Out of Body: Experiencing Dissociation in Varying Forms of Grief

by

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Abstract

Grief is a universal experience of loss that is pervasive and exists on a spectrum outside of bereavement and trauma. The somatic consequences of grief and grieving can lead to dissociation and disembodiment and these are understudied effects of the grief experience. Currently, literature within the field of psychology primarily focuses on the physiological effects of trauma, traumatic grief and complicated grief, rather than that of the more universal experiences found in disenfranchised and anticipatory grief. The importance of the research conducted in this capstone is to highlight a gap in the field while exploring how these forms of grief relate to dissociation and disembodiment, and how individuals can begin to heal while living with grief. The intersectionality found within the spectrum of grief lends an importance to heeding culturally competent and trauma-informed care, particularly pertaining to disembodiment. There are correlations in the neuroscientific, somatic and attachment findings of trauma and complicated grief. These lend to the validity and importance of the field expanding its care, use of integrative interventions and research to those living with dissociation and disembodiment in relation to disenfranchised and anticipatory grief.

Keywords: anticipatory grief, culturally competent care, dissociation, disembodiment, disenfranchised grief, integrative approaches, somatics, trauma-informed.

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Chapter 1: Introduction

While there is grief in all trauma, there is not trauma in all grief. Within the field of psychology there is extensive international literature relating to trauma: the neuroscience of it, how people experience dissociation or disembodiment, how to heal trauma through talk therapy, expressive arts and somatic therapy, and more (Bernstein, 2022; Briere, & Scott, 2014; Fay, 2021; Gray, 2017; McKissick, 2019; Porges & Dana, 2018; Prashant, 2018; van der Kolk, 2014; Weber, 2019). There is also extensive literature in the field in relation to prolonged grief, otherwise known as persistent complex bereavement disorder, and yet the intersections of this scope of work prove to be limited (American Psychiatric Association, 2013; James & Friedman, 2014; O'Connor, 2019, 2022). Furthermore, the correlation between disembodiment/dissociation and varying forms of grief is vastly underestimated in the field, whereas we mainly hear about this correlating with trauma.

If grief is "the normal and natural reaction to loss of any kind" (James & Friedman, 2014, p.3), then it is important to note the numerous categories of grief, including that of complicated grief, disenfranchised grief and anticipatory grief. These will all seek to be explored alongside what embodiment is considered to be, as well as disembodiment and dissociation as loss lives in the body (Prashant, 2019). If there is grief in all trauma, and everyone experiences many varying forms of grief in their lifetime, the questions of intent I am seeking to primarily examine are how grief correlates to dissociation/disembodiment, what the importance of this is, and how can people begin to heal dissociation/disembodiment in relation to grief?

The scope of this research paper will seek to explore the following: what is meant by grief, disembodiment and dissociation, and to look at the relationship between embodiment/disembodiment and the neuroscience of grief and trauma. Additionally, this

capstone will investigate the relationship between grief, embodiment, and disembodiment with a particular focus on disenfranchised and anticipatory grief and how they relate to attachment, multiculturalism and somatics. Finally, empirical evidence of interventions used to heal disembodiment/dissociation through the lens of trauma and grief will be shared as well as presenting a framework for counsellors to utilize in guiding people through the journey of finding embodiment through grief.

Theoretical/Conceptual Framework

The conceptualization of this paper will be primarily based within the intersectional lenses of feminism, multiculturalism and anti-oppressive frameworks that encapsulate compassion. The theories and modalities that will be pulled upon throughout this paper include trauma-informed somatics, principles and practices relating to grief counselling, mindfulness based cognitive behavioural therapy, expressive arts, feminist narrative, conscious embodiment practices, and yogic and attachment theory (Palmer, 2009; Prochaska & Norcross, 2018; Wayment & Vierthaler, 2002). These approaches are a combination of top-down and bottom-up (see below in glossary). In top-down therapies they rely on a person's ability to remember and apply the interventions when an event takes place, therefore relying more on the cognitive state. Top-down approaches can help with the management of symptoms, whereas bottom-up approaches work from within the body and the basis of one's sensory input system. This has also been referred to as "body memory" (Kuhfuß et al., 2021; van der Kolk, 2014).

Contribution to Field

This literature review serves to primarily benefit those within the field of psychology or those with an interest in incorporating grief work into their fields of study that are trauma-informed. In using the above theoretical and conceptual frameworks, the layers of somatic

effects of grief will be explored while utilizing the breadth of research relating to trauma to interrogate grief's neurological and physiological effects that can lend to someone becoming disembodied/dissociated. In addition to this, language surrounding the varying forms of grief within the field of psychology host such minor differences that consideration will be given to simplifying terminology so as to make it more accessible on a systemic level. Ultimately the contribution to the field is in highlighting the importance of studying varying forms of grief that are pervasive in society and how they correlate to disembodiment/dissociation.

Positionality/Reflectivity

The basis of the literature review is primarily qualitative, though some research findings are mixed mode. As listed above, the intersectional lenses of feminism, multiculturalism and anti-oppressive will be the bases of the framework for the paper alongside utilizing varying modalities that relate to conscious embodiment and healing grief that incorporate both top-down and bottom-up approaches. There is also the lens of the researcher, which will inseparably involve a level of subjectivity and inference in the chosen frameworks, research, and study design(s).

For the purpose of sharing the researcher's lens of perspective, I will be transitioning from the use of third person to first person. I, Kai, am white, non-binary/genderqueer, able-bodied while living with chronic illnesses, queer, non-religious and a settler. I am currently residing on the traditional, ancestral and unceded territory of the Coast Salish peoples - Musqueam, Squamish and Tsleil-Waututh nations and was raised until I was 16 years old on Mi'kmaq territory. It is with this current lens of perspective that my relationship to the effects of grief have been shaped. My hope is that in exploring the relationships between grief, trauma, somatics and the language of pathology that there can be more awareness within the field to the

necessary interchange between grief and trauma studies, and less confusion as to the saturation of terminologies. I also hope to explore more about the somatic and neurological consequences of unaddressed trauma and therefore grief, with a particular focus on disenfranchised and anticipatory grief. Oftentimes grief studies highlight complicated, or bereavement, grief only and I feel it is important to include the spectrum of grief, albeit its difficulty in measurability.

These nuances are to highlight the importance of having accessible mental health services to reach the general population who have vast lived experiences with grief and trauma. Also important to note is that I am not aiming to denounce or deviate from the importance of studying disembodiment/dissociation relating to trauma by honing in on grief. Rather, I am aiming to address the gaps in the field of grief by highlighting the vastly important work done in relation to trauma. In this, advocating for the study and practice of interdisciplinary somatics and grief could allow it to become normalized within the field, therefore engaging in less pathologizing language surrounding loss and a greater foundation for holistically and compassionately understanding why individuals can become disembodied.

Defining Language

While there are numerous categories of grief, “Grief is derived from the Latin gravare, meaning to burden or to cause distress” (Dunne, 2004, p. 45), and is the “normal and natural response to loss” (Harris & Winokuer, 2021, p. 28). If we are to understand grief it is important to understand loss, as the two are innately intertwined.

Loss is defined as “an experience where there is a change in circumstance, perception, or experience where it could be impossible to return to the way things were before” (Harris & Winokuer, 2021, p. 28). There are a multitude of divisions of disordered grief that are used interchangeably in literature such as complicated grief (CG), prolonged grief disorder (PGD),

persistent complex bereavement disorder (PCBD) and traumatic grief (TG) (Harris & Winokuer, 2021). Presenting research notes that the majority of studies focus on complicated grief, stemming from bereavement, as well as the physical effects of trauma on the body.

Complicated, or complex, grief is defined as having "prolonged acute grief symptoms" (Harris & Winokuer, 2021, p. 158). In about 10-15% of individuals, complicated grief includes an intense resistance to accepting the loss in their lives. There is a variance within the DSM and other literature as to the timing of prolonged grief/complicated grief: some note six months, whereas others say anything lasting over one year (American Psychiatric Association, 2013; Harris & Winokuer, 2021). Separation distress and traumatic distress are also additional components to be considered within these terms. As Harris and Winokuer (2021) note: "current consensus regarding the criteria for CG states that it may be present after any loss that is extremely personally devastating" (p. 158). This distinction is important to note as this level of prolonged grief in the majority of literature and the DSM-IV specifically focus on bereaved individuals rather than the variance in grief experiences.

Loss is inherently more vast than bereavement alone and also varies in intensity and duration of the grief resulting from the loss (Dunne, 2004; Harris & Winokuer, 2021; James & Friedman, 2014; Prashant, 2018; Solorzano, 2012). An acute grief reaction outside of bereavement that could stem from any other form of loss in one's life, such as a separation, moving, miscarriage, loss of faith and other life or role transitions, is typically referred to as disenfranchised grief. This is when the loss is not validated or accepted socially. More specifically, when an individual is anticipating a loss in one's life, this is referred to as anticipatory grief (Harris & Winokuer, 2021; James & Friedman, 2014; Prochaska & Norcross, 2018).

While the clinical features of complicated grief in the DSM-5 do not include somatic symptomatology, the clinical features of post-traumatic stress disorder (PTSD) do (American Psychiatric Association, 2013). These include physiological reactions in remembering or encountering cues that resemble the trauma(s), sleep disturbances and other marked alterations in behaviour (American Psychiatric Association, 2013). In trauma-distinct literature as well as varied scopes of grief, numerous overlaps of somatic symptoms are discussed, including but not limited to: sleep disturbances, headaches, impaired concentration, limbic system activation, compromised immune system, and more (American Psychiatric Association, 2013; Brom et al., 2017; Harris & Winokuer, 2021; O'Connor, 2019, 2022; Prashant, 2018; Solorzano, 2012; Wayment & Vierthaler, 2002).

To better understand disembodiment/dissociation in relation to trauma and therefore grief, the somatic focus of this paper, let us first indicate that these terms will be used interchangeably. These definitions are oftentimes relative to one another, finding themselves intertwined in literature. For this purpose, hereafter, when referring to disembodiment or dissociation, the two are meant to represent one and the same and are defined below, alongside embodiment.

The major focus of this capstone is in highlighting disenfranchised and anticipatory grief(s) and how these categories of grief relate specifically to disembodiment. This is to offer both normalization and to underscore gaps of research within the field. While noting findings relating to complicated and prolonged grief, as well as traumatic grief, are also important, the reason disenfranchised, and anticipatory grief become crucial to investigate is because of the stigma and lack of understanding around them.

Definitions

While the majority of terms used throughout the literature review are mentioned above, below is a brief glossary of major terms used. The terms are in alphabetical order, sourced from Anwar (2022), Carter (2002), Harris and Winokuer (2021) and Palmer (2009).

Anticipatory Grief (AG)

Anticipating an impending death of a loved one with terminal prognosis. This can also be applied to other forms of loss.

Bottom-Up Approach

Interventions begin with information stemming from the body's sensations.

Complicated Grief (CG)

Involves prolonged acute grief symptoms, where the bereaved have difficulty functioning and challenges arise in the ability to rebuild a meaningful life following their loved one's passing. CG is used interchangeably with prolonged grief disorder (PGD), persistent complex bereavement disorder (PCBD) and traumatic grief (TG).

Disembodiment/Dissociation

Carter (2002) cites McFarlane, and Weisaeth (1996), noting "a compartmentalization of experience in which elements of a trauma are not integrated into a unitary whole or an integrated sense of self' (p. 306). Most definitions refer to a loss of sense of self in one's body, where a "person's psychic and somatic connection is rendered totally or partially disabled" and may result in "depersonalization or derealization at the other end" (p.4).

Disenfranchised Grief (DG)

A significant reaction to a loss or losses, but the loss and grief are not recognized or validated socially.

Embodiment

Palmer (2009) defines embodiment as "the manifestation of our capacity to stay in the present, to hold the space of the moment, and to be with our body sensations, which enhances our ability to see and navigate skillfully" (p. 20).

Grief

The normal and natural response to loss.

Loss

An experience where there is a change in circumstance, perception, or experience where it would be impossible to return to the way things were before.

Somatics

The mind/body interface and the practices that use mind-body connection as a means of healing.

Top-Down Approach

Interventions begin with information stemming from the mind and its interpretations.

Trauma

A deeply distressing event resulting in mental, emotional and/or physical stress.

Defining Differences and Overlaps

Trauma, the Limbic System and Neurological Effects

In keeping the above definition of loss in mind, loss directly correlates with trauma: hence why all trauma hosts grief. As noted, not all grief involves trauma or PTSD symptoms, for instance. However, "to some extent, all grief is traumatic" (Harris & Winokuer, 2021, p. 164), as the severe losses in one's life result in a shattering of previous assumptions. After experiencing the initial trauma there is subsequent trauma that develops. As van der Kolk (2015) states, "The

emotions and physical sensations that were imprinted during the trauma are experienced not as memories but as disruptive physical reactions in the present" (p. 206). This is not only because there has been a loss but there is a direct shift in their interpretation of safety, triggering the limbic system within the nervous system, leading to states of hyper- or hypoarousal. When this happens, the individual is pushed outside of their "window of tolerance – the range in optimal functioning. We become reactive and disorganized; our filters stop working" (van der Kolk, 2015, p. 207). In this fight or flight mode is where other theories, such as the Polyvagal Theory, can come into play in better understanding the individual's safety response to perceived traumatic events in their autonomic nervous system (Dana, 2020; Porges & Dana, 2018).

During the recollection or re-experiencing of trauma the amygdala, which is part of the emotional (limbic) center of the brain, is activated and sends disorganized signals to the hippocampus. From here the locus coeruleus, which is the brain's alarm/stress center, is activated. This sends a "cascade of changes in the neurotransmitters throughout the brain. Once sensitized, the locus coeruleus reacts to smaller stressors as if they were recurrences of the original trauma" (Schiraldi, 1999, p. 368 as cited in Solorzano, 2012, p. 22). The body then reacts accordingly, reliving the initial trauma. While grief may not encompass the extreme response of that found in the limbic system during traumatic recurrences/occurrences, trauma and the somatic reactions that follow certainly involve grief (Porges & Dana, 2018; Solorzano, 2012; van der Kolk, 2015).

Research indicating relations between disenfranchised and anticipatory grief and its effects on the brain is lacking in the field of psychology, but there has been more research in recent years relating specifically to complicated grief and neurological findings. Given this field of study is relatively new, there are still gaps in research. There is, however, a significant amount

on the neurological implications of trauma. Interestingly within this differentiation, however, there is a novice amount of research analyzing the long-term neurological effects on the brain throughout development when children encounter traumatic events. This is an important consideration when treating children or adults who are living with trauma; thereby grief. The literature indicates a necessity for more research on the effects of grief and trauma on the brain through functional magnetic resonance imaging (fMRI) and the electroencephalogram (EEG); this will be invaluable to better understanding the neurological and physiological effects of unaddressed trauma and grief (McKissick, 2019; O'Connor, 2019, 2022; Weber, 2019).

Grief and Body Systems Reflected

Common somatic reactions to grief include pain, fatigue, exhaustion, sleep disruption, headaches, tightness in the chest and/or throat, myocardial infarction, shortness of breath, stomach pain, hypertension, restlessness, and irritability (Harris & Winokuer, 2021; O'Connor, 2019; Prashant, 2018; Solorzano, 2012). Dysregulated hypothalamic-pituitary-adrenal axis (HPA axis) activity and higher levels of cortisol and blood pressure were found in bereaved up to six months following a loss. Pro-inflammatory markers of immune changes are also documented, but require more supporting evidence and research, particularly within the entirety of the spectrum of grief (Buckley et al, 2012; O'Connor, 2019).

Serious difficulty in processing loss may lead to somatic symptoms and/or could be delayed, showing itself as pain years later. Loss inherently challenges one's assumptive world, in other words, their "taken for granted" (Dunne, 2004, p.48) world. Inability to process disillusionment could lead to maladaptive coping patterns and a loss of trust with oneself and others (Dunne, 2004; Prashant, 2018). Within the DSM-IV, the somatic disorders listed provide all of the above bodily symptoms, but do not link somatic disorders to grief (American

Psychiatric Association, 2013). Severe grief reactions are also linked to increased levels of anxiety, depression, and overall increased use of health services (Thimm et al., 2020). However, within all the clinical features of complicated grief in classification systems, there are no somatic symptoms listed (Shear, 2010 as cited in Harris & Winokuer, 2021).

There is a good deal of literature on the "broken heart syndrome", more currently known as the "widowhood effect". Usually occurring within the first six months following a loved one's passing, the bereaved individual faces increased risk of mortality due to a heart attack or cardiovascular event (Prashant, 2018). This was first written about in 1963 but in 1990 Sato and colleagues, as cited in O'Connor (2019), reported on Takotsubo cardiomyopathy which is "acute stress-induced cardiomyopathy involving left ventricular apical ballooning that mimics acute myocardial infarction" (p.4). While this event could be due to other life stressors, it is oftentimes related to the death of a loved one and has therefore become synonymous with a broken heart. It is for this reason that the field of psychology has shifted from "broken heart syndrome" to the "widowhood effect" (O'Connor, 2019, p. 4). There is a confining nature to this term; it reduces bereavement of any attachment figure to the death of a spouse.

According to Bowlby (1996 as cited in Dunne, 2004; Fay, 2021; MacCallum & Bryant, 2018; Scourfield, 2021; Wayment & Vierthaler, 2002), our attachment system becomes threatened when a loved one passes. During the courses of infanthood and childhood, developmental bonds that result in varying forms of attachment are created by primary caregiver(s) in interaction with their children. The health and strength of these bonds are what determines whether an individual becomes securely attached, avoidantly attached, anxiously attached or disorganized in their attachment. Secure individuals will more accurately perceive and respond to others because their caregivers demonstrated consistent and responsive

availability. Avoidant individuals usually have learned to develop a sense of safety through denying their own emotions and needs after being consistently disregarded, dismissed and rejected by their caregivers. Anxiously attached people typically closely monitor moods, adapting and shifting as perceived to be needed to maintain a sense of safety after experiencing inconsistency from their caregivers. Disorganized attachment is a combination of anxious and avoidant beliefs and behaviours after experiencing unpredictable and sometimes abusive environments (Bowlby 1996 as cited in Scourfield, 2021).

Bowlby believed that people with anxious attachment are more prone to being "readily and strongly activated during times of distress, and, during separation, they anxiously seek an attachment figure…Bowlby theorized that such individuals would display a more chronic grief pattern (Wayment & Vierthaler, 2002, p. 131). Ultimately, regardless of one's attachment style, findings have unanimously indicated that the greater the attachment to the individual that has been lost, the greater the impacts and timeline of the grief, thus requiring self-compassion and compassion on behalf of the practitioner (O'Connor, 2022; Wayment & Vierthaler, 2002).

Interestingly, from a more spiritual perspective paired with clinical findings, both Palmer (2009) and Taylor (2017) have concurrently written about dissociation being linked to feelings of "separateness" within society, a loss of self. For instance, Taylor refers to dissociation as "rather than seeing the body as an integrated part of our being, we saw the self – our own ego – as an entity trapped inside a body that was somehow *other* to us" (p. 14). Investigating other systems of oppression that could lead to grief and disembodiment through varying lenses and cultural belief systems will also enable further understanding of other modalities for healing such disconnections.

Outline of Chapters

The upcoming chapters will include explorations of attachment styles in relation to the somatic body, trauma, and the primary forms of grief; anticipatory, complicated and disenfranchised. Stages of grief and grief work as being no longer relevant work within the field of psychology will be mentioned while further investigating the widest used modalities and models within psychology in relation to trauma and grief, as well as what it means to become safely embodied through using both bottom-up and top-down approaches (Fay, 2021; Palmer, 2009; van der Kolk, 2014). Research will also be reviewed on the variance of recognition and healing practices within a social context framework, highlighting the need for mindfulness and awareness of cultural traditions, practices, and perceptions.

Given the vast and varying types of grief, the field of neuroscience could benefit from further engagement with both complicated and disenfranchised grief clients. Although grief is a universal concept, processing lies within the context of the grief: whether that be socio-cultural, the field's understanding of language use and the practice of understanding grief as an adaptive response rather than a pathology, or the interchange of research findings within grief, trauma, and the somatic consequences of unaddressed grief. Ultimately, how do we seek embodiment while living with varying forms of grief (Fay, 2021; Harris & Winokuer, 2021; Maccallum & Bryant, 2018; Palmer, 2009; Stroebe et al., 2017; Wayment & Vierthaler, 2002)?

Chapter 2: Literature Review

Understanding Pathologies

Reviewing Grief, Grieving and Complicated Grief

All forms of grief are relevant, particularly in relation to disembodiment. In chapter one the foundational definitions for grief and loss were explored. I believe it is crucial to further deepen our understanding of grief and its varying categories in order to understand more about "the most neglected and misunderstood experience, often by both the grievers and those around them. Grief is the conflicting feelings caused by the end of or change in a familiar pattern of behaviour" (James & Friedman, 2014, p. 3). What is meant by this is that when experiencing grief there is typically an overlap of conflicting emotions. For instance, when a loved one who has been suffering dies there may be relief alongside sorrow. Or when one moves to a new job or city there may be excitement as well as a sense of grief over what has been left behind. The first example, as we have learned, is related to complicated grief whereas the second example correlates to disenfranchised grief. Another important distinction is what is meant by grief versus grieving.

Researchers have subjectively defined grief and loss for decades with some overarching collective insights, having described it as "the normal and natural reaction to loss of any kind" (James & Friedman, 2014, p. 184), "the intense emotion that crashes over you like a wave, completely overwhelming, unable to be ignored…a moment that recurs over and over" (O'Connor, 2022, p. 3), and ultimately noting the autonomous qualities of grief, thereby making it "an individualized phenomenon among individuals" (Dunne, 2004, p. 48). The act of grieving, however, is a process that has no linear trajectory, though has been said to occur in phases and

one's processing through adaptation to the grief shifts over time (Dunne, 2004; James & Friedman, 2014; O'Connor, 2022).

Ultimately, there is no one right way to grieve, contrary to popular belief. Various cultures prescribe bereavement and have many rituals surrounding grief. In Western society, grief is less normalized and tailored solutions to moving through grief have been relied upon. Kübler-Ross's five stages of grief grew in popularity as a means to coping with death and dying. The five linear stages outlined were: "denial, anger, bargaining, depression, acceptance" (Kübler-Ross, 1969 as cited in Dunne, 2004, p. 47). Important to note was that this model was developed through clinical impressions following cancer patients moving through these stages to reach acceptance of their own terminal illnesses. This was never intended for people grieving their loved ones and has been criticized in the field for its lack of clarification and that people could interpret the works in blanketed ways, believing it to be a prescription for healing (Dunne, 2004; Harris & Winokuer, 2019; James & Friedman, 2014; O'Connor, 2022; Stroebe et al., 2017).

While most people experience adaptive grieving processes, there are cases in which the field of psychology sees individuals as having prolonged difficulties, manifesting as maladaptive coping mechanisms over durations deemed unacceptable. Complicated, or prolonged, grief has also been referred in literature as unresolved grief, abnormal grief, pathological grief, chronic grief, delayed grief and exaggerated grief (Fernández-Alcántara et al., 2021; Hooley et al., 2016). As cited in Dunne (2004), "Horowitz et al (1993) assert that three categories of symptoms exist in pathological grief: intrusion, denial and dysfunctional adaptability" (p. 51). Intrusion is when the individual cannot adjust or adapt to the loss and is prone to appeasing oneself through fantasy and memory of the deceased person for extended periods. Denial is both implicit and explicit; the

person has not personally accepted the loss and has also ensured that certain environmental factors remain intact. For example, keeping their loved one's room the same without any changes for months or years. Dysfunctional adaptability relates to an inability to move through phases of grief and can result in "an inability to make decisions, a failure to resume work, excessive fatigue and somatic symptoms" (Dunne, 2004, p. 51). O'Connor (2022) puts it a bit more simply, suggesting that the main symptoms related to chronic grieving are "(1) the preoccupation with yearning for the deceased, and (2) traumatic symptoms caused by the loss" (p. 87).

Another important note regarding the trajectories grieving individuals can take is whether a person is experiencing depression or grief, or both. This is also helpful to the field of diagnosis and treatment, though one could also argue that grief does not require pathology to be effectively treated. This will be discussed further in clinical implications. Bonnano et al. (2008) as cited in O'Connor (2022) encountered four trajectories of grieving when conducting their *Changing Lives of Older Couples* (CLOC) study:

> These trajectories include: *resilient* (those who never develop depression after the death of a loved one), *chronic grieving* (depression that began after the death of a loved one and is prolonged), *chronic depression* (depression that began before the death of a loved one and continues or worsens after the death), and *depressed improved* (pre-existing depression that abates after the death of a loved one). (p. 82)

While these trajectories have been widely used since, it is wise to consider that this study was founded in following couples and individuals prior to the passing of their loved one(s). Therefore, when considering the use of these trajectories in practice, it is important to differentiate grief from depression (Wayment & Vierthaler, 2002).

While this capstone's primary focus is on disenfranchised and anticipatory grief, there will still be important empirical and observational evidence from literary works in the field that primarily have researched the effects of complicated grief. Furthermore, as O'Connor (2022) says, "I like the term *complicated grief,* because it reminds me of complications that can happen in any normal healing process" (p. 90). Adopting this lens of normalcy in the complicated is yet another reason that makes complicated grief an important category to understand.

Reviewing Disenfranchised and Anticipatory Grief

While there is still negligible research pertaining to disenfranchised/anticipatory grief, some scientific literature has taken note that the adaptation to loss can be particularly challenging to manage when the grief process is not acknowledged within its social environment; such is true particularly for disenfranchised grief (Fernández-Alcántara et al., 2021). Interestingly, Thimm et al. (2020) have also found that people with lower socio-economic status were more closely related to severe grief, though the conditions by which this discovery is made possible were not explored and is an oversight from a socially just lens. To be disenfranchised means to be "people who are stripped of their power, like *disenfranchised* post-Civil War African Americans who were deprived of their right to vote even after being freed from slavery" (IXL, 2023, para. 1). The psychology of disenfranchisement theory proposed the following three components to being disenfranchised within minority groups: "alienation, cynicism and perceived victimization" (Wikipedia, 2023, para. 2). When we consider the colonial lens within the field of psychology it becomes interesting to note the language used in reference to individuals' grief; how it simultaneously accurately calls to attention the unjust ways in which varying forms of grief can be defined while also pulling from Black liberation within a predominantly Euro-centric field. This is not to say that the term "disenfranchised" should or should not be used to describe the

experience of those living with losses not socially accepted, but that we should also pay heed to the irony of the colonial tendency to appropriate words from other cultures.

Anticipatory grief is still vastly understudied, though findings agree that this phenomenon is prevalent and persists among caregivers and loved ones who are anticipating a loss; specifically, in relation to someone's terminal prognosis. As Anwar (2022) shares, "an estimated 25% of patients themselves may also experience it…anticipatory grief is the entire combination of all the reactions – affective, cognitive, social and cultural – that both patients and families might feel as they are expecting loss" (para. 6). Studies from the 1990's also suggest that while grief outcomes are still individualized and inconsistent, anticipatory grief can invoke more emotional instability, bursts of anger and hostility, anxiety, despair, somatic distress, guilt, denial, lethargy, and sleep difficulties (Anwar, 2022; Dunne 2004). The same could be said for disenfranchised grief, though there is even less research pertaining to this as it does not necessarily correlate to bereavement.

Reviewing Disembodiment and Dissociation

Disembodiment appears to have no congruent definitions throughout the field of psychology literature. Palmer (2009) shared that they viewed disembodiment as disconnect through the axes (see below) and that an interesting aspect of it is that "we may see, think and function with a clear and precise intellectual capacity, while lacking any bodily sensations to accompany our mental activities…it allows us to escape the pressure, feeling, or sensations of the present moment" (p. 100). Kessler and Braithwaite (2016) determined through reviewing research that "out of body experiences (OBEs) occur due to a temporary disruption in multisensory integration processes, where typically stable egocentric processing has become impaired to such an extent that it can no longer represent a coherent sense of embodied 'self'" (p.

3). Some authors believe there to be a Horizontal Axis, which is the means in which we connect with our external world, as well as a Vertical Axis, which is how one connects to their psychological self through their sensory body and heart-based experiences (Fay, 2021; Palmer, 2009). They believe that a lacking in either of the axes can result in disembodiment.

Carter (1996 as cited in McFarlane & Weisaeth, 2002) noted that dissociation or disembodiment is "a compartmentalization of experience in which elements of a trauma are not integrated into a unitary whole or an integrated sense of self' (p. 306). Most definitions refer to a loss of sense of self in one's body, where a "person's psychic and somatic connection is rendered totally or partially disabled" and may result in "depersonalization or derealization at the other end" (p.4). Dissociation is directly correlated to the freeze response from the primary three survival-based responses: fight, flight, freeze. It is also correlated with activation of the dorsal vagal branch of the vagus nerve in Polyvagal theory (Dana, 2020; Hargis, 2020; van der Kolk, 2014).

Dissociation has been directly linked to overstimulation/sensory overload, bereavement, and post-traumatic stress disorder. Hargis (2020) described it as "feeling disconnected from myself…hearing muffled noises…anxiety as fired up, but I grew quiet, turned towards myself, and shut down" (p. 2). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013) names dissociative reactions as an intrusive symptom of post-traumatic stress disorder, having recorded these "reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring" (p. 271). In both of these examples, the individual has disengaged from their present-state within their body's normal homeostasis and have entered freeze responses. The difference in all of the above definitions,

however, lies in whether researchers and practitioners believe dissociation/disembodiment to be purely mental versus physical.

The DSM-5 (American Psychiatric Association, 2013) also denotes key symptoms of dissociation that can lead to depersonalization and derealization. Depersonalization is the "persistent or recurrent experiences of feeling detached from, and as if one were an outsider of, one's mental processes or body" (p. 272). Derealization is when the person experiences "persistent or recurrent experiences of unreality of surroundings" (5th ed.; DSM–5; American Psychiatric Association, 2013, p. 272). As mentioned in chapter one, for the purposes of this capstone and given the incongruency in literature, dissociation and disembodiment will be used interchangeably.

So, if all of the above constitutes what the symptomology and sensory-based experience(s) are, then what does it mean to be embodied? Palmer (2009) shared the following signs that one may be unified, or embodied: "awareness of breath, sensations of gravity, softness and alertness in our bodies, an internal feeling of clarity and focus" (p. 104). In yoga, the *koshas* are access points to different ways of knowing through the body, and these already exist within and are waiting to be accessed. Both Fay (2021) and Palmer (2009) note Buddhist philosophy and suggest that being aware of one's full sensory experience in the here and now, rather than the past, indicates a sense of embodiment. In this sense, dissociation is both physical and mental, and thus treatment should address both of these arenas.

Overlaps

Ultimately, within the lens of grieving and healing Stroebe et al. (1999, 2005) proposed loss versus restoration orientations within models of coping while grieving called the dual-process model. As cited in Dunne (2004), Harris and Winokuer (2019), and O'Connor (2022),

what this means is that the individual is simultaneously coping with both their loss as well as their coming to terms with the loss. In the diagram Stroebe et al. (1999, 2005) created, there is a zig zag line oscillating between the dual paradigms, indicating the very process of grieving and how it is non-linear (Harris & Winokuer, 2019; O'Connor, 2022). This could also easily run in tandem with Palmer (2009) and Fay's (2021) horizontal and vertical axis theories, as dual processes are ever-occurring in relation to both grief and disembodiment.

Trauma and Disembodiment

Traumatic Grief

Given the magnitude of research pertaining to trauma and disembodiment, and the fact that all healing modalities should be trauma-informed, it is also important to pay heed to traumatic grief. As noted in chapter one, trauma is not the event that happens but the effects on the nervous system and present day disruptive physical reactions and sensations (O'Connor, 2022; Porges & Dana, 2018; van der Kolk, 2015). Traumatic grief, however, specifically refers to the grief experienced by someone following a traumatic loss, rather than the traumatic event itself. A traumatic loss is in reference to a "death that occurs as a result of an event that would be seen as traumatic" (Harris & Winokuer, 2019, p. 164). These types of losses can result in PTSD, of which we explored the symptomology outlined by the DSM-5 (American Psychiatric Association, 2013) in chapter one, section *Defining Language*, and helps to better understand the physical symptoms that can relate to varying forms of grief as well. This also highlights how the field of psychology has selected certain forms of grief and trauma to pathologize while not engaging in diagnostic criteria for others, and the benefits and limitations of this.

Somatics and Neuroscience of Trauma

Trauma theory has evolved since its conception in psychoanalytic theory by Freud (1957). Originally, Freud thought trauma to be held dormant in the mind as libidinal energy, only attainable through the unconscious mind (Dunne, 2004; Weber, 2019). It has since developed and been studied and understood as existing within the conscious mind, though separate from the dissociated mind. Radstone (2007, as cited in Weber 2019) shared that:

> Trauma theory's topography of the inner world dispenses with the layering of conscious/subconscious and unconscious, substituting for them a conscious mind in which past experiences are accessible, and a dissociated area of the mind from which traumatic past experiences cannot be accessed. (p. 16)

This showcases the ability for one to eventually access memory recall "once the trauma has been integrated through a neurological approach to trauma" (Weber, 2019, p. 8). This also helps to explain the neurological processes, as described in chapter one, relating to one's inability to recall traumatic events. When trauma is experienced either once or polyvictimization (multiple times), the body's stress response system is activated, the window of tolerance is lowered and therefore neuroplasticity, and the pre-frontal cortex goes "offline". It is in this process of neurological survival system activation that one loses the ability to remember what has occurred and somatic symptomology, such as dissociation, chronic pain, inflammation, increased blood pressure, and more can happen in tandem (Conti, 2022; McKissick, 2019; Porges & Dana, 2018; van der Kolk, 2014).

As explored in chapter one, it is also possible to relive the initial trauma(s) when the limbic centre of the brain and sympathetic nervous system (vagus nerve) are triggered, activating the hypothalamic-pituitary-adrenal axis, and releasing corticotrophin hormones. This further

exemplifies the physiological reactions to trauma, even years later, and how the dissociative brain works to protect an individual. In fact, dissociative symptoms, avoidance, intrusive images, and sleep disturbances are all connective diagnoses for complicated grief (CG), traumatic grief (TG) and post-traumatic stress disorder (PTSD) (Briere & Scott, 2014; James & Friedman; 2014).

The primary differences between TG/CG and PTSD are that the individual mourns separation distress when experiencing TG/CG, and when it comes to avoidance people with CG tend to avoid things related to their bereaved and those with TG/PTSD tend to avoid reminders of the trauma (American Psychiatric Association, 2013; Harris & Winokuer, 2019). As grief exists in all trauma, it is also important to highlight how "traumatic material will tend to overshadow the grief-related symptoms at first because clients who are experiencing symptoms related to trauma will not be able to focus on other aspects of their experience until they feel safe" (Harris & Winokuer, 2019, p. 165).

Grief and Disembodiment

There has long been interest in bereavement and its effects on the body, though this is non-inclusive of disenfranchised grief. O'Connor (2019) noted that studies involving the immune correlates of bereavement date back to 1977, and that interest in grief being a legitimized topic for research dated back to George Engel's (1961) work. For the purposes of this capstone, I will first focus on where the majority of findings lie, relating to complicated grief, indicating that grief is in fact correlated to disembodiment.

Neuroscience of Grief

The field of psychology is entering a new frontier regarding the study of neurology and grief through studies using functional neuroimaging, structural neuroimaging, and animal models

of bereavement. First discovered by Gündel et al. (2003) and later developed further by O'Connor (2019, 2022), "Grief is mediated by a distributed neural network that subserves affect processing, mentalizing, episodic memory retrieval, processing of familiar faces, visual imagery, autonomic regulation, and modulation/coordination of these functions. This neural network may account for the unique, subjective quality of grief" (p. 1946).

The first functional neuroimaging study was conducted by Gündel et al. (2003) using functional magnetic resonance imaging (fMRI). They displayed photos of deceased loved ones to individuals, captioned with grief related words and contrasted this with photos of strangers, captioned with neutral wording. This elicited grief responses in the brain and the studies found that regions such as the posterior cingulate cortex (PCC, associated with retrieval of autobiographical memories and enables feelings of grief), medial prefrontal cortex (mPFC, correlated to the precuneus which is involved in the recall of imagery that is memory based as well as the ability to relate to others) and the dorsal anterior cingulate cortex (dACC, associated with the cerebellum and insula and is the base of cognitive and emotional function), were all activated. The PCC and mPFC are now included as a part of the default network of the brain and the dACC is considered a hub within the salience network of the brain, in other words, the moderator portion of the brain. There is also growing evidence that the posterior and anterior cerebellum play a major role in the brain when grieving due to its' essential role of modulating emotional and cognitive functioning (Gündel et al., 2003; O'Connor, 2019, 2022).

Further to these findings, the exact location of brain maps has been discovered within the hippocampus (responsible for learning and memory, found in the limbic system). The brain map acts as a sort of field map for places, things and people experienced. The example O'Connor (2022) uses is when someone goes to the kitchen for a glass of water in the middle of the night.

After getting out of bed, even without turning lights on, they can likely navigate their way to the kitchen, pour the glass of water, and make their way back to the bed. This applies to other virtual brain maps as well, such as expecting to see loved ones. Where the scenario shifts is when that person expects to hit the corner of their dining room table on the way to the kitchen, because it has always been there. What they forgot in that moment, however, was that they just relocated it in the home. It has not yet become a part of the brain map. The experience of losing someone or something that is familiar is much the same, in that "neurons still fire every time we expect our loved one to be in the room" (O'Connor, 2022, p. 7). What all of these findings show us is that grief "is very mentally demanding" (O'Connor, 2022, p. 94). They also tell us that while there is some variance in neuroscientific findings, people who experience trauma and/or grief both experience limbic and paralimbic activity. The nervous system ultimately ties these two together.

Somatics of Grief

The DSM-5 (American Psychiatric Association, 2013) does not list any somatic symptomology under "Persistent Complex Bereavement Disorder", which highlights a gap in the field. In studies conducted by O'Connor (2019), the following biomarkers were found in bereaved individuals as well as those living with chronic grief: "…increased heart rate (resting and 24-hour), heart rate variability, systolic and diastolic blood pressure…higher levels of cortisol and dysregulated HPA axis activity are also seen" (p. 6). They also found that people who experienced psychological numbness following the death would later have higher cortisol levels. Bereavement was also found to be linked to lower immune responses and decreased antibody responses to vaccinations.

The somatics surrounding more generalized loss, which includes that of disenfranchised grief and anticipatory grief, are also very similar in James and Friedman's (2014) findings. They

also shared that after witnessing thousands of grievers that one of the substantial somatic impacts is loss of energy, particularly pertaining to unresolved grief of any kind. They also found that individuals' diminished energy levels were inaccurately diagnosed as burnout, depression, and more. It is not to say these comorbidities are not at play, but professionals need to pay heed to the somatic effects of grief. Prashant (2018) had similar somatic findings. Atop severe fatigue, they also included other symptoms such as sleep and appetite disruption, tight or heavy feelings in the chest and/or throat, restlessness, dry mouth, tension, and more. They also found increased sensory stimulation sensitivity, which was also noted earlier in this capstone in the subsection *Reviewing Disembodiment and Dissociation* (Anwar, 2022; Prashant, 2018).

Attachment and Grief

O'Connor (2019) found that certain attachments influenced whether a bereaved individual would develop complicated grief. These included excessive rumination (anxious attachment, associated with hyperarousal) and deliberate grief avoidance (avoidant attachment, associated with hypoarousal). It should also be noted that those who experienced an unexpected death or traumatic grief are more at risk of developing maladaptive coping and therefore attachment insecurities. Studies have also shown that the content specific to maladaptive grief rumination includes counterfactuals (Dunne, 2004; O'Connor, 2019; Wayment & Vierthaler, 2002). These include examples such as, "…could I have done something to prevent the death, and self-focused on preservation on the injustice of the death (e.g. why did this happen to me and not someone else?). Maladaptive rumination predicts depressive and complicated grief symptoms" (O'Connor, 2019, p. 8).

To build upon the attachment findings from chapter one, where holding a multidimensional lens in regard to attachment styles and grief outcomes is important, it has also

been researched and suggested that attachment styles can lend to the type of comorbid disorders found during complicated grief. Theorized and control group studies suggest that anxiously attached individuals pose a higher risk for developing complicated grief and avoidantly attached individuals are predisposed to developing depression (Dunne, 2004; Harris & Winokuer, 2019; MacCallum & Bryant, 2018; Scourfield, 2021; Wayment & Vierthaler, 2002).

Mismatches between cultural expectations and an individuals' behaviour can also lead to pathologizing clients as having abnormal behaviour instead of being culturally appropriate reactions to grief (Hooley et al., 2016). This also lends itself to attachment theory, as many cultures outside of Western society believe that family units should remain together intergenerationally within the household, or how overcontrolled behaviour is underpinned in respect and virtue in other cultures worldwide. Routhbaum et al. (2006, as cited in Hooley et al. 2016) conducted cross-cultural research within the United States and Japan. They found vast differences between Western and Eastern based beliefs in what fosters secure attachment. For instance, in the United States they found that the majority of subjects believed secure attachment "to occur when a mother responds in a sensitive fashion to a child's signals (e.g., signs of hunger or discomfort) yet gradually allows the child to explore the environment and develop some autonomy" (p. 101). In Japan, however, they found that the goals of caregivers were to "anticipate all the child's needs and thereby avoid any exposure to stress such as hunger or discomfort and to foster dependency" (p. 102). Japanese culture values social harmony, so children who are dependent and restrained are seen as socially competent. Therefore, when questioning whether someone's symptoms when grieving are normal or abnormal, professionals should be considering their cultural values. As noted within Routhbaum et al. 's (2006) findings, a Western based therapist without a multicultural view may encourage a client to be more

independent, forging their own path. Whereas an Eastern based therapist may see more value in encouraging clients to be grateful and dutiful to their loved ones. It is in these systemic conditionings that one must consider not just varying cultural rituals surrounding grief, but the larger value systems at play when offering holistic care.

Replications of O'Connor's (2019) first functional neuroimaging study occurred with subjects believed to have normal grief versus complicated grief. The findings did indicate a difference in their brains: part of the basal ganglia called the nucleus accumbens were more activated in the participants who self-reported higher levels of yearning, or attachment to the deceased. This part of the brain, when activated, relates to the release of dopamine through perceived motivation and action. "Because nucleus accumbens activity is high in response to living loved ones, and is high in those with complicated grief, one speculative possibility is that activation in this region in response to reminders of the deceased decreases over time in non-complicated grief, as the reminder of the attachment figure no longer generates an intense yearning response" (O'Connor, 2019, p. 9). This indicates the importance of holding a neuroscientific and attachment theory-based lens when working with grieving individuals, as maladaptive coping usually occurs when the attachment to the loss is ruptured or challenging in nature. When the maladaptive attachment is addressed and integrated as earned security, "our connection to the deceased may be different, but it's never really gone" (Scourfield, 2021, p. 68). In the case of understudied disenfranchised and anticipatory grief, I believe healing this attachment wounding would also be efficacious as the pain experienced when grieving stems from the lost 'objects' in one's life, therefore requiring them to find new ways to reframe their relationship to the loss and to what is presently around them (Dunne, 2004; Fay, 2021; James & Friedman, 2014; O'Connor, 2022).

Additional Thoughts on Grief and Disembodiment

What if grief was viewed as a survival mechanism, the way trauma is? It is well known that when in survival mode the autonomic nervous system becomes dysregulated, activating the dorsal vagus and hypoarousal (freeze response) or hypervigilance/hyperarousal (fight/flight response), all of which happen in tandem with other neuroscientific findings when experiencing grief. It has been well studied that when an individual loses something or someone it shatters their assumptive views of the world. In other words, the level of trust one has with themselves can directly correlate to their sense of embodiment. So, the question then becomes: how does one begin to reframe and regain trust within their sense of self, thus learning to become embodied while grieving? How does one not remain separate to oneself? Taylor (2017) suggests that due to Western societies' way of being, that is, in a state of disconnection from others, nature and ourselves, that humans are collectively grieving and are thus fragmented and dissociated.

Interventions

The interventions outlined below are far from the breadth of modalities used in the field to treat trauma, grief and/or disembodiment. Rather, these have been selected as a part of an attempt to review a holistic application of top-down approaches meeting bottom-up approaches. While the primary thesis of this capstone is to focus on healing disembodiment experienced while grieving, particularly in the context of disenfranchised and anticipatory grief, the selected interventions are not necessarily widely used for treating just this. What they are, how they aim to help, and what they are typically used to treat will be reviewed. The top-down focused interventions that will be explored are feminist narrative therapy and mindfulness-based cognitive behavioural therapy (MBCT) to talk and experiential therapy. There will also be discussion surrounding mindfulness and compassion interventions and whether mindfulness

should be considered top-down or bottom-up. The bottom-up focused interventions that will be studied further in depth are somatic approaches in therapy through expressive arts, of which the primary interests are dance movement therapy and somatic body mapping through visual arts, as well as conscious embodiment interventions (Bernstein, 2022; Chiesa et al., 2013; D'Cruz et al., 2019; 5Rhythms (n.d.), Gray, 2017; Pellitero & Hunter, 2020; Prochaska & Norcross, 2018; Madigan, 2019; Mazza, 2018; Segal et al., 2013; Selissky, 2017; Schwalbe, 2023).

Some important modalities and interventions not explored below, but that have contributed greatly to the arenas of grief, trauma and embodiment work from a multicultural lens include Polyvagal Theory by Steven Porges, Somatic Experiencing by Peter Levine, the range of breathwork and meditation practices stemming from Hinduism, Buddhism, Taoism, Shamanism, Sufism, Qigong and more, and Complicated Grief Treatment by Katherine Shear (Ogden et al., 2006; Porges & Dana, 2018; Prochaska & Norcross, 2018; Stein, 2021).

Foundations of Understanding for Chosen Interventions

Co-regulation. Co-regulation is the ability to "regulate emotions and behaviours to soothe and manage stressing internal sensory input or external situations, with the support and direction of a connecting individual" (Victoria, 2022, para. 8). Co-regulation begins in infancy with caregivers and shifts over time to include others, including that of therapist-client relations.

Interoception. Interoception is when the mind and body inherently inform one another's practices by interpreting signals. When conceptual information is processed, it presents itself through the body (Häfner, 2013). For example, when thinking about how elderly people may walk more slowly (Bargh et al., 1996). Vice versa can also be said, as cognitive structuring can occur because of sensorimotor states. For example, when someone is carrying a heavier weighted foreign currency in pocket it may lead them to believe it to be valued as more than it possibly is

(Jostmann et al., 2009). These are salient examples of how interoception relates to symptoms of dissociation and how they occur on a mind-body level (5th ed.; DSM–5; American Psychiatric Association, 2013).

Mirror Neurons and Mirroring. Mirroring is when the client requires the therapist, or another client, to join them in a bodily experience such as pushing/pulling, dancing, or yelling with. Many people have never experienced avenues in which to be supported in their initial reactive states of attachment, therefore helping to alleviate the alienation that can come from withholding (Carter, 2002). Much like mirroring, mirror neurons are a specific class of neurons in the brain that "discharge both when an individual executes a motor act and when he observes another individual performing the same or a similar motor act" (Acharya & Shukla, 2012, p. 118). Further to this, findings suggest that mirror neurons can enable engagement in self-reflective second-order awareness of one's own brain processes (Acharya & Shukla, 2012, O'Connor, 2022).

Neuroplasticity. Neuroplasticity is a vital notion in the treatment of trauma, in particular, as neurons have the ability to evolve and form new bonds, even those that were damaged through repetitive cycles of traumatic reactions and traumatic reliving. This is an integral part of the integrative process of healing trauma, as it creates more equilibrium of emotional and cognitive functioning through communication within the default mode network of the brain. This equanimity also lends to activation of the parasympathetic nervous system, the rest and digest state of being as the individual is now out of survival mode (Conti, 2022; Dana, 2020; van der Kolk, 2014; Weber, 2019).

Clinical Significance

The clinical significance of choosing both top-down and bottom-up approaches is in integrating talk therapy with more experiential therapies. Thus, enabling someone to safely move through their disembodiment while processing their grief. Weber (2019), quoting Ogden (2006, p. 23), shares that "top-down and bottom-up processing represent two directions of information flow, and their interplay holds significant implications for the occurrence and treatment of trauma" (p. 5). They can also help to downregulate states of arousal within the nervous system, therefore proving efficacious in healing trauma and grief (Brom et al., 2017; Kuhfuß et al., 2021, Ogden & Fisher, 2019, Solorzano, 2015).

Interventions - Top-down

Feminist Narrative and Expressive Arts Poetry

The notion of decentering found in top-down approaches such as dialectical behavioural therapy (DBT) and mindfulness based cognitive therapy (MBCT) is at the heart of narrative therapy, but is referred to as externalizing. Coined by Michael White and extrapolated upon by Madigan (2019), externalization is purposefully not "privatizing the problem inside the clients' body" and is "relationally repositioning" (p. xxi). It is from this positioning that narrative therapy was born from post-structural theories, posing the "self as a relational identity" (Madigan, 2019, p. 12) to allow individuals to re-author their lives. There are several useful techniques to aid in a clients' ability to re-author, such as externalizations that becomes deconstructed to gain a better understanding of how these narratives and externalizations relate to the individual's wider meta-narratives, schemas, and assumptions (Lee, 1997; Madigan, 2019). The ability to reframe narratives speaks highly to an individual's ability to engage with neuroplasticity and is used in the context of grief to re-tell, re-member and re-author one's experience with loss, particularly

relating to bereavement but could be applied to both disenfranchised and anticipatory grief (Madigan, 2019). James and Friedman (2014) take this one step further in their book, outlining how to prepare *Loss History Graphs*, and *Relations Graphs* that become converted to recovery components through letter writing.

Anti-realism is also at the heart of narrative practice, aiding in the belief of someone's perception of their reality, which is also inherently feminist. This means that no objective reality truly exists and therefore aims to meet clients where they are at, to not pathologize them and to believe their retelling of their lived experience(s) (D'Cruz et al., 2019; Lee, 1997; Madigan, 2019). This is particularly important in the case of disenfranchised grief, where the loss the person is experiencing has otherwise been deemed unacceptable societally. An example in practice of this is after an acquired brain injury. It is known that clients suffer with grieving a loss of identity. Narrative therapy can be used as a tool for reconstructing these lost identities. (D'Cruz et al., 2019) state that it is the marriage of narrative storytelling and story sharing that shows promise both in one-on-one therapy sessions and in group therapy, but more research is required in the healthcare context, and for these clients to be able to share in a safe and ethical way.

Poetry is an intersection of narrative therapy and is more closely linked to being a top-down approach than a bottom-up approach, like most other expressive arts. It is believed that poetry is inherently related to social issues in that narrative and poetic means help to heal and create new stories within individuals and communities as agents of change and to build hope, health, and fulfillment (Mazza, 2018). Poetry's ability to be flexible, allusive, and metaphorical is also argued to be an "out-breath of spiritual experience" (Taylor, 2017, p. 47). Poetry therapy is defined as "the use of language, symbol, and story in therapeutic, growth, educational, and

community building capacities" (Mazza, 2012, p. 1434 as cited in Mazza, 2018) and is conducted in a couple of different formats for use of intervention. One is where poetry is recited to the group and there are reflection-based activities, and the other is where group writing of poetry can take place (Goldstein, 2018).

Specifically particularized to poetry therapy rather than narrative at large, there is the Receptive/Prescriptive, Expressive/Creative, Symbolic/Ceremonial (R.E.S) practice and research model, which has proven efficacious with cancer patients and reducing their overall distress and anxiety while grieving their impending loss, therefore relating to anticipatory grief. (Mazza, 2018) shares the basis for R.E.S practice:

> (1) (R) The receptive/prescriptive component involving the introduction of literature (e.g., poem, short story, and literary excerpt) into practice. (2) (E) The expressive/creative component involving the use of client writing. (3) (S) The symbolic/ceremonial component involving the use of metaphors, rituals, and storytelling. (p. 17)

Mindfulness Based Cognitive Behavioural Therapy

While mindfulness can be found in all third-wave modalities such as DBT, acceptance and commitment therapy (ACT) and emotion focused mindfulness therapy (EFMT), the focus of this subsection is MBCT (Prochaska & Norcross, 2018). MBCT was created by Zindel Segal, Mark Williams and John Teasdale in response to prevention of relapse for major depressive disorder (as cited in Segal et al., 2013). It has been shown to improve emotional regulation among participants through internetwork re-organizations while in resting states, thereby exhibiting efficacious neuroplasticity when practiced (Huang et al., 2021). Pulling from second wave therapy, Segal et al. based MBCT in Beck's work on cognitive behavioural therapy in the 1960's that focused on an individual's internal belief system, or schemas, as well as their internal

assumptions. The approach focuses on shifting mindset; specifically reframing automatic negative thoughts, which will then shift behaviour (Prochaska & Norcross, 2018; Solorzano, 2015). Influenced by third wave therapy and Eastern philosophical roots, they also incorporated mindfulness.

Mindfulness stems from Eastern philosophies, particularly derived from Zen Buddhist practices (Prochaska & Norcross, 2018). In dialectical behavioural therapy (DBT), created by Linehan in the 1970's to specifically treat "chronically suicidal or self-injurious patients" (Prochaska & Norcross, 2018, p. 274) living with borderline personality disorder, the concept of decentering from negative thoughts is used. Linehan relayed the use of mindfulness as a tool to decenter to Teasdale and Williams while in Cambridge in 1991 (Segal et al., 2013), sharing her learnings from Jon Kabat-Zinn and the mindfulness-based stress reduction programs he was utilizing to treat chronic pain. Mindfulness, as described by Jon Kabat-Zinn, is when we "pay attention on purpose, in the present moment, non-judgmentally, as if our life depends on it" (PsychAlive, 2013).

As mentioned above, the foundations of MBCT intertwine more cognitive approaches with body-specified mindfulness. MBCT consists of eight weekly sessions, typically delivered in a group format, that are divided in half to address varying needs. For instance, the first four sessions focus on teaching participants mindfulness skills: paying attention, noticing mind wandering, and directing the mind to a neutral and singular focus. The latter four sessions revolve around employing these mindful skills when experiencing negative mood shifts to protect against MDD relapse. The therapist, often referring to themselves as the "instructor", conducts the weekly sessions which are hosted as collaborative spaces. Open and engaged questions, such as "What are you experiencing now?" are used to prompt "joint and interactive

sharing" (Prochaska & Norcross, 2018, p. 279). Segal et al. (2013) noted the paramount importance of embodying the work, stating that "teachers of mindfulness are practitioners of mindfulness in their own daily lives" (p.6,7). They believe that without hosting this responsibility, the ethics of MBCT are lost. Another intervention used by instructors are the "body scan", which takes clients through a meditative practice in giving awareness to specific parts of their body; scanning from the head to toes or vice versa. This has been widely used in varying modalities and is important to note that it stems from yogic meditation (Satchidananda, 1984). While this capstone will not be exploring the breadth and forms of meditation, it is important to note that two things aid in rudimentary meditation practices: "repetition of a word, a sound or a movement, and the ability to turn off everyday thoughts" (Altschuler, 2017, para. 4).

Compassionate Mindfulness and the In-Between

When being mindful, it is also key to be compassionate. As Brach (2004) shares, "We often distance ourselves from emotional pain - our vulnerability, anger, jealousy, fear - by covering it over with self-judgement…we cannot be accepting of our experience if our heart has hardened in fear and blame" (p. 199). Developing compassion is particularly important in the case of living with disenfranchised grief by the very nature of it not being a socially recognized and accepted form of grief and grieving, therefore lending to typically feeling fear, shame, and anger (Fernández-Alcántara et al., 2021; James & Friedman, 2014; O'Connor, 2022). It is also a practice of re-learning trust through compassion and patience (Fay, 2021).

A few interventions used for developing self-compassion include "Internal Family Systems (IFS) parts practice" (Fay, 2021, pp. 112-114), the "Buddhist meditation called *metta"* (Palmer, 2009, pp. 31-32), and metaphorically symbolic exercises like "Hello Kitty" (Bush, 2015, p. 91). These all aim to shift individuals' "lack of self-esteem and the propensity for self-

blame" (Bush, 2015, p. 91). Whether these compassionately mindful practices are viewed as top-down or bottom-up is debated, but the general consensus is that more short-term therapeutic approaches, such as brief-therapy models, employ more top-down emotional regulation whereas longer term therapy allows for more bottom-up approaches (Chiesa et al., 2012). For the purpose of this capstone, compassionate mindfulness has been labelled "in-between" as findings and recommendations pertain to short and long-term therapies.

Honing in on the very real limitations of meditation, which inherently requires a person to occupy their body and engage in witnessing their breath through "attention training" and "letting go of distractions" (Altschuler, 2017; Satchidananda, 1984), is the Cheetah House. They have dedicated their careers to understanding the maladaptive effects of meditation when undertaken without appropriate instruction, engaged with in ways the client is not ready for, or when facilitated in a way that is not trauma-informed. Specific somatic findings they have found with observable changes in bodily function or physiological process include fainting, gastrointestinal distress and nausea, cardiac irregularity, and more (Britton, 2021). These serve as important reminders to assess the potential harm or risk these practices could pose for any particular client at any particular time, as untoward negative effects could be delayed.

Interventions - Bottom-up

It is important to pay heed to the fact that all of these interventions utilize mindfulness in their bottom-up approaches to treat trauma, grief and dissociation.

Expressive Arts

Dance Movement Therapy

Dance Movement Therapy (DMT) is a type of biopsychosocial therapy that uses bodily movement to support the integration of the emotional, cognitive, and social aspects of an

individual. It uses and analyzes body experiences and expressions such as movement, mimicking, gestures, body posture, touch and so on to work with clients. DMT therapists believe that physical movements reflect emotional states and by changing physical movements, one can change their psychosocial experience (Martinec, 2018). Through the engagement of somatic, perceptual, and emotional processes, DMT aims to develop an attuned, embodied awareness of the client's physical and emotional state.

Pylvänäinen (2010, as cited in Martinec 2018) suggested that DMT may facilitate relaxation and the parasympathetic nervous system, which would help with clients' experiencing dysregulation surrounding their grief. They also suggested it would induce images, memories, and associations, which proves efficacious to activating the posterior cingulate cortex when affected due to grief. It also helps to embody play through the use of props, improvisation, and imagery duets, and also promotes presence and learning how to be in the body and developing symbolic expressions of self through the body (Bernstein, 2019). Movement engages physiological processes that are related to certain emotions and make them more available to the conscious mind. This is done through the vagus nerve while employing Polyvagal-informed DMT (Gray, 2017). By allowing the release of energy that can come from a more survival-based place (hyperarousal in the sympathetic nervous system, hypoarousal in the dorsal branch of the vagus nerve), one can have a greater chance of reaching their vagus nerve and therefore homeostasis. This, paired with respecting one's own body and the right to embody, are suggested to enhance the individuals' trust with themselves, thus enabling embodiment (Bernstein, 2019; Gray, 2017; van der Kolk, 2014).

While this practice does not fall under the official DMT designations, 5 Rhythms is considered to be a movement meditation. Developed by Gabrielle Roth in the late 1970's, it aims

to improve individuals' balance, energy levels and sense of connection via community. 5 Rhythms moves through a bell-curve like, musical-genre bending, dynamic dance practice where people can focus solely on themselves or consensual engagement with others. The five elements are Flow, Staccato, Chaos, Lyrical and Stillness. Flow is typically softer music, allowing the entryway to grounding and activation of the parasympathetic nervous system through receptivity of bodily needs. Staccato is characterized by stronger movements and establishes a connection through repetitive and self-expressive motions. Chaos is the dissolution of structure and enters complete free-flow, untameable movements. Lyrical is a lighter and more playful dance, aiming to re-center oneself through their creative and empowered expression. Stillness refers to the slow falling into silence on the dance floor, noting the end of the journey. This practice highlights a specified arch to employ for movement-related therapies (5Rhythms (n.d.).

The way one uses props in dance is a path to cultural competency that is trauma-informed. For instance, using props like rope or blindfolds can have many different, negative, effects on clients. As noted by Jorden (2021), rope has been used to oppress people, to hang people, so to be aware of the intergenerational trauma and legacy this holds for some clients, alongside death by suicide. Even moving clients into certain positions that are well-used in DMT, such as a living statue, should be taken into consideration from a cultural context. "A teacher who identifies as white sculpted him, not holding the awareness of her white body instructing how a black body should move. Not holding the awareness that black men, women and gender non-conforming folks are being shot and asked to put their hands up seconds before death" (Jorden, 2021, p. 2).

As DMT is a largely a nonverbal form of treatment, it is particularly suited to be used in settings where the therapist and client do not share a common spoken language. When working

in other cultures, DMT therapists must adapt their Western-centered tools to meet the needs of the community and culture they are working in (Bernstein, 2019). In a study conducted by Pellitero et al. (2020), they paired DMT with a sense of belonging within urban spaces and disenfranchised grief with immigrants. “Through revising the memories of place, participants also reported experiencing a personal confrontation with the sense of a loss of place, of spatial dislocation or relocation, cultural de-contextualization or a hopeful expectation yet to be discovered” (p. 259). To aid in connecting with other cultures, DMT therapists can use local or culturally familiar music to engage with clients of different cultures. Additionally, clients can bring forms of dance, movement, and rituals from their own culture into this intervention.

Visual Arts – Body Mapping

Somatic body mapping is a visual representation of the felt sensory experience within one’s body by using marks, images and symbols on the page. These represent the present-moment experience in an individual’s body such as places that hold pain and places that sensation tingles or lingers in (Schwalbe, 2023). Much like the brain’s map (O’Connor, 2022), the somatic body map holds valuable information to retrieve.

In a study conducted by Kruk et al. (2014), researchers used brain imaging techniques during art processes involving drawing. Findings showed “activity in the occipital, parietal and temporal lobes. Increased beta activity was found in the left medial temporal, left frontal, and left prefrontal lobes” (p. 53). These findings are valuable in that the left hemisphere of the brain relates more to verbal processing, which can be inaccessible during trauma and grief, particularly if someone is dissociated. Artistic mediums can help to “fire” the left hemisphere to allow for bilateralization of left and right brain activity (Weber, 2019).

Conscious Embodiment

In conscious embodiment, pioneered by Palmer (2009) and Fay (2021), both stress the importance of practice. “It is crucial that we practice just for the sake of the practice” (Palmer, 2009, p. 56). Many of the practices outlined by Palmer (2009) require mirroring, as they are based in Aikido practices. Aikido’s process of *irimi:* “moving into a situation, embracing life, and developing deeper contact with our center” is paid heed to, enabling the horizontal and vertical axis of healing to take place (Palmer, 2009, p. 3). This innate internal wisdom is what drives conscious embodiment, as it stems from learning how to trust one’s own abilities and intuition through being completely in the present moment.

Palmer (2009) spoke of form as a rudimentary tool to come back to, sharing the gravity of learning to stay with sensations in the body. “In conscious embodiment, form is the foundation of mastery because it establishes a clear, tangible reference point…we begin to focus our attention by becoming aware of the posture of our body” (Palmer, 2009, p. 168). It is by focusing on the body and its sensations that it becomes the teacher and primary source of wisdom in conscious embodiment while asking oneself self-awareness questions such as, “What would it be like if I had more of __ quality?” (Palmer, 2009, p. 32), and creating cognitive flexibility through “yes….and…” practices, which are also employed in MBCT (Palmer, 2009, p. 49). There are many different exercises outlined, including those which invoke self-realization, internal family systems (IFS) parts work to create the whole self and re-associate, and more. Another important and interesting epicenter of Conscious Embodiment work is also accepting the mystery of the unknown, of what one cannot control. This would prove effective for those living with disenfranchised, and in particular, anticipatory grief (Fay, 2021; Palmer, 2009).

Interventions at Play

None of the above interventions employ the out of date "grief work hypothesis" of "letting go", "moving on" or relinquishing the thing(s) or person(s) lost. Rather, the adopted attitude is more about moving forward and finding ways to honour the loss(es) (Harris & Winokuer, 2019, p. 35). There is also levity that can come from employing any of the above interventions and in this, highlights the importance of play/playful attitudes within the therapeutic space while engaging in mirroring and co-regulation, thus improving distress tolerance, awareness, cognitive flexibility, and sense of self through embodiment (Harris & Winokuer, 2019; O'Connor, 2022; Palmer, 2009; Segal et al., 2013). Further to this, it is through the relational space that one can heal trauma and grief by virtue of having a safe connection source (Fay, 2021; Ogden & Fisher, 2006; Porges & Dana, 2018; van der Kolk, 2014).

When considering the autonomic nervous system and maintaining one's window of tolerance, certain conditions need to be met for an individual to feel safe enough to begin addressing their grief and dissociation. Porges and Dana (2018) share the following conditions for engaging safety cues: "1) The autonomic nervous system cannot be in a state that supports defense; 2) the social engagement system needs to be activated to down regulate the sympathetic activation and functionally contain the sympathetic nervous system and the dorsal vagus circuit within homeostasis that would support health, growth and restoration; 3) cues of safety need to be available and detected via neuroception" (pp. 61-62). This also lends itself to the importance of maintaining social justice frameworks that are trauma-informed and anti-oppressive when working with clients to maintain a sense of safety, as well as being aware of concurrent factors such as religion, personality, cultural and familial factors, and rituals (Arthur, 2018; Dunne, 2004; Harris & Winokuer, 2019; Jorden, 2022).

Ultimately, if an individual feels safe enough to engage in the relational healing found in therapeutic spaces while invoking interventions such as top-down MBCT and Feminist Narrative, while playing through means such as poetry or within bottom-up approaches such as DMT, Somatic Body Mapping or Conscious Embodiment exercises, there is a strong likelihood of becoming embodied while tending to their disenfranchised and anticipatory grief from a compassionate lens. In experiencing bottom-up approaches that are trauma-informed, paired with top-down approaches that are anti-oppressive, one can see how embodied cognitions are possible (Häfner, 2013).

Clinical Implications

Limitations

Findings related to neuroimaging studies have found that more reliable diagnostic criteria are required in order to investigate salient differences in disordered grief compared with controls that would result in more reliably defined neural processing. Given the current breadth of categorizations of grief in the field, there appears to be a lack of clearly defined criteria, therefore affecting the validity and reliability of studies due to a lack of congruency in definitions. In this sense, the field is asking for deeper criteria to pathologize to enable more clarity in research. This could prove helpful for individuals who feel impaired by their grief, though it does further pathologize individuals. It also does not account for factors like pre-existing conditions in participants, heterogeneity of sample sizes, and comorbidity (O'Connor, 2019, 2022).

Other limitations to conducting neuroscientific studies are the lack of funding and conditional environmental and relational factors in conducting research. Lack of funding may impact the population sample size used, alongside the ability to have comparison groups. It is recommended that the field see grief as pervasive and therefore cardinal in providing more

resources (Brom et al., 2017; Gündel et al., 2003; O'Connor, 2019, 2022). In observational studies, whether the environment is indicative of being truly naturalistic is under scrutiny. Factors such as the behaviour of the therapist(s) and their offerings, or whether the therapist is offering congruent care among different group participants are to be considered in these small sample studies (Gündel et al., 2003; O'Connor, 2019).

Summary

While there is some variance in neuroscientific findings, people who experience trauma and/or grief both experience limbic and paralimbic activity. Neuroscientific research states that when an individual experiences grief there are areas of the brain that are affected. This indicates that the neurological and autonomic nervous system sequelae of grief are similar to those of trauma. This not only highlights the importance of furthering research pertaining to grief but highlights a visible gap in a field focused more on complicated grief rather than disenfranchised and anticipatory grief.

Using an integrative approach allows for a biopsychosocialspiritual perspective, regardless of short or long-term therapy (Chiesa et al., 2012; Hooley et al., 2016). MBCT focuses on treating the potential for relapse of MDD, and as noted in chapter two's subsection *Reviewing Grief, Grieving and Complicated Grief*, the symptomatology of grief and depression are quite similar and can oftentimes be comorbid in nature (O'Connor, 2022; Wayment & Vierthaler, 2002). Feminist narrative focuses on externalizing and re-authoring from an anti-realist perspective that will inevitably help the client with any distressful or maladaptive ruminations. Compassion helps the individual to re-build their self-esteem and patience to increase distress tolerance and allow them to come from a more self-accepting place, regardless of intervention or attachment style. Bottom-up approaches such as DMT, Somatic Body Mapping and Conscious

Embodiment help to create an experiential practice, allowing trust and safety to reform within an individual's sensory input and sense of self. Most importantly, all of the interventions have been proven efficacious in both individual therapeutic as well as group settings, thus lending to varying forms of connection in the grieving process (Bernstein, 2022; Fay, 2021; Kosminsky & Jordan, 2016; Kuhfuß et al., 2021; Lee, 1997; Madigan, 2019; Mazza, 2018; Pellitero & Hunter, 2020; Palmer, 2009; Prashant, 2018; Segal et al., 2013).

Why is it that the field is studying trauma/traumatic grief and not more surrounding complicated grief, let alone expanding the field of study to include disenfranchised/anticipatory grief? Further to this, is complicated grief maladaptive or a normal part of processing grief with varying severities? As defined by James and Friedman (2014), "Grief is the *conflicting* feelings caused by the end of or change in a familiar pattern or behaviour" (p.3). From this lens of attempting to normalize all forms of loss and the dissociation that can follow, chapter three will further discuss recommendations for best practices that hold an integrative biopsychosocialspiritual perspective.

Chapter 3: Discussion, Recommendations, and Applications

The subjectivity of grief is important to consider. Individuals and professionals tend to pathologize and over-diagnose when people are "simply trying to explain their experience in a culture that does not understand the universal grieving process" (O'Connor, 2022, p. 102). There are benefits to having criteria, however, in being able to provide support and interventions as well as the ability to gain funding for further research in the field (O'Connor, 2022). While there have been distinctions made between depression and grief as well as their overlaps, one has to consider clinical limitations, such as not knowing a client prior to their loss and therefore not knowing if they already have experienced depressive symptoms prior to the loss. As James and Friedman (2014) discuss, "When grievers use the word *depression*, they are typically signifying a "lowered case state of feeling or energy…doesn't a lowered level of energy seem logical? isn't the griever entitled to some diminished feelings as he or she adapts to the painful and confusing new reality? We think so" (p. 48). This poses an interesting perspective as to the universality of grief and grieving as well as the normalization of the symptoms associated.

Further to this, studies relating to grief and neuroscience are still in their infancy and researchers such as O'Connor and team share how this can only be directed toward complicated grief as it is the only form of grief in the DSM-5 and therefore diagnosable (O'Connor, 2019, 2022). However, should varying forms of grief be pathologized? On one hand, professionals should question whether grief ought to be considered "disordered". Is classifying grief as a disorder further polarizing social inequities through a predominantly Euro-centric lens? On the other hand, if it enables more scientific study and additional client support, perhaps there should be further investigation of the categorizations of grief and their symptomatology. If this were to occur within the field, it is recommended that a subsection within complicated grief should be

made to adjust this from grief pertaining to bereavement to inclusion of disenfranchised and anticipatory grief. This could allow for more studies to be conducted and for normalization of varying forms of grief and their symptomatology within the field of grief. There are, however, downsides to pathologizing normal human responses, as mentioned above, and there needs to be careful consideration given to the ethical implications.

A gap in the field that warrants highlighting is that the DSM-5 (American Psychiatric Association, 2013) does not list any somatic symptomatology as a part of the diagnostic criteria for persistent complex bereavement disorder, yet this is a part of PTSD. From neuroscientific findings, to attachment and dissociation, the research in this capstone has showcased the cross-over between trauma and grief. This therefore validates the need for more research to be conducted pertaining to grief, its' varying forms, and how this can correlate with disembodiment. It also provides proof of somatic symptomatology stemming from varying forms of grief and warrants extending this knowledge into the field so as to treat clients from a more holistic lens. If dissociation is both a mental and physical reaction to trauma and grief and can be interocepted, then treatments with bottom-up approaches that still integrate talk therapy's top-down approaches are suggested for a more unified process that, depending on selected interventions that the client is consents to, could produce a more biopsychosocialspiritual approach to treatment.

Another consideration when using the interventions outlined in this capstone is whether touch therapy could be interwoven, such as a hand on a shoulder signifying support or encouragement. Such touch has been shown to be a co-regulatory tool in the healing professions (Carter, 2002). This, depending on the client, could prove helpful from a dissociative lens, as a form of connection through supportive touch can help when grieving. Touch has been lost within

the field of therapy, leaving others in helping professions such as nurses, registered massage therapists, and others to have hands-on healing for somatics with clients (Carter, 2002). This could further aid in co-regulation becoming an essential tool for healing, particularly when a client wants to engage in being mindfully present. While there are ethical implications in using touch with clients, and it is vital to obtain fully informed consent and to use culturally sensitive/appropriate touch, it is ultimately up to the practitioner's discretion (Truscott & Crook, 2013). It is suggested that therapists engaging in bottom-up approaches be particularly open to a clients' request for comforting touch, or to use this as an invitation, thereby checking for ongoing consent, when in the therapeutic setting.

Safety and Preparation

Culturally Competent Practice

Culture is an ever-shifting evolution of customs, values, and traditions that people integrate into their conditioning via their environment(s) and social/cultural contexts through consistent learning (Arthur, 2018). Professionals should remain empathetic and curious to clients' lived experiences, maintaining a culturally conscientious practice that can hopefully allow for safety cues to materialize. An adaptation of Bordere's (2016) work by Harris and Winokuer (2019) noted five key elements to providing a more culturally mindful practice: (a) acknowledge, (b) ask, (c) accept, (d) align, and (e) apologize. These not only allow for the client to be the dominate voice and expert on their own lived experience, but also leaves room for modeling humility and rupture repair within the therapeutic space, thus lending to a greater sense of safety while centering the client's experience (Arthur, 2018; Harris & Winokuer, 2019; Truscott & Crook, 2013).

Another question to be raised is what is “grievable”? From a cultural standpoint that holds true the systemic oppression and wars on people of colour, particularly Black people, as well as the war on transgender bodies, grief becomes an inherent part of these individuals’ existences (Arthur, 2018). Holding this systemic point of view becomes important when temptation to pathologize is present. For instance, this understanding moves beyond the DSM-5 (American Psychiatric Association, 2013) culture-related diagnostic issues that name how disorders relating to grief are only diagnosable when the “persistent and severe responses go beyond cultural norms of grief responses and are not better explained by culturally specific mourning rituals” (p. 791).

Given the level of concurrent stressors, practiced rituals, and multiplicities of culture at play within any given individual’s life, holding any one world view on someone’s subjective reality could inherently become ethnocentric and oppressive in practice (Arthur, 2018; Dunne, 2004; Harris & Winokuer, 2019; Jorden, 2022). While no one can ever fully understand what it is to be in another person’s experience, practitioners can ask many curious questions without expecting their clients to teach them. This means working to identify systemic barriers, disability injustices, derogatory attitudes and exclusionary factors that present barriers (Brown, 2021). It is also in trusting that if a professional believes the care they are providing is out of their scope of competence, then it is most ethical to refer the client to culturally competent care (Arthur, 2018; Truscott & Crook, 2013).

The importance of developing rituals in relation to loss, particularly in Western cultures, is paramount to the process of integrating the despair of loss and the reframed relationship to the loss for continuing bonds (Harris & Winokuer, 2019; O’Connor, 2022). “Active process” (James & Friedman, 2014) involves ritual of some sort, determined by the grieving individual’s

expression of choice. For instance, this could include lighting a candle to honour the loss, writing a letter, going to each room of a home and going through memories made there to release the space prior to moving, and more (Harris & Winokuer, 2019; James & Friedman, 2014). It is recommended that professionals seek to explore the clients' values, belief systems and cultural lenses as to aid in the development or continued practice of rituals surrounding their disenfranchised and anticipatory grief; therefore offering moments of mindfulness and presence which also lend to the practice of conscious embodiment.

Practitioner Self-Awareness and Care

Practitioner self-reflexivity is important in a number of ways. One is knowing one's own capacity and bandwidth, and the other is to attempt to ensure ethical care is being carried out with clients. Stephen Levine says that "we can only be truly available to others in loss and grief to the extent we know our own grief" (as cited in Prashant, 2019, p. 19). Therefore, professionals who are working with grievers, who may also be disembodied, must practice self-care due to the 'somatic resonance' that our bodies register while witnessing and co-regulating within the therapeutic space with the other. This is true to being the instrument of our craft (Bush, 2015). When involved in empathic communication, that which mirrors the experience of the other, professionals are "grief adjacent" and one must take care of the self to prevent compassion fatigue and burnout (O'Connor, 2022; Prashant, 2019). This can be done through various rituals and practices, all of which encourage mindfulness to maintain ethical awareness (Bush, 2015; Truscott & Crook, 2013).

Whether an intervention is appropriate to use with a client also requires practitioner awareness. This is not only to self-address whether the practitioner themselves are competent in administering the intervention, but also to pay heed to consistently assess whether a client could

be ready for or could likely benefit from a particular intervention. For example, if part of a client's grief relates to gender dysphoria, it is suggested that the practitioner focus first on the relational aspects within the therapeutic experience while employing top-down approaches. Bottom-up approaches should only be utilized when the client feels safe enough to begin engaging with their physical form, thus slowly titrating these approaches as a source of healing. It is part of the responsibility of the practitioner to provide ethical care and these self check-ins, as well as maintaining self-care, are an important part of this process (Truscott & Crook, 2013).

Safety in Groups

Safety within groups is necessary to discuss as potential for healing in group environments has been shown to be efficacious within all interventions outlined in chapter two (Bernstein, 2022; Fay, 2021; Kosminsky & Jordan, 2016; Kuhfuß et al., 2021; Lee, 1997; Madigan, 2019; Mazza, 2018; Pellitero & Hunter, 2020; Palmer, 2009; Prashant, 2018; Segal et al., 2013). Due to this, a workshop is proposed below for a group healing process.

Important considerations for safety start prior to the group entering the room and are followed through while they are present. These include the groups' inclusionary and exclusionary criteria and how this could influence a sense of safety within shared space, the kinds of community or group agreements that will be upheld by the facilitator(s) and whether the group can democratically make additions or edits, and more (QMUNITY, n.d.; Yalom & Leszcz, 2020). When the group is in session, paying heed to psychoeducational components that are trauma-informed and anti-oppressive are essential to share. For example, it is recommended that facilitator(s) explain the difference between self-regulation and co-regulation and why it is important for each individual to self-determine their own boundaries in regard to sharing personal stories and information, even when the space is confidential. This also encourages self-

trust, an important component in the case of this capstone to re-establishing a sense of trust with one's perceived reality and sense of embodiment while grieving.

Proposed Workshop

The proposed workshop, entitled "Coming Back into Body While Grieving All Forms of Loss" (see Appendix), is meant for anyone of any background, ability and ethnicity who are 19+ and are experiencing disembodiment while grieving, and in particular forms of grief that are disenfranchised or anticipatory. It is adaptable to shifting into a teaching format for professionals and aims to encompass theories like the dual-process model as a remembrance that people are trying to cope/heal with loss while also living their lives, as well as feminist narrative, anti-oppressive, client-centered, and trauma-informed lenses, all of which I believe will offer a biopsychosocialspiritual perspective. While many workshops that focus on somatics only offer bottom-up approaches, this framework has decidedly intertwined both top-down and bottom-up. As noted throughout chapter two and summarized in the subsection *Interventions at Play* above, using both of these approaches can result in embodied cognitions (Fay, 2021; Häfner, 2013; Palmer, 2009).

There are many different frameworks available to facilitator(s). For instance, Katherine Shear's (2005) ten-session program for anticipatory grief in caregivers for those living with dementia, as cited in Fernández-Alcántara et al. (2021), included psychoeducational models, exposure techniques, as well as role playing situations to help address grief related symptoms. This workshop will be drawing from the efficacy of frameworks such as this but will primarily focus on psychoeducation, dyadic and group sharing, so as to have spaces where all voices feel safe to explore and engage more intimately into the practice(s).

Final Thoughts

When loss occurs and an individual's assumptive world is put into question, the consequences of experiencing grief on a physiological level results in dysregulation and potentially disembodiment (Fay, 2021; Harris & Winokuer, 2019; O'Connor, 2019, 2022). Compassion becomes a vital offering, both self-compassion as the griever and offering compassion to the grieving. The emotional rollercoaster of loss can dissuade connection, as well as receiving and offering support. This activation of certain areas of the brain and limbic system increase cortisol levels, as shown in studies. Interventions such as MBCT, feminist narrative, poetry therapy, DMT, body mapping and conscious embodiment practices help to centre, to bring individuals back to the present moment with compassion.

We can be so hard on ourselves while in pain, grieving or healing. How can we look at life through the eyes of our hearts, even if our hearts feel bruised? How do we come back to a greater sense of ease and peace while experiencing something so pervasive and normal? Coming back to "slowing down and returning to form" (Palmer, 2009, p. 176), as well as "simply noticing what you are feeling fosters emotional regulation, and it helps you to stop trying to ignore what is going on inside of you…once you start approaching your body with curiosity rather than with fear, everything shifts" (van der Kolk, 2015, p. 275). The findings in this capstone reveal how can we begin to heal disembodiment in relation to grief, and particularly losses that relate to disenfranchised and anticipatory grief.

The process by which someone can embody a sense of safety and trust while coping with life's many losses is multifaceted and deeply individual. However, this literature review has indicated the efficacy in employing an integrative approach utilizing interventions that are top-down and bottom-up. In recommending this it can allow for biopsychosocialspiritual

perspectives to therapy that are more “unified” in nature while normalizing various forms of grief and why/how people dissociate in relation to these non-linear experiences of disenfranchised and anticipatory grief (Harris & Winokuer, 2019; Hooley et al., 2016). Above all else, grieving individuals need “to be heard and to be met emotionally just where they are” (Prashant, 2019, p. 19). Grief, and its somatic affects, is a universal experience in this human life; let us better understand it so we can become more compassionately and consciously embodied while living with grief.

References

Acharya, S., & Shukla, S. (2012). Mirror neurons: Enigma of the metaphysical modular brain. *Journal of Natural Science, Biology, and Medicine*, *3*(2), 118–124. https://doi.org/10.4103/0976-9668.101878

Altschuler, C. (2017). *How to meditate when you can't sit still.* Chicago Tribune. https://www.chicagotribune.com/lifestyles/health/sc-fam-how-to-meditate-1017-story.html

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.) Washington, DC.

Anwar, B. (2022). Anticipatory grief: signs, causes, & coping tips. *Talkspace*. https://www.talkspace.com/blog/anticipatory-grief/

Arthur, N. (2018). *Counselling in cultural contexts.* Springer International Publishing. https://doi.org/10.1007/978-3-030-00090-5

Bargh, J. A., Chen, M., & Burrows, L. (1996). Automaticity of social behaviour: direct effects of trait construct and stereotype activation on action. *Journal of Personality and Social Psychology*, 71, 230-244. doi:10.1037/0022-3514.71.2.230

Bernstein, B. (2022). Empowerment-focused dance/movement therapy for trauma recovery. *American Journal of Dance Therapy*, *41*(2), 193–213. https://doi.org/10.1007/s10465-019-09310-w

Brach, T. (2004). *Radical acceptance: embracing your life with the heart of a Buddha*. Random House Publishing Group.

Briere, J. N., & Scott, C. (2014). *Principles of trauma therapy a guide to symptoms, evaluation, and treatment (2nd ed.).* Sage.

Britton, W. (2021). Resources for meditators-in-distress. *Cheetah House*. Retrieved April 14, 2023, from https://www.cheetahhouse.org/.

Brom, D., Stokar, Y., Lawi, C., Nuriel-Porat, V., Ziv, Y., Lerner, K., & Ross, G. (2017). Somatic experiencing for posttraumatic stress disorder: A randomized controlled outcome study. *Journal of Traumatic Stress*, *30*(3), 304–312. https://doi.org/10.1002/jts.22189

Brown, S. (2021). Three ways you as a social worker can meaningfully work towards disability justice. https://socialwork.ubc.ca/news/three-ways-you-as-a-social-worker-can-meaningfully-work-towards-disability-justice/

Buckley, T., Sunari, D., Marshall, A., Bartrop, R., McKinley, S., & Tofler, G. (2012). Physiological correlates of bereavement and the impact of bereavement interventions. *Dialogues in Clinical Neuroscience*, *14*(2), 129–139. https://doi.org/10.31887/DCNS.2012.14.2/tbuckley

Bush, A. D. (2015). *Simple self-care for therapists: restorative practices to weave through your workday.* WW Norton.

Carter, V. S. (2002). *Reminding the body: using touch therapy with female incest survivors.* (Publication No. 3068731) [Doctoral dissertation, California Institute of Integral Studies]. ProQuest Dissertations and Theses Global.

Chiesa, A., Serretti, A., & Jakobsen, J. C. (2013). Mindfulness: top–down or bottom–up emotion regulation strategy? *Clinical Psychology Review*, *33*(1), 82–96. https://doi.org/10.1016/j.cpr.2012.10.006

Conti, P. (2022). *Trauma: the invisible epidemic: how trauma works and how we can heal from it.* Random House.

Dana, D. (2020). Being polyvagal: The polyvagal theory explained. *Windhorse Integrative Mental Health*. https://www.windhorseimh.org/being-polyvagal-the-polyvagal-theory-explained/.

D'Cruz, Kate, Douglas, Jacinta & Serry, Tanya (2019) Narrative storytelling as both an advocacy tool and a therapeutic process: perspectives of adult storytellers with acquired brain injury. *Neuropsychological Rehabilitation*. 30:8, 1409-1429, DOI: 10.1080/09602011.2019.1586733

Dunne, K. (2004). Grief and its manifestations. *Nursing Standard*. *18*(45), 45–51. https://doi.org/10.7748/ns2004.07.18.45.45.c3652

Fay, D. (2021). *Becoming safely embodied: A guide to organize your mind, body and heart to feel secure in the world.* Morgan James Publishing.

Fernández-Alcántara, M., Kokou-Kpolou, C. K., Cruz-Quintana, F., & Pérez-Marfil, M. N. (2021). Editorial: new perspectives in bereavement and loss: complicated and disenfranchised grief along the life cycle. *Frontiers in Psychology*, *12*, 691464. https://doi.org/10.3389/fpsyg.2021.691464

5Rhythms (n.d.). 5Rhythms as a movement meditation practice. *Happiness.com.* https://www.happiness.com/magazine/health-body/5-rhythms-movement-meditation/

Goldstein, Marion (2018) Narrative perspectives: personal reflections of a poetry therapist. *Journal of Poetry Therapy*. 31:4, 256-259, DOI: 10.1080/08893675.2018.1505244

Gray, A. E. (2017). Polyvagal-informed dance/movement therapy for trauma: A global perspective. *American Journal of Dance Therapy*, *39*(1), 43–46. https://doi.org/10.1007/s10465-017-9254-4

Gündel, H., O'Connor, M.-F., Littrell, L., Fort, C., & Lane, R. D. (2003). Functional neuroanatomy of grief: an FMRI study. *The American Journal of Psychiatry*, *160*(11), 1946–1953. https://doi.org/10.1176/appi.ajp.160.11.1946

Häfner, M. (2013). When body and mind are talking. Interoception moderates embodied cognition. *Experimental Psychology*, *60*(4), 255–259. https://doi.org/10.1027/1618-3169/a000194

Hargis, B. (2020). Overstimulation and the dissociative brain. https://www.healthyplace.com/blogs/dissociativeliving/2020/1/overstimulation-and-the-dissociative-brain

Harris, D. L., & Winokuer, H. R. (2019). *Principles and Practice of Grief Counseling, Third Edition.* Springer Publishing Company, Incorporated. https://play.google.com/store/books/details?id=IdbZxwEACAAJ

Hooley, J. M., Butcher, J. N., Mineka, S., & Nock, M. K. (2016). *Abnormal psychology, global edition.* Pearson Education Limited. https://play.google.com/store/books/details?id=oj-gjwEACAAJ

Huang, F.-Y., Hsu, A.-L., Chao, Y.-P., Shang, C. M.-H., Tsai, J.-S., & Wu, C. W. (2021). Mindfulness-based cognitive therapy on bereavement grief: Alterations of resting-state network connectivity associate with changes of anxiety and mindfulness. *Human Brain Mapping*, *42*(2), 510–520. https://doi.org/10.1002/hbm.25240

IXL (2023). Disenfranchised. *In Vocabulary.com*. https://www.vocabulary.com/dictionary/disenfranchised

James, J. W., & Friedman, R. (2014). *The grief recovery handbook, 20th anniversary expanded edition.* Harper Perennial.

Jorden, T. L. (2022). Acknowledging the past: trauma informed social justice & dance movement therapy. *Body, Movement and Dance in Psychotherapy*, 1–17. https://doi.org/10.1080/17432979.2021.1896579

Jostmann, N. B., Lakens, D., & Schubert, T. W. (2009). Weight as an embodiment of importance. *Psychological Science*, 20, 1169-1174. doi:10.1111/j.1467-9280.2009.02426.x

Kessler, K., & Braithwaite, J. J. (2016). Deliberate and spontaneous sensations of disembodiment: capacity or flaw? *Cognitive Neuropsychiatry*, *21*(5), 412–428. https://doi.org/10.1080/13546805.2016.1203769

Kosminsky, P. S., & Jordan, J. R. (2016). Attachment-informed grief therapy: the clinician's guide to foundations and applications. *Routledge.* https://play.google.com/store/books/details?id=fjb7CwAAQBAJ

Kuhfuß, M., Maldei, T., Hetmanek, A., & Baumann, N. (2021). Somatic experiencing - effectiveness and key factors of a body-oriented trauma therapy: a scoping literature review. *European Journal of Psychotraumatology*, *12*(1), 1929023. https://doi.org/10.1080/20008198.2021.1929023

Lee, J. (1997). Women re-authoring their lives through feminist narrative therapy. *Women & Therapy*, *20*(3), 1–22. https://doi.org/10.1300/J015v20n03_01

MacCallum, F., & Bryant, R. A. (2018). Prolonged grief and attachment security: A latent class analysis. *Psychiatry Research*, 268, 297–302. https://doi.org/10.1016/j.psychres.2018.07.038

Madigan, S. (2019). *Narrative therapy (2nd ed.).* American Psychological Association.

Martinec, R. (2018). Dance movement therapy in the wider concept of trauma rehabilitation. *Journal of Trauma and Rehabilitation, 1*(1). https://www.researchgate.net/publication/327418865_Dance_Movement_Therapy_in_the_Wider_Concept_of_Trauma_Rehabilitation

Mazza, Nicholas (2018). No place for indifference: poetry therapy and empowerment in clinical, educational, and community practice. *Journal of Poetry Therapy*, 31:4, 203-208, DOI: 10.1080/08893675.2018.1505248

McKissick, S. (2019). Effects of childhood trauma on neurological development and mental, physical health in adulthood. *D.U. Quark, 3*(2), 51–60. Retrieved from https://dsc.duq.edu/cgi/viewcontent.cgi?article=1034&context=duquark

O'Connor, M.-F. (2019). Grief: A brief history of research on how body, mind, and brain adapt. *Psychosomatic Medicine, 81*(8), 731–738. https://doi.org/10.1097/psy.0000000000000717

O'Connor, M.-F. (2022). *The grieving brain: The surprising science of how we learn from love and loss.* Harper Collins.

Ogden, P., Pain, C., & Fisher, J. (2006). A sensorimotor approach to the treatment of trauma and dissociation. *The Psychiatric Clinics of North America, 29*(1), 263–279, xi – xii. https://doi.org/10.1016/j.psc.2005.10.012

Palmer, W. (2009). *The intuitive body: discovering the wisdom of conscious embodiment and aikido.* North Atlantic Books.

Pellitero, A. M. M., & Hunter, V. (2020). Somatic landscapes and urban identities: mapping emotional engagements through site, dance and body connections in Raval, Barcelona, a Case Study. *Athens Journal of Architecture* (pp.249-272). https://www.athensjournals.gr/architecture/2019-2870-AJA-ARC-Moya-Pellitero-03.pdf

Porges, S. W., & Dana, D. (2018). Polyvagal theory: A primer. *Clinical applications of the polyvagal theory: The emergence of polyvagal-informed therapies* (pp. 50–69). essay, W.W. Norton & Company, Inc. https://integratedlistening.com/wp-content/uploads/2020/10/polyvagal-primer-from-clinicalapplicationofpolyvagaltheory-3.2019.pdf.

Prashant, L. (2018). *Transforming somatic grief* (pp. 1–76). San Jose, CA: Degriefing.

Prochaska, J. O., & Norcross, J. C. (2018). *Systems of psychotherapy: a transtheoretical analysis.* Oxford University Press.

PsychAlive. (2013). What is Mindfulness? *YouTube.* https://www.youtube.com/watch?v=HmEo6RI4Wvs&ab_channel=PsychAlive.

QMUNITY (n.d.). Community Agreements. qmunity.ca/resources

Satchidananda, S. (1984). *The yoga sutras of Patanjali: Translation and commentary by Sri Swami Satchidananda.*

Segal, Z. V., Williams, M. G., Teasdale, J. D., & Kabat-Zinn, J. (2013). *Mindfulness-based cognitive therapy for depression (second edition).* The Guilford Press.

Schwalbe, A. (2023). Somatic body mapping. https://www.annetteschwalbe.co.uk/body-mapping/

Scourfield, D. (2021). Do attachment styles impact the way we grieve? *Camino Recovery Spain.* https://www.caminorecovery.com/blog/do-attachment-styles-impact-the-way-we-grieve/

Selissky, M. A. (2017). Embodiment of a fictional character during dance movement therapy with an adolescent ADD patient: Case study. *Body, Movement and Dance in Psychotherapy, 12*(3), 195–209. https://doi.org/10.1080/17432979.2017.1344140

Shear, M. K. (2015). Clinical practice. Complicated grief. *The New England Journal of Medicine*, *372*(2), 153–160. https://doi.org/10.1056/NEJMcp1315618

Solorzano, C. (2012). *A four-week treatment model of an integrative approach to treating post-traumatic stress disorder through cognitive behavioural therapy and chakra balancing.* (Publication No. 3067831) [Doctoral dissertation, California Institute of Integral Studies] ProQuest Dissertations Publishing.

Stein, M. (2021). *Breathwork for resistance in art therapy: letting go of fear through a body-oriented approach.* [Doctoral dissertation, California Institute of Integral Studies] ProQuest Dissertations Publishing.

Stroebe, M., Schut, H. A. W., & Boerner, K. (2017). Correspondence and comments—cautioning health-care professionals: bereaved persons are misguided through the stages of grief. *Omega: Journal of Death and Dying, 75*(1), 92-94. https://doi.org/10.1177/0030222817701499

Taylor, S. (2017). *The leap: The psychology of spiritual awakening.* New World Library.

Thimm, J. C., Kristoffersen, A. E., & Ringberg, U. (2020). The prevalence of severe grief reactions after bereavement and their associations with mental health, physical health, and health service utilization: A population-based study. *European Journal of Psychotraumatology*, *11*(1), 1844440. https://doi.org/10.1080/20008198.2020.1844440

Truscott, D., & Crook, K. H. (2013). *Ethics for the Practice of Psychology in Canada, Revised and Expanded Edition.* University of Alberta. https://play.google.com/store/books/details?id=YavfAAAAQBAJ

van der Kolk, B. (2014). *The body keeps the score: brain, mind and body in the healing of trauma.* Penguin Books.

Victoria. (2022). Co-regulation. *The OT Toolbox.* https://www.theottoolbox.com/co-regulation/

Wayment, H. A., & Vierthaler, J. (2002). Attachment style and bereavement reactions. *Journal of Loss & Trauma,* 7(2), 129–149. https://doi.org/10.1080/153250202753472291

Weber, K. (2019). The study of neurological response in art therapy and trauma: A Literature Review. [Masters dissertation, Lesley University] Digital Commons Lesley University.

Wikipedia (2023). Psychology of disenfranchisement. *Wikipedia, The Free Encyclopedia.* https://en.wikipedia.org/w/index.php?title=Psychology_of_disenfranchisement&oldid=1146024124

Yalom, I. D., & Leszcz, M. (2020). *The theory and practice of group psychotherapy.* Basic Books.

Appendix

Proposed Workshop Outline

"Coming Back into Body while Grieving All Forms of Loss"

First half of the day: top-down and bottom-up approaches

Introductions

- Only include self-identifiers people are comfortable with (to be extrapolated upon in safety conversation next)

Safety Conversation and Community Agreements

- Gauge temperature of willingness/safety levels to try to turn inward through the body as this needs to be titrated
- Discuss red-yellow-green lights as safety words
- Discuss co-regulation and self-regulation
- Review pre-existing community agreements (i.e. confidentiality). Democratically discuss to see if there are any amendments or additions.

Psychoeducation

- Talk about what grief is; particularly disenfranchised and anticipatory grief
- Talk about what dissociation/disembodiment is
    - Encourage group discussion around pre-existing beliefs and anything that comes up during this psychoeducational component

Exercise for embodiment through dance/movement warm up and mindfulness practice

- Dance with guided instruction to pay attention while moving to certain body parts: inner body, outer body, with others, with space (pulling from DMT, mindfulness, yogic, 5 Rhythms and conscious embodiment practices)

- Dyads to discuss what they experienced
- Group share extending from dyads

Psychoeducation/Reflection

- Talk about dual-process & bottom-up/top-down and quickly explain the survival response. Give people time to ask questions about these as we normalize the grief experience and body experience.
- Take time to journal - any notes, their intentions for the workshop
- Read a poem on dissociation and discuss
- Group - talk about what happens before dissociating - what are their body signals? Start paying attention to these. What thoughts come into mind?

Exercise, vagus nerve

- Demonstrate and invite group to participate in strengthening the vagus nerve

LUNCH BREAK

Second half of the day: bottom-up approaches

Exercise: Embodied Boundaries in Movement

- Demonstrate with an assistant or co-facilitator how when someone pushes you, you can lose your balanced energy field. Discuss how to rebalance and try again (Palmer, 2009).
- Dyads to practice and discuss
- Group discussion on findings (correlate to finding embodiment while grieving)

Exercise: Embodied Boundaries while Speaking

- Groups of three (One person posing the question, one answering, one witnessing – rotation). Question to repeatedly ask: “What do you want?” Take time here for 5-10 minute sharing on how the body reacted to being pushed, what the initial responses were,

and what it's like to be in body while speaking one's vulnerable truth and the other party actively listens. Note: "Compassionate Listening Exercise" (Prashant, 2019).

- Group discussion on findings (correlate to finding embodiment while grieving)

Psychoeducation

- Tie the findings from the previous two exercises to attachment theory and polyvagal theory.
- Talk about the importance of slowing down and being in the present moment.

Exercise: Somatic Body Mapping

- End with somatic body mapping as a visual representation/exercise - body scan meditation and drawing (highlight this to continue building trust in listening to one's own sensations, therefore practicing embodiment and how it contributes to grief processing).
- Group shares and closing with a *metta* meditation