Spring 5-22-2021

DMT and Dissociation: Opening the Window of Tolerance to Embodiment; Development of a Method

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Capstone Thesis

Lesley University

April 5th, 2021

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Dance/Movement Therapy

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Abstract

Dissociative symptoms show in many different types of diagnoses, and dance/movement therapists have the skill set to introduce embodiment as a distress tolerance and regulatory skill. The current literature regarding effective dance/movement therapy as a tool for working with dissociative symptoms does not include the intersection of those that hold a queer identity. Inclusion of dissociative symptoms with trans* (any person who is not cisgender) identity allows for empowerment of recovery. The discussed development of a method is designed to contribute to the strengths and limitations dance/movement therapy holds in relation to dissociative symptoms, specifically working within the window of tolerance trauma model and with trans* individuals where the intersection of dissociation can be aligned with gender dysphoria. This method was implemented with queer adults at a partial hospitalization program, and it was observed that the intervention of active embodiment in the relationship to regulating dissociative symptoms led to activation in itself. Individual validation and specific mention of systemic discrimination in regard to trans* people's lived experience with dissociation was also observed. Future research should examine a more specific practice of embodiment that focus around the queer identity as empowerment and expression. Dance/movement therapists should continue to explore how the integration of dance/movement therapy tools for regulation of dissociative symptoms can be best applied to trans* clients.

Keywords: LGBTQ+ adults, dance/movement therapy, dissociation, window of tolerance, embodiment

DMT and Dissociation: Opening the Window of Tolerance to Embodiment; Development of a Method

With the rise of normalizing mental illness on social media, a certain meme topic has picked up more steam than its counterparts: the act of dissociating. Generation Z has created a perfect storm where access to mental health information is becoming rapidly accessible, increasingly less taboo to talk about, perfectly packaged in with goofy pictures with humor filled sentiments. While one could argue that this humanization of dissociative symptoms gives more space for open conversation, is it really helpful? Normalizing dissociative symptoms can create a culture of empathy, but also has the potential to paint a false picture of what dissociation is. Especially in LGBTQ+ spaces, there is a sentiment that one can only be truly trans* (a term I will be using throughout the paper that is inclusive of transgender, genderqueer, non-binary, and all identities that are not cisgender), if they experience dissociative symptoms. This falsehood is heightened by the gatekeeping of medical professionals, where a trans* person must many times report specific diagnostic criteria in order to access gender-affirming care. While dissociative symptoms present in a multitude of diagnoses, there is a tendency within academic literature to focus exclusively on only talking about it within the culture of PTSD or transness.

I seek to explore the intersection of dissociative symptoms specifically within the LGBTQ+ population, and with individuals with multiple diagnoses. The intersection of mental illness presenting as dissociative symptoms and LGBTQ+, specifically trans people, is a corner of mental health that has limited research around it. I hope to use dance/movement therapy (DMT) techniques to instill not only coping mechanisms as preventative measures against dissociative symptoms but to increase body-centered awareness that drives self-acceptance.

Currently, there is limited research regarding trans* individuals that is not inherently pathologizing of the trans* experience (Mizock 2016). However, Barbee's (2002) work with trans* people centers their own stories and prioritizes the trans* experience and the uniqueness of each individual. Part of the process of depathologizing queerness, given its history in the field, is to center the

stories of queer clients over stories that told about them (Veltman & Chaimowitz, 2014,). Much debate in the field surrounding trans* people currently is the diagnosis of gender-identity disorder (GID), and its potential removal from the next edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). However, this seems to be the majority of the field's interest with trans* people, instead of working with them, and building connection (Burke, 2011; Lev, 2007). In my proposed method, I hope to center the resilience, and joy of being trans*, as it is revolutionary within this field. As I am a trans* non-binary person in training to be a DMT, I feel there is a create potential correlating between lessened dissociative symptoms with the integration of body-based interventions.

There is a common thread of self-criticism leading to higher rates of dissociation and gender-dysphoria in trans* people, when there is a level of self-acceptance, then dysphoria levels drop (McGurie et al., 2016; Pulice-Farrow et al., 2019). DMT naturally incorporates the somatic symptoms of mental illness, and several DMT's specialize in working with trauma. Jorba-Galdos (2014) spearheads the way by offering DMT techniques for a dissociative state through exercises that promote grounding and orientation to the environment. Her work pairs nicely with Pierce's (2014), who advocates for the integration of right brain functions through DMT as a way to support those who experience dissociative symptoms. However, within these studies, there is not an emphasis on the trans* identity, nor the incorporation of other diagnosis than PTSD. I am curious of the intersection between transness, dissociation, and a mental health diagnosis. When the element of the lived experience of trans* people is added to the identity of a client, the entirety of the work should shift to mold around the parts of themselves that need to be validated and seen. Through an identification of themselves with their bodies there is a potential for a reunification that could be entirely restorative, and new to the field.

In my method, I will be limited to LGBTQ+ adults that live within Massachusetts and have access to a partial level hospitalization setting. The method's participants will have chosen to be in the specific group. I hope to explore the intersection and implications between borderline personality disorder

(BPD), post-traumatic stress disorder (PTSD), transgender and gender-variant people, and disassociation as a symptom of BPD, as well as a coping mechanism of gender dysphoria. I hope to find a positive correlation between dance/movement therapy interventions and a decrease of dissociative symptoms.

Over the course of one day I offered two 45-minute sessions. I provided one psychoeducational session regarding the window of tolerance model in relation to different types of dissociative symptom presentations. In the second session, the clients were led through an experiential where they were encouraged to find a movement or gesture that brings them comfort, and to experiment with the DMT tools provided bringing them through up and down regulation. By creating a space where the client was able to tell their own body-story, I predicted there would be a gaining of autonomy.

Literature Review

Dissociation

Dissociation is, at its core, a trauma response. To dissociate is to lose connection from reality, the body, or the self, and sometimes all three (Jorba-Galdos, 2014). Dissociation disconnects a person from body, mind, emotion and spirit. Within dissociation there are four subcategories: depersonalization, the loss of connection to the body; derealization, the loss of connection to the world around; identity confusion, the loss of identity and understanding of self; identity alteration, the loss of memory of old selves or who one has been. The feelings of dissociation have been, explained to be alienating, a felt sense of trauma (Linder 2015). Van der Kolk and Fisler (1995) identify dissociation to manifest as a coping mechanism when a person has experienced trauma as a way of protection. Dissociation impacts the psyche, altering the way somebody lives in the world.

Most of the recent literature that explores dissociative symptoms does so under the context of PTSD. While a large majority of those with a PTSD diagnosis experience dissociation, it does not end there (Martinez-Taboas, 2004; Malachiodi, 2020). There are accounts of dissociation with those who are diagnosed with a personality disorder, most commonly borderline personality disorder (BPD).

Furthermore, dissociation is common in anxiety disorders, and dissociative disorders, such as general anxiety disorder (GAD) and dissociative identity disorder (DID). When clinicians incorporate the knowledge of potential dissociative symptoms in a multitude of clients, they are able to more easily identify the dissociation. By understanding the broad-brush trauma paints with, a clearer picture can be seen.

Queerness in the Field

A brief history looking back upon the treatment of queer people by therapeutic and medical professionals would include institutionalization, hypnosis, and trying to treat the sexuality of the client, as if it was mental illness (Drescher, 2015). While homosexuality has been removed from the DSM, the heaviness of the past still weighs in on the treatment of queer clients today (Drescher, 2015). What Barbee (2011) aims to do in his work with trans* people is to let them tell their own stories. The reclamation of queerness, not as an illness, or what is to be treated in the therapeutic space, but as a piece inherent and unique to each client's already multifaceted identity is radical. When the treatment is of a part of somebody's identity, it is no longer humane. The approach Barbee (2011) takes of letting the clients be the master of their own story, levels the relational power dynamic between client and therapist. When so much autonomy has been taken away from a minority group, there is restoration in giving that back in the place of their own healing.

There is a sentiment within the discussion of transness that to be trans* one must experience dysphoria and/or dissociation. While this is meant to be a distinction that is validating for some peoples' experience, it can also be used as an erasure of trans* people that do not experience this. In the worst case, a trans* person will not be able to access proper services if they do not fit into the societal expectation of what it is to be trans*, often times perpetuated by cisgender clinicians. Furthermore, as explored in Pulice-Farrow et al. (2020), clinician's gatekeeper treatment and access to hormones, resulting many times in the clients sharing information that may not be accurate to their actual

situation, but instead share only what can be defined as clinical criteria to access services. When put in a situation of accessing essential treatment by only recognizing transness as a homogeneous experience, the field is setting itself up to be lied to. The blame must be put on the field and the clinicians that created the environment, not the individuals that must survive in it.

Dance Movement Therapy

Much of the recent literature in regard to dance/movement therapists and their work with dissociation has been centered around the implication of a three-part method in which the end goal is an integration of the trauma into the consciousness and the body (Linder, 2015; Pierce, 2014; Ray 2006). A common DMT belief is that trauma is stored in the body, even if we are not aware of this on a conscious level.

In working with clients with DID, dance therapist Jorba-Galdos (2014) uses a model of "(a) safety and stabilization, (b) trauma processing, and (c) identity integration" (p. 465) so as to best assist the clients in working through trauma and dissociation while limiting the potentials of re-traumatization. While her work is specific to clients with DID, Jorba-Galdos highlights the ability of DMT specifically to "identify subtle changes in the use of the body and space" (p. 471), which can be indications of a client starting to dissociate. This sentiment is essential to consider in relation to the proposed method of this thesis. Dance/movement therapists are trained in somatic nuance and skilled in the meaning-making of gestures so subtle other professionals may not have considered them relevant. The trained eye of a dance movement therapist comes into play in all three stages Jorba-Galdos (2014) proposes.

Pierce (2013), when working with adults with dissociative symptoms and developmental trauma, uses a similar three step framework, "1.) Safety and stability, 2.) integration of traumatic memories, 3.) development of the relational self and rehabilitation" (p. 10). This model reflects the clientele of Pierce (2013) and is more applicable to that of the population in the proposed method. Bringing in the window of tolerance model, a common trauma visualization used to exemplify how

dysregulation can swing into hyperarousal or hypo-arousal behavior (Ogden et al., 2006). Pierce (2013) is able to gracefully fit the window of tolerance model into DMT work, modeling how DMT skills can be taught as coping tools for dissociation. Pierce integrates specific DMT tools in each phase, and equates tools to either up or down regulate arousal. Within these three zones, a window of tolerance is created, where the optimal therapeutic space being the mid zone, or the "optimal zone" (p. 12). When working in a trauma informed way, especially in a body-based practice, being vigilant of the client's arousal zone is vital to their well-being.

Integration of Embodiment

Ray (2006) through a series of case studies displays an in-depth analysis of the battle between embodiment and dissociation found in clients that have been traumatized. If embodiment is the opposite of dissociation (Pierce, 2013), active embodiment is skill building for future situations where the client may find themselves starting to dissociate. In short, the act of embodiment is restorative. Caldwell (1996) speaks of awareness of the body being the essential tool of combatting dissociation. By claiming this can be done by listening to the body's reactions to stimuli, and engagement with trauma responses on a somatic level, she points towards a direction of presence. Presence being defined as the act of noticing sensations, breath, and the thoughts the body brings. Presence brings the practice of sitting in discomfort, allowing the body to anxious, upset, allowing the trauma responses that lead to hyper/hypomania to be noticed. Without awareness, without presence, there is no warning for dysregulation. If there can be a notching of when dysregulation is starting to occur, there is a chance of not allowing further escalation. This is the benefit of active embodiment (Pierce, 2007)

It is vital also to name that there is a mistrust of the body after experiencing some forms of trauma. The body is not always a *safe* place to inhabit, and doing so can lead some clients to dysregulation, and then dissociation (Ogden et al., 2006). This is especially true in trans* clients. Much of the trauma trans* clients are experiencing is the trauma of the body not being a place they want to

inhabit, as it does not fit their schema of self. To ensure safety of the clients, the naming of this should be part of the session, and allowing the client to be a master of their own body and experience should be offered by the clinician.

In Hricko's (2014) dissertation she defines embodiment as healing in itself. To name with such simplicity comes from the work of many and the current understanding of embodiment (Levine 2010; Caldwell 1996; van der Kolk & Fisler, 1995). Hricko (2014) goes further to name the process of embodiment to hold the act of disconnection followed by a reconnection. In many cases, the seeking out of the disconnect is the key, as many times the clients expressed that they did not know they were in a state of disconnection to start with.

Methods

I implemented this two-part method once in a partial hospitalization program in the Greater Boston area serving LGBTQ adults with an extensive range of diagnoses. These individuals are offered a weekly trauma and recovery group and an expressive therapies group among the 25 groups weekly that they must attend. Multiple clinicians run the expressive therapies group, including two registered drama therapists, a social worker, and another intern. The interns work under the supervision of a licensed mental health counselor. The method was approved to occur in March of 2021. The sessions I led consisted of 16 individuals in the first group and 14 individuals in the second group who wished to participate in groups centered around dissociation. A registered drama therapist from the site observed each session.

The purpose of this method is to first identify dissociative tendencies in a psychoeducational approach during the "Trauma and Recovery" group and then to introduce DMT techniques in the "Expressive Therapies" group. The techniques being presented being those that endorse somatic regulation and lessen dissociative episodes from escalating. The groups needed to keep the duplicate titles they do each week not to dysregulate the patient's schedules. The method took place over Zoom.

Prior to the first session, I explained to the milieu that the two groups labeled "Trauma and Recovery" and "Expressive Therapies" would be interconnected, created to understand dissociative symptoms better and navigate potential dissociative episodes by implementing dance therapy techniques. I asked that the patients who attended the first group, Trauma and Recovery, also attend the second group, Expressive Therapies, after the lunch break. I disclosed that the groups would be part of my thesis and that I would not be collecting any data or specifics about the group members.

The Trauma and Recovery and Expressive Therapy groups are held every Thursday at 12:00 PM and 1:30 PM respectively, each for 45 minutes. The patients are given the option weekly to attend either an art/writing therapy group or a dance/movement/drama therapy group. The 16 individuals who participated on this date were majority White, with two people of color, and majority trans*, with five participants being cisgender. In the second group of 14, two group members from the previous group did not attend, and no new group members joined.

The intervention was designed as a modification on Pierce's (2014) work, aligning DMT tools with the window of tolerance model to help within dysregulation zones and deescalate potential hypo/hypermanic states. Embodiment was defined and utilized as a tool to combat dissociation as suggested by Ray (2006), Malachiodi (2020), and Jorba-Galdos (2014). The inclusion of queer identity and mention of body dysmorphia and validation of the queer experience was needed to create a safe processing space (Barbee, 2002; Pulice-Farrow et al., 2020).

In the first group, we checked in with names and pronouns, as is the group norm. I, as well as the observing clinician, checked-in as well. I then began an open discussion concerning dissociation, asking the question, "What does dissociation feel like?". This was to form a baseline understanding of the group's knowledge and lived experience of dissociation, allowing them to process and validate each other's experiences. As the conversation progressed, I asked clarifying questions, repeated some individual's responses, and thanked the group for sharing their experiences. As the group spoke about

their own dissociation experiences, I noticed some individuals start to fidget or rock back and forth. I offered a breath to the group, modeling raising my hands as I inhaled and "following the breath down" as I exhaled. I did this twice more.

I then presented the worksheet in Appendix A that details the different types of dissociation; sharing depersonalization, derealization, identity alteration, and identity confusion. I asked a group member to read the first corner, depersonalization. The group was given space to digest, ask questions, and share experiences. Once the group had warmed up, I read the remaining three corners, leaving space between each section for responses and feedback. With each section being read, I asked the same question: “Does anybody have a question or experience that aligns with this that they would like to share with the group?”

I then introduced the second worksheet found in Appendix B, a simplified version of the window of tolerance model, where dissociation is added to both ends of the hypomanic/hypermanic scale. The previous week's Trauma and Recovery group had been centered around the complete window of tolerance model, so I asked a group member to explain what the worksheet meant. I then detailed how in hypermanic states, the type of dissociation may be more towards derealization, whereas hypomanic states may be more towards derealization. As is customary in the group, room was made for questions and further discussion to the psychoeducational piece. The patients were asked to identify what types of dissociative tendencies they may experience for their reflection and if they had any warning signs for when they were becoming dysregulated. I asked the group to continue their consideration over the lunch break. I thanked the group members for their presence and attention and offered the same three breaths from earlier in the group to close out the group.

In the second part of the proposed method, the group came back from lunch break and checked-in again with names and pronouns, and I asked them what they had thought about over the lunch break. I presented a brief recap of what we had discussed before the break and invited them to

create a space that would be comfortable for them for the next 45 minutes. I gave the suggestions of lighting a candle, getting some water, or cueing up music they like to listen to. I clarified choosing music that was more "chill and relaxing," as more up-tempo music may induce more anxiety as we moved. I started with the offering of three breaths, modeling raising my hands on the inhale, lowering as we exhale, as we did the previous group. I then explained what we were to do in the next 45 minutes to create a container that was the most trauma-informed. I reminded the group that while we were moving, they could take a break or sit and observe, whatever they felt was right for their minds and bodies.

I first invited them to start their music and stand up, modeling this myself. I asked them to start by walking around their space, trying to get as comfortable as possible. If they remained sitting, I offered the same prompt of just trying on movements that may feel good, relying on self-soothing. I modeled and verbally provided different options, including neck rolls, shoulder rolls, placing a hand on the heart, placing a hand on the belly. I then asked the group to stay with one movement or gesture that was the most comfortable, informing them to remember this gesture as we would come back to it.

I then verbally prompted the group that we were going to try on some movements that may help when experiencing hypomania. Taking from Pierce (2014) and Grey (2017), I led the group in the following techniques: stomping the feet to endorse proprioceptive senses; containment and squeezing of the arms and sides of the body to support bodily recognition; and, swaying and rocking motions to endorse orientation to space. For each technique, I modeled the movement, reminding the group to make alterations to movements if they did not feel correct for their body. After spending 1 to 2 minutes *trying on* each exercise, I asked the group to go back to the original gesture that offered them comfort and to stay there for a moment and recalibrate.

I informed the group that we were going to try on movements that may help when approaching hypomanic dysregulation. I again led the group through the following techniques, modeling each as I

verbalized that the goal was to connect to the world around: reaching cross laterally and cross diagonally, endorsing orientation to space; turning the head to each corner of the room, to endorse orientation to space; and, pushing against a wall with the arms, to endorse orientation to space and weight.

Finally, I asked the group to return to the first movement or gesture they found the most comfort in and return to their places to be seen in the Zoom room. Once everyone had gathered, I asked the group to share the movement or gesture that they found the most comfort in and pass the share to another group member. I asked that the group mirror the sharer and try the movement on with them. I started and modeled to establish the norm, passing the share off to group members. The group passed to each member, and finally to the clinician observing the group.

To conclude the group, the remaining 10 minutes were used for verbally processing, where I asked the group members if anybody wanted to share their experience. To close the session, I offered the three visual breaths again, closing with a shake-out of any energy the group did not want to carry into the rest of their day. I transcribed the sessions the week after they occurred.

Results

Psychoeducational session

When I asked the group what came up for them at the mention of dissociation, most group members shared a personal experience, a few shared a short sentence, and one patient shared a poem they had written earlier that day. When the patients spoke regarding what dissociation felt like to them, there was a level of distress, and I observed a few group members begin to look away from the screen, and become visually disengaged. This is when I invited a breath, hoping to bring some patients back to the present. One group member explicitly mentioned their queerness as it related to dissociation and gender dysmorphia, and I witnessed several group members snap their fingers as is customary in the group to show that they agree with what has been shared.

I transitioned into the first worksheet (Appendix A) as I felt the groups energy closing, as I wanted to transition into the psychoeducation portion and preserve time. I asked a group member to read the first portion on depersonalization, several group members raised their hands. This showed their engagement with the worksheet. As I asked the group how they have experienced depersonalization or if any questions arose more than four group members raised their hands. Each member shared a lived experience that was unique to them. Several patients who spoke referred back to other group members, sharing that they had similar experiences.

The next three blocks I read aloud, as they were single sentences, and the group was actively engaged so I felt there was no need to call in support from the group. With each block that was read an average of four patients shared experiences of how it felt for them to be in the dissociative states. The patients showed moderate to high energy levels throughout the conversation, and twice I had to move on while group members still had their hands up to ensure we had enough time to complete the discussion. The group members who engaged most actively in the didactic portion were trans* or non-binary, speaking directly to that experience most specifically when the topics of identity alteration and identity confusion were being discussed. Two individuals shared the experience of feeling identity confusion when considering themselves pre-coming out. When discussing identity alteration one client shared their diagnosis of BPD as it felt relevant to their experience. Group members who shared a BPD diagnosis offered this group member support by snapping or using the heart react emoji that Zoom provides.

In the last 15 minutes of the group I transitioned into the second worksheet (Appendix B), and gave a brief explanation on the window of tolerance model as it relates to dissociation, feeling that there was more value in the conversation and sharing of the group members than the more straightforward explanation of a concept many of them already had familiarity with. I asked the group to identify where they would place the four types of dissociation discussed within the last half hour. Group

members identified hyperarousal matching their experience of depersonalization and hypoarousal matching the experience of derealization. Not all group members agreed, and voiced their opposition to broad statements as not being inclusive of their own lived experience. I validated the different lived experiences of group members and reminded them that dissociation is a personal experience that belongs to them.

At the close of the group, I offered for one final member to share before I closed the group for lunch. One patient who actively spoke throughout the group offered gratitude towards me and other group members, sharing that they had been invalidated by medical professionals in the past on their experience of dissociation. Many group members snapped in agreement and shared the Zoom heart emoji response. I closed the group with a final breath and an offering of rest over the 50-minute lunch break.

Movement session

As the group returned back from lunch, I invited the same breath practice to reopen the group space and reorient the members to our continued discussion. I observed the groups energy level as lower than before the lunch break. I invited the members to que up some music to be used later in the group, and find a space where they could stand up and move. I waited for a minute while group members adjusted their cameras and moved to different locations. A few group members remained seated. One member asked to clarify if the music's mood should be relaxing or energizing in nature, I suggested more calming music as we were going to be practicing distress tolerance, and energizing music may perpetuate a heightened state that may be detrimental to the activity.

Initiation to baseline

Once I had observed the group become settled again, I stood up and invited the group to start to walk around their space. I verbally instructed the group to begin stretching and finding movements that felt good while also participating. I observed most group members mirror my stretching. I emphasized trying

on movements and gestures that felt good in their specific bodies. I spoke of the comparison to animals never moving in ways that aren't comfortable to them, which instigated sever group members to move in more experiential ways, instead of liner stretching. Participants explored pandiculation, twisting, and enveloping movements. As I instructed them to find one specific gesture that felt comfortable, I witnessed several group members stop in the middle of exploration and go to a more minute gesture within the near reach kinesphere. I gave another minute of exploration while modeling my own comfort gesture, rolling both my shoulders with my hands placed on my heart center.

Hypermania

As I witnessed the group members settling on one repetitive gesture, I moved into exploration of DMT tools to be used in hyperarousal. I noticed some resistance from group members into the initial shift into a higher energy movement. I chose to start with feet stomping as to engage the group and boost energy levels. While stomping I noticed half the groups resistance to stomping full body in the way that I was modeling, and the other half of the group participate in an engaged way. I noticed some of the group members that were stomping in full also smiling and laughing. I shared this observation verbally with the group and encouraged laughing.

Moving into containment after a few minutes of stomping, I noticed more engagement from the group, all members trying out the containment exercise. As this continued, I provided limited psychoeducation of white muscle tissues role in containment (Grey, 2017) and group members nodded along while participating, signaling that they were following along. As the group began to look around their spaces, and become visually disengaged as they continued containment, I transitioned into rocking and swaying.

This method invited the most participation, as all group members began to find a rhythm that was suitable to their needs. Many group members continued the containment gesture of squeezing the

upper arms in the swaying motions. I spent the most time in this exercise, as it seemed to be the most regulating for the majority of group members.

As I asked group members to return to their comfort gesture before transition into the hypoarousal tools, I noticed almost half of the group keep the rhythm of the sway as they returned to their initial baseline gestures.

Hypomania

As I modeled the cross lateral reaching, I noticed hesitation from group members to fully extend their limbs, reaching with bent arms, only into the mid-reach space, instead of the far-reach. This shifted when I modeled also spreading my legs, and reaching down. Many more group members engaged fully when the lower body was added into the orientation. This created a natural flow for introducing the spatial orientation of moving the full head to look at each corner. Most group members did not turn their bodies around, or explore their back-reach space, or the corners behind them. Finally, I modeled the wall push, and about half of the group tried this tool.

Reorientation to Baseline; Integration

As I could tell the groups energy levels were dwindling, I asked the group to once again return to the comfort gesture. This reengaged the group members who had limited or no participation in the hypomania portion. I stated that we were all going to check-in with either a movement that they liked or their comfort gesture. I started by modeling, and passed the check-in to a group member who was considered a leader within the group, in hopes that their participation would help shyer group members feel at ease. As group members checked-in, most members shared their comfort gesture, while a quarter shared enjoying the sway motion, and two participants did not share a gesture.

I actively mirrored each gesture that was shared, and as the check-ins went forward, an increasing amount of group members also mirrored their peers. For the group members that chose not to share a gesture, I mirrored back their posture, as to include their experience. One group member

chose to share a gesture that he did not do within the group, but found was regulating for him, the cobra pose.

Once all group members had shared, I offered the last 10 minutes to any verbal processing that the group wished to share. Three group members spoke, all holding trans* identities. One group member shared that they had found themselves beginning to dissociate during the session, and then was able to connect back to themselves and continue. Another group member shared feelings of overwhelm in regard to trying to be embodied, and the difficulties that they had.

I validated these experiences, and named that this was a practice in distress tolerance, and not easy. This statement got the reaction of snapping and Zoom heart emoji responses. In closing I offered three breaths and a shaking off of any energy or gesture that they did not want to keep with them throughout the rest of the day.

Discussion

The purpose of this study was to gain a better understanding of the relationship between dissociative features, specifically with trans* people, and the potentials of using DMT techniques to manage dissociative symptoms. In this method, two 45-minute sessions centering dissociation were done with LGBTQ adults in a partial hospitalization program. The first psychoeducational and didactic in nature, and the following being a DMT group.

There are three key finding of the present method. Firstly, that LGBTQ adult and trans* people specifically benefit from validation of their unique dissociative experiences. Secondly, that DMT tools for regulation are beneficial to LGBTQ+ adults in distress tolerance. Thirdly, that active embodiment with LGBTQ+ adults has benefits on a community level when in a group therapy setting. LGBTQ+ adults, specifically trans* individuals, gain insight to their own lived experiences and somatic sensations when given the non-judgmental and validating community space to explore.

Findings

Psychoeducational Session

The disengagement that I observed when dissociation was first brought up may have been a signal of initial activation. It is not uncommon for group members to be activated or triggered by verbal mentions of trauma responses and even the word "trauma" (Ray, 2006; van der Kolk, 1994). By noticing that I had potentially started a nervous system reaction in a few group members by asking what dissociation has felt like to them, I was, on a minor level, asking them for a body-memory of that experience, which can be inherently activating. I offered a breath as a re-centering to the present moment, in hopes that stimulating oxygen intake would reduce distress and bring the focus back to the group (Pierce, 2014).

It is essential to continue to center the stories that trans* people bring of their own lived experience, as Barbee (2002) recognized. I was not surprised at the inherent mention of queer identity by group members in relation to dissociation. By participants correlating their dissociative symptoms to their experiences with gender dysphoria, they were reclaiming lived experiences that may have been invalidated by medical professionals and those with power over their recovery. Within this conversation, I was careful to also validate that some trans* people do not experience dissociation that relates to their trans* identity, but is a trauma response. When managing dissociative symptoms, naming that they are not inherently tied to queerness is part of a continued process of depathologizing queerness (Drescher, 2015; Pulice-Farrow et al., 2020). Allowing group members to share their own experiences with dissociation, and encouraging questioning continues the work of Pulice-Farrow et al. (2020), as individuals are empowered to articulate symptoms that may not be seen as valid by those gatekeeping treatments.

One group member's specific identification of identity confusion and identity alteration dissociation being a symptom of their BPD diagnosis was exceptionally interesting, and several other group members showed their support and agreement. In particular, the connection of identity confusion

was related to the experience of pre-coming out, and questioning how to refer to the self in the past tense, especially in terms of pronoun use. This intersection of queer identity, dissociation, and BPD diagnosis is not one that has been explored to my knowledge.

Movement Session

Within the movement session, the patients showed both enthusiasm and resistance, this pattern is consistent with present literature of Pierce (2014), Ray (2006), and van der Kolk (1994), as movement can be a venerable modality, and embodiment can lead to dissociation for those who have experienced trauma. The resistance shown may have also been because of the telehealth aspect of the session.

Hypermania and Hypomania

The initial resistance to engagement at the beginning of the hypermania potion may have been due to the heightened energy, (Jorba-Galdos, 2014). As the session continued the participants became less resistant, potentially because of witnessing other group members participate. The most engagement I witnessed was during the swaying, which I hypothesize is because of accessibility and self-soothing nature. Many group members continued the vertical sway rhythm as the session continued, carrying it into the discussion piece and integrated it into their own comfort gesture.

Most of the far and behind body space was not explored, even, potentially because of the demands of telehealth care and having to face a camera for the entirety of treatment.

Integration

When participants shared their comfort movement from the session, there were three themes that emerged: enveloping, holding, protecting. Many participants also incorporated the swaying motion from Pierce's (2014) tools, showing an integration of the material to their embodied responses. The lessened verbal engagement at the close of the movement session may have been an indication of the participants being actively embodied, as is reflected in Ray's (2006) work.

Limitations and Future Research

The main limitation of this research was the fact of it being a telehealth group. While this is common within the time of the research, being during the COVID-19 pandemic, it was potentially detrimental to the effectiveness of the method. As DMT is a modality that lives in the present moment, the physical space of the group is a crucial consideration to the potential of the effectiveness. I hypothesize that if this method were to be done in person, the results would have shifted exponentially in the favor of active participation from group members. In future studies, if given the opportunity, this method should be introduced in a physical space where the three zones (hypomania, hypermania, and baseline) are separate parts of the space, encouraging group members to pendulate between the three. In consideration of the lack of BIPOC (Black, Indigenous, and People of Color) representation within the participants, there is the limitation of using this method with queer BIPOC (QBIPOC), as it may not fully hold the specific experience and intersection of identities. While the mention was made of negligence and disbelief from medical professions in regard to the symptoms of trans* clients, there is a longer and far more detrimental history between BIPOC and healthcare professions specifically. In future methods there should be the specific naming of this. Furthermore, there is the understanding that some BIPOC in treatment do not feel fully at ease under the presence of a White facilitator. The presence of Whiteness can be detrimental to the integration of mental health recovery to some POC. The results of this method may be altered if the group was a majority BICOC, with a BIPOC facilitator.

The limitation of time constraints was also present within this method. As is the structure of the partial hospitalization program, each group is 45 minutes. As many times in the psychoeducation session, I had to move forward while participants still had hands raised, it would be beneficial to the results if more time was allotted per session. As one of the main goals of the didactic session was to validate the experiences of the participants, having more time for each participant to share would have been beneficial. Future studies may benefit from hour long sessions, or potentially having the same participants in multiple groups discussing types of dissociation. This method may also be completed

multiples times at the same site with different milieus to observe the varying results of how different diagnoses may interact with the method.

Finally, this method was done with cisgender and trans* clients with varying diagnoses, so it is not an accurate measure of specifically trans* people, or a specific majority diagnosis. While a few participants identified their BPD diagnosis as influencing their dissociative symptoms, further studies could be implicated to more specific intersections, specifically trans* people with BPD diagnosis. As the program is continuously shifting, there is no steady milieu, meaning the functioning levels in each group are fluctuating. If this method were to be done with a steady milieu that had reached group cohesion, there may be more in-depth time spent in the DMT session. As to match the functioning level of the entirety of the group, limited time was spent in the movement portion, as the act of embodiment can be triggering to clients. If this method was to be practiced with trans* people that did not have mental illness, or had more stabilized baselines, more time could be spent in movement exploration safely.

Conclusion

Despite these limitations, the present inquiry has enhanced our understanding of the relationship between DMT-based tools, LGBTQ+ adults, and dissociation. There is a present need for LGBTQ+ in managing dissociative symptoms, and DMT techniques are a potential avenue towards embodied and empowered recovery. Further implications of this method may be used to continue conversations around legitimizing trans* people's dissociative experiences, instead of the monoliths that are currently recognized by healthcare professionals, leading to active embodiment and lessening of distress.

References

Barbee, M. (2002). A visual-narrative approach to understanding transsexual identity. *Art Therapy, 19*(2), 53-62. https://doi.org/10.1080/07421656.2002.10129339

Drescher J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences (Basel, Switzerland)*, *5*(4), 565–575. https://doi.org/10.3390/bs5040565

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

Jorba-Galdos, L. (2014). Creativity and dissociation. Dance/movement therapy interventions for the treatment of compartmentalized dissociation. *The Arts in Psychotherapy,41*(5)*,* 467-477. https://doi.org/10.1016/j.aip.2014.09.003

Lev, A. I. (2007). Transgender Communities: Developing Identity Through Connection. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (p. 147–175). American Psychological Association. https://doi.org/10.1037/11482-006

Linder, J. (2015). Exploring soul loss through arts-based research. *International Journal of Transpersonal Studies, 34*(1-2), 144-151. http://dx.doi.org/10.24972/ijts.2015.34.1-2.144

Malchiodi, C. (2020). Trauma and expressive arts therapy: Brain, body, and imagination in the Healing Arts. Guilford Publications.

Martinez -Taboas, A. (2004). A case study illustrating the interplay between psychological and somatic dissociation. *Interamerican Journal of Psychology, 38*(1), 115-120. https://doi.org/10.30849/rip/ijp.v38i1.847

Merloo, J. (1968) *Creativity and externalization*. Humanities Press.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. Norton.

Price, C. J., McBride, B., Hyerle, L., & Kivlahan, D. R. (2007). Mindful awareness in body-oriented therapy for female veterans with post-traumatic stress disorder taking prescription analgesics for chronic pain: A feasibility study. *Alternative Therapies in Health and Medicine, 13*(6), 32-40. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3037268/

Pierce, L. (2014). The integrative power of dance/movement therapy: Implications for the treatment of dissociation and developmental trauma. *The Arts in Psychotherapy, 41*(1), 7-15. https://doi.org/10.1016/j.aip.2013.10.002

Pulice-Farrow, L., Cusack, C.E., & Galupo, M.P. (2020) "Certain parts of my body don't belong to me": Trans individuals' descriptions of body-specific gender dysphoria. *Sexuality Research and Social Policy, 17*, 654–667. https://doi.org/10.1007/s13178-019-00423-y

Ray, S. L. (2006). Embodiment and embodied engagement: Central concerns for the nursing care of contemporary peacekeepers suffering from psychological trauma. *Perspectives in Psychiatric Care, 42*(2), 106-113. https://doi.org/10.1111/j.1744-6163.2006.00047.x

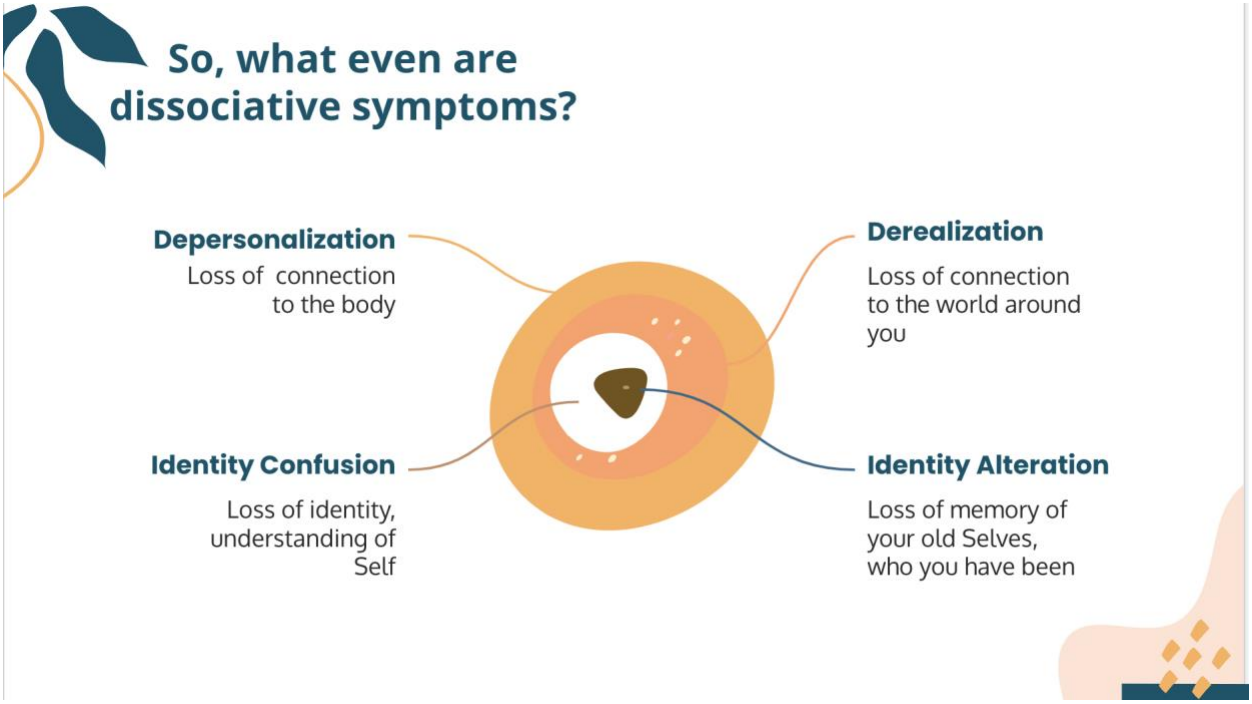
Scaer, R. C. (2001). The neurophysiology of dissociation and chronic disease. *Applied Psychophysiology and Biofeedback, 26*(1), 73-91. https://doi.org/10.1023/a:1009571806136

van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1*(5), 253-265. https://doi.org/10.3109/10673229409017088

Veltman, A., & Chaimowitz, G. (2014). Mental health care for people who identify as lesbian, gay, bisexual, transgender, and (or) queer. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *59*(11), 1–8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4244881/

Appendix A

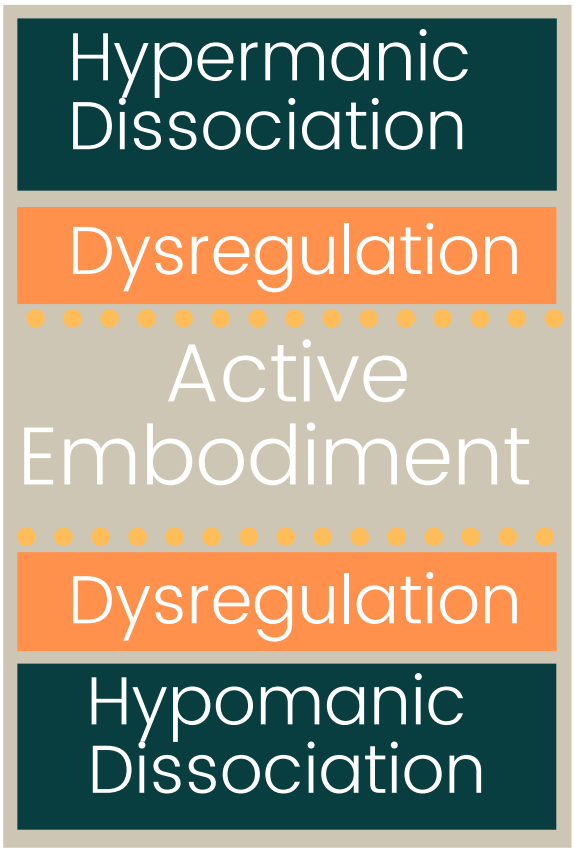
Dissociative Symptoms Handout



Note: A synthesis of the information presented by Jorba-Galdos (2014) created by E. Wilmanns.

Appendix B

Window of Tolerance Model



Note: An adaption of the window of tolerance model from Pierce's (2014) work created by E. Wilmanns.

THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Dance/Movement Therapy, MA

Student's Name: Erin Wilmanns

Type of Project: Thesis

Title: DMT and Dissociation: Opening the Window of Tolerance to Embodiment; Development of a Method

Date of Graduation: May 22, 2021
In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Donna C. Owens