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Mapping the Dissociated Body

Elizabeth Hough

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Abstract

This capstone thesis explored the use of body mapping and body scans as a tool for assessing and tracking somatic dissociation and embodiment. The researcher utilized a client-centered approach and mindfulness-based interventions and theory to ground the work with the clients. While there were a variety of questionnaire-based tools for assessing dissociation with clients, many of them were lacking in the somatic component of dissociation. The available assessments were also exclusively self-reported and written or verbal, which had the potential to result in biased reporting. Clients may have also struggled to identify their level of somatic dissociation due to an inherent disconnection or dismissal of their somatic experience. This research described two case studies in which body scans and body mapping were utilized as a method to assess and track the client's level of body dissociation and embodiment. Both the clients were young adults who identified as women and experienced significant sexual trauma as children in addition to ongoing trauma throughout the rest of their lives. The researcher found that the body scan was a more applicable assessment tool than the body map, but that the exercise might need to be adapted to be more successful as an assessment tool. While neither of the clients were able to successfully complete a full body scan, the researcher was able to glean valuable assessment information from their reactions to the exercise.

Introduction

“Here I am, in borrowed bones, in makeshift skin, looking out in eyes that are a construct, breathing with lungs that are only a step—a basic rearrangement—away from leaves. How funny, to have a body when I am not a body? How funny, to be inside when I am outside.”

(Fox, 2020, p. 114)

Dissociation is a phenomenon associated with many mental health conditions as well as a feature of typical human experience (Manford, 2014). Dissociation is often connected to traumatic experiences and is defined by Manford (2014) as “the mind's attempt to flee when the body freezes” (p. 1). While typical experiences of dissociation may be as unremarkable as becoming absorbed in a film or mobile app, clinical experiences of dissociation can be as severe as dissociative amnesia, and the personality splitting present in dissociative identity disorder. In between these two extremes lies a wide range of dissociative experiences, which can have significant impacts on the afflicted individual. Lyssenko et al. (2018) identified that dissociative symptoms have been linked to dysfunction in a wide range of mental health conditions. These included impairments in executive functioning skills, ability to recognize emotions, and interpersonal skills (Dorathy, 2010). Dissociation has also been linked to nonresponsiveness to therapeutic treatment (Lyssenko et al, 2018).

Dissociation is often considered to have the functional purpose of helping the individual to “reduce or avoid adverse emotional states” (Lyssenko et al, 2018, p. 38). While mild and occasional dissociation may be healthy, chronic dissociative episodes can increase stressors in an individual's life by reducing cognitive functioning and an individual's sense of control. Chronic and severe dissociation can also have major impacts on an individual's vocation, interpersonal

functioning, and sense of self. These impacts have been observed in a range of mental health conditions associated with dissociation including depression, eating disorders, panic disorders, and obsessive-compulsive disorder. Dissociative symptoms can also be measured across a wide range of diagnosis beyond those classified as dissociative disorders including but not limited to schizophrenia, addiction, and borderline personality disorder (Lyssenko, et al., 2018).

It is widely recognized that dissociative disorders have a somatic component to them (American Psychiatric Association, 2013). In the field of dance/movement therapy, embodiment is often emphasized as the antidote to both typical and clinical levels of dissociation (Papadopoulos & Röhricht, 2018). Papadopoulos and Röhricht (2018) defined embodiment as “the unity of emotions, cognitions, movement, and perception” (p. 40). Embodiment can also be expressed as an increased attunement to one’s own inner senses. In dance/movement therapy, therapists utilize a variety of exercises to help support an increased attunement to one’s own body. Dance/movement therapists may also work to increase an individual’s body attunement to others as well as working to attune to their clients. These practices and theories all relate to the dance/movement therapy concept of kinesthetic empathy. Kinesthetic empathy is a tool rooted in the neurological phenomenon of mirror neurons, an important part of the process by which individuals build interpersonal closeness (Burns, 2012).

Though embodiment may be considered as the antidote to dissociation, and dissociation may have clearly disruptive impacts on an individual’s functioning, the method for marrying the two may not be as clear. The treatment resistance that dissociation breeds is likely not exempt from dance/movement therapy or somatically based treatments. However, a more somatically connected therapist may be able to use their tools of somatic awareness and kinesthetic empathy

to deepen their understanding and awareness of a client's dissociation and levels of embodiment, and by extension provide more suitable treatment for that individual client.

While there may be exciting treatment potential for the blending of more embodied treatment with clients experiencing dissociation, few studies have successfully employed a method of tracking and recording levels of body-based dissociation or embodiment (Manford, 2014). Colace (2017) presented Laban movement analysis (LMA) as a method for tracking changes in client's movement and body attitude over time. While LMA may serve as a tool for tracking movement, it may not prove reliable for measuring a client's sense of unity with their own body. Colace (2017) also emphasized the importance of body-based knowing for the dance-movement therapist and the use of attunement as a method of identifying a client's level of body-based dissociation.

In an effort to embrace the importance of kinesthetic empathy and attunement and to test the use of LMA for assessing dissociation, this researcher conducted a study in which they used LMA to assess the movement and body posture differences when in a dissociated and typical state. They found that there were significant differences in the way that their body was held and moved in these different states. They also found that the dissociated state caused their movement and body posture to be less expressive and connected, often moving only one part of the body at a time in a slow and direct manner. When they moved in a dissociated state, they also experienced significantly increased difficulty in connecting with their own inner states and with those around them (Hough, 2019).

This research was conducted in to examine potential methods of tracking dissociation and embodiment using somatic and dance/movement therapy tools. It was this researcher's hope that

this research could expand assessment tools for dissociation beyond the primarily cognitively based Dissociative Experiences Scale (DES) (Lyssenko et al., 2018). This research was also an experiment in the use of assessment and treatment integration and co-created treatment planning and processes with clients. While the researcher led and presented the treatment options to the clients, the clients were encouraged to take an active role in expressing which methodologies were most appropriate for them and in guiding which treatment and assessment tools were incorporated into the following sessions.

The framework of this study was to use a mindfulness-oriented approach to treatment in an attempt not to eradicate a client's dissociative states or reduce a client's symptomatology, but to change a client's relationship to their dissociation and to allow them to become a partner in their own treatment through a co-created process of assessment. Mindfulness in the mental health context can be defined as "attention to focus on the present moment with openness and acceptance" (Lopez-Navarro, 2015, p. 231). While the goal of mindfulness is to focus on accepting and acknowledging the present moment and letting go of efforts to change or escape the present experience, studies have found that training in mindfulness often reduces an individual's distress. Mindfulness is also a unique combination of assessment and treatment as it requires the client to acknowledge and accept what they are experiencing in the present moment (Lopez-Navarro, 2015).

Literature Review

Dissociation measures

Lyssenko et al. (2018) completed a meta-analysis of studies utilizing the Dissociative Experiences Scale (DES) and found that dissociation was present not only in dissociative disorders, but also in a variety of other conditions including eating disorders, trauma-related

disorders, and depressive and anxiety disorders. The DES was identified as the most widely used assessment tool for dissociation and comprised 28 different questions self-reported by clients on an 11-point Likert scale ranging from zero to 100. These questions related to a range of types of dissociation including depersonalization, derealization, absorption, and amnesia. The DES has shown high predictive validity for dissociative disorders as well as for post-traumatic stress disorder (PTSD) (Lyssenko et al., 2018). Dorahy (2010) also found high rates of interpersonal disconnectedness with individuals demonstrating pathological levels of dissociation as measured by the DES. Dorahy (2010) found that these high levels of dissociation were even more predictive of interpersonal disconnectedness than what they identified as “lifetime shame.”

Cernis, Cooper, and Harlow (2018) argued that while the DES may have been the most widely utilized measure of dissociative symptoms, the assessment had not incorporated any information gleaned from research that has taken place over the last 30 years, and had questions which primarily focused on the dissociative identity type dissociative experiences. They argued that the field of dissociation had expanded to include a wide range of dissociative experiences and associated diagnoses. Some of these dissociative experiences included interrupted experiences of “memory... sense of self... consciousness/perception... somatic/bodily symptoms...” (Cernis et al., 2018, p. 229-230).

An additional assessment tool that Cernis et al. (2018) identified for the measurement of dissociative symptoms was the Wessex Dissociation Scale (WDS). While this scale was considered more current, being published in 2004, the scale had undergone little external validation, having been largely based on the authors’ clinical experiences and theoretically grounded exclusively in their own cognitive model. As of May 2018, the WDS “[had] been used

in eight research studies or theses. This suggests that researchers [have not opted] to use the WDS as an outcome measure” (Cernis et al, 2018, p. 230).

Cernis et al. (2018) also identified seven additional scales, which had been created to measure dissociation. However, five of the seven scales were more than 30 years old, rendering them outdated due to recent research. The remaining two assessment tools had demonstrated to be impractical for research purposes or had minimal external review. Cernis et al. (2018) conducted their own factor review from data they pulled from surveys with both clinicians and service users regarding their experiences of dissociation. Through this review they determined that the five main themes present were “subjective experiences of unreality...feeling emotionally numb or disconnected...having memory blanks...zoning out...experiencing a vivid internal world” (Cernis et al. 2018, p. 233).

While the dissociative scale that Cernis et al. (2018) were able to create through consumer and clinician data did appear to be more accessible than the updated DES-II, their questionnaire eliminated any measures directly relating to the body or somatic experiences of dissociation. The DES-II did include two questions focused on somatic experiences of dissociation, “some people have the experience of feeling that their body does not seem to belong to them” and “some people find that they sometimes are able to ignore pain” (Carlson & Putnam, 1993, p. 26, 27). While the inclusion of these two measures were important, they are hardly sufficient for fully measuring the range of body dissociation which individuals can experience, especially when considering such complex diagnoses as conversion disorder or body dysmorphism.

The Scale of Body Connection is a self-reported measure developed by Price, Thompson, and Cheng, (2017). The measure included scales for both body awareness and body dissociation

and consisted of 20 total questions. While this measure was the most congruent of all reviewed measures, it still relied heavily upon client self-report. Although client self-report is an important assessment tool, clients experiencing high levels of dissociation may not be fully aware of the level of dissociation they are experiencing and may therefore not be reliable reporters.

Embodiment

Colace (2017) utilized a more subjective and nuanced approach to measuring dissociation in their work with a woman in their mid-twenties who was struggling with abuse and isolation. The approach focused on moving from dissociation to conflict in order to move past the client's stuckness. The therapist utilized Laban movement analysis for both identifying and tracking their client's movements and their change over time. This therapist emphasized the role of the therapist's own body and attunement as a methodology for identifying the client's sense of embodiment or relationship to their own body. They also acknowledged that somatic countertransferential experiences can inform a therapist's understanding of the client's own somatic experiences. While Colace's (2017) ideas and approaches appear to have been effective in their work with their client, they were very individualized to their own practice and did not present a transferrable model for measuring and tracking dissociation.

Manford (2014) discussed their experiences working with an individual with borderline personality disorder who experienced a high level of dissociation and a significant trauma history. Like Colace (2017), Manford focused on using enactment and attunement as primary treatment methodologies for their clients. Manford (2014) however, did not utilize LMA as a method for assessing their client's level of embodiment or dissociation. They instead utilized psychoanalysis interpretation of the client's enactments to determine the stages of the therapeutic process. Manford (2014) suggested that individuals with a high level of dissociation may

struggle to identify their relationship to their bodies through words and may instead engage in more non-verbal communication or movement processing. Their suggestions begs the question whether a written self-reported scale may be the best method of measuring dissociative symptoms. Particularly when working with a client with a strong somatic dissociation, there may be either a lack of awareness or an unwillingness to acknowledge somatic dissociative symptoms (Manford, 2014).

Papadopoulos and Röhrich (2018) utilized a variety of measures for their work with a man experiencing severe conversion disorder and somatoform disorder. In addition to using movement observation data and symbolic movement analysis, they also utilized the PHQ-15 and CORE-OM-34. These assessments were administered pre and post treatment and showed significant score improvements in pain reduction, subjective well-being, and symptomatology. While these measures helped to provide a balance of quantitative data to the qualitative changes that the therapists were witnessing in the client, neither of these measures specifically addressed dissociation.

Mindfulness

Lopez-Navarro et al. (2015) completed a randomized trial exploring the impacts of mindfulness-based work on chronically mentally ill individuals. In their study they utilized a variety of mindfulness techniques including body awareness exercises and guided meditations. The study compared the results of clients who received a mindfulness intervention against those who received cognitive behavioral therapy for equal lengths of time. The mindfulness intervention focused on building awareness and acceptance. The study found that integrating mindfulness into an integrated rehabilitation treatment yielded notable improvements in clients'

quality of life scores, particularly in the realm of psychological quality of life which encompassed “self-esteem, positive feelings, and body image, and reduced frequency of negative feelings” (Lopez-Navarro et al., 2015, p. 534). While this measure did not directly focus on somatic dissociation, it appeared that there were some similarities regarding clients’ reports of somatic dissociation.

Kratzer et al. (2018) analyzed the relationship of mindfulness and dissociation to PTSD symptomatology in individuals who had experienced childhood abuse. They found that mindfulness mediated the symptomatology of these individuals as a direct counterpoint to their experience of dissociation. Kimbrough et al. (2010) found that a mindfulness intervention program, that incorporated elements of somatic awareness significantly, reduced the amount of avoidant/numbing behaviors participants engaged in. These mindfulness interventions included body scans, yoga practice, sitting meditation focused on building body connection, and walking meditation. While Kimbrough et al. (2010) did not directly tie dissociation to avoidant/numbing behavior, they defined numbing as “the effort to escape or hide from traumatic thoughts, feelings, or memories” (p. 29), which is congruent with previous definitions of dissociation listed in this research. Sharma et al. (2016) found that a similar mindfulness-focused treatment program was associated with a reduction in dissociative scores for adolescents with subclinical levels of dissociation in India.

Methods

This capstone thesis concept originally stemmed from this researcher’s experience of working with clients with trauma. In this researcher’s own work individuals with trauma often experience strong body disconnects, especially if that trauma was physically rooted, such as a

physical injury, or ongoing physical or sexual abuse. As a dance/movement therapist, this body disconnect was very relevant, particularly for the purposes of assessing what types or intensities of dance/movement therapy might be most appropriate to that individual's level of body connection at that time.

The development of this method took place over several months. This researcher initially developed their understanding of this topic through personal reflection and recording through an LMA project (Hough, 2019). Through this project the researcher was able to identify some personal aspects of somatic dissociation and the connection between emotional, somatic, and cognitive dissociation. The researcher created recordings of them self in a dissociated state and analyzed those recordings utilizing LMA. Though the researcher determined that LMA was a useful tool in assessing somatic dissociation, the researcher determined that creating the baselines that would be required for successful analysis through LMA was not realistic.

The researcher moved forward with developing a method through their internship. The researcher was placed at an internship site exclusively serving Medicaid clients under the age of 25 living near the city of Seattle, WA. Clients were seen at the researcher's main office site. The researcher was assigned six clients to their caseload and was able to identify two clients who were appropriate for the development of a method process. Clients were deemed to be appropriate for this process based on their active current experiences with dissociation, distress related to this dissociation, a willingness to work with dissociation in therapy sessions, a willingness to work with mindfulness in therapy sessions, and regular attendance in therapy sessions.

The identified clients were both female and had both survived sexual trauma as children; while this was not a component of the selection criteria, it is consistent with research regarding dissociation. Both clients exhibited significant dissociative symptoms in the somatic, emotional, and cognitive realm. The clients were identified as needing intensive outpatient services and were offered sessions twice per week. Both clients struggled to attend sessions and frequently no-showed to sessions. Despite no shows, the researcher was able to conduct more than 12 sessions with each client.

This researcher determined that the most appropriate tools for initial assessments with clients would be a body scan meditation led by the researcher and an arts based body mapping tool utilizing color and shape to identify which sensations or lack of sensations each client was experiencing in their body. These interventions were all led within individual sessions ranging from 60-90 minutes with each client in a therapy space at this researcher's internship office site. This researcher had initially planned on creating a collaborative process with clients in order to co-create a process of method development. As this researcher worked with these clients it was quickly determined that this would not be appropriate for treatment and that the clients this researcher was working with were most in need of building safety and would prefer to be led by the researcher.

The researcher then utilized a client-centered approach in their research with both clients. This resulted in methods for treatment varying significantly between each client. The researcher ensured client wellbeing through utilizing verbal check-ins and attunement with each client. Prior to completing the body scan, the researcher completed a long check-in and session with each client, allowing them to determine what they needed from the session that day. Based on each client's presentation regarding verbal and non-verbal cues, the researcher then determined

whether it would be appropriate to incorporate body scan or body map work into that session. The researcher communicated the exercise to the client and asked if they would be willing to participate. The researcher explained some of the potential risks and benefits of the exercise to the clients. If the client did not want to participate in the exercise, the researcher suggested other activities they could complete during their session.

The researcher communicated to the client that they had the power to end the body scan or body map exercise at any time they would like if they did not feel safe or comfortable. Following the exercises, the researcher checked in with the client verbally regarding how they were relating to their body and led additional grounding exercises if the client identified feeling dysregulated or negatively impacted by the exercise. If the client was able to complete the body scan feeling emotionally regulated, the researcher would progress to completing a body map exercise with the client where they would identify sensations they were experiencing in their body.

The researcher recorded data gleaned from these exercises through clinical case notes maintained at the researcher's internship site through an electronic database. The researcher also maintained the body scan art created within the sessions. The researcher utilized body check ins with themselves after each session as an attempt to utilize attunement as a measure for somatic dissociation in addition to the information gleaned from the exercises with the clients and the clients' verbal communication to the researcher.

After the sessions the researcher debriefed with the capstone thesis consultant and their on-site supervisor to analyze the information from the session and determine the most appropriate approach for moving forward. The researcher also discussed their observations with

each client to determine their interpretations of the exercise as well as the impacts that they felt before, during, and after the exercise.

Body Map

The body map exercise began with the researcher prompting the client to quickly notice any sensations in their body. The researcher provided a variety of art implements, including markers, pens, and crayons, and asked the client if they would like to draw a body outline or if they would like the researcher to draw a body outline. After the outline was drawn, the researcher asked the client if they would like to draw or describe what they were feeling within their body for the researcher to draw.

If the client requested to draw their own body map, they were allowed as much time as needed and had the freedom to choose whichever drawing materials they desired. If the researcher was asked to draw for the client they would ask the client to describe each sensation they were feeling within their body one by one, assigning these sensations at least one color, shape, and location. The researcher drew each sensation as it was described and show the client to ensure it was translated properly. After the body map was drawn, the researcher and client processed the drawing.

Body Scan

The body scan exercise began with the client being asked to assume whatever position was most comfortable to them, with the researcher emphasizing that they were welcome to stand, sit, or lay down. Once the client was able to settle into a comfortable position, they were invited to close their eyes, or to try to relax their gaze depending on what was most comfortable for

them. The researcher began the body scan at the tip of the toes and slowly moved up the body, finally ending at the crown of the head. At each stopping point within the body, the researcher invited the client to breathe into that body part, and identify if the sensation they were feeling in that part of their body was pleasant, unpleasant, or neutral.

Once the researcher had completed each section of the body, the client was invited to identify which body parts were feeling the most intense sensations whether they were pleasant or unpleasant. The client was then invited to take three deep breaths directing them into each of those body parts. Once the client had completed these breaths, they were directed to take as much time as they needed to reconnect and come back to the room.

Results

Client X

Client X was a young woman in their early 20s with a diagnosis of Schizophrenia, PTSD, and attention-deficit/hyperactivity disorder (ADHD). X initially came into the clinic where this researcher was interning in order to access medication for ADHD. The clinic director determined that the client needed a higher level of treatment and the client was involuntarily hospitalized for one month. X was released from hospitalization without reaching full recovery on an agreement that they would cooperate with intensive outpatient treatment. The researcher worked with a psychiatrist to support this client in stabilizing through the combination of therapy and medication.

This researcher worked with X to explore their relationship to their body and determine the most appropriate interventions for assessing the client's level of somatic dissociation. The

researcher determined that it was most appropriate to wait until X's psychosis had stabilized through treatment with the psychiatrist which occurred approximately 12 sessions into treatment. At this point in treatment X still expressed some somatic delusions but was able to maintain linear thought processes throughout full sessions.

Client X came into a session and identified that they was feeling very depressed. This researcher determined that it would be appropriate to utilize the body scan treatment in order to address some of the dissociative symptoms that the client was reporting. The researcher asked the client to move to a comfortable position and invited to relax their eyelids or close their eyes. The client chose to lay on their back on the couch and relax their eyelids but not fully close their eyes. This researcher prompted X to begin at their toes and guided them incrementally up their legs and into their torso while imagining golden rings of light highlighting each section. The researcher encouraged X to identify the sensations they were feeling in each part of the body without judgement.

Initially the client was still and appeared settled. As the researcher moved up to the client's calves, X's body jolted abruptly. The researcher checked in with the client regarding how they were feeling and asked if this exercise was too intense. X responded that they were okay and wanted to continue with the exercise. The researcher reminded X that they could end the exercise at any time if it was too intense. The client continued to jolt abruptly at various intervals throughout the body scan. As the researcher finished up the torso section of the body scan, X sat up from the couch and asked the researcher a question unrelated to the body scan. The researcher interpreted this as a request to stop the exercise and answered the question.

After some discussion, the researcher checked in with the client regarding how the body scan had felt and if it had been too intense for them. The client responded that they had liked it and that it had helped them feel calm. The researcher noted the difference in the client's verbal and non-verbal responses to the body scan and their apparent disconnection.

Client Z

Client Z was an adolescent in their mid-teens with a diagnosis of PTSD, and severe major recurrent depressive disorder. Z was initially brought to the clinic by their mother after voluntary hospitalization for suicidal ideation. Z also self-identified as having an eating disorder, and their mother reported that they would often not eat and was losing weight. Z identified experiencing body dysmorphia. Z experienced multiple additional hospitalizations due to substance use related attacks on hospital staff after being brought in by their mother for concerns regarding suicidal ideation. Z was seen for both individual and family sessions. Body scans and body mapping were only incorporated in individual sessions.

This researcher was initially working with Z to reduce their suicidal ideation and improve their relationship skills. In their initial treatment planning sessions, Z indicated that they eventually wanted to work on trauma processing eventually but did not feel ready yet. Z and the researcher also worked on improving the client's communication skills, particularly within their family. Due to the client's intense relationship to their body and their high level of risk, the researcher was very careful about when they introduced the body scan in order to reduce the risk of triggering the client.

Z came into the session one day with a deeply incongruent affect to their mood. They identified that they had been having increased feelings of suicidal ideation and had been feeling

very depressed. Z was smiling and laughing and appeared almost manic while disclosing this, laying on the couch and bobbing their head with wide eyes. The researcher and client discussed their affect incongruity and how one can sometimes use humor or silliness to feel less vulnerable. Z shared with the researcher that they had been feeling disconnected from their body that week. The researcher offered the body scan exercise to Z, who agreed to try the exercise. The researcher led the client through the exercise, starting at the toes and working incrementally up the body. Z sat hunched over on the couch and closed their eyes to complete the exercise. The researcher instructed Z to identify whether each part of their body felt pleasant, unpleasant, or neutral. As the researcher moved up to the stomach, Z asked to stop and began to sob.

Z informed the researcher that they were feeling intensely dissociated from their body. Z shared that they could not sense where the edges of their body were and said that their body felt bigger than the room. The researcher engaged the client in grounding exercises utilizing muscle tension to help them to regulate her emotions. Before ending the session, the researcher checked in with Z to ensure that they were feeling regulated enough to go home safely. Z informed the researcher that they were still feeling dysregulated but that they were feeling more grounded than they had when they initially came into the session.

Two months later, the researcher revisited the exercise with the client. Z was continuing to use substances heavily and had experienced no changes in frequency and intensity of suicidal ideation. Z came into the session expressing that they were feeling dissociated from their body. The researcher offered the exercise of the body map to Z. Z was actively engaged in drawing at the time, so the researcher offered to create the image while Z described the sensations in their body through colors and shapes. The researcher drew an initial body outline and added Z's descriptions to it.

Following the body map exercise, the researcher suggested to Z that they complete the body scan. The researcher reminded Z of what had happened last time they completed the body scan to ensure that Z felt that they were in a place to complete the exercise. Z informed the researcher that they felt okay to complete it and the researcher progressed with the exercise. Z chose to lay on their side on the couch, and they quickly assumed a relaxed body posture. The researcher led Z through the exercise instructing them to visualize rings of golden light around each body part as they checked in with them and identified the sensations they were feeling in each body part as pleasant, unpleasant or neutral. The researcher noted Z's slowed and deepening breath as the body scan continued and interpreted this as a positive sign that the exercise was not causing dysregulation. At the end of the exercise the researcher invited Z to come back into the room with plans of revisiting the body map. At this point the researcher determined that the client had fallen asleep. The researcher allowed the client to sleep for the rest of the session and decided to debrief the exercise at their next session.

At the following session, the researcher and Z discussed how the exercise had felt for them and the differences in response that they had. The researcher reminded Z of their reaction the first time they had completed the exercise. Z shared that the initial experience of intense body dissociation had been very overwhelming and confusing to them. Z also apologized for falling asleep during the second session, and the researcher assured them that this was okay. The researcher and Z both determined that Z was more relaxed during the second exercise although they was not able to fully complete it.

Discussion

The results of this study were very limited when compared with previous research but they also shed some light on the clinical applications of both the body scan and the body map within the context of dissociation and trauma. The most surprising aspect of this study was the inability of either of the participants to fully complete the body scan. While this result limited the ability of the researcher to assess this approach, it still allowed the body scan to function as an assessment tool. Each of the client's responses offered valuable information regarding where each client was in relation to their bodies and somatic dissociation.

The case studies of these two clients offered three different responses to the body scan, and the verbal expressions of each client in relation to these scans. While the body scan plans did not pan out as the researcher initially intended, they all offered valuable insight in regard to where each client was. The researcher was able to integrate the gleaned information into each client's clinical treatment plan for future sessions. It seems from these results that the body scan may have been too uncomfortable for these clients to complete fully.

The most interesting contrast within the body scan exercise was with Client Z, who initially reacted to the exercise by becoming significantly emotionally dysregulated and then fell asleep during the exercise. Falling asleep could be interpreted in a variety of different ways and is complicated further when examined within the context of their previous response to the exercise. Viewed through the window of tolerance model, falling asleep could be a symptom of hypoarousal, a somatic response to trauma activation within the parasympathetic nervous system. This would mean that the exercise had triggered the client's trauma response and therefore may have been too intense for them at their current stage of healing. However, sleeping could also indicate that Client Z had not been able to fulfill their sleep needs due to experiencing states of

trauma and anxiety related hyperarousal and was able to take advantage of a relaxing and safe place to meet their body's sleep needs (Corrigan, Fisher, & Nutt, n.d.).

The researcher was unable to implement the body map as much as initially planned with each client. The single implementation of the body map exercise offered the researcher some information, but much less than initially expected. The body map the researcher completed with Client Z ultimately became a map of the client's physical sensations on their body, which although related to somatic dissociation and embodiment, did not necessarily directly reflect or offer the researcher enough information to incorporate into a clinical treatment plan. While the body map should not be dismissed as a useful intervention or assessment tool, it was not as immediately useful as an assessment tool or intervention with the clients who participated in this research.

A body map could however be a valuable assessment tool when working with a client experiencing severe dissociation manifesting through somatoform disorders, such as the loss of an ability to move a certain body part or pain. In these cases, a body map could function as a highly valuable tool in assessing an individual's physical sensations and their changes over time. The body map allows for some additional creativity and interpretation which could allow the clients to relate to their physical sensations in a more symbolic or emotional way.

While body scans and body maps are already being utilized widely among somatic and dance/movement therapists, this research sheds light on the accessibility of these interventions and their potential to be utilized as assessments. The benefits of these interventions are that they can be integrated easily into an already established practice and require no special tools, materials, or training to perform beyond a dance/movement or somatic therapist's base training.

They also offer clients a practice which can be utilized at home and which could be tracked daily by the client if deemed appropriate for treatment.

While the body scan and body map exercises alone may not provide a full view of a client's experiences of dissociation, they may offer a meaningful complimentary assessment tool which in combination with a self-reported or cognitive measure, could give a therapist a more robust understanding of a client's relationship to their bodies and their cognitive function through dissociative experiences. These exercises have the potential to be viewed not as standalone assessments, but a complementary assessment which could provide further information.

This research offers only a small slice and the presentation of a clinical concept in the context of a much wider topic. The literature on dissociation and trauma responses is vast and growing larger by the day. As research continues, it becomes clearer that trauma and dissociation are not only impacted in the mind but manifest in notable ways in the body as well. As this topic continues to be explored, there are many ways that this research can be refined and expanded upon.

One of the major limitations of this study was the small size and scale. While the small size of the study allowed for a more in-depth look at each client's responses to the exercises, it did not allow for any kind of reliability or validity proof for the use of either exercise as a reliable assessment. Further research would need to utilize the exercises with a larger group of clients within a range of dissociative disorders or symptoms. This larger research would require the standardization of each exercise, as well as a system of assessing each client's response to the exercises through an inter-rater reliability study.

Due to the qualitative nature of these exercises implemented as assessments, establishing inter-rater reliability, or establishing these exercises within the realm of diagnostic tools could prove very difficult. This is perhaps why many of the currently existing and widely used measures rely more heavily on self-reported scales than clinician or researcher observation. Interpretation results in much more nuance and the potential for a wide variance in assessment results. This discrepancy further emphasizes the importance of including a more quantitative assessment tool in conjunction with a more interpretive tool. The combined use of these two tools also opens the possibility of assessing a client's awareness of their dissociation. For example, if a client self-reports experiencing little to no somatic dissociation, but is unable to engage in a body scan without becoming emotionally dysregulated, this could offer valuable information for a client's treatment moving forward and give a fuller picture of their dissociative symptoms.

The most incongruent finding of this study with the literature review was the client's inability to complete the body scan. Several of the studies incorporating mindfulness treatment utilized body scans as an intervention with clients experiencing dissociative symptoms with no significant reported issues within each process. It seems that the appropriateness of these exercises as well as the accessibility of the exercises for a range of mental health conditions is something that needs to be further examined. This researcher believes that a range of adapted body scan exercises may allow clients to participate more fully and may also serve as an assessment tool as clients are able to complete increasingly in-depth body scan exercises.

Furthermore, the most important learning from this research was the importance of building trust and attunement within trauma and dissociation work. The ability of each client to trust that the researcher was offering them a safe but potentially challenging exercise was critical

to the researcher's ability to complete this study. The researcher also found that one of the most important components of the trust relationship was that the clients both understood that they had the ability to set boundaries with the researcher regarding what they were and were not willing to do. As survivors of sexual trauma, both clients had experienced difficulties with boundary setting when they felt unsafe. The ability of this exercise to allow them to say no without consequence became a critical component of the client-centered and co-created aspect of this work. While this was not the initial focus of the research, it may have been the most therapeutically important.

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Student's Name: Elizabeth Hough

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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