying new things. Participants express enjoyment with statements like "sometimes I do go on the walk and I am glad that I have because I come back totally refreshed" (Crone, 2007, p. 176). Further participant response suggests that connecting with others, socializing, connection with nature, purposeful activity, aiding sleep, and increasing spiritual connection are some of the outcomes. One participant shares "when I am actually walking, going up a hill. When I am going up that hill I feel as if I am

going up there for a purpose" (Crone, 2007, p. 177). This is a lovely example of how the state of walking can relate to achievement and create momentum.

This study is important to WT because there is a strong sense that participants feel they can not get themselves out for walking without a program drawing them out. It is useful to consider that some people impacted by grief and trauma struggle to motivate themselves to get out, connect with others, or be physically active. Thus, this is where a WT therapist can be helpful; if a client will come to therapy, then it is perhaps a small matter to incorporate an activity such as group or individual WT to enhance the experience and encourage further participation. Furthermore, there is an awareness that in participating in even a monthly walking group can boost one's quality of life in several ways. This is useful to acknowledge because it speaks to the frequency of sessions that a WT could think about scheduling, and, particularly when one is working with grief or trauma, it sometimes seems just not possible for clients to get to therapy every week.

Fifth, Richardson (2015) provides a qualitative study of the *Tribute Center Walking Program* which is run by 245 trained volunteer docents; people who were significantly impacted by loss/ trauma/ grief due to the 9/11 terrorist attacks in 2001 and now volunteer to lead tour groups around the World Trade Centre site. Each tour is 50% about factual information, and 50% the volunteer talking about their experience of 9/11 (Richardson, 2015). One theme Richardson highlights is:

> …the healing benefits of story-telling. Docents… find it particularly rewarding to share their story and listen to others. Responses suggested that the sharing of stories while conducting tours provides a therapeutic and healing mechanism for docents, acting as a form of ''positive therapy.'' I always come away from a tour with an ''upbeat'' feeling.

> It's a form of positive therapy for me. For many years, after losing a family member, I was not involved in anything involving the WTC. Tribute has helped me grieve and address many of the questions which I still have about that day. (p. 26)

Other themes were sense of community/ kinship with others who were impacted, education (which I see as a form of narrating the event in the way that gives the most meaning/ sense to the teller), and reconnection with the world as a safe place. The re-narrating (education) is apparent in this quote from a participant who shares that a powerful point of connection with the group is "Ensuring that the real story is told" (Richardson, 2015, p. 26). Reconnection with the world as a safe place comes across in this quote: "The continuing interest of visitors, particularly their emotions—the world feels much smaller when you understand how good people can be to each other. For me it greatly diminishes the cruelty of the few who perpetrated the attacks" (Richardson, 2015, p. 26). Table 8.3 provides a more comprehensive overview of how participating in this program is impacting volunteers.

Table 8.3
How Volunteering as a Tour Guide at the World Trade Centre Site has Helped the Healing Process for People who were Impacted on 9/11

Description	All	Lost child ($n = 8$)	Lost spouse ($n = 11$)	Survivor/ worked at WTC ($n = 17$)	Survivor/ witness ($n = 10$)	First responder ($n = 15$)	Downtown resident ($n = 7$)	Volunteer/ recovery worke ($n = 24$)
Learning to appreciate other September 11 experiences that were different from mine	58	50	73	65	40	47	86	54
Preserves an important historic event	46	63	45	47	30	20	71	54
Meeting others who have shared similar experiences	35	38	18	53	30	47	57	17
Helps to manage my emotions (anger, frustration, grief, loss)	22	—	9	24	30	33	29	21
Keeps memories of colleagues alive	21	—	—	29	20	53	14	13
Keeps memories of loved ones alive	18	63	45	—	10	20	—	13
Provides a place to talk about loved one	17	75	55	—	10	—	14	8
Helps to reduce trauma of events	15	—	9	12	40	20	29	8
Facilitates grief process	11	—	9	6	20	33	—	4

Note. Values represent the percentage of docents in each category who selected that answer.

Note: This table is copied from Richardson, K. M. (2015). Sharing stories of the 9/11 experience: an exploratory study of the tribute walking tour program. *Journal of Loss and Trauma, 20*. DOI: 10.1080/15325024.2013.819276

This study specifically references how participation in a group where the person impacted by grief/ trauma speaks about their experience of a traumatic event while walking is able to

process aspects of the grief/ trauma. Specifically, re-establishing a sense of safety, connecting with others who shared the experience of distress, and who can hold space for the telling of the story, and the overall healing benefits. These are important clues to how WT can support grief/ trauma movement. If WT can replicate even some of these aspects, WT clients are likely to see improvements in their quality of life and symptoms. The wildcard here is that this group actively includes a level of exposure therapy; the participants ongoingly re-expose themselves to the scene of the trauma. This is something that WT may or may not be able to (or wish to) integrate, depending what the grief/ trauma stems from. It is possible, for example, that walking and talking with a therapist in the neighbourhood one was assaulted in, could be helpful. Alternatively, going to a gravesite together could be helpful. What is crucial to think about is whether exposure in this form is likely to be helpful or harmful to a client.

Summary and implications. The research on group WT is limited by quantity, specific attention to how walking impacts an intervention, lack of congruency (the research is not categorized by the authors as even remotely a type of WT), population studied (three of the five studies covered rely on outpatient populations; this limits the capacity of generalization), and small sample size. However, the research does show congruent results covering improvements in mental well-being, depression, stress, affect, mood, skills, emotional regulation, psychosocial functioning, emotional pain, withdrawal, oppression, feelings of insecurity, isolation, rejection, fragmentation, hopelessness, purposelessness, and worthlessness. Better results are linked to longer walk times and more frequent walks; the setting (urban or farmland) is less crucial than the group component. Hypotheses for how group WT helps involve the impact of nature, the feeling of safety/ inclusion/ connection that being in a shared-experience group engenders, the positive feelings from participating in walks, and the healing aspect of narrating one's

experience. There is evidence specifically linking group WT to reduction in grief/ trauma symptoms suggesting WT to be a good fit, although this research is compounded by an element of exposure therapy.

The examples given show WT in practice, even as the literature does not name it so. Additionally, specific to grief/ trauma work, participant comments relating to the idea of movement forward (striving), feeling safe, feeling refreshed, finding enjoyment, social connection, shared experience of distress, opportunity to strategize, positive memory association, use of metaphor, and finding meaning, are crucial. Further participant response suggests that connecting with others, socializing, connection with nature, purposeful activity, aiding sleep, and increasing spiritual connection are other potential outcomes of WT groups.

For WT, these studies add to practice by encouraging therapists to think about: longer more frequent sessions, not worrying much about the setting for walking, the sense of supporting people to get out and be active and connect with others, the possibility of including exposure therapy in session, and the idea that a therapist and a client one-to-one is a group, of sorts. Furthermore, the symptoms addressed in these studies link directly to those experienced with grief/ trauma. The knowledge that grief work is especially well supported by group counselling adds to the idea that WT groups could be especially useful. It is important to acknowledge that the research overall supports the idea of using WT groups with grief and trauma, particularly as once again there is a prevalence of related practice as will be discussed in the next section.

The Precedence and Prevalence of Practice of Group Walking Therapy

In this section, I provide an overview of groups which are in fact WT groups to some degree, and which are practicing in a capacity related to grief/ trauma despite a lack of evidence around efficacy. The groups I cover are *Walk with a Doc*, *Street Wisdom,* psychiatric in-patient

walking groups, and hospice walking groups.

Walk with a Doc. This group was created by a medical doctor, Dr. David Sabgir (Yablon, 2013; Walk with a Doc, n.d.). It constructs an opportunity for patients to walk with physicians (Yablon, 2013; Walk with a Doc, n.d.). The purpose is to allow patients to feel they have enough time to have an in depth discussion with a doctor and to bypass the excuse of not having enough time to walk despite understanding there are significant gains walking can achieve (Yablon, 2013; Walk with a Doc, n.d.). 50 – 200 people of all ages regularly turn up for these walks, which have spread across the world (Yablon, 2013; Walk with a Doc, n.d.). Dr. John Nasser, who also took on this practice, suggests that sometimes people, despite how easily accessible walking is, need a push to do it (Yablon, 2013). The *Walk with a Doc* website provides a list of 100 reasons to walk, with links for each reason to relevant articles (media and academic) and YouTube videos (ie. see http://walkwithadoc.org/why-walk/) (Walk with a Doc, n.d.). The reasons listed include physical and psychological improvements (Walk with a Doc, n.d.).

Obviously, this is not strictly a WT group, however, by a slight stretch, it can be seen as one, at least sometimes. First, doctors are often the first call for people who are struggling with mental wellness/ mental health; in a sense, doctors are baseline mental health experts. Second, doctors lead these walks, which suggests a sort of facilitation would occur. While this discussion would not be limited to mental/ emotional health, and would likely fixate more prominently on physical conditions, it is not impossible to imagine that this group would draw out people who have pervasive grief/ trauma symptoms. Indeed, recalling how impactful grief/ trauma can be on the body, it would not be surprising to find that many participants have experienced a loss of some type related to the onset of symptoms. This would be an excellent area for future research;

to explore the background of participants with particular focus on the experience of loss and grief/ trauma reactions. In my experience, people who have ongoing struggles with their physical and mental health often have an unacknowledged grief/ trauma history. Furthermore, a large focus of *Walk with a Doc* is on improving mental health conditions. This indicates an understanding that the doctors leading the groups understand walking with clients as having a potentially significant impact on clients' mental health, as well as shows that there may be a valid need to educate people about how walking can be helpful in this day and age.

Of particular note for WT is how popular this program is; there is a huge demand for the opportunity to walk with a medical doctor. This is useful to think about (along with the idea that many people will seek medical advice as a first call for mental health), because it creates the opportunity for WT practitioners to think about partnering with medical doctors to provide groups like this and deliver a better quality of care for clients from both medical and therapeutic perspective. (Additionally, partnering with medical professionals could mitigate some of the risk around getting clients to engage in physical activity as part of therapy; medical professionals such as nurses and doctors obviously have more relevant credentials in terms of assessing the physical stress/ benefits on people than most therapists).

Street Wisdom. Street Wisdom is a therapy-like group led by facilitators around the world combining walking and mindfulness (Maxten, 2017; Street Wisdom, n.d.). Workshops are three hours long and encourage participants to use urban streets and group work to quest for answers to questions and problems. All participants need to bring to a workshop is clothing/ footwear suitable for walking, and a question they would like to seek some insight on. Figure 8.1 is a screenshot from the *Street Wisdom* website showing some of commonly asked questions participants seek answers to during the workshop as metaphorically depicted by road signs. The

idea of using road signs for metaphorical/ symbolic relating is a good idea for those interested in WT to consider. The "no turn," "dead end," "no exit," signs might relate particularly well to trauma and grief reactions of feeling trapped, stuck, or unable to move ahead, for example. The *Street Wisdom* process is to do a short warm up/ ice breaker, do four 10 minute walks with distinct themes (Be Drawn to What Attracts You/ Slow… Right… Down…/ Notice the Patterns/ and See the Beauty in Everything), followed by a 1 hour "Street Quest" which involves wandering with a question in mind, and finishing with a group sharing (What happened? What did you learn? How can you use what you learned?) (Street Wisdom, 2017).

It is because *Street Wisdom*'s process combines walking with psycho-education followed by a metaphorically introspective questioning/ questing experience and group processing, that I feel it constitutes a form of WT. Interestingly, the *Street Wisdom* facilitation manual is available.

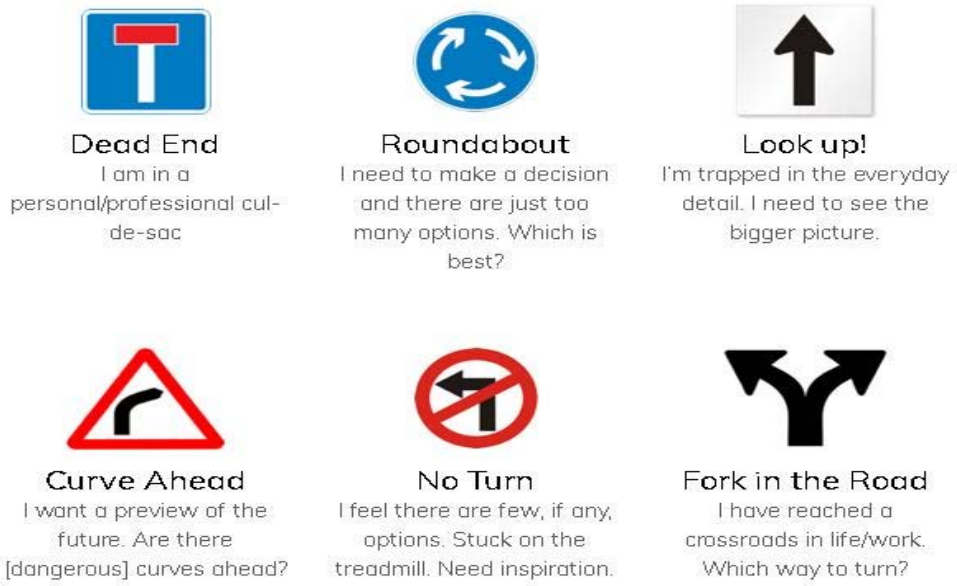


Figure 8.1 Common Questions addressed by Street Wisdom Workshop Participants. This screenshot is from Street Wisdom (https://www.streetwisdom.org/about/) and demonstrates how even walking in urban environments, there is ample opportunity to seek metaphor and symbolism about any life-circumstance.

for free, and the website will publish and sell tickets to any planned walks where the method follows the guide. This is conditional on facilitators offering the workshops for free or donating a

fair portion of proceeds to *Street Wisdom* to support the ongoing development (Street Wisdom, n.d.). It appears a popular program worldwide; on the site right now (Sept 4, 2017) there are 49 events listed for September to November, 2017 from Europe to Kenya to North America to Australia to South America to the Middle East. Figure 8.2 provides a screenshot of past and present events from the *Street Wisdom* website showing this worldwide coverage.

Figure 8.2 Street Wisdom around the World. Screenshot of past and present *Street Wisdom* workshops; past workshops in yellow and red showing upcoming workshops. From: https://www.streetwisdom.org/events/

In my opinion, the *Street Wisdom* guide and site could be highly useful for practitioners wanting to offer WT. Not only does the website offer a free and easy way to organise and market these workshops, the structure is entirely therapeutic in composition, and the guide covers everything a WT would need to think of in planning this type of workshop, including how to select safe and fruitful locations and a reminder to think about liability/ waivers. For me, it feels easily possible to organize a workshop specifically for people experiencing grief/ trauma

meriting clinical intervention and/or their support people. (Alternately, this could be highly marketable for other WT focusses; imagine, for example, using this approach as a therapeutic team-building opportunity for work teams, leadership retreats, addictions work, as a way to recruit potential individual clients, etc.). Furthermore, the requirement for participants to come to the session with a question they seek clarity on, aligns well with the meaning-making task of grief (as discussed by Neimeyer & Sands, 2011). Alternatively, Worden and Winokuer (2012) outline a task model for grief proposing the following steps: acknowledge the reality of the loss, process the pain, adjust to a world without the deceased, find an enduring connection and embark on a new life (p. 58-65). Any component of this task model could be reworked into a question for a grief-impacted participant (ie. “How can I adjust to a world without the thing/ person I have lost?” or “What possibilities are there for me to have an enduring connection in the face of my loss?”).

Psychiatric In-Patient Walking Groups. If you have ever had the opportunity to visit a psychiatric wing of a hospital in the Lower Mainland (and perhaps less locally, but I can only speak to my experience), you may have become aware of the various activities that are offered for inpatient treatment. Most of the time, in my experience, there is a walking option of some sort. This option compliments other in-house counselling or treatment groups. The walking programs are not called WT groups, however, as I will show in discussing the publically available information about the Toronto General Hospital and the Victoria (BC) Psychiatric Day Hospital walking programs; they certainly are.

The mental health inpatient unit in Toronto General Hospital provides a handbook for patients detailing the option of joining a walking group while in the hospital (Chandler, 2017). The purpose of this walking group is to learn a coping strategy, be active, and have the option of

group participation without the requirement for talking. The information on the program in this handbook is sparse; there are no details about who leads the walking group, what topics are encouraged/ discouraged as part of the group, or how many participants regularly do the group. There are no specifics about how helpful staff or clients find this group. The only publically accessible information is that these groups are part of the treatment options for people in the inpatient program and that improves coping, activity level, and the possibility of talking while walking are potential outcomes.

In Victoria, BC, the Psychiatric Day Hospital advertises several programs for outpatients (Island Health, 2011). The program targets clients with diagnoses of disorders such as schizophrenia, bipolar, and depression who do not meet criteria for full hospitalization (Island Health, 2011). Of particular relevance is the Power Walking Group for outpatients. It is meant to improve fitness, increase confidence and accomplishment for those who would benefit from support in management of mental illness, socialization, or a leisure activity (Island Health, 2011). Relatedly, Qi Gong, strength training, and West African Drumming, are also offered (Island Health, 2011). Qi Gong is provided for calming and relaxing the body and mind, particularly around stress, anxiety, and thought management (Island Health, 2011). Strength training aims to promote a positive connection between physical activity and mood, develop a healthy lifestyle habit (Island Health, 2011). A West African Drumming group is advertised as a way to distract the mind from distressing of intrusive symptoms, increase motivation, provide a means of self-expression and socialization, and build self-esteem (Island Health, 2011).

As in the Toronto program, there are no specifics on how the program is working (or not working) to achieve the advertised objectives. However, the take away from this is that there is a prevalent belief in medical facilities that mind-body therapies, and WT particularly, can target

aspects of grief/ trauma such as coping, depression, confidence, accomplishment, stress, anxiety, thoughts, connection between mood and physical activity, motivation, self-expression, socialization, and self-esteem.

Hospice Walking Groups. A newspaper article by reporter, Andriana Barton (2011), initially drew my attention to hospice walking groups and sparked the idea for this thesis. In this article, Barton speaks to the popular implementation of walking groups at hospices across Canada while highlighting the lack of research on said groups. Barton suggests grief walking groups originated at the Victoria Hospice Society in 1986 in response to a community member suggesting the idea as an alternative to "sitting around in a circle talking about loss" (para 5).

According to Barton (2011) the Victoria Hospice Society takes great care in differentiating their walking program from therapy sessions. There are no handouts on stages of grief, and the group is deliberately therapist-free (Barton, 2011; Victoria Hospice, 2017). The Victoria Hospice group meets and walks silently together for one hour before members either speak or listen to the group in a 30 minute facilitated reflection period (Victoria Hospice, 2017; Barton, 2011). The Victoria Hospice Bereavement Coordinator, Marg Cook, suggests that the group is good for people who are doers who may not be interested in a process based on emotional disclosure (Barton, 2011). Further, Cook suggests that the group often leads to enduring friendships (Barton, 2011).

The Vancouver Hospice walking group operates slightly differently. In this program, the group starts with members each saying the name of the person they lost out loud, then walking together while talking if they want to. The coordinator of the Vancouver program, Sharon Harowitz, indicates the volunteers are "there simply to listen and to offer support… 'We're not counsellors,' she says, 'We don't try to fix anything'" (Barton, 2011, para 4). Vancouver

Hospice walking group participant, Kymn Goodman, indicates she was attracted to the walks because “I liked the idea of being physical, of something getting me out of the house – not just to sit in someone’s office” (Barton, 2011, para 13). Goodman also indicates that knowing she had committed to meeting the group was often what would get her out of bed and walking (Barton, 2011). Goodman describes the feeling after a walk as “Everybody just seemed a little bit lighter at the end” (Barton, 2011, para 16).

Barton’s (2011) newspaper article very clearly covers how these hospice walking groups support people struggling with grief, and indicates a prevalence of practice across Canada. Indeed, I compiled a list of hospices across Greater Vancouver advertising walking groups for people who are bereaved; there are numerous hospices instinctively connecting walking in groups with movement through grief (see Appendix B). Furthermore, these walking groups are typically facilitated by volunteers trained in core counselling skills (see Appendix B). These groups rely on body movement, exercise, socialization, being outdoors, and therapeutic practices to move through grief (Barton, 2011). Also, hospice walking groups are habitually offered as an alternative/ adjunctive option often overlapping with individual/ group clinical counselling (see Appendix B). Overall, in spirit, these groups constitute a form of WT specific to working with grief. Being that hospices commonly understood as the agencies most responsible to support grief work, it is clear that grief-specialists are designing, promoting, and facilitating WT groups due to an instinctive recognition that these groups have a special degree of helpfulness not found in traditional talk therapy sessions for some people.

The awareness of hospice WT groups and the work with grief that volunteers are facilitating in the guise of not-counsellors (I say guise because they are trained in the core skills of counselling to run the groups, and the purpose is certainly therapeutic) is important to this

thesis. That these groups are well attended and described by programmers and participants as useful and meaningful is no small particular. WT practitioners would be wise to observe the structure, culture, and accessibility of these groups. Recalling that most grief classified as likely to benefit from clinical intervention includes an element of trauma, these groups provide tangential evidence of WT group work for both grief and trauma.

Implications. In this section, I covered examples of four types of groups which by combining walking, talking, and therapeutic facilitation can be read as illustrative of WT groups. The existence of these groups despite a lack of evidence speaks to a precedence not only for WT, but in some cases for group WT in grief/ trauma work. These examples provide information that is consistent with outcomes and feedback from the studies on WT groups above, as well as on the individual WT studies and practices described in the previous chapter. The examples cover WT group intervention inspired by medical models (*Walk with a Doc*, and hospital groups), a grief-expert model (hospice) and speak to addressing symptoms of trauma/ grief as well as specific to bereavement and/or mental health conditions. The groups all-together indicate an avid interest from people around the world in having a different forum for meeting with health and mental health professionals and/or to move through certain conditions and seek meaningful/ insightful answers to life situations. Furthermore, in comparing the symptoms addressed in the various groups, there are implications for psychotherapists to partner with laypeople and medical doctors and in considering client engagement for WT; group settings with a variety of expertise offered could serve multiple needs, particularly for grief/ trauma work. Another inference is that some of the tasks associated with grieving, like meaning making, or acknowledging the reality of a loss, can be metaphorically processed by interaction with the environment, even highly urban environments, using a system like *Street Wisdom*. Practical thinking about liability is mentioned,

and is certainly important for clinicians to think about in terms of insurance coverage for any kind of WT. One aspect that seems omitted from group WT concerns is around confidentiality. Perhaps this concern is just not brought up in the literature I found, or perhaps there is a perception that group WT does not have this same concern as compared to individual WT? It is unclear, but worth thinking about if one is interested in offering group WT.

A Note on Engagement

Engaging clients is an area deserving special attention in regards to WT groups. Despite the high number of participants found in some of the walking groups described above, engaging grief/ trauma impacted clients is a special consideration. Kassavou, Turner, and French (2015) examine what impacts participants' engagement in walking groups and find that initial integration as well as gaining long-term social and health benefits linked to participation/ attendance. This is important because it influences the idea of using WT groups versus one-to-one counselling. If grief/ trauma impacts a person's social connections and physical health, initial integration in a group would be highly important to focus on so that these benefits might be possible. Thus, considering factors such as how to welcome new members to a WT group, how to manage interaction between participants to best support inclusion and support, and how to monitor the client experience of the group is important. Additionally, Kassavou et al. find that health benefits outweigh social benefits. WT practitioners may wish to highlight that joining a WT group has additional health benefits compared to traditional counselling groups due to the inclusion of walking. Moreover, perceived stigma may be another factor to consider. McDevitt et al. (2005) find that participants in a psychiatric outpatient walking group are not comfortable doing activities on walks that could draw attention to themselves, such as overtly swinging/ pumping arms. A remedy, as McDevitt et al. put it, is "One way to avoid the hurt of stigma, as

played out in gratuitous insults from strangers, is to be unremarkable" (p. 94).

Conclusion

My purpose in this chapter was to combine overviews of the research on and practice of WT groups to build the understanding of WT in general, and relate WT further to grief/ trauma work. Despite research limited by low numbers of studies, lack of congruency, and difficulty with generalizing beyond specific populations studied, the research on groups where walking, talking, and facilitated therapeutic intent coexist does consistently show trends in positive outcomes for mental, emotional, and physical health and wellness which could be directly associated with grief/ trauma. In some cases, the groups discussed are specific to grief/ trauma work; the improvements citied by participants in these groups add data to thinking of group WT as effective for grief/ trauma work.

I relied heavily on quotes from participants in walking groups in building this chapter, because the participant perspective is one piece that I find greatly lacking in WT research overall. Whether groups are designed/ facilitated by medical professionals, grief experts, laypeople, volunteers, or others, there are some common themes voiced in the participant experience. One is the sense of connection that participants seem to find from being in groups; especially useful in processing, in feeling safe, and in normalizing responses to distress. Another is connecting with nature or the surrounding environment in a metaphorical manner; an area that skilled practitioners can certainly support, and which seems linked to meaning making and movement forward. Another theme relates to the idea of moving forward both metaphorically and literally as participants identify a feeling of accomplishment with the walks completed. A further theme is around the engagement of clients, the sense that participants both need and benefit from a commitment to a WT group; it draws people out when they otherwise would not

feel able. A final theme is that WT can be healing and soothing as it combines the experiences of walking (particularly in the exposure therapy sense) and the telling and retelling of a personal story of grief/ trauma to help integrate the experience.

I discussed that key components related to WT practice arise in terms of session logistics and client engagement. Further, I showed there is some evidence that longer and more frequent WT groups are more beneficial, but that even one session a month can be helpful. Also, altogether, the studies above indicate that WT groups anywhere are helpful no matter where they take place. Issues of liability do come up as needing addressed by WT practitioners. Likewise, for clients who struggle to get to traditional/ individual therapy, there is something about WT groups which encourages getting out to the sessions, and as the examples of prevalence of practice show, there is a high demand for WT type groups worldwide. Additionally, using WT as a form of exposure therapy may have additional benefits (and conversely risks) which could be explored in future research. Further, there is an opportunity for providing psycho-education to clients around the benefits of walking related physical and psychological health. Moreover, WT practitioners might find partnering with physicians and other medical/ mental health professionals to best serve clients and mitigate liability concerns. On top of this, *Street Wisdom* offers a free workshop manual and marketing service, which could be highly useful for WT practitioners drawn to that specific approach (and it is an approach that seems likely to merge well with grief/ trauma work). Additionally, thinking about being inconspicuous in public when facilitating a WT group, and about how to welcome and include members are important factors related to client engagement. Finally, it is noteworthy how accepted group WT is in the medical field; doctors are walking and talking with patients, hospitals are marketing walking groups as beneficial for learning coping skills and improving mental health and holistic wellness. There is

some extra weight that informally is attributed to interventions backed by the medical world, even in the face of low evidence.

Overall, studying WT groups adds to the understanding of WT in general. Furthermore, as some of the literature relates specifically to grief and loss work, insight into how WT group practice could be used is uncovered. In sum, WT groups seem a highly practical tool for counsellors to consider for working with loss, particularly if traditional therapy does not seem the best fit for particular clients. It is important now to cover other types of therapy that involve walking to complete the picture of WT as a useful practice for grief/ trauma work.

Chapter IX Of Mindfulness and Labyrinths

This chapter is the end of my pilgrimage to validate, explain, and explore the idea of WT through studies and non-academic correlations. In the previous chapters, I built on the natural act of walking as a therapeutic process unto itself by reviewing literature associated with individual and group WT. In this chapter, I take one final step and explore two specific types of walking which have been associated with therapy, and specifically with grief and trauma work: Mindful Walking and Labyrinth Walking.

Mindful Walking in Gardens and Elsewhere

Mindful Walking is just what it sounds like; applying the mindfulness practice of paying attention on purpose, in the present moment, and nonjudgmentally to walking (Teasdale, Williams, & Segal, 2014). Indeed, Gros (2014) captures the essence of walking mindfully saying:

> When you walk for a long time, there comes a moment when you no longer know how many hours have passed, or how many more will be needed to get there; you feel on your shoulders the weight of the bare necessities, you tell yourself that's quite enough – that really nothing more is needed to keep body and soul together – and you feel you could carry on like this for days, for centuries. You can hardly remember where you are going or why; that is as meaningless as your history, or what the time is. And you feel free, because whenever you remember the former signs of your commitments in hell – name, age, profession, CV – it all seems absolutely derisory, minuscule, insubstantial. (p. 10)

This displays how in becoming immersed in walking, one can lose track of all interrupting thoughts, feelings, and happenings, and rest instead in the very experience of walking. In a sense, the movements of one's body become the reality worth noticing, and intrusive thoughts and

feelings are released, or at the very least set aside.

More specifically, however, Teasdale et al. (2014), in a Mindfulness-based CBT program manual, state:

> In mindful walking, you walk, knowing that you are walking, feeling the walking, being fully present with each step, walking for its own sake, without any destination. The focus is on maintaining moment-to-moment awareness of the sensations accompanying your movements, letting go of any thoughts or feelings about the sensations themselves. (p. 128)

Becoming so engrossed and attentive to the walk itself seems the way to enter Mindful Walking. Staying with the walking, and not letting the mind wander to other areas is what makes the walk therapeutically beneficial (Teasdale et al., 2014).

Further, in describing the steps to practice Mindful Walking, Teasdale et al. (2014) specify:

> To begin with, walk at a pace that is slower than usual, to give yourself a better chance to be fully aware of the sensations of walking. Once you feel comfortable walking slowly with awareness, you can experiment as well with walking at faster speeds, up to and beyond normal walking speed. If you are feeling particularly agitated, it may be helpful to begin with walking fast, with awareness, and to slow down naturally as you settle. (p. 127)

In other words, using the pace of the walk to process emotions, to become grounded, and to try new and different sensations associated with speed can also be seen as a therapeutic potential in Mindful Walking.

Overall, Mindful Walking is a way of combining mindfulness practice with the natural

movement of walking where the sensations of walking and noticing the environment through which one walks become the forefront of the thought.

In my experience, it is absolutely simple to do Mindful Walking. Also in my experience, Mindful Walking can be done individually, with a therapist, or with a group. It is artless and straightforward to understand and to practice. Further, my experience of Mindful Walking is that I feel young and playful when I connect with the movement of walking. However, I have found in groups that I have facilitated that some participants like it, while others find it tedious and/or frustrating. I find the slowness of it can be a challenge for some, as can attuning to specific cues in the body, mind, heart, and environment. What I see it as offering particularly to grief and trauma work is a sense of escape and change, and even building the mind's capacity to interrupt and rework thoughts and emotions that could be disruptive.

Beyond my personal observations, there are only two peer-reviewed and published studies (Teut et al., 2013; Ruggiero, 2015) examining the use of Mindful Walking as a stand-alone intervention. Neither is particular to grief or trauma. However, both studies provide training in mindful walking to participants and find significant positive impact on variables such as mental health, vitality, emotional role function, social role function, anxiety, depression, sleep, mood, mindfulness, physical self-efficacy, and activity. Problematically, the results cannot be attributed specifically to either mindfulness or to walking, do not involve long term intervention (just 4 weeks in each case), and involve low enrollment (74 subjects and 3 subjects, respectively). Teut et al. (2013) utilize a group approach while Ruggiero's (2015) intervention is individual with no group component. Furthermore, Ruggiero (2015) requires participants to do 30 minutes/ day of mindful walking for two of four weeks. This is understandably quite the commitment for anyone to make, and seems unlikely to be replicable for most people outside of

a supervised environment. In sum, while these studies again can be said to show a link between reducing symptoms associated with grief and trauma, the results are quite limited due to the complexity of the interventions as well as the small sample size. It is useful to note, however, that both group work and individual work can be impactful.

Studies unintentionally studying Mindful Walking. On top of these studies specifying Mindful Walking as a target, there are at least two cases where Mindful Walking is inadvertently studied; it is not called Mindful Walking by the authors, and yet, in essence, is exactly what is studied.

Firstly, McCaffrey and Lier (2016) observe ideal changes in stress levels around hopefulness, personal growth, and quality of life when 220 people participate in guided reflective garden walking. The program provides the opportunity to walk a Japanese garden 12 times over six weeks using a written guide. The garden walking can be understood as a form of Mindful Walking as participants follow a reflective guidebook focussing on use of metaphoric interaction with the garden. The guidebook is composed of "short readings and pages for journaling" (McCaffrey & Lier, 2016, p. 179) to enhance participant experience of walking in the garden. Table 9.1 lists the reflective metaphors found in the guide provided to participants for each stopping spot. Significant positive changes are found in experiences of loneliness, fatigue, sadness, restlessness, inability to concentrate, and hopelessness. (See Appendix C for more information on this program.)

Secondly, McCaffrey, Liehr, Gregersen and Nishioka (2011) find that in a similar program, depression is decreased. McCaffrey et al. provide three interventions to older adults with depression: art therapy, individual garden walking, and group garden walking with a facilitator trained in guided imagery. There is no control group. The facilitator guided walking

group is an example of a Mindful Walking group. All three groups are six week interventions, and in every group depression lessens significantly. This demonstrates that walking alone and walking in a group with a trained facilitator could have the same effectiveness as Art Therapy in decreasing depression.

Table 9.1
Example of Metaphors Associated with Stopping Spots in a Japanese Garden Walk

Stopping Spot	Meaning
Circle of life (wisdom ring)	All our lives are a circle, and moving through the circle brings us to an understanding of the different stages of life and the benefits of each stage.
Straight bridge	The straight bridge is a metaphor for times in our lives when we are on a straight and sure path. We know exactly where we are going and how we can get there.
Zigzag bridge	The zigzag bridge is a metaphor for times in our lives when we were not sure where we were going. When you put your foot on the zigzag bridge you cannot see the other side and you must walk in faith that the path will lead you where you want to go.
Gate	The gate is a metaphor for walking into a new beginning and leaving past troubles and sorrows behind.
Contemplation pavilion	The contemplation pavilion is a place to think about self-care. Without caring for ourselves we cannot care for others. This is a refreshing stop and is restorative and pleasant.
Waterfall	The waterfall is a place of beauty and serenity. It speaks of the beauty that can be found in nature and in our lives.

Note. Examples of metaphors that can be used in a Japanese Garden for WT; participants were guided to each of the "stopping spots" in the garden and offered the opportunity to reflect on the metaphors in the "meaning" column. From: McCaffrey, R., & Liehr, P. (2016). The effect of reflective garden walking on adults with increased levels of psychological stress. *Journal of Holistic Nursing : Official Journal of the American Holistic Nurses' Association, 34*(2), 177.

These studies do not use the term Mindful Walking to describe the interventions used. However, due to the manner in which participants are trained to walk the gardens, or are led through the gardens, it is clear that Mindful Walking is utilized. Thus, it is reasonable to associate the findings (decrease in depression, experiences of loneliness, fatigue, sadness, restlessness, inability to concentrate, and hopelessness) with Mindful Walking. It is further reasonable to argue that once again these findings tie in well with grief and trauma work due to the similarity in the symptoms. It is also assumable that WT practitioners could incorporate the use of mindfulness in WT sessions in a similar manner.

Finally, Riggiero (2015) posits that Mindful Walking is accessible in terms of cost and fitness level, can be done with minimal training, has no troublesome side-effects, and can be

independently maintained.

A subjective conceptualization of Mindful Walking. Mindful Walking is incidentally addressed by Kostrubala (2013). Kostrubala describes at least two incidents of mindfulness that spontaneously occur for him while running. He associates these occurrences with a change in attention and clarity brought on by heightened mental abilities engendered by running. Kostrubala also highlights the feeling of euphoria which running brings on. Kostrubala relates running to meditation, prayer, and spirituality in terms of what it brings up for people. Running, of course, is a faster paced and less careful version of walking; but the mindful experience of running is unquestionably a form of Mindful Walking.

It is important to note that the subjective experience of mindful running coming from a clinician who advocates for and practices WT is a distinct perspective. On one side, it is key to note the obvious bias; this person logically wants people to see mindful running as useful, helpful, and easy to achieve. At the same time, it is important not to dismiss the personal experience of someone who can be seen as an expert in the field. Hays (1994) indicates that Kostrubala is the person who first uses running/ walking with clients as a unique form of psychotherapy. Therefore, the idea that Mindful Walking/ Running can leave a person more attentive, euphoric, and clear-headed, is important to consider. Furthermore, there is something to be said for WT practitioners who can so thoroughly get behind the benefits. The essence of practicing what one preaches is demonstrated here.

Client feedback on Mindful Walking. Teasdale et al. (2014) offer the testimony of program participants about walking participation:

- I like walking meditation, because I can be conscious of it when I leave work. I have to pick up the kids, and sometimes I'm marching up the path to get to the school. I often

find I am stomping and marching because I'm in a rush and getting a bit stressed.

- Sometimes now I'll be aware of it, and I'll walk more slowly and, you know, breathe with the steps. So by the time I actually get to the kids waiting at the top of the path, I'm composed.
- If I slow down, everything else slows down and I become more aware of what's going on. And what might just take me ten seconds to get to the top of the path is then thirty or forty seconds, which is well worth it. (p. 128)

This feedback demonstrates that some find Mindful Walking helpful because it increases awareness of emotional/ mental state as bodily expressed, and it creates the opportunity to change the way one is feeling and becoming more aware of what is going on by slowing down physically, for example.

Overall summary and implications of mindful walking. Mindful Walking incorporates mindfulness practice into the experience of walking. There is limited evidence correlating the impact of Mindful Walking on mental health, vitality, quality of life, emotional role function, social role function, anxiety, depression, sleep, mood, mindfulness, physical self-efficacy, activity, experiences of loneliness, fatigue, sadness, restlessness, inability to concentrate, euphoria, and hopelessness. The studies cover both group and individual work, and the results for both group and individual interventions have indicated improvement. Finally, the subjective experience of a WT practitioner can be cautiously added to further support these findings.

Sample sizes in the above studies are small and encompass specific populations, making generalization challenging. The interventions are quite complex, and any number of variables could be responsible for the changes. Further, the rigorous nature of some interventions would be challenging to replicate without supervision. This research is limited in relevance to WT as the

research does not separate mindfulness practice from walking. Furthermore, it may be that in studies related to walking in gardens, the garden setting rather than walking is what is most responsible for any changes.

The relevance of these studies to doing WT for grief and trauma work echoes the overall theme of information in the previous three chapters: the symptoms addressed are too similar to ignore, and it seems that walking outdoors alone, in groups, with and without facilitation but with a meditative focus; all are attributable to improvement. WT can certainly support clients having this kind of focussed experience, as well as get clients started on these types of practice.

Labyrinth Walking

Solnit (2014) describes her personal experience of walking through a labyrinth as follows:

> Keeping to the winding path became important, and with one's eyes fixed upon it, the space of the labyrinth became large and compelling….That circle became a world whose rules I lived by, and I understood the moral of mazes: sometimes you have to turn your back on your goal to get there, sometimes you're farthest away when you're closest, sometimes the only way is the long one.

If this quote leaves you confused or uncertain about the experience of Labyrinth Walking, I suggest paying a visit to one. Locally, in Port Moody, BC, directly across from the hospice, there is a labyrinth healing garden I would recommend. It is small; if you were to walk the labyrinth without stopping, and at an average speed, you might spend five minutes to wind your way to the centre and back out again. However, the instructions at the gate read:

> How to walk a labyrinth path
>
> Pause before entering the garden. Take a deep breath. Relax. Concentrate on each step

> that you take trusting that the path will lead you into the centre. In the centre, take a moment to reflect on your journey. When you are ready, exit the labyrinth by retracing your steps.

This indicates that more than ten minutes is likely to be spent within this labyrinth, despite the small size. The sign at the entrance advises the path is there for the public to meditate, reflect, and heal. The path winds past knee-high boulders neatly inscribed with words inspiring these traits, such as: *Truth, Balance, Inspire, Compassion, Mindful*. It is a simple space between a busy road and a recreation centre, and in my experience, it is not well known. Figure 9.1 is a collage of some pictures I took of this labyrinth.

I first came upon this labyrinth with my children in tow when they were very young. I remember seeing them climbing onto these rocks and feeling moved at the juxtaposition of these words and my children. Seeing these small beings perched atop the word *Hope*, for example, I remember feeling such a warm glow come through me, as I saw them bathed in the sun, and I could picture their futures bright before them, and see how their presence added so much to my life. I had not read the directions, nor had I planned to reshape my images of my children or myself that day, but there was a power in the presence of this place for me. With this in mind, I acknowledge my bias; I believe that walking a labyrinth can be very powerful and helpful.

Despite this personal experience, Labyrinth Walking is a late addition to this thesis. I had not considered Labyrinth Walking at all in preparing my research for this paper. In fact, I am not sure what it was I read that sparked a connection, but somewhere amidst the many resources I pursued, I came across it and recalled my own experience. I was then surprised to find there is a website listing labyrinths all around the world. Indeed, labyrinths have been built into hospitals, churches, medical/ health care centres, rehabilitation centres, schools, psychiatric hospitals,

Figure 9.1 Photos of the Crossroads Healing Labyrinth Garden. This labyrinth is in Port Moody, BC and features rocks with inspirational words carved into them along the path. Photos taken by Thea Megas, Sept 2017.

retreat centers, university campuses, prisons, private spaces, and parks worldwide and there is a deep history of Labyrinth Walking as a healing, meditative, and therapeutic practice (Hong & Jacinto, 2012; Zucker & Sharma, 2012; Bigard, 2009). To understand the therapeutic potential of walking in labyrinths for WT with grief and trauma, we need to know the general history of labyrinths, historic use of labyrinths, and the recommendations for the use of Labyrinth Walking in counselling.

History of Labyrinths. Labyrinths are not mazes; the path in twists and turns, but leads to one point, usually the centre, and the same path leads back out (Hong & Jancito, 2012; Zucker & Sharma, 2012; Bigard, 2009; Sandor & Froman, 2006). Therefore, one can never be lost in a labyrinth. Bigard (2009) advises that the universal labyrinth pattern has been found on every continent except Antarctica. The earliest known labyrinth is on the wall of an Italian tomb dating 2500-2000BC (Saward, 2003 as cited by Bigard, 2009), though Hong and Jancito (2012) cite Schaper and Camp (200) that "Gambitus, an anthropologist, reported that she discovered some of the earliest evidence of labyrinth-like images on a figure in the Ukraine dated 15,000 to 18,000 BCE" (p. 622). Interestingly, Hong & Jacinto (2012) discuss the use of finger walking in labyrinth work: small portable labyrinths can be traced with fingers in cases where walking a labyrinth is not suitable or possible. Either way, labyrinths, for walking or finger tracing, have been around for centuries, and the pattern is considered universally symbolic of growth, transformation, unity, wholeness, structure, and orientation (Bigard, 2009). Today, there are portable labyrinths available for purchase online, either as giant folding out canvasses or as hand sized finger-walking versions.

What is a labyrinth? Bigard (2009) describes labyrinths as meditative tool used for thousands of years to metaphorically reflect one's life journey through a kinesthetic and

introspective experience. Bigard stipulates:

> …the labyrinth has been suggested for accomplishing such preventive and developmental goals as encouraging reflective thought, enhancing communication and connection with self and others, focussing cognition, enhancing problem solving, fostering creativity, promoting personal and/or spiritual growth, and aiding in relaxation. (p. 138)

In many manners then, walking a labyrinth is a form of Mindful Walking, just in a highly particular setting and manner.

Current use of labyrinths. Labyrinth Walking appears to be another example of a therapeutic walking practice with a prevalence and precedence for use not well backed by research. Presently, labyrinth uses include "adjunct to counseling, stress management, meditation, personal and spiritual growth, education, ritual, community building, problem solving, conflict resolution, creative arts, and fundraising events" (Bigard, 2009, p. 141). Further, people facilitating labyrinth use come from assorted academic backgrounds "i.e., from horticulture, classical studies, foreign language, theology, student services, or counseling centers" (Bigard, 2009, p. 141). The uses for labyrinths comprise "teaching, service learning, community building, relaxation, memorial services, open walks, and faith services" (Bigard, 2009, p. 141). This is, according to Bigard (2009), in spite of little published academic research on Labyrinth Walking toward therapeutic outcomes. Instead, per Bigard, "John Rhodes, The Labyrinth Society Research Committee chair, has completed a summary of 16 action research or empirical studies… that report the effects of walking the labyrinth…" (p. 141). This research has resulted in Rhodes proposing:

> a two-part theoretical construct that can be helpful in understanding the effects of walking the labyrinth. It seems that walking the labyrinth might enable a set of physical

> responses (increased calm, quiet, and relaxation and decreased agitation, anxiety, and stress) that allow for a set of state-of-mind responses (increased levels of centeredness, clarity, openness, peace, and reflection). In turn, these state-of-mind responses might increase one's receptivity to flashes of intuition and other types of insight into one's concerns. (Bigard, 2009, p. 141)

It is not clear whether Rhodes' theory is accurate or not, but this is a useful way to think about Labyrinth Walking potentially impacting a counselling client. Zucker and Sharma (2012) advise that labyrinth walkers claim the practice relaxes, focuses, and provides new understanding of old problems (citing Woodside, 2004). Indeed, Hong and Jacinto (2012) suggest:

> One of the key benefits of labyrinth work is insight. Individuals who engage in labyrinth work often have flashes of insight while walking the terrain of the labyrinth. In addition, along with insights, each individual has a particular experience while walking. The combination of the experience (visual, auditory, kinesthetic) as it interacts with thoughts and a feeling assembles rich material to use in successive therapy sessions. For some individuals, the labyrinth experience may reduce the number of sessions needed to address the presenting problem (Harris, 2002, 2008). (p. 631)

Overall, much of the ideology about the impact of Labyrinth Walking is speculative. However, Sandor and Froman's (2006) research suggests that walking in labyrinths has immediate effects in regard to affective improvements. Furthermore, one particular use which has been singularly studied is Labyrinth Walking in a prison environment.

Labyrinths in prisons. Zucker and Sharma (2012) conduct a study of how Labyrinth Walking in a prison supports stress management. They find that including a Labyrinth Walking program (walking through a labyrinth with specific intentions and mindful awareness) in

correctional settings can increase inmate's attentiveness to stress, which is related to emotional regulation as well as reducing substance use. Zucker and Sharma find there are shifts in positive emotions/ thoughts, self-improvement, positive actions/ intentions, reflective thoughts/ self-awareness, and self-esteem for inmates who participate in facilitated Labyrinth Walking and journaling. Zucker and Sharma suggest that a Labyrinth Walking program in prisons can increase participant awareness around stress management, as well as provide an opportunity to find some peace. I perceive that this relates to WT for grief and trauma due to the sense of *stuckness* around being trapped in jail (it is reflective of how people can experience grief/ trauma), the general symptomology of loss, as well as the statistical likelihood that people who are imprisoned have some trauma history.

Recommendations for use of Labyrinth Walking in counselling. Working with labyrinths in counselling can be done in session or as an adjunct and can involve walking labyrinths or finger labyrinths (Hong & Jacinto, 2012).There are some recent research-based recommendation for expanding the settings which utilize labyrinths as well as suggestions around how to use labyrinths effectively in counselling.

Future settings for labyrinths. Bigard (2009) suggests labyrinths be used by counsellors in post-secondary settings as a method of increasing engagement via outreach as well as increasing right-brain thinking as in accessing creativity and intuition. Zucker and Sharma (2012) suggest that labyrinths be used in prisons. Personally, I suggest using labyrinths for all manners of counselling by taking advantage of pre-existing labyrinths around the world. Alternatively, to easily add labyrinth walking to WT, perhaps drawing simple labyrinths on beach sand is possible.

How to use a labyrinth in counselling. Bigard (2009) suggests following four stages in

walking a labyrinth:

- Remember: pause before entering to focus thoughts and intentions.
- Release: Enter the labyrinth, pay attention to breath, focus on the physical sensation of walking and release thoughts.
- Receive: At the centre stay a while and notice what is found there.
- Return: Walk out again, reflecting on application and integration of any findings

These four stages could be useful for WT all around, as they match rather simply with the general progression of counselling sessions. These stages could also be seen as convergent with aspects of grief or trauma work, particularly the gentle noticing of intention, the focus on grounding, the going in and then out of the pattern.

Alternatively, Hong and Jacinto (2012), who explore the use of reality therapy in conjunction with walking a labyrinth, also divide Labyrinth Walking into four stages:

- Beginning: Reflect on "What do I want?"
- Middle: Pause, reflect, visualize, ask "What am I doing to get what I want?" Speak with therapist about "What do I want?" and "What am I doing to get what I want?" and "How will I know if what I am doing is working?" Select an inspirational word to carry out of the walk.
- End: Walking back ask "How will I know if what I am doing is working?" while reflecting on the inspirational word.
- Debriefing: Debrief and homework assigned.

This technique is more cognitively based than Bigard's (2009) idea and is much more specific to how a counsellor can support the process. It is useful for WT practitioners to have a model like this to refer to in thinking about the structure of a WT session whether a labyrinth is involved or

not.

Client suitability for Labyrinth Walking counselling. Hong and Jacinto (2012) provide this synopsis of the types of clients who could likely benefit from Labyrinth Walking:

> Examples of those who can benefit from labyrinth work include those experiencing a life transition that is chosen or not, bereavement, grief, existential malaise, substance-dependent individuals who are substance-free, and individuals who are depressed or anxious and stabilized on appropriate medication. Those experiencing attachment issues could potentially benefit from labyrinth work; however, the individual's developmental level must be a factor considered by the therapist. In regard to individuals who experience trauma, the therapist would need to determine what type of trauma was experienced, the length of time the person has lived with the traumatic experience, and the potential for the individual to gain insight from the labyrinth experience. In cases of domestic violence survivors, it would be beneficial to use labyrinth work after the individual has left the abusive relationship and was in the process of reorganizing life circumstances (Turnage et al., 2003). Those who may not benefit from labyrinth work are would be those experiencing chronic and persistent mental illness, stabilized on medication, and experiencing psychotic symptoms." (p. 631)

In sum, Labyrinth Walking is presented as a useful option for most clinical populations, including people in grief and trauma. However, in cases of medication, chronic mental illness or psychosis there is a need for caution.

Summary and implications. Labyrinths, despite a lack of peer reviewed research, remain symbolic of growth, transformation, unity, wholeness, structure, and orientation and have an incredibly long history of use in all manner of settings. Anecdotally, Labyrinth Walking

correlates with therapeutic intention such as insight, meditation, reflection, enhancement, problem solving, creativity, growth, and relaxation and is suitable for most clinical populations, including people impacted by grief or trauma. What makes Labyrinth Walking so impactful is unclear, but there is speculation that it may be the body-mind interaction. There are recommendations for how to use Labyrinth Walking independently and with a therapist, which are similar in structure: they invite being intentional and reflective, finding groundedness and meaning, applying findings to forward movement and planning, and returning to the regular world. All of this is highly reflective of general counselling practice, and is quite adaptable to the use of WT with or without a labyrinth. The steps in these techniques are reminiscent of aspects of grief and trauma work, and should translate well to these areas. Because labyrinths are publically accessible and free in many cases, and suited to walking, WT practitioners would be wise to look into using labyrinths.

Conclusion

In this chapter, two distinct forms of WT practice are examined: Mindful Walking (the practice of walking while integrating mindfulness) and Labyrinth Walking (the ancient practice of walking a labyrinth while mindfully seeking enlightenment, healing, or growth of some sort). Both of these practices can be done alone, with a written guide, with a therapist, or with a group with a minimal amount of training for participation. Both rely on tuning into thoughts, emotions, and bodily reactions as well as to the surrounding environment and what it might offer. In both cases, benefits are observed when the practice is trialed, but in neither case is it clear exactly what aspect is responsible for any correlations: Is it the walking? Is it the mindfulness? Is it the metaphor of the setting? Is it the process followed? These questions remain unaddressed in current research and literature, although theories have sprung up both on why these techniques

work, and what good practice using these techniques looks like. Counsellors interested in WT are wise to acknowledge the protocols and practices used in Mindful Walking and Labyrinth Walking: these pieces can be easily integrated in WT. Neither practice is studied or documented as hugely relied upon for grief or trauma, however, both tie in well to the working theories on grief and trauma as well as to the symptomology. Furthermore, the fact that labyrinths are located in so many spiritual and medical facilities does tentatively suggest an instinctive connection to grief and trauma work. I have now covered all research and literature which I can find relating to WT in general and as a practice particularly useful for grief and trauma work. The next chapter addresses suggested practice and limitations prior to the conclusion of this paper.

Chapter X Conclusive Best Practice for Walking Therapy with Grief and Trauma

This chapter is a conclusive summation of the best practice application for WT in working with grief and trauma, and a conclusion to this thesis overall. I began this thesis with three problems:

1. Grief and trauma are not well understood in the world of psychology. There is a need for exploration and clarity, particularly on how they are experienced holistically as conditions of the mind, heart, and body.
2. Walking with counselling clients is widely practiced, but not well researched: there is a research gap and a need to establish a sense of efficacy in the face of prevalence of practice.
3. Despite a lack of clarity on grief and trauma, as well as a lack of research supporting efficacy of WT in general, there is a recognizable tendency to use WT to address grief and trauma in some settings, such as hostels. There is a need to understand why WT is being used so commonly to address grief and trauma.

Overall, I hoped to demonstrate that WT is not only a long-standing practice instinctively utilized to address grief and trauma, but is also a validated and useful clinical intervention generally.

To this point, I have been able to demarcate grief and trauma through a historical ethnographical epistemological literature review. I have shown that grief and trauma are symptoms not just of the mind and heart, but additionally of the body. I have argued that this resultantly merits a holistic mind-body therapeutic intervention. I have proposed that WT is a simple solution validated by a precedence and prevalence of practice albeit not well-documented in academia. I have explored how walking, individual WT, group WT, and Mindful/ Labyrinth

Walking can impact the grief/trauma experience. All that remains to do is clarify exactly why I believe WT is a viable and useful approach to working clinically with grief/ trauma counselling and cover treatment protocols and considerations recommended for walking therapy.

Why use WT with Grief and Trauma

Throughout this paper, I have drawn attention to how grief and trauma counselling may relate to the use of WT. This has mostly involved remarking on the symptomology of grief/ trauma in regards to research showing positive outcomes in related areas. For example, one symptom associated with grief and trauma is anger (ie. refer back to Table 4.1). Anger is addressed in using individual WT by Hays (2010), who finds that individual WT helps reduce agitation (as cited by Hays and Sime, 2014). Anger is also addressed by Aspinall et al. (2013), Moules et al. (2007), and Richardson (2015) who find, respectively, that walking decreases frustration, increases groundedness, and helps manage anger, frustration, grief, and loss. Furthermore, Zucker and Sharma (2012) find that walking in labyrinths can create shifts in positive emotion, intention, and self-awareness. In sum, it is fair to surmise that using walking/ WT is a potentially viable intervention for addressing anger. In actuality, every symptom of grief/ trauma introduced in the first half of this thesis (as listed in Table 4.1) is addressed in the second half of the thesis in a similar fashion: by looking at how research/ documentation specific to walking/ exercise as a stand-along intervention, individual WT, group WT, or Mindful/ Labyrinth Walking impacts that particular symptom. Table 10.1 (see Appendix G) captures this information, showing how various sources on the therapeutic impact of walking/ WT address every symptom of grief/ trauma in the same manner in which I have discussed anger.

In short, although there is no research directly linking WT with grief/ trauma counselling, WT is a useful practice to consider for grief and trauma work because there is documentation of

efficacy for every symptom associated with grief and trauma. Furthermore, WT has been shown to be an adaptable, simple, cheap, and responsive tool which therapists can easily include in their practice and which might appeal to people who are not interested in traditional indoor/ seated talk therapy. Additionally, WT offers an excellent opportunity for use of metaphor, meaning-making, movement forward, accomplishment, meditation, and momentum building, among many other possibilities associated with grief/ trauma work. At the same time, there are some concerns about the use of WT which I must address here.

Concerns for Use of WT

Essentially, concerns about the use of WT from a variety of sources (Revell & McLeod , 2016; Kassavou et al., 2015; King, 2015; Hays et al, 2014; McKinney, 2011; Pasquariello, 2011; Jung, 2011; Beauchemin et al., 2008) can be divided into two sections:

1. Engagement/ logistics within liability.
2. Ethical considerations.

These areas apply when working with grief/ trauma and any other conditions.

Defining engagement/ logistics within liability. This refers to the idea that there is a need to set up WT sessions in a way that is safe for the client and therapist, and which professional liability insurance will cover. Specifically, these concerns are around how to properly plan a session (the length, frequency, and setting), how to ensure that there is physical health and safety in place for client and therapist, and determining a goodness of fit (in terms of physical capability, cultural agility, and type of treatment condition).

Defining ethical considerations. This refers to items which relate to the code of ethics counselling professionals subscribe to. Confidentiality, competence (qualified as a therapist with an ability to do therapy properly while walking and under appropriate supervision), and

boundary setting are three areas that come up in the literature as areas of ethical concern.

Addressing limitations of engagement/ logistics & ethical considerations.

Cumulatively, information from Kassavou et al. (2015), King (2015), Payne et al. (2015), Hays et al. (2014), Oppezzo and Schwartz (2014), Teasdale et al. (2014), Kostrubala (2013), Hong and Jacinto (2012), McKinney (2011), Jung (2011), Scott and Duerson (2010), Beauchemin and Manns (2008), Berger (2008) (as cited by King, 2015), Schwartz (2008), Pasquariello (2011), clarifies the following steps as best practice to ethically engage clients in WT:

1. Assessment: Assess client's suitability and interest in WT as part of initial screening/ assessment/ intake; offer WT if it seems like a good fit for client's interest and level of fitness. Consider seeking medical clearance from a qualified person. Consider that for people who may experience panic attacks, trauma/ grief reactions, or similar, or who have addiction concerns or eating disorders, the environment can be unpredictable and triggering, running has a history of becoming addictive in its own right, and the meditative process of walking could lead to a trauma reaction. Remember that alternatives like finger-walking labyrinths and being pushed in a wheelchair outside have been suggested, and that treadmills in an office are another option.
2. Informed consent: Explain WT. Cover length of walking, location, weather dependant factors, indoor/ outdoor options, appropriate footwear/ clothing, walking side by side instead of seated together facing one another, possible benefits (ie. enjoyable environment, invigorating, refreshing, mood-altering benefits of exercise, emotional-cognitive catharsis, lucid thinking and introspection), limitations & options (ie. client can opt out if intimidated/ distracted/ uncomfortable and concerns about

confidentiality). Contemplate providing this information in pamphlets or on websites and as part of informed consent documents to make sure clients understand. Plan for crying in public (ie. wear sunglasses/ carry tissue), meeting people along the way (ie. avoid them, or say a brief hello and keep walking), being triggered in public and how that can be handled (ie. sitting for a while, walking in silence).

3. Notice client's experience of WT and act responsively and responsibly: For example, include a leisurely warm-up, recommend a pedometer and adjunct walking instead of WT if client might prefer that, or encourage commuting by foot or a home exercise program if possible/ appropriate. Use mood scales and similar to monitor impact. Ensure that WT does not detract from the content/ goals/ emotional integration. Tailor walks to participants needs. Consider factors that enhance engagement, such as encouraging rewards, attendance, and walking outside of therapy sessions. Have back up plans for weather. Have options for destinations, and places to stop along the way if breaks are needed for emotional safety or physical resting.
4. Act within competence & ethics: Be aware of risks and benefits and weigh them carefully. Set exercise goals with client only if trained in physiology; otherwise outsource and/or get medical clearance for clients to exercise. Maintain boundaries and be professional: clients seem to appreciate the less formal nature of WT, but therapists must maintain their position as professionals and act accordingly. Speed up and slow down to create privacy as needed, as well as to support processing of emotions (ie. speed up if agitated; see if that helps). Access a supervisor who understands the extra needs for attention to boundary setting, confidentiality, informed consent, and goodness of fit in WT (not necessarily a supervisor who

practices WT or is trained in kinesiology).

5. Encourage client to find ways to increase exercise outside of therapy (ie. involve social supports), and consider behaviour modification and psycho-education to increase walking outside of therapy sessions.
6. Plan for fluctuations in interest and failure in ongoing involvement in exercise. Build up contingency plans and reasons why to continue.
7. Be aware of the profile of WT as perceived by the public, third-party billing agencies, and other practitioners. Be prepared to address concerns such as efficacy, lack of research, newness in field, and lack of training. Be aware that neglect and abuse have happened in other outdoor therapies, which have resulted in injury and death; be diligent and conscientious.

These steps cover many engagement logistics and ethical considerations, and offer a straightforward and simple platform that WT practitioners may wish to use as a starting point. This applies to WT in general, and certainly to working with grief/ trauma. Additional special considerations for grief and trauma, as previously discussed, might be around including an element of exposure therapy, practicing a coping strategy prior to walking with a client to prepare for triggers, and considering connections that can be helpful and supportive if a WT group is implemented. Use of Mindful Walking components and Labyrinth Walking can be particularly helpful, as can group WT methods used to explore meaning making, and narrative reconstruction in particular. Metaphors can easily be drawn from surroundings, and from the speed at which WT sessions are paced. Links between bodily states and feelings or thoughts can be encouraged.

Addressing further limitations. It is important to acknowledge that walking, whether as

part of a therapy session or simply as a stand-alone, is not meant to be understood as a cure-all. In fact, in discussing walking through grief and trauma, it is not my perspective that grief or trauma are conditions to be resolved, but rather these are experiences that have the potential to be integrated in a manner which allows for forward movement in life overall. This is similar to how Bonanno (2004) differentiates recovery and resiliency:

- Recovery is when function returns to pre-event levels.
- Resilience is when a stable equilibrium is maintained despite a traumatic event.

Instead, the focus is on addressing posttraumatic growth; "the possibility that grief and loss, however painful and unwanted, can be a "good part" of life through its power to expand the capacities of the self" (Buagher, 2015, p. 312). In other words, the purpose of WT is to support movement toward a stabilized state, which is supported both by therapeutic means, and by the action of walking. In the end, I tend to agree with Leseho and Maxwell (2010) who propose:

> There is power in movement whether one is aware of it or not. Movement helps bypass the mind, which often keeps a client stuck in certain ways of thinking or behaving or blocks access to information and emotions stored in the body. (p. 27)

Yes, there is little research which specifically demonstrates this, and yet, there is a commonly acknowledged truth here, which merits further investigation and validation.

Conclusion

The entire idea of walking as a healing and helpful practice for grief and trauma work is just that; an idea. It is based in understanding grief and trauma as conditions of the body as well as the heart and mind, and that walking seems to have some power to impact all of these areas in a productive manner. Indeed, as Bessel Van der Kolk, M.D., a trauma clinician, researcher, and teacher, posits, "People get traumatized, they lose touch with their bodies and they lose touch

with their lives as they wander through the journey of each day" (PESI Publishing & Media, 2011, 1:47:00). So, one has to ask; why not literally walk with these clients? Why not shift from a metaphorical practice to a concrete and tangible one? Additionally, understanding grief and trauma as conditions impacting the mind, heart, and body, and thinking about treatment approaches that can address all of these areas, is it any wonder that WT has been so commonly practiced? For, as Gros (2014) writes:

> Walking can provoke these excesses: surfeits of fatigue that make the mind wander, abundances of beauty that turn the soul over, excesses of drunkenness on the peaks, the high passes (where the body explodes). Walking ends by awakening this rebellious, archaic part of us: our appetites become rough and uncompromising, our impulses inspired. Because walking puts us on the vertical axis of life: swept along by the torrent that rushes just beneath us. (Kindle location 121)

And, a full century prior, Shand (1914) writes:

> There are men who walk slowly whose minds are quick and active; and when their thoughts are most active and concentrated, their movements are slowest or stop altogether, when not agitated by emotion. There are men who are slow to form resolutions because their minds are quick to foresee consequences that escape other men; or who are slow of speech because they think before they speak; or who appear slow of thought because they discern difficulties and contradictions, and exercise self-control to avoid precipitate judgments. All self-control delays action, and, apart from other influences, those are quickest who are the most impulsive. (p. 140)

Thus, we can see: walking has an incredible history of being acknowledged as therapeutic, and with great potential for adjusting thoughts and feelings.

Finally, consider this: Vanderbilt (2012), in discussing the term pedestrian, states "the Greek πεζός meant "prosaic, plain, commonplace, uninspired (sometimes contrasted with the winged flight of Pegasus)" (para 3). This is the bare and raw truth about walking with clients: it is simple, straightforward, plain, un-fancy, and practical rather than sensational. Perhaps this is part of why WT is so easily dismissed or frowned upon in some circles. At the same time, this is exactly what makes WT so intriguing and useful: walking is just right there waiting for therapists to take advantage of, and there is nothing in the research to suggest that this is an idea unworthy of further exploration.

.

References

Abcarian, R. (2017, Jul 5). A new twist on mental health: running with the therapist while discussing life's problems. *California Journal; Los Angeles Times.* Retrieved from: http://www.latimes.com/local/abcarian/la-me-abcarian-running-therapy-20170705-story.html

Allen, Jon G. (1995). *Coping with Trauma: A Guide to Self-Understanding*. Washington, DC: American Psychiatric Press.

American Psychiatric Association. (APA) (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Andrews, L. W. (Mar 22 2016). Walking through grief and healing: walking to cope with grief one step at a time. *Psychology Today*. https://www.psychologytoday.com/blog/minding-the-body/201603/walking-through-grief-and-healing

Archer, J. (1999). *The nature of grief: the evolution and psychology of reactions to loss (1).* New York, New York. Routledge. Retrieved from http://site.ebrary.com/lib/cityuniv/reader.action?docID=10097473 ISBN 0-203-36065-6

Aspinall, P., Mavros, P., Coyne, R., & Roe, J. (2015). The urban brain: Analysing outdoor physical activity with mobile EEG. *British Journal of Sports Medicine, 49*(4), p. 272-276. doi:10.1136/bjsports-2012-091877

Attig, T. (2010). *How we grieve : Relearning the world: Relearning the world* (Rev.2nd; ed.). USA: Oxford University Press – Special. Retrieved from: https://ebookcentral.proquest.com/lib/cityuseattle/reader.action?docID=3053957

Bartlett, R. C. & Collins, S. D. (2011).Introduction. In R.C. Bartlett & S. D. Collins (Trans) *Aristotle's Nicomachean Ethics.* Chicago: University of Chicago. Retrieved from:

https://books.google.ca/books?id=3JuePlN_03cC&pg=PR8 &dq#v=onepage&q&f=false

Barton, A. (2011, March 06). Walking groups help you through grief, step by step. *The Globe and Mail*. Retrieved from: http://www.theglobeandmail.com/life/relationships/walking-groups-help-you-through-grief-step-by-step/article570272/

Beauchemin, J., & Manns, J. (2008). Walking talking therapy. *Mental Health Today*, *34*(5). Retrieved from http://proxy.cityu.edu/login?url=https://search-proquest-com.proxy.cityu.edu/docview/212489408?accountid=1230

Beijng Scene. (n.d.). Ask Ayi: Walking backwards in Beijng. *Beijng Scene 5*(10): May 28–June 3. Retrieved from http://www.beijingscene.com/V05I010/ayi/ayi.htm

Ben-Ner, A., Hamann, D. J., Koepp, G., Manohar, C. U., & Levine, J. (2014). Treadmill workstations: The effects of walking while working on physical activity and work performance. *PloS One, 9*(2), e88620. doi:10.1371/journal.pone.0088620

Berger, R., & McLeod, J. (2006). incorporating nature into therapy: A framework for practice. *Journal of Systemic Therapies, 25*(2), p. 80-94. doi:10.1521/jsyt.2006.25.2.80

Berman, M. G., Jonides, J., & Kaplan, S. (2008). The cognitive benefits of interacting with nature. *Psychological Science, 19*(12), p. 1207-1212. doi:10.1111/j.1467-9280.2008.02225.x

Bigard, M. (2009). Walking the labyringht: an innovative approach to counseling center outreach. *Journal of College Counselling, 12*(2), p. 137-148.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*(1), p. 20-28. doi:http://dx.doi.org.proxy.cityu.edu/10.1037/0003-066X.59.1.20

Boss, P. (2007) Ambiguous loss theory: challenges for scholars and practitioners. *Family Relations, 56*, p. 105-111. DOI: 10.1111/j.1741-3729.2007.00444.x

Boss, P. (2010). The trauma and complicated grief of ambiguous loss. *Pastoral Psychology, 59*(2), p. 137-145. doi:http://dx.doi.org.proxy.cityu.edu/10.1007/s11089-009-0264-0

Boulanger, G. (2016, May 30). When is vicarious trauma a necessary therapeutic tool? *Psychoanalytic Psychology*. Advance online publication. http://dx.doi.org/10.1037/pap0000089Bovin

Bovin, M. J., and Marx, B. P. (2011). The importance of the peritraumatic experience in defining traumatic stress. *Psychol. Bull. 137*(47). doi: 10.1037/a0021353

British Columbia Provincial Mental Health & Practice Counsel (BCPMHPC) (2013). *Trauma-informed Practice Guide.* Retrieved from: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Brown, H. (2016, Mar 29). Virtual reality research and rehabilitation in the canadian forces: part 3. *CAOT's Occupational Therapy within the Military and Veterans Affairs Canada Network (MAVAN).* Retrieved from: https://otmavan.wordpress.com/2016/03/29/virtual-reality-research-and-rehabilitation-in-the-canadian-forces-part-3/

Browning Hamilton, R. (1936). Along the road. *A Book of Personal Poems*, W. R. Bowlin (Ed.). Chicago: Albert Whitman Company.

Burton, R. (1867). *Melancholy Anatomized: Causes, Consequences, and Cure with Anecdotic Illustration drawn from Ancient and Modern Sources and Principally Founded on the Larger Work Entitled Burton's Anatomy of Melancholy* (2nd ed.). London: William Tegg. Retrieved from: https://books.google.ca/books?id=6-

ZBAQAAIAAJ&printsec=frontcover&dq=inauthor:%22Robert+Burton%22&hl=en&sa=X&ved=0ahUKEwiYouyR5LrTAhVU9mMKHXqHDbUQ6AEINzAD#v=onepage&q&f=false

Burton, R. (2004). *The Anatomy of Melancholy* (Kindle edition). In K. Hagen & D. Moynihan (Ed. & Trans.). Project Gutenberg: EBook #10800.

Callahan, A. B. (2011). The parent should go first: a dance/movement therapy exploration in child loss. *American Journal of Dance Therapy, 33,* p. 182-198. DOI 10.1007/s10465-011-9117-3

Canadian Broadcasting Corporation (2015, Jun 8). *Experimental PTSD therapy gets traumatized soldiers walking toward relief.* Retrieved from http://proxy.cityu.edu/login?url=https://search-proquest-com.proxy.cityu.edu/docview/1686847023?accountid=1230

Carey, I.M., Shah, S.M., DeWilde, S., Harris, T., Victor, C.R., & Cook, D.G. Increased risk of acute cardiovascular events after partner bereavement matched cohort study. *JAMA Intern Med*. *174*(4). p. 598-605. doi:10.1001/jamainternmed.2013.14558 Retrieved from: http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1832196

Chandler, J. (2017). *Welcome to 8 Eaton South Mental Health Inpatient Unit at Toronto General Hospital: A Handbook for Patients.* University Health Network: Toronto. Retrieved from: http://www.uhn.ca/PatientsFamilies/Health_Information/Health_Topics/Documents/Inpatient_Psychiatry_TGH_EatonSouth8_Handbook.pdf

Chillag, A. (2017, Apr 5). It's spring! Take a walk with your therapist. *CNN Staying Well*. Retrieved from http://www.cnn.com/2017/04/05/health/sw-walk-and-talk-therapy/index.html

Clayton, P. J. & Darvish, H. S. (1979). Course of depressive symptoms following the stress of

bereavement. *Stress and mental disorder,* pp. 121-136.

Clayton, P., Desmarais, L., & Winokur, G. (1968). A study of normal bereavement. *The American Journal of Psychiatry, 125*(2), p. 168-178.

Clifton, S. (2014). Grieving my broken body: an autoethnographic account of spinal cord injury as an experience of grief. *Disability and Rehabilitation*, *36*(21), p. 1823-1829. DOI: 10.3109/09638288.2013.872202

Connor, S. R. & Monroe, B. (2012). Bereavement services provided under hospice model of care. In Neimeyer, R., Harris, D. Winokuer, H., & Thonton, G. (Eds.), *Grief and bereavement in contemporary society* (p. 325-337). New York, NY: Routledge.

Coverley, M. (2012). *Art of Wandering: The Writer as Walker*. Oldcastle Books: Harpenden 2012. Retrieved from: ProQuest Ebook Central.

Crone, D. (2007). Walking back to health: A qualitative investigation into service users' experiences of a walking project. *Issues in Mental Health Nursing, 28*(2), p. 167.

Darwin, C. (1872). Chapter iii: general principles of expression – concluded. *The Expression of the Emotions In Man and animals*. London: John Murray. Retrieved from https://cityu-illiad-oclc-org.proxy.cityu.edu/illiad/illiad.dll?Action=10&Form=75&Value=3694

De Quincey, T. (2001). *Suspiria De Profundis*. Proofed by JP MOURLON. Paris: Blackmask Online. Retrieved from: http://public-library.uk/ebooks/28/2.pdf

DeAngelis, T. (2013). A natural fit. *Monitor on Psychology, 44*(8). Retrieved from: http://www.apa.org/monitor/2013/09/natural-fit.aspx

Dench, L. N. (2002). Exercise and movement as an adjunct to group therapy for women with chronic mental illness. *Women & Therapy, 25*(2), p. 39-55.

DePrince, A. P. & Freyd, J. J. (2002). The harm of trauma: pathological fear, shattered

assumptions, or betrayal? In J. Kauffman (Ed.) *Loss of the Assumptive World: a theory of traumatic loss.* (p. 71 – 82). New York: Brunner-Routledge.

Devereaux, C. (2008). Untying the knots: Dance/movement therapy with a family exposed to domestic violence. *American Journal of Dance Therapy, 30*(2), p. 58-70. doi:10.1007/s10465-008-9055-x

Doucette, P. A. (2004). Walk-and-talk: An intervention for behaviorally challenged youths. *Adolescence, 39* (154), pp. 373-388. Retrieved from: http://search.proquest.com.proxy.cityu. edu/docview/195935637?pq-origsite=summon

Elliott, D. M. (1997). Traumatic events: Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology, 65*(5), p. 811-820. Retrieved from http://proxy.cityu.edu/login?url=http://search.proquest.com.proxy.cityu.edu/docview/210620254?accountid=1230

Elwert, F., PhD., & Christakis, Nicholas A, MD,PhD., M.P.H. (2008). The effect of widowhood on mortality by the causes of death of both spouses. A*merican Journal of Public Health, 98*(11), 2092-8. Retrieved from http://proxy.cityu.edu/login?url=http://search.proquest.com.proxy.cityu.edu/docview/215088490?accountid=1230

Fernandez-Alicant, M., Garcia-Caro, M. P., Montoro, C. H., & Cruz-Quintana, F. (2016). Feelings of loss and grief in parents of children diagnosed with autism spectrum disorder (ASD). *Research in Developmental Disabilities. 55.* Retrieved from https://cityu-illiad-oclc-org.proxy.cityu.edu/illiad/illiad.dll?Action=10&Form=75&Value=3636 DOI: 10.1016/j.ridd.2016.05.007

Forces in Mind Trust (FIMT). (2017, July 20). New forces in mind trust funded project: novel approach to treating post-traumatic stress disorder. *Latest news*. Retrieved from:

http://www.fim-trust.org/news/new-forces-mind-trust-funded-project-novel-approach-treating-post-traumatic-stress-disorder/

Freud, S. (1917). Mourning and Melancholia. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (1914-1916): On the History of the Psycho-Analytic Movement, Papers on Metapsychology and Other Works*, p. 237-258. Retrieved from: http://www.arch.mcgill.ca/prof/bressani/arch653/winter2010/Freud_Mourningandmelancholia.pdf

Gehart, D. (2014) *Mastering competencies in family therapy: a practical approach to theories and clinical case documentation*. Brooks/Cole, Cengage Learning: Belmont, CA

Gibson, Andrea (2014). The madness vase. *The Madness Vase* (Kindle Edition). SCB Distributors.

Gontang, A. (2009, July). The journey of a walking/ running therapist. Retrieved from: http://www.mindfulness.com/2009/07/06/the-journey-of-a-walkingrunning-therapist/

Goodland, K. (2006). *Resistant female grief in the english lazarus plays: "Us for to wepe no man may lett". Female Mourning and Tragedy in Medieval and Renaissance English Drama: From the Raising of Lazarus to King Lear.* Hampshire: Routledge. Retrieved from: https://books.google.ca/

Gordon, B. (2016). How I learnt to love therapy on the run. *Stuff Well & Good.* Retrieved from: http://www.stuff.co.nz/life-style/well-good/motivate-me/87960611/how-i-learnt-to-love-therapy-on-the-run

Gordon, N. (2012). Acute stress disorder. In C. R. Figley (Ed.), *Encyclopedia of trauma: An interdisciplinary guide* (p. 8-9). Thousand Oaks, CA: SAGE Publications Ltd. doi: 10.4135/9781452218595.n3

Grayeff, F. (1974). Chapter 1: life of aristotle. *Aristotle and his school; an inquiry into the history of the Peripatos with a commentary of Metaphysics [zeta], [eta], [lambda] and [theta]*. London: Duckworth.

Green, J. L., Skukauskaite, A. & Baker, W. D. (2011). Ethnography as epistemology. *Research Methods and Methodologies in Education*. Retrieved from http://www.academia.edu/1014039/Ethnography_as_epistemology_An_introduction_to_educational_ethnography

Gros, F. (2014) *A Philosophy of Walking* (Kindle Edition). (Tran. John Howe). London: Verso. eISBN-13: 978-1-78168-271-5 (US)

Gudmundsdottir, M. (2009). Embodied grief: Bereaved parents' narratives of their suffering body. *OMEGA — Journal of Death and Dying, 59*(3), p. 253-269. doi:10.2190/OM.59.3.e

Harvey, J. H., & Miller, E. D. (1998). Toward a psychology of loss. *Psychological Science, 9*(6), p. 429-434. doi:10.1111/1467-9280.00081

Hays, K. F. (1994). Running therapy: special characteristics and therapeutic issues of concern. *Psychotherapy, 31* (4), p. 725 – 734.

Hays, K. F., & Sime, W. E. (2014). Clinical applications of exercise therapy for mental health. In J. L. Van Raalte, & B. W. Brewer (Eds.), *Exploring Sport and Exercise Psychology (3rd ed.)*, p. 209-239. Washington, DC: American Psychological Association. DOI: http://dx.doi.org.proxy.cityu.edu/10.1037/14251-010

Hodgeson, H. (Mar 22, 2013). *Walking your way out of grief.* http://www.opentohope.com/walking-your-way-out-of-grief/

Hong, Y. J. & Jacinto, G. A. (2012). Reality Therapy and the Labyrinth: A Strategy for Practice. *Journal of Human Behavior in the Social Environment, 22*(6), p. 619-634. DOI:

10.1080/10911359.2012.655561

Hunt, H. (2004). *Joy-bearing Grief: Tears of Contrition in the Writings of the Early Syrian and Byzantine Fathers.* Leiden, NL: BRILL. Retrieved from: http://site.ebrary.com/lib/cityuniv/detail.action?docID=10171586

Island Health (2011). *Psychiatric Day Hospital Treatment Group Descriptions.* Retrieved from: https://www.viha.ca/NR/rdonlyres/C602CD1C-4350-4119-BED8-7BDB63AB2D00/0/DayHospitalGroupDescriptionsupdatedJuly2011.pdf

Johnson, C. S. (2002). Nutritional considerations for bereavement and coping with grief. *The Journal of Nutrition, Health & Aging, 6*(3).

Jordan, M., & Marshall, H. (2010). Taking counselling and psychotherapy outside: Destruction or enrichment of the therapeutic frame? *European Journal of Psychotherapy & Counselling, 12*(4), p. 345-359. DOI: 10.1080/13642537.2010.530105

Jung, C. (2011). *Walk-and-talk career counseling: A holistic intervention for indecisiveness* (Master's Thesis). Retrieved from http://search.proquest.com/docview/914240536

Kalaga, W. (2013). Introduction: grieving, knowledge, wisdom. In Zbigniew Białas, Paweł Jędrzejko and Julia Szołtysek (eds.) *Culture and the Rites/ Rights of Grief.* Cambridge Scholars Publishing: Newcastle. Retrieved from http://www.cambridgescholars.com/download/sample/58420

Kassavou, A., Turner, A., & French, D.P. (2015). The role of walkers' needs and expectations in supporting maintenance of attendance at walking groups: a longitudinal multi-perspective study of walkers and walk group leaders. *PLoS ONE 10*(3), p. 1 - 15. doi:10.1371/journal.pone.0118754

Kelly, T. (2008, Mar 31). Walking the talk therapy. *City Room: The New York Times.* Retrieved

from: https://cityroom.blogs.nytimes.com/2008/03/31/walking-the-talk-therapy/?mcubz=0&_r=0

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and ptsd prevalence using dsm-iv and dsm-5 criteria. *Journal Of Traumatic Stress*, *26*(5), p. 537-547.

King, K. (2015). *The Shared Experiences of Counselors Who Practice in Natural Environments* (Doctoral dissertation). ProQuest Number: 3736694

King, L. S., Osofsky, J. D., Osofsky, H. J., Weems, C. F., Hansel, T. C., & Fassnacht, G. M. (2015). Perceptions of trauma and loss among children and adolescents exposed to disasters a mixed-methods study. *Current Psychology, 34*(3), 524-536. doi:http://dx.doi.org.proxy.cityu.edu/10.1007/s12144-015-9348-4

Klinic Community Health Centre (2013). *Trauma-Informed: The Trauma Toolkit* (2nd ed.). Retrieved from: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

Knox, C. (2017, Aug, 13). Move on up: enhance your quality of life by dynamic running therapy. *Sunday Express.* Retrieved from: http://www.express.co.uk/life-style/life/838844/Dynamic-Running-Therapy-health-fitness-exercise

Kofod, E. H. (2015). Grief as a border diagnosis. *Ethical Human Psychology and Psychiatry, 17*(2), 109-124. Retrieved from http://proxy.cityu.edu/login?url=http://search.proquest.com.proxy.cityu.edu/docview/1727434556?accountid=1230

Kostrubala, T. (2013). *The Joy of Running* (Kindle Edition). Santa Fe: Ora Productions.

Kübler-Ross, K. D. (2005). *On grief and grieving: finding the meaning of grief through the five stages of loss.* London: Simon & Schuster.

L'Engle, M. (1994). Foreword. In C. S. Lewis (Auth) *A Grief Observed.* Retrieved from: https://korycapps.files.wordpress.com/2012/11/cs-lewis-a-grief-observed.pdf

Laërtius, D. (1925). Book v. In R. D. Hicks (Trans) *Lives of Eminent Philosophers.* Retrieved from: https://en.wikisource.org/wiki/Lives_of_the_Eminent_Philosophers/Book_V

Lange, C. G. (1895). *Les emotions; etude psychophysiologique*. Paris: Felix Alcan. Retrieved from: https://play.google.com/books/reader?id=h4YFAQAAIAAJ&printsec=frontcover&output=reader&hl=en&pg=GBS.PP14

Leseho, J., & Maxwell, L. R. (2010). Coming alive: creative movement as a personal coping strategy on the path to healing and growth. *British Journal Of Guidance & Counselling, 38(*1), p. 17-30. doi:10.1080/03069880903411301

Lewis, C. S. (1994). *A Grief Observed.* Retrieved from: https://korycapps.files.wordpress.com/2012/11/cs-lewis-a-grief-observed.pdf

MacDonald, M. (1981). *Mystical Bedlam: Madness, Anxiety and Healing in Seventeenth-Century England*. Cambridge University Press: Cambridge. Retrieved from https://books.google.ca/books?id=P5bmPMT4cZwC&q=grief#v=onepage&q&f=false

Magner, E. (2017, Jun 20). Therapists are now seeing patients on the run – here's why. *Well+Good.* Retrieved from: https://www.wellandgood.com/good-sweat/run-walk-therapy-benefits/

Maher, K. (2017, Jun 25). Stressed out? try 'walk and talk' therapy for a change of pace. *MichiganLive*. Retrieved from: http://www.mlive.com/news/ann-arbor/index.ssf/2017/06/therapy_walking_from_the_offic.html

Marselle, M. R., Irvine, K. N., & Warber, S. L. (2013). Walking for well-being: Are group walks in certain types of natural environments better for well-being than group walks in urban

environments? *International Journal of Environmental Research and Public Health, 10*(11), p. 5603-5628. doi:10.3390/ijerph10115603

Maxted, A. (2017, Jan 8). Can walking with a therapist really cure my anxiety? why it's unlike any counselling session I've had before. *DailyMail UK*. Retrieved from: http://www.dailymail.co.uk/femail/article-4100234/Can-walking-therapist-REALLY-cure-anxiety-s-unlike-counselling-session-ve-before.html

McCaffrey, R., & Liehr, P. (2016). The effect of reflective garden walking on adults with increased levels of psychological stress. *Journal of Holistic Nursing : Official Journal of the American Holistic Nurses' Association, 34*(2), p. 177.

McCaffrey, R., Liehr, P., Gregersen, T., & Nishioka, R. (2011). Garden walking and art therapy for depression in older adults: A pilot study. *Research in Gerontological Nursing, 4*(4), p. 237. doi:10.3928/19404921-20110201-01

McDevitt, J., Wilbur, J., Kogan, J., & Briller, J. (2005). A walking program for outpatients in psychiatric rehabilitation: Pilot study. *Biological Research for Nursing, 7*(2), p. 87.

McKinney, B. L. (2011). *Therapists Perceptions of Walk and Talk therapy: a grounded study* (Doctoral dissertation). Retrieved from: http://austintalktherapy.com/images/McKinney Dissertation.pdf

Merom, D., Phongsavan, P., Wagner, R., Chey, T., Marnane, C., Steel, Z., . . . Bauman, A. (2008). Promoting walking as an adjunct intervention to group cognitive behavioral therapy for anxiety disorders: a pilot group randomized trial. *Journal of Anxiety Disorders, 22*(6), 959.

Milligan, L. (2015, Apr 9). Therapy on the run. *Vouge UK*. Retrieved from: http://www.vogue.co.uk/article/dynamic-running-therapy-psychoanalysis-outdoors-

william-pullen

Moody, R., Jr., & Arcangel, D. (2001). *Life after loss: Conquering grief and finding hope*. New York: HarperCollins Publishers. Retrieved from http://browseinside.harpercollins.ca/index.aspx?isbn13=9780062517302

Moote, A. L. & Moote, D. C. (2008). *The Great Plague: The Story of London's Most Deadly Year*. John Hopkins University Press: Baltimore. Retrieved from http://site.ebrary.com/lib/cityuniv/reader.action?docID=10256354

Moules, N. J., Simonson, K., Fleiszer, A. R., Prins, M., & Glasgow, R. B. (2007). The soul of sorrow work: Grief and therapeutic interventions with families. *Journal of Family Nursing, 13*(1), p. 117.

Moules, N. J., Simonson, K., Prins, M., Angus, P., & Bell, J. M. (2004). Making room for grief: Walking backwards and living forward. *Nursing Inquiry, 11*(2), 99.

Napier, J. (1967) The antiquity of human walking. *Scientific American.* Retrieved from: https://learning.hccs.edu/faculty/molly.morgan/anth2301/course-materials/the-antiquity-of-human-walking

Neely, K. (2017, Feb 13). Trailtalk: provo office providing therapy with a walking twist. *Daily Herald.* Retrieved from: http://www.heraldextra.com/business/local/trailtalk-provo-office-providing-therapy-with-a-walking-twist/article_5e25ec90-fd7b-5480-8f20-8d3c9f997fde.html

Neimeyer, R. & Sands, D. (2011). Meaning reconstruction in bereavement: From principles to practice. In Neimeyer, R., Harris, D. Winokuer, H., & Thonton, G. (Eds.), *Grief and bereavement in contemporary society*, p. 9-22. New York, NY: Routledge.

Neimeyer, R. A., Harris, D. L., Winokuer, H. R., & Thornton, G. F. (Eds.). (2011). *Grief and*

Bereavement in Contemporary Society: Bridging Research and Practice (Kindle Edition). New York: Taylor and Francis.

NewsRx (staff reporter). (2017, Aug 13). Post-Traumatic Stress Disorders: novel approach to treating post-traumatic stress disorder. *NewsRx Health & Scienc, 193*.

Nguyen, S. D. (2008). Abstract. *Simultaneous Technique of Exercise and Psychotherapy (STEP) as an adjunct to multidisciplinary treatment in acute inpatient psychiatric hospitalized older adults with depressive symptoms* (Doctoral dissertation). Retrieved from: http://search.proquest.com.proxy.cityu.edu/docview/89208410/abstract/1B341A7D3FB14590PQ/1?accountid=1230

Nguyen, S., Marshak, H., Dos Santos, H., Luu, S., Berk, L., McMahon, P., & Riggs, M. (2014). The effects of simultaneous exercise and psychotherapy on depressive symptoms in inpatient, psychiatric older adults. *Advances 28*(4), p. 8-17.

Nietzsche, F. (2014). *The Joyful Wisdom (10th ed)* (Kindle Edition). Tran T. Common. Ed O. Levy. Retrieved from: https://ebooks.adelaide.edu.au/n/nietzsche/friedrich/n67j/index.html

Noffke, S. (2014). *Awoken: A Dreamer's Journey (The Lucidites Book 1)* (Kindle Edition). One-Twenty-Six Press.

Northcut, T. B., & Kienow, A. (2014). The trauma trifecta of military sexual trauma: A case study illustrating the integration of mind and body in clinical work with survivors of MST. *Clinical Social Work Journal, 42*(3), p. 247-259. doi: http://dx.doi.org.proxy.cityu.edu/10.1007/s10615-014-0479-0

O'Sullivan, A. (2017, Aug 7). This therapist takes her sessions off the couch and onto the roads. *Runner's World*. Retrieved from: https://www.runnersworld.com/general-interest/this-

therapist-takes-her-sessions-off-the-couch-and-onto-the-roads

Oppezzo, M., & Schwartz, D. L. (2014). Give your ideas some legs: The positive effect of walking on creative thinking. *Journal of Experimental Psychology. Learning, Memory, and Cognition, 40*(4), p. 1142-1152. doi:10.1037/a0036577

Oxford English Dictionary (OED). (2017a). Grief. In *Oxford English Dictionary Online* (2nd ed.). Retrieved from http://www.oup.com

Oxford English Dictionary (OED). (2017b). Trauma. In *Oxford English Dictionary Online* (2nd ed.). Retrieved from http://www.oup.com

Packham, A. (2015, Jun 5). Dynamic running therapy with a stranger made me feel completely empowered. *HuffPost UK.* Retrieved from: http://www.huffingtonpost.co.uk/2015/06/04/dynamic-running-therapy_n_7441660.html

Pamela (2014, Dec 30). Breathing and healing [Amazon.com customer review]. Retrieved from: https://www.amazon.com/Grief-Walking-Prayerful-Steps-Healing-After/dp/0870293168

Papa A, Lancaster N, Kahler J. (2014). Commonalities in grief responding across bereavement and non-bereavement losses. *Journal of Affective Disorders, 161*, p. 136–143.

Papa, A., & Maitoza, R. (2013). The role of loss in the experience of grief: The case of job loss. *Journal of Loss and Trauma, 18*(2), p. 152-169. DOI:: 10.1080/15325024.2012.684580

Park, C. L., & Halifax, R.J. (2011). Religion and spirituality in adjusting to bereavement: Grief as burden, grief as gift. In Neimeyer, R., Harris, D. Winokuer, H., & Thonton, G. (Eds.), *Grief and bereavement in contemporary society* (p. 355-363). New York, NY: Routledge.

Parkes, C. M. (2011). Introduction: the historical landscape of loss: development of bereavement studies. In R. A. Neimeyer, D. L. Harris, H.R. Winokuer, & G. F. Thornton (Eds.), *Grief*

and Bereavement in Contemporary Society: Bridging Research and Practice (p.1-8). New York: Routledge Taylor & Francis Group.

Parkes, C. M., Benjamin, B., & Fitzgerald, R. G. (1969). Broken heart: A statistical study of increased mortality among widowers. *The British Medical Journal, 1*(5646), p. 740-743. doi:10.1136/bmj.1.5646.740

Pasquariello, C. D. (2011). Let's get physical: the role of physical activity in the training of graduate mental health students (Master's Thesis).

Payne, P., & Crane-Godreau, M. A. (2015b). The preparatory set: A novel approach to understanding stress, trauma, and the bodymind therapies. *Frontiers in Human Neuroscience*, *9*, p. 178.

Payne, P., Levine, P. A., & Crane-Godreau, M. A. (2015a). Somatic experiencing: Using interoception and proprioception as core elements of trauma therapy. *Frontiers in Psychology*, *6*(FEB), p. 1–18. https://doi.org/10.3389/fpsyg.2015.00093

Pearlman, L. (2012). Vicarious trauma. In C. R. Figley (Ed.), *Encyclopedia of trauma: An interdisciplinary guide* (p. 783-786). Thousand Oaks, CA: SAGE Publications Ltd. doi: 10.4135/9781452218595.n271

PESI Publishing & Media (2011). *Trauma, Attachment & Neuroscience* [Video File]. Van der Kolk, B. (Presenter). Retrieved March 23, 2017, from Academic Video Online: Premium.

PESI Publishing & Media (2016, Jan 12). *Trauma & The Body: Sensorimotor Psychotherapy* [Video file]. J. Fisher (Presenter). Retrieved March 23, 2017, from Academic Video Online: Premium at https://search-alexanderstreet-com.proxy.cityu.edu/view/work/3399181

Pillai-Friedman, S., & Ashline, J. (2014). Women, breast cancer survivorship, sexual losses, and disenfranchised grief – a treatment model for clinicians. *Sexual & Relationship Therapy*, *29*(4), p. 436-453.

Plante, T. G., Gores, C., Brecht, C., Carrow, J., Imbs, A., & Willemsen, E. (2007). Does exercise environment enhance the psychological benefits of exercise for women? *International Journal of Stress Management, 14*(1), p. 88-98. doi:10.1037/1072-5245.14.1.88

Plato (n.d.a). In B. Jowett (Trans) *Symposium.* Retrieved from http://classics.mit.edu/Plato/symposium.html

Plato (n.d.b). In B. Jowett (Trans) *Theaetetus.* Retrieved from: http://classics.mit.edu/Plato/theatu.html

Priest, P. (2007). The healing balm effect: Using a walking group to feel better. *Journal of Health Psychology, 12*(1), p. 36.

Prieto, L. R. (2011). Introduction to the special section on grief, loss, and bereavement. *Journal of Mental Health Counseling, 33*(1), p. 1-3. Retrieved from http://proxy.cityu.edu/login?url=http://search.proquest.com.proxy.cityu.edu/docview/851297996?accountid=1230

Psychotherapy Networker (2012). *The Body in Trauma Work* [Video file]. P. Ogden (Interviewee) & R. Simon (ed.). Retrieved March 24, 2017, from Academic Video Online: Premium.

Psychotherapy Networker (2014, Aug 11). *Bessel van der kolk explains what trauma is* [Video File]. B. Van der Kolk. (Interviewee) & R. Simon (Interviewer/ Editor). Retrieved from https://www.youtube.com/watch?v=6vwNX0Qo1IA

Rahman, M.Z., El Werfalli, R., & Lehmann-Waldau, F. (2017) current evidence and use of

physical activity in the treatment of mental illness: a literature review. *Deutsche Zeitschrift Für Sportmedizin, 68*, p. 93-100. DOI: 10.5960/dzsm.2017.279

Raine, A. (2000). Walk with grief. *Celtic daily prayer.* From the Northumbria Community. London: HarperCollins. ISBN 0551032669

Revell, S., & McLeod, J. (2016). Experiences of therapists who integrate walk and talk into their professional practice. *Counselling and Psychotherapy Research, 16*(1), p. 35-43. doi:10.1002/capr.12042

Richardson, K. M. (2015). Sharing stories of the 9/11 experience: an exploratory study of the tribute walking tour program. *Journal of Loss and Trauma, 20*. DOI: 10.1080/15325024.2013.819276

Ringel, S. (2010). Overview. *Trauma: Contemporary Directions in Theory, Practice, and Research.* Sage Publications. DOI: http://dx.doi.org/10.4135/9781452230597.n1

Robertson, R., Robertson, A., Jepson, R. & Maxwell, M. (2012) Walking for depression or depressive symptoms: a systematic review and meta-analysis, *Mental Health and Physical Activity*, *5* (1), p. 66-75.

Ruggiero, S. *Effectiveness of Mindful Walking on Anxiety, Depression, Sleep, Mood, Mindfulness, Physical Self-Efficacy and Activity* (Doctoral Dissertation). ProQuest Number: 3723116.

Salloum, A. & Overstreet, S. (2008). Evaluation of individual and group grief and trauma for children post disaster. *Journal of Clinical Child & Adolescent Psychology, 37*(3), p. 495-507.

Sandor, M. K., & Froman, R. D. (2006). Exploring the effects of walking the labyrinth. *Journal of Holistic Nursing : Official Journal of the American Holistic Nurses'*

Association, 24(2), p. 103.

Sauve, W. M. (2013). Posttraumatic stress disorder: what have we learned in 3000 years? *CNS Spectrums, 18*, p. 69–70. doi:10.1017/S1092852913000175

Schwartz, A. (2008). *Mind -body therapies: Beliefs and practices of professional psychologists* (Doctoral dissertation). Retrieved from: https://search-proquest-com.proxy.cityu.edu/docview/304835744?pq-origsite=summon

Scott, D. A., & Duerson, L. M. (2010). Continuing the discussion: A commentary on "wilderness therapy: Ethical considerations for mental health professionals". *Child & Youth Care Forum, 39*(1), p. 63-68. doi:http://dx.doi.org.proxy.cityu.edu/10.1007/s10566-009-9090-x

Shah, A. (2014, Feb 24). Walk and talk therapy may be gaining ground. *Star Tribune*. Retrieved from: http://www.startribune.com/walk-and-talk-therapy-may-be-gaining-ground/246937041/

Shand, A. F. (1914). *The Foundations of Character: Being a Study on the Tendencies of the Emotions and Sentiments.* London: Macmillan & Co.

Shapiro, F. & Forrest, M. S. (2016). *EMDR: The Breakthrough therapy for overcoming anxiety, stress, and trauma.* New York: Basic Books. Retrieved from https://books.google.ca/books?id=lynXCwAAQBAJ&pg=PT205&lpg=PT205&dq=van+emdr&source=bl&ots=0Rn7trUy0d&sig=MqNywAbLisIw20sUzuCqk6sqGnU&hl=en&sa=X&ved=0ahUKEwiMkLv4uIHTAhVN9mMKHWEtATwQ6AEIQTAF#v=onepage&q=van%20emdr&f=false

Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N.,… Keshaviah, A. (2011). Complicated grief and related bereavement issues for dsm-5. *Depression and Anxiety, 28*(2), p. 103–117. http://doi.org/10.1002/da.20780

Shelley, C. (2015). The three registers: an instrumental metaphor in adlerian counselling therapy, training and supervision. *UK Adlerian Yearbok*, p. 11-36.

Sheth, H., Gandhi, Z., & Vankar, G. (2010). Anxiety disorders in ancient indian literature. *Indian Journal of Psychiatry, 52*(3), p. 289-291. doi:http://dx.doi.org.proxy.cityu.edu/10.4103/0019-5545.71009

Solnit, R. (2014). *Wanderlust: A History of Walking* (Kindle Edition). Granta Books.

Solomon, E. P., Solomon, R. M., & Heide, K. M. (2009). EMDR: An evidence-based treatment for victims of trauma. *Victims & Offenders, 4*(4), 391-397. doi:10.1080/15564880903227495

Stanton, R. & Reaburn, P. (2014). Exercise and the treatment of depression: a review of the exercise program variables. *Journal of Science and Medicine in Sport, 17,* p. 177-182.

Stauffer, C. (2014). Walk and talk: therapist takes her counseling sessions to local trails. *LancasterOnline.* Retrieved from: http://lancasteronline.com/lancaster/news/walk-and-talk-therapist-takes-her-counseling-sessions-to-local/article_945fb0ec-f0ac-11e3-95c0-0017a43b2370.html

Street Wisdom (2017). *How to Host and Lead your own Street Wisdom event.* Retrieved from: https://www.streetwisdom.org/wp-content/uploads/2016/01/Street-Wisdom-Guide-2017.pdf

Street Wisdom (n.d.). https://www.streetwisdom.org/about/

Tan, L., Zhang, L., Qi, R., Lu, G., Li, L., Liu, J., & Li, W. (2013). Brain structure in post-traumatic stress disorder: *A voxel-based morphometry analysis*. *Neural Regeneration Research*, *8*(26), p. 2405–2414. http://doi.org/10.3969/j.issn.1673-5374.2013.26.001

Teasdale, J., Williams, M., Segal, Z. (2014). *The Mindful Way Workbook: An 8-Week Program*

to Free Yourself from Depression and Emotional Distress. New York: Guilford.

Tennyson, A. L. (1895). *In Memoriam.* Boston: Houghton, Mifflin & Co.. Retrieved from https://ia802604.us.archive.org/8/items/inmemoriambyalfr00tennuoft/inmemoriambyalfr00tennuoft_bw.pdf

Teut, M., Roesner, E. J., Ortiz, M., Reese, F., Binting, S., Roll, S., . . . Brinkhaus, B. (2013). Mindful walking in psychologically distressed individuals: A randomized controlled trial. *Evidence-Based Complementary and Alternative Medicine*, p. 1-7. doi:10.1155/2013/489856

Tripp, T. (2007). A short term therapy approach to processing trauma: art therapy and bilateral stimulation. *Art Therapy: Journal of the American Art Therapy Association, 24*(4), p. 176-183.

Vable, A. M., Subramanian, S. V., Rist, P. M., & Glymour, M. M. (2015). Does the "widowhood effect" precede spousal bereavement? results from a nationally representative sample of older adults. *The American Journal of Geriatric Psychiatry, 23*(3), p. 283-292. doi:http://dx.doi.org.proxy.cityu.edu/10.1016/j.jagp.2014.05.004

Vanderbilt, T. (2012 Apr 10). The crisis in american walking: how we got off the pedestrian path. *Slate.* Retrieved from: http://www.slate.com/articles/life/walking/2012/04/why_don_t_americans_walk_more_the_crisis_of_pedestrianism_.html

Van der Kolk, B. A. & McFarlane, A. C. (1996). The black hole of trauma. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (eds.), *Traumatic stress: the overwhelming experience on mind, body, and society* (pp. 3-23). New York, NY: The Guilford Press. Retrieved from: https://ebookcentral.proquest.com/lib/cityuseattle/reader.action?docID=330594

Van der Kolk, B. A. (2014). *The Body Keeps Score: Brain, Mind, and Body in the Healing of Trauma.* Penguin Books: New York

Van der Kolk, B.A, Weisaeth, L., & Van der Hart, O. (1996). Preface to the paperback edition. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (eds.), *Traumatic stress: the overwhelming experience on mind, body, and society* New York, NY: The Guilford Press. Retrieved from: https://ebookcentral.proquest.com/lib/cityuseattle/reader.action?docID=330594

Van der Kolk, B.A. (1996). Trauma and memory. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (eds.), *Traumatic stress: the overwhelming experience on mind, body, and society.* New York, NY: The Guilford Press. Retrieved from: https://ebookcentral.proquest.com/lib/cityuseattle/reader.action? docID=330594

Vereniging EMDR Nederland (VEN EMDR) (2014). *EMDR interview Francine Shapiro* [Video File]. J. Spierings (interviewer) & F. Shapiro (Interviewee). Retrieved from https://www.youtube.com/watch?v=8GUd5hhnkVE

Victoria Hospice (2017) *Support Following a Death*. Retrieved from https://www.victoriahospice.org/counselling-care/support-following-death

Walk with a Doc (n.d.) http://walkwithadoc.org/

Walter C.A. & McCoyd, J. L. (2009) *Grief and loss across the lifespan: a biopsychosocial perspective.* New York: Springer. Retrieved from: https://books.google.ca/books?id=WwwKhOq02VkC&printsec=frontcover#v=onepage&q&f=false

White, P. D., Goldsmith, K. A., Johnson, A. L., Potts, L., Walwyn, R., DeCesare, J. C.,… PACE trial management group. (2011). Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic

fatigue syndrome (PACE): A randomised trial. *The Lancet, 377*(9768), p. 823-836. doi:10.1016/S0140-6736(11)60096-2

Winokuer, H. R. & Harris, D. L. (2012). *Principles and practice of grief counseling.* New York: Springer Publishing Company.

Worden, J. William. (2008). *Grief counseling and grief therapy, fourth edition : A handbook for the mental health practitioner* (4th; ed.). New York: Springer Publishing Company. Retrieved from: https://ebookcentral.proquest.com/lib/cityuseattle/reader.action?docID=423643

Worden, J.W. & Winokuer, H. R. (2012). A task-based approach for counseling the bereaved. In Neimeyer, R., Harris, D. Winokuer, H., & Thonton, G. (Eds.), *Grief and bereavement in contemporary society* (p. 57-58). New York, NY: Routledge.

Wright, S. (2008, Apr 11). Walk and talk therapy: Exercise is good for the body and the mind. It may improve psychotherapy sessions, too. *WebMd.* Retrieved from http://www.webmd.com/balance/features/walk-and-talk-therapy

Yablon, M. (2013, Sep 22). Walk therapy. *The Poughkeepsie Journal.* Retrieved from http://proxy.cityu.edu/login?url=https://search-proquest-com.proxy.cityu.edu/docview/1434605256?accountid=1230

Yalom, I. (2005). *The Theory and Practice of Group Psychotherapy(5th ed)* (Kindle edition). New York: Basic Books.

Zachary, L. B. (2011). *When men cry: male demonstrations of grief in beowulf, the song of roland, and sir orfeo* (Master's Thesis). Retrieved from: http://scholarworks.uark.edu/cgi/viewcontent.cgi?article=1090&context=etd

Zepinic, V. (2011). *Hidden Scars: Understanding and Treating Complex Trauma.* Xlibris

Corporation.

Zhang, B., El-Jawahri, A., & Prigerson, H. G. (2006). Update on bereavement research: Evidence-based guidelines for the diagnosis and treatment of complicated bereavement. *Journal of Palliative Medicine, 9*(5), p. 1188.

Zisook, S. Sheer, K. (2009). Grief and bereavement: what psychiatrists need to know. *World Psychology, 8,* p. 67-74.

Zucker, D. M., & Sharma, A. (2012). Labyrinth walking in corrections. *Journal of Addictions Nursing, 23*(1), 47.

Appendix A

List of Websites of some Therapists Offering WT

Bercier, M. http://elmhurstwalkandtalk.com/

Brokamp, E. http://www.alexandriawomenscounseling.com/walk-talk-therapy/#sthash.MRmhTeOE.dpbs

Brown, M. http://walkandtalktherapist.com/

Cockrell, C. http://walkandtalk.com/

Growth Counselling Services. http://www.growthcounselingservices.com/walk-talk-therapy-glendora-ca

McCoy, S. http://www.walk-n-talk.org/

Rosenbloom, T. & Jennifer (no last name provided) http://www.walktalktherapymn.com/

Ryan, W. http://walkandtalkottawa.ca/

Shull, M. http://www.therapydoylestown.com/walk-talk-therapy/

Wetmore, E. http://www.wetmorecounselling.ca/

Note: This list is not exhaustive, and would be expanded on for my thesis. For example, McKinney (2011) found 27 therapists advertising WT online in North America. Revell and McLeod (2016) found 32 therapists in the UK advertising WT.

Links to sites offering WT Client Testimonials

http://www.dailymail.co.uk/femail/article-4100234/Can-walking-therapist-REALLY-cure-anxiety-s-unlike-counselling-session-ve-before.html

http://www.walktalktherapymn.com/testimonial/

http://www.walkandtalk.com/testimonials.html

https://www.streetwisdom.org/reviews/

http://www.walkandtalktherapy.ie/testimonials-archive/

https://www.walkandtalkuk.org/testimonials

http://walkandtalk.ca/testimonials/

Appendix B

Summary of Information Collected from Lower Mainland Hospice Websites

Below is a list of all the hospices I could find in the Lower Mainland area. I have reviewed the information on these sites and compiled a summary of services, training conditions for volunteer walk facilitators, and information on the walking group sessions.

Hospice Websites Accessed.

Burnaby Hospice Society http://burnabyhospice.org/

Canuck Place Children's Hospice http://www.canuckplace.org/

Crossroads Hospice Society http://www.crossroadshospice society. com/

Delta Hospice Society https://deltahospice.org/

Fraser Canyon Hospice Society http://www.frasercanyonhospice.org/our-programs.html

Langley Hospice Society http://langleyhospice.com/

Mission Hospice http://www.missionhospice.bc.ca/

White Rock South Surrey Hospice Society http://www.whiterockhospice.org/

Vancouver Hospice Society http://www.vancouverhospice.org/

Victoria Hospice http://www.victoriahospice.org/

Summary of Services. Burnaby Hospice Society, White Rock South Surrey Hospice, Delta Hospice Society, Vancouver Hospice Society, and Langley Hospice use a registered clinical counsellor for individual, family, and group counselling and offer walking groups supported by trained volunteers. Fraser Canyon Hospice Society in Hope and Crossroads Hospice Society (serving Coquitlam, Port Coquitlam, Port Moody, New Westminster) do not use a clinical therapist for any of the support programs, but do include volunteer supported walking groups and grief groups. Mission Hospice, Canuck Place Hospice do not appear to have walking

groups based on the information available on the agency websites. Victoria Hospice includes a walking group; it is a silent walking group focussed on mindfulness. No sites use a clinical counsellor during the walking groups. Some sites require the clinical counsellor to place participants in the walking group, some sites allow any bereaved person to access the group with no pre-screening. Some sites require an extended period of grieving (six months to one year) as a criteria to access walking groups.

Training. Volunteer training at the hospices tends to be approximately 20 – 30 hours depending on the site. All hospices require volunteers to complete training to volunteer in a supportive role. Some sites have the clinical counsellor provide the training. The websites that discuss volunteer training suggest that positive regard, active listening, and empathy are the core qualities volunteers are taught and expected to use.

Walking Group Sessions, Length and Duration. Length of walking group tends to be around 1-2 hours once a week. Access to Walking Groups can be as short as 6 weeks and as long as 1.5 years.

Appendix C

More Information and Tidbits on Concepts Mentioned Throughout this Thesis

Military Motion Memory Desensitization and Reprocessing (3MDR). If one is interested in seeing how deeply realistic the 3MDR experience can be, an informative video of the Computer-Assisted Rehabilitation Environment (CAREN) system in Ottawa used in this study can be seen here: http://www.ohri.ca/rehabilitation/RVRLab.aspx or seen in action with treating PTSD for veterans here http://www.ptsd-forum.net/post-traumatic-stress-disorder/video-post-traumatic-stress-disorder/experimental-ptsd-therapy/

Walking for Health Program. More information about this program can be found at https://www.walkingforhealth.org.uk/ which includes a link to a report called *Walking Works: Making the Case to Encourage Greater Uptake of Walking as a Physical Activity and Recognize the Value and Benefits of Walking for Health* by Des de Moor and The Ramblers (n.d.) (based on the reference list, which includes works from 2013, it is a fairly recent document). This report could be a useful resource for WT practitioners.

Garden Walking Program. A video on the Japanese Garden Walking program mentioned in Chapter IX can be found at https://www.youtube.com/watch?v=juDP3JCaA2o. This offers a very personalized interaction opportunity for anyone interested in the idea of using mindful walking, reflection, and/or walking therapy. On this video, one cancer survivor shares the grief, trauma, and loss due to cancer and the recovery she has through this program. Another person shares how his PTSD has been processed by participation in the program. Another participant with PTSD describes being able to use the images of aspects of the garden to self-regulate, find peace, and move forward in life. Another participant speaks to recapturing serenity

and joy through the experience. A final interviewee speaks to the ability to take back control among many wonderful features as notable.

Labyrinth Finder. This is a site listing labyrinths around the world: https://labyrinthlocator.com/. Actually, it is certain that there are more labyrinths than listed here. For example, there is one in Port Moody, BC that was made by the hospice there, which is not on the list.

Appendix D

A Brief Exploration of Five Historical Walkers

Plato & Socrates. It is somewhat commonly believed that Plato walked and talked as part of his teaching process (Gros, 2014). In theory, this would be the first documented example of the practice of using walking to enhance thinking. However, I have not found evidence of this. What I have found is that in one of his works, *Symposium*, Plato's (n.d.a)[17] narrator, in preparing to tell the story, and establishing himself as knowing what he is about to speak to, says:

> And so we walked, and talked of the discourses on love; and therefore, as I said at first, I am not ill-prepared to comply with your request, and will have another rehearsal of them if you like. For to speak or to hear others speak of philosophy always gives me the greatest pleasure, to say nothing of the profit. (para 7)

Being that this is the voice of the narrator, a fictitious character, it is important to remember that although the suggestion is made that walking and talking was an activity associated with philosophic discussion, this could be simply a case of colouring the story. Further, if philosophers did walk and talk, this could be simply circumstantial rather than intentionally linked to improving thoughts. It is not known from this excerpt whether walking and talking about philosophy was a common activity for Plato or any other philosopher.

However, Gros (2014) cites Diogenes Laërtius (1925), who lived sometime around the 3rd century AD, in his work, *Lives of Eminent Philosophers,* as having made passing reference to Plato teaching while walking. Gros argues that Plato's mentor, Socrates, is well known to have always been on the move, and wonders whether Plato may have emulated this characteristic as well. At the same time, Gros points out that for Socrates, it was not the walking that was

[17] Plato's works, as translated by Benjamin Jowett, are noted as Jowett as being written in 360 B.C.E.

imperative, it was the ability to meet and interact with people. Furthermore, per Gros, Socrates is depicted in Plato's *Phaedrus* as being "indifferent to walking, resistant to the countryside: Nature had not enough to say to him" (p. 129). Conversely, Plato (n.d.b) scripts Socrates in *Theaetetus* as saying, "And is not the bodily habit spoiled by rest and idleness, but preserved for a long time by motion and exercise?" Coverley (2012) suggests that while Socrates was known to walk, it seems to have been only as a means to an end, with no indication that philosophers at the time made any connection to walking enhancing discussion.

In sum, it is unclear what exactly Plato and Socrates did; did they walk with students as part of the teaching process, did they walk at all while teaching, did they believe that exercise was useful for enhancing mental function, or is it all speculation? Although there is no clear answer, it is relevant to WT practitioners to note the likelihood of a long lineage of walking and talking with a person in a position of responsibility/ authority/ of counsel and their patron. As will be discussed further, issues around boundary-setting concerns are common among WT clinicians (Revell & McLeod, 2016; Hays & Sime, 2014; McKinney, 2011; Pasquariello, 2011; Beauchemin & Manns, 2008; Schwartz, 2008), so it is important to recognize that something similar in practice has likely been done for centuries.

Aristotle. There is a common belief that Aristotle had a habit of walking with his students while teaching (Bartlett & Collins, 2011; Solnit, 2014; Gros, 2014). According to Grayeff (1974), as cited by Solnit (2014) and Gros (2014), this belief seems tied to the name bestowed upon his students, "Peripatetics." This word comes from the Greek verb peripatein meaning to walk or stroll about (Bartlett & Collins, 2011) or "one who walks habitually and extensively" (Solnit, 2014), or "to walk," "to converse," and "to engage in dialogue while walking" (Gros, 2014). Grayeff (1974) says:

> A covered colonnade led to the temple of Apollo, or perhaps connected the temple with the shrine of the Muses; whether it had existed before or was only built now, is not known. This colonnade or walk (peripatos) gave the school its name; it seems that it was here, at least at the beginning, that the pupils assembled and the teachers gave their lectures. Here they wandered to and fro; for this reason it was later said that Aristotle himself lectured and taught while walking up and down. (p. 38)

Indeed, Laërtius (1925), (the afore-mentioned biographer who lived around the third century and focussed on writing about philosophers), writes of Aristotle:

> …he would walk up and down discussing philosophy with his pupils until it was time to rub themselves with oil. Hence the name "Peripatetic." But others say that it was given to him because, when Alexander was recovering from an illness and taking daily walks, Aristotle joined him on certain matters. (Laërtius, 1925, Book V, point 2)

Thus, it is not clear if Aristotle and the Peripatetics did walk as part of the philosophic process, even as the name does seem to lend some support to this idea. Furthermore, Gros posits that Aristotle's nickname, "Walker," (peripatêtikos) speaks to the likelihood that he did walk while philosophizing[18]. However, Gros advises that, per Laërtius, Aristotle "had skinny legs, and once he had a good number of disciples he preferred to sit" (p. 130). Coverley (2012) flat-out dismisses the notion that Aristotle walked with students, and stipulates the root of the naming of the students has been commonly misquoted and misunderstood; the name simply refers to the setting.

Overall, it is also unclear whether Aristotle did indeed walk with students. Further, if walking and talking was an aspect of Aristotle's teaching, whether it was about increasing

[18] Gros does not list a reference for this point; I am unable to verify this through any other source I have found.

creativity, clarity, or mental capability (or any other asset that might be linked with walking while talking) is uncertain. However, it is useful for WT practitioners to be aware that the precedent for WT may in some sense have been set centuries ago by philosophers.

Freud. Hays (1994), a WT clinician, argues that Anna Freud's development of play therapy in 1928 is where the idea of physical activity as part of therapy started. However, Anna Freud is not the Freud cited as walking while conducting therapy; this falls on Sigmund Freud. According to Jordan and Marshall (2010), it is known that S. Freud would take walks through Vienna's streets prior to establishing boundaries and structure as components of psychoanalysis. Indeed, Payne and Crane-Godreau (2015b) suggest:

> Freud's mentor Pierre Janet first formulated and practiced body-oriented psychotherapy, using massage, breathing techniques, and guided movement to encourage the release of emotional blockages. (p. 14)

Although this might suggest that Freud walked with clients during sessions for therapeutic reasons, WT practitioner Kostrubala (2013) argues:

> Now there were friends and analysands of Freud who would take walks with him in the Vienna woods. They would have chats about the unconscious and it was considered analysis. But that seems to be the extent of the therapeutic physical activity on the part of Freud. (location 1947)

So, once again, while colloquially believed to have done some sort of WT, the evidence is inconclusive. Furthermore, if Freud did walk with clients, there is no certainty it was for therapeutic purposes, or if it had any particular impact. As with the previous philosophers mentioned, it is important for WT practitioners to know that saying Freud walked with clients may not be an ethical standpoint to practice on considering the holes in the tale.

Glasser. McKinney (2011) states:

> William Glasser, father of reality therapy, used running therapy in the 1970s (Kottler & Carlson, 2003). In his book, *Mummy at the Dinner Table*, Glasser disclosed his skepticism that talk therapy alone has enduring effects. During this time, Glasser was a strong believer of prescribing exercise to his clients for healthy habits. For one particular client, who was eating garbage from trashcans, he felt that sitting in an office would do no good. Therefore, they met twice a week on a Los Angeles street where many people ran, instead of in his office (Kottler & Carlson, 2003). For many months they ran and talked together for 30 minute sessions. After completing a run, they sat down in the parking lot to discuss her life and future goals. Glasser was successful using running therapy to help this client overcome negative behaviors. (p. 26)

In this case alone, there is a direct claim of WT being used for therapeutic purposes around goodness of fit and client engagement (though notably not specifically to address any therapeutic outcomes, and certainly not grief or trauma).

Appendix E

A Possible Link between Walking and EMDR

At the back of my mind, when I started this thesis, was a questioning about how and if there was some overlap between EMDR and walking. I found myself wondering if the bilateral stimulation component of EMDR might somehow be mirrored in walking. Although I have not found anything clarifying this, I have come across a related area. It lies within how Shapiro & Forrest (2016) explain Shapiro's initial conceptualization of EMDR:

> The seed of EMDR sprouted one sunny afternoon in 1987, when I took a break to ramble around a small lake. It was spring. Ducks were paddling by, and bright blankets full of mothers and babies were laid out on wide green lawns. As I walked along, an odd thing happened. I had been thinking about something disturbing; I don't even remember what it was, just one of those nagging negative thoughts that the mind keeps chewing over (without digesting) until we forcibly stop it. The odd thing was that my nagging thought had disappeared. On its own. When I brought it back to mind, I found that its negative emotional charge was gone. I must confess that one of my college heroes was Mr. Spock on Star Trek. Like him, I had always considered emotions a challenge, but I had never noticed such a quick shift of thoughts and feelings before. Because I had been using myself as a laboratory for mind-body investigation for eight years, this change definitely captured my interest. (p. 21)

Shapiro goes on to recount noticing that her eyes were rapidly moving as she walked, which she feels is what allowed her to process the negative thoughts she was experiencing. This is the way in which Shapiro states she discovered the EMDR process. From my understanding, EMDR initially relied on provoking those rapid eye movements and has evolved to a highly structured

form of safety-creating and exposure therapy components with bilateral stimulation included (Shapiro & Forrest, 2016).

Interestingly, Tripp (2007) designed an art therapy intervention relying on EMDR for inspiration in terms of protocols and the use of bilateral stimulation to process and reintegrate trauma. Tripp proposes that by using both hands to do art therapy, both hemispheres of the brain can be engaged, sensory awareness is promoted, affective and emotional regulation could be heightened, and overall by accessing both right and left brain, traumatic events could be better integrated and trauma symptoms lessoned. Picturing this, and thinking about how Shapiro came up with EMDR, I have continued to wonder about an overlap in EMDR and WT.

You see, although Shapiro proposes her insight on EMDR is due to rapid eye movements, there is so much in her account that I link instead to the simple process of walking. How many people have found taking a walk has mysteriously supported the development of a new idea, the vanishing of a troubling problem, shifts in thoughts and feelings, and so forth? Personally, I have found taking walks when I am stuck in writing this thesis has almost magically shifted this stuckness away and suddenly I have been able to write again. (Imagine how many less pages there might have been for this document, had I not taken so many walks!) This is, of course, highly speculative on my part, but it is certainly a wondering that WT clinicians interested in doing trauma work might consider: Is there something in the state of walking, whether it is the right-brain/ left-brain connection, bilateral stimulation, or something else entirely, which can address trauma in a capacity similar to EMDR? This would be an excellent area to research further.

Appendix F

Summary of media coverage of WT by reporters[19]

Connie Knox (2017) covers the work of psychotherapist and author of *Run for Your Life, Mindful Running for a Happy Life*, William Pullen. Pullen created the phrase "Dynamic Running Therapy" to describe his version of WT, which he says, can involve either walking or running with a therapist, as well as interacting with nature (Knox, 2017). Pullen believes depression and the feeling of being stuck are addressed when you move (Knox, 2017). Pullen is also featured by Magner (2017) where he stipulates that people with eating disorders, addiction concerns, and those in a major crisis may not be able to do this type of therapy, saying "…it may be too much, too quickly" (para 7). Pullen is quoted by reporter Anna Maxted (2017) speaking to the release, clarity, and shifts that he perceives in his WT clients. Writer Amy Packham (2015) also interviews Pullen; Packham states that being side by side is easier, expresses enjoying the mindfulness component of the session, and that she is surprised by the ease of which she expresses feelings and shares details of her life. *Vogue.co.uk* news editor, Lauren Milligan (2015) writes of her session that although she did not feel it offered her anything new in terms of insight, she did feel happier and lighter post-session and would start incorporating small walks in her regular life resultantly. *Sutt.co.nz* lifestyle writer, Bryony Gordon (2016), also writes about a session with Pullen and says "the physical sensation of movement really helps me feel that I am mentally moving through problems" (para 9).

Robin Abcarian (2017), publishes a piece with the *California Journal* in the *Los Angeles Times* covering her running interview with WT therapist Sepideh Saremi who's private practice is called "Run Walk Talk." Saremi cites the case of psychiatrist Wayne Sandler who she says has

[19] All authors cited in this section are reporters unless otherwise noted.

two treadmills in his office, and therapist, Willian Pullen, mentioned above as inspiration. Saremi notes anxiety, depression, schizophrenia, and PTSD as conditions for which this modality has seemed appropriate and helpful in her practice (Abcarian, 2017). Reporter Annie O'Sullivan (2017) also interviews Saremi. In this interview, Saremi draws attention to the collaboration and ease that comes from running with clients, and links to the idea that running alone can be meditative, but running with a therapist is about the relationship and conversation as well (O'Sullivan, 2017). Reporter Erin Magner (2017) interviews Saremi while running with her, and states that just by Saremi asking "Would you say that's also how you approach your life?" in response to Magner expressing that usually running isn't enjoyable because there is a sense of having to push herself to keep up, Magner had an a-ha moment about her relationships.

Amy Chillag (2017) covers WT through speaking with Sine Clark, a marriage and family therapist in Atlanta. Clark refers to the idea of getting clients unstuck, being less formal, and uses mindfulness in her practice (Chillag, 2017). A client of Clark's, Edward Adams, speaks to enjoying the sense of being outdoors and connecting with nature, being natural, and coming away with a sense of accomplishment. Clark suggests the therapist is responsible for adjusting pace to maximize confidentiality (stay away from groups) and monitor the client's tolerance for the activity (Chillag, 2017).

Kit Maher (2017), speaks to therapist Jennifer Blough, who echoes the idea that doing WT is symbolically associated with moving forward. Blough further suggests that the casual nature of the setting and even the way the therapist dresses can be helpful (Maher, 2017). Blough also highlights that pets are welcome to join; a novel idea with many other therapeutic outcomes likely (Maher, 2017). Blough advises that people who struggle with boundaries may not be suitable for WT, as there is a difference with two friends walking versus doing WT (Maher,

2017). However, it is my opinion that these are the same boundary issues a therapist needs to address in an office setting.

Karissa Neely (2017), speaks to therapists Megan Perry and Allison Page about their practice, Trailtalk. Neely quotes one of Perry's clients as saying WT is cathartic and helps with sharing. Another client says WT normalizes therapy, increases collaboration, and being outside encourages conversation (Neely, 2017). Perry advises that in her experience, when you walk with a client they seem to forget they are with a therapist and just start talking (Neely, 2017). Perry and Page drive the Trailtalk van to sessions which can be used as a mobile office if needed; they leave the back door of the van open to the view if using it for parts of sessions (Neely, 2017).

Anna Maxted (2017), describes a session with psychotherapist, Jonathen Hoban. Hoban advises that clients sitting in rooms, particularly with no windows, appeared to feel more anxious and trapped, so he took his practice outside (Maxted, 2017). Hoban indicates walking side-by-side is easier for difficult issues due to lack of eye contact (Maxted, 2017). Hoban, in rebuttal the idea that WT cannot deal with deeper more intense moments, offers that therapists can stop and hold a client's gaze as needed, should a heavier issue arise (Maxted, 2017).

Cindy Stauffer (2014), meets with therapist Sharon Lauriello and her client Glenda Winters (and Winter's dog, Chloe) to observe WT. Winters is seeing a therapist due to grief and trauma (having lost a son to suicide and a husband to Lou Gehrig's disease) and indicates she prefers the natural and less invasive feel of WT to traditional therapy (Stauffer, 2014). Winters describes much improvement from when she was initially "numb" with grief and did not care about anything (Stauffer, 2014).

Allie Shah (2014), interviews three practitioners of WT and one person who opposes the

practice; therapists Tammie Rosenbloom, Clay Cockrell, and Megan Brown versus Christopher Vye, chairman of the University of St. Thomas's Graduate School of Professional Psychology. Rosenbloom indicates that clients who have an Autism diagnosis have indicated that traditional therapy does not work because of the eye contact being overwhelming (Shah, 2014). Thus, WT is a good fit for these clients (Shah, 2014). Rosenbloom also feels that clients can move through stuckness and will have a sense of accomplishment (Shah, 2014). Vye struggles with the ethics of being out in public with a client, despite informed consent (Shah, 2014). Rosenbloom states that the benefits outweigh concerns (Shah, 2014). Cockrell suggests the informed consent mitigates the risks (Shah, 2014). Brown offers practical suggestions like clients can wear sunglasses, therapists can carry tissue and find places to sit if clients cry or get anxious (Shah, 2014). Vye also expresses concerns about lack of research and professional boundaries (Shah, 2014). Rosenblook and Cockrell indicate they are aware of and have ways of dealing with boundaries (Shah, 2014).

Freelance writer, Tori DeAngelis (2013) provides a piece on WT featured in the *APA Monitor on Psychology.* This article features psychologist Michelle Joshua who calls her practice in North Carolina "Work It Out LCC." Joshua indicates that WT is more comfortable and more active, as well as an opportunity for clients to fit therapy in by combining exercise and therapy into one time-slot. Also featured is psychologist Jennifer Lager who practices in Virginia. Lager suggests that particularly in working with people who survived a trauma, direct eye contact and face-to-face office settings can be too intense, and for people with ADHD, sitting still is not workable (DeAngelis, 2013). Lager also suggests rapport and collaboration are enhanced (DeAngelis, 2013). Lager advises that to protect confidentiality she and her clients plan for running into people they know; they will let each other know, stop talking, and wait until the

person is far enough away before continuing (DeAngelis, 2013). Also, Colorado psychotherapist Katie Asmus contributes, suggesting that she can use the natural world to bring in metaphor and symbolism, like finding a rock to symbolize groundedness. Finally, APA Assistant Executive Director for Practice Research and Police, Lynn Bufka, recommends clinicians ensure they are accomplishing treatment goals if using WT (DeAngelis, 2013).

Tina Kelly (2008), describes her encounter with clinical social worker, Karen Arthur, who offers "Walking and Talking Psychotherapy." Arthur associates the idea of WT with EMDR (though it is not clear why) and reports that the three or four clients who do WT with her find it refreshing and creativity-enhancing (Kelly, 2008). (For a reflection on the potential links between EMDR and WT, see Appendix E.)

Finally, *WebMD* writer, Suzanne Wright (2008), provides a comprehensive article covering interviews with WT practitioners Clay Cockrell, Kate Hays, Cathy Brooks-Fincher, and Carlton Kendrick. Cockrell suggests movement enriches the counselling experience and intrigues clients who like being outdoors. Further, he suggests it is particularly useful for male clients to open up and be vulnerable due to less eye contact and the side-by-side stance. One of his clients is quoted as feeling more open and comfortable, more able to work through emotions and thoughts, and being more open to new ideas. Hays finds WT encourages use of physical activity for mental and physical reasons, gets clients unstuck, and incites more creative and deeper ways of thinking. Hays suggests using WT when clients are at an impasse or if a client feels alienated. Hays feels working with domestic abuse is a good fit for this therapy. Brooks-Fincher finds WT sessions more relaxed, productive, natural, and enticing for clients, with especially good results for relationship, depression, anxiety, and grief work. On grief specifically, Brooks-Fincher says:

Because grief can be so totally consuming and feel so heavy, having the counterpoint of

> being outdoors and accomplishing something positive for one's health can provide a sense of aliveness… (Wright, 2008, para 26)

Kendrick suggests being in sync and moving together creates more parity, bondedness, freedom, and less confrontation. Wright (2008) also asks this group of therapists about confidentiality and benefits to therapists. The interviewees unanimously agree that confidentiality is not a concern; the therapist needs informed consent and to steer the client away from groups of people known to the therapist, for example, and to set a plan for what to do if someone the client knows is encountered. Additionally, all therapists report greatly enjoying WT and finding it mutually beneficial.

Appendix G

Research Supporting that WT Directly Targets Grief & Trauma on a Symptomatic Level

In Table 10.1, I list the possible symptoms of grief/ trauma as previously explored in Table 4.1. I juxtapose this list with sources discussing how individual walking therapy, group walking therapy, walking as a stand-alone intervention, and Mindful/ Labyrinth Walking might address these symptoms. This table shows how every symptom of grief/ trauma is conceivably addressed by one or more of these walking-based interventions.

Table 10.1

Comparison of Symptomology of Grief & Trauma with Symptoms noted as addressed by Walking Therapy

Grief/ Trauma Symptom	Source(s) Discussing Individual WT Regarding this Symptom	Source(s) Discussing Group WT Regarding this Symptom	Source(s) Discussing Walking/ Exercise Regarding this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking Regarding this Symptom
Anger	Hays (2010) (as cited by Hays and Sime, (2014): helps manage agitation		Aspinall et al. (2013): decrease frustration Moules et al. (2007): increase groundedness Richardson (2015): helps manage anger, frustration, grief, and loss	Teasdale et al. (2014): mindful walking allows letting go of emotions Zucker & Sharma (2012): shifts in positive emotion, intention, and self-awareness
Anxiety/ Exaggerated Worry/ Startle Response	Hays (2010) (as cited by Hays and Sime, 2014): helps manage anxiety Chillag (2017); Shah (2014): sense of accomplishment	Priest (2007): decreases feelings of insecurity	Rahman et al. (2017): decrease depression Moules et al. (2007): increase groundedness Merom et al. (2008): decrease anxiety/ stress Nguyen (2008): decrease anxiety	Teasdale et al. (2014): mindful walking allows letting go of emotions Ruggiero (2015): decrease anxiety Zucker & Sharma (2012):shifts in self-reflective thinking
Avoidance		Richardson (2015): ongoing exposure to 9/11 site keeps loved ones alive, helps reduce trauma of events, facilitates the grief process		

Table 10.1 (*cont.*)

Possible Symptom of Grief/ Trauma (as explored previously in Table 4.1)	Source(s) Discussing Individual Walking Therapy Beneficial for this Symptom	Source(s) Discussing Group Walking Therapy Beneficial for this Symptom	Source(s) Discussing Walking/ Exercise as Beneficial for this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking as Beneficial for this Symptom
Cognitive Disruption/ Mental Fatigue/ Madness	Beauchemin et al. (2008): increase energy level	Island Health (2011): targets mental health for people with disorders such as schizophrenia and bipolar	Oppezzo & Schwartz. (2014): increase creative ideation Moules et al. (2007): increase groundedness White et al. (2011): decrease chronic fatigue Nguyen (2008): increase clarity and mental functioning	Teasdale et al. (2014): mindful walking allows letting go of emotions Zucker & Sharma (2012): shifts in positive emotions and thoughts
Compulsive Behaviour			Darwin (1872): compulsive pacing naturally occurs and abates in some cases of traumatic grief	
Denial/ Protest	Maher (2017): symbolically moving forward		Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of disruptive emotions/ thoughts
Depression	Nguyen et al. (2014): decrease depression	Marselle et al. (2013): decrease depression	Robertson et al. (2012); Rahman et al. (2017): decrease depression Moules et al. (2007): increase groundedness Merom et al. (2008): decrease depression Nguyen (2008): decrease depression	Teasdale et al. (2014): mindful walking allows letting go of emotions McCaffrey et al. (2011): decreased depression
Despair		Priest (2007): decreases emotional pain, feelings of hopelessness, increases feelings of safety	Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of emotions McCaffrey et al (2016: increased hopefulness, personal growth, quality of life

Table 10.1 (*cont.*)

Grief/ Trauma Symptom	Source(s) Discussing Individual WT Regarding this Symptom	Source(s) Discussing Group WT Regarding this Symptom	Source(s) Discussing Walking/ Exercise Regarding this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking Regarding this Symptom
Difficulty Concentrating			Ben-Ner et al. (2014): increase performance Rahman et al. (2017): decrease depression Oppezzo & Schwartz (2014): increase creative ideation Berman et al. (2008): increase function Moules et al. (2007): increase groundedness Nietzsche (1882): increases creativity Nguyen (2008): increase mental functioning and clarity	Teasdale et al. (2014): mindful walking allows letting go of thoughts Ruggiero (2015): increased mindfulness
Disordered eating	Kostrubala (2013): helpful for tuning into the body and mitigating eating disorders			
Disorganization	Hays (1994): increase cognitive restructuring/ clarity		Ben-Ner et al. (2014): increase performance	Ruggiero (2015): increased mindfulness
Dissociation		Island Health (2011): targets mental health for people with disorders such as schizophrenia and bipolar	Rahman et al. (2017): reduces psychiatric symptoms related to schizophrenia Moules et al. (2007): increase groundedness	
Distress	Hays (1994): mood improvement Maxted (2017): lowers feelings of being anxious/ trapped	Marselle et al. (2013): stress decreases/ mental well-being increases Priest (2007): decreases oppression, feelings of insecurity; increases feelings of safety	Plante et al. (2007): increase calmness Aspinall et al. (2013): meditative aspects Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of emotions Tuet et al. (2013): decreased psychological distress Bigard (2009): aid stress management, meditation

Table 10.1 (*cont.*)

Grief/ Trauma Symptom	Source(s) Discussing Individual WT Regarding this Symptom	Source(s) Discussing Group WT Regarding this Symptom	Source(s) Discussing Walking/ Exercise Regarding this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking Regarding this Symptom
Emotional Disturbances/ Mood Swings		Hutchenson et al. (2010): distraction from thoughts Marselle et al. (2013): improve positive & negative affect Island Health (2011): targets mental health for people with disorders such as schizophrenia and bipolar	Aspinall et al. (2013): increase engagement, excitement, and meditation/ decrease frustration Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of emotions Ruggiero (2015): increased mindfulness & mood Bigard (2009): aid stress management, meditation Zucker & Sharma (2012): shifts in positive emotions/ self-awareness
Fear		Priest (2007): decreases feeling of insecurity, hopelessness, emotional pain; increases feelings of safety	Rahman et al. (2017): decreases PTSD symptoms Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of emotions McCaffrey et al (2016: increased hopefulness & quality of life
Isolation	Wright (2008): addresses feelings of alienation	Hutchenson et al. (2010): develop social networks and positive identity Priest (2007): decreases withdrawal, isolation, rejection, feelings of worthlessness; increases "being part" Richardson (2015): comfort in feeling of shared distress, community, kinship	Ben-Ner et al. (2014): increase social connection	
Hallucinations		Priest (2007): when psychotic can provide groundedness Island Health (2011): targets mental health (ie. re: schizophrenia and bipolar)	Rahman et al. (2017): reduces psychiatric symptoms related to schizophrenia	

Table 10.1 (*cont.*)

Grief/ Trauma Symptom	Source(s) Discussing Individual WT Regarding this Symptom	Source(s) Discussing Group WT Regarding this Symptom	Source(s) Discussing Walking/ Exercise Regarding this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking Regarding this Symptom
Longing		Priest (2007): decreases emotional pain, withdrawal, isolation, hopelessness	Oppezzo & Schwartz (2014): increase creative ideation	Teasdale et al. (2014): mindful walking allows letting go of emotions and thoughts McCaffrey et al (2016: increased hopefulness, personal growth, quality of life
Intrusive or Painful Thoughts	Wright (2008): able to work through emotions and thoughts	Hutchenson et al. (2010): distraction from thoughts Priest (2007): decreases emotional pain, intrusive thoughts; increases feelings of safety Island Health (2011): targets mental health for people with disorders such as schizophrenia and bipolar	Berman et al. (2008): increase function Oppezzo & Schwartz (2014): increase creative ideation Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of thoughts Ruggiero (2015): increased mindfulness Zucker & Sharma (2012): shifts in positive emotions/ thoughts
Loss of Connection	Hays (2010) (as cited by Hays and Sime, 2014): helps develop rapport King (2015): relationship/ trust/ openness increase Stauffer (2014): improvement in not caring about anything	Hutchenson et al. (2010): develop social networks and positive identity Priest (2007): decreases emotional pain Priest (2007): decreases withdrawal, isolation, rejection, insecurity, hopelessness, feelings of worthlessness, fragmentation; increases "being part" and "being me" Richardson (2015): comfort in feeling of shared distress, community, kinship Barton (2011): increases	Rahman et al. (2017): decreases PTSD symptoms Ben-Ner et al. (2014): increase social connection	McCaffrey et al (2016: increased hopefulness, personal growth, quality of life

socialization

Table 10.1 (*cont.*)

Grief/ Trauma Symptom	Source(s) Discussing Individual WT Regarding this Symptom	Source(s) Discussing Group WT Regarding this Symptom	Source(s) Discussing Walking/ Exercise Regarding this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking Regarding this Symptom
Loss of Faith		Priest (2007): increase in sense of spirituality Crone (2007): increased spiritual connection		Bigard (2009): aid personal and spiritual growth
Loss of meaning/ Loss of assumptive world	Hays (1994): increases problem solving Berger & McLeod (2006): metaphorical meaning making	Hutchenson et al. (2010): meaningful occupation Priest (2007): decreases feelings of purposelessness, hopelessness, and worthlessness; increase in meaningfulness Richardson (2015): re-narrating for meaning & education Street Wisdom (n.d.): aids search for meaning or purpose	Hodgeson (2013): life can be good again	Ruggiero (2015): increased physical self-efficacy McCaffrey et al (2016: increased hopefulness, personal growth, quality of life Bigard (2009): aid personal and spiritual growth & problem solving Hong & Jacinto (2012): increases insight Zucker & Sharma (2012): shifts in self-improvement, positive actions/ intentions
Numbness	Doucette (2004): increase in self-awareness & self esteem Hays (2010) (as cited by Hays and Sime, 2014): bypass emotional impasses Stauffer (2014): improvement in numbness	Priest (2007): decreases withdrawal, feelings of fragmentation, hopelessness & purposelessness; increases feelings of safety, openness, ability to be vulnerable, feeling of striving Crone (2007): decreases feeling of not being able to do anything (ie. get out) Richardson (2015): reconnection to world as a safe place		McCaffrey et al (2016: increased hopefulness, personal growth, quality of life

Table 10.1 (*cont.*)

Grief/ Trauma Symptom	Source(s) Discussing Individual WT Regarding this Symptom	Source(s) Discussing Group WT Regarding this Symptom	Source(s) Discussing Walking/ Exercise Regarding this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking Regarding this Symptom
Physical Ailments (ie. headaches, sleep problems, digestive problems)	McKinney (2011): increased physical health, body awareness, and self-care	Marselle et al. (2013); McDevitt et al. (2005): physical benefits	Charles Dickens as cited by Coverly (2012) used walking for physical health	Ruggiero (2015): increased physical self-efficacy & sleep
	Revell & McLeod (2016): improves physical fitness	Crone (2007): aids sleep	Rahman et al. (2017): changes in biological factors	
	Wright (2008): physical benefits		Kierkegaard as cited by Coverly (2012): walk away from illness	
	Walk with a Doc (n.d.): physical improvements			
Psychosomatic*	*see all other mental/emotional symptoms listed as addressed by WT	*see all other mental/emotional symptoms listed as addressed by WT	*see all other mental/emotional symptoms listed as addressed by WT	*see all other mental/emotional symptoms listed as addressed by WT
				John Rhodes as cited by Bigard (2009): enable a set of physical responses that lead to state-of-mind responses
Relationship Disruptions	Magner (2017): a-ha moment about relationships	Hutchenson et al. (2010): develop social networks and positive identity		
	Wright (2008): good for relationship work	McDevitt et al. (2005): improved psychosocial functioning		
		Priest (2007): decreases withdrawal		
		Barton (2011): increases socialization		
Searching		Priest (2007): feeling of getting away & striving	Moules et al. (2004): new perspective	Bigard (2009): aid personal and spiritual growth
		Street Wisdom (n.d.): aids search for answers to questions and problems		

Table 10.1 (*cont.*)

Grief/ Trauma Symptom	Source(s) Discussing Individual WT Regarding this Symptom	Source(s) Discussing Group WT Regarding this Symptom	Source(s) Discussing Walking/ Exercise Regarding this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking Regarding this Symptom
Self-Blame/ Guilt	Doucette (2004): increase in self-awareness & self esteem	Priest (2007): decreases emotional pain, feelings of insecurity, oppression, fragmentation, and worthlessness… less self-consciousness, increase in self-acceptance	Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of emotions Zucker & Sharma (2012): shifts in self-improvement, self-awareness, self-esteem
Self-harm/ Risk-taking		Priest (2007): increases feelings of safety	Moules et al. (2007): increase groundedness	Zucker & Sharma (2012): shifts in self-improvement, self-awareness, self-awareness, positive actions/ intentions
Shame/ Self-Hate	Doucette (2004): increase in self-awareness & self esteem	Priest (2007): decreases emotional pain, feelings of worthlessness & insecurity; increases self-acceptance	Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of emotions Zucker & Sharma (2012): shifts in self-improvement, self-awareness, self-esteem
Shock		Priest (2007): healing and soothing, increases feelings of safety Richardson (2015): healing benefits of story telling	Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of emotions McCaffrey et al (2016: increased hopefulness, personal growth, quality of life
Stress-Related Conditions	Hays (2010) (as cited by Hays and Sime, 2014): cathartic release	Priest (2007): decreases emotional pain, withdrawal, feelings of oppression, stress	Aspinall et al. (2013): excitement, engagement, and meditation increase/ frustration decreases Moules et al. (2007): increase groundedness Merom et al. (2008): stress	Teasdale et al. (2014): mindful walking allows letting go of emotions Tuet et al. (2013): decreased psychological distress/ perceived stress Zucker & Sharma (2012): manages

stress

Table 10.1 (*cont.*)

Grief/ Trauma Symptom	Source(s) Discussing Individual WT Regarding this Symptom	Source(s) Discussing Group WT Regarding this Symptom	Source(s) Discussing Walking/ Exercise Regarding this Symptom	Source Discussing Mindful Walking/ Labyrinth Walking Regarding this Symptom
Substance Use	Kostrubala (2013): helpful for redirecting addiction	Gontang (2009): refers to research by Jim Hornsby around using running and walking groups for people with substance use issues	De Quincey (as cited by Coverly, 2012): ease opium addiction	x
Suicidal thoughts		Priest (2007): increases feelings of safety & purposefulness; decreases hopelessness	Moules et al. (2007): increase groundedness	Teasdale et al. (2014): mindful walking allows letting go of thoughts McCaffrey et al (2016: increased hopefulness
Yearning		Priest (2007): decreases emotional pain	Hodgeson (2013): decrease in yearning Moules et al. (2004): look past what was and move on	Teasdale et al. (2014): mindful walking allows letting go of emotions and thoughts McCaffrey et al (2016: increased hopefulness, personal growth, quality of life

Note. This table was created by pulling out symptoms from sources discussing the concepts of grief and/or trauma and comparing these symptoms with ways in which different walking based interventions target these symptoms. Sources used in this table are cited throughout the thesis.