

Authentic Movement as a Movement Meditation Practice

Support for Immune Mediated Inflammatory Disease

Elyn Selu

ABSTRACT

This article details a study conducted with a group of women diagnosed with multiple sclerosis (MS) in rural Western North Carolina (WNC) who participated in a six-week Authentic Movement (AM) class. The study was conducted as part of the author's doctoral dissertation in somatic depth psychology at Pacifica Graduate Institute. MS is a physical illness, meaning that the psychological impact of living with the many neurologic symptoms is rarely addressed. The purpose of this study was to explore the lived experiences of women with MS by providing a way to be in relationship with symptoms. The intention was to explore how a self-directed movement meditation practice could cultivate interoception and active imagination, both self-reflective tools that support psychological wellness. The central finding of this study is that movement meditation practices must accommodate diverse cultural communities who may not have interoceptive knowing. The practice of group support became the medium through which participants acquired the language of embodiment. By developing interoceptive literacy, those with the immune-mediated disease of MS often discover a stronger sense of self and an internal locus of control that may have been lost in the disease course..

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This study addressed the lived experience of those diagnosed with multiple sclerosis (MS), an immune mediated inflammatory disease (IMID) that affects the central nervous system (CNS) and inhibits voluntary motor movement, cognition, and mood. As it is often psychologically experienced as betrayal by one's own body, the objective was to explore a means of cultivating a renewed relationship with one's body. The original intent of the study was to discover whether participants with MS could access their symptoms, and, in doing so, shift their relationship to their symptoms and diagnoses. Because the participants lacked interoceptive awareness, they found it difficult to access symptoms during the practice sessions and report on them. However, the participants had vivid meditations during the practice that led to changes in self-care and return to an internal locus of control. In a review published in *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging* by Khasla et al. (2018), the authors presented current findings detailing how a lack of interoception adversely affects mood disorders, addictions, and post-traumatic stress disorder (PTSD), among many other mental health issues.

In this study, MS was explored through the practice of Authentic Movement (AM), a somatic movement modality grounded in witnessed presence to self through movement. The findings reveal that long-term psychoeducative training in interoceptive awareness – the capacity to observe and learn from phenomena occurring internally in the body – is paramount to the ways that those with MS experience the transformative benefits of AM. The most central

finding is that movement meditation practices like AM must possess the flexibility to accommodate diverse cultural communities who may not have access to movement modalities that entrain interoceptive knowing.

The study participants included three women diagnosed with MS who engaged in a six-week practice of AM. Authentic Movement provides an avenue to being psychologically available to and accepting of the actual state of one's body – whether or not a flare-up or relapse is present. The study also argues that a concrete relationship to interoceptive experience is understood to be paramount to psychological wellness, and enhance one's physical and emotional wellness.

Interoception, the ability to sense internal bodily changes and how those physical sensations interact with cognition and emotion, and further defined by Porges (2004) as “how neural circuits distinguish whether situations or people are safe, dangerous, or life threatening,” is often dampened in a person who has an autoimmune illness (e.g., spasticity is a common symptom of MS, making interpretation of bodily functioning difficult). Dissociation often becomes a coping strategy for those who suffer daily with difficult and painful symptoms. The study engaged research participants who had no previous movement meditation experience or somatic training in developing interoceptive awareness. Their exploration of their bodies and symptoms yielded a glimpse into how to approach and work with underserved and chronically ill populations when exploring somatic interventions.

Multiple Sclerosis – An Overview

Multiple sclerosis is a disease that inhibits movement, rest, cognition, and mood. It is a challenge to the entire system. The body stiffens, aches, and ignores the simplest motor commands as in the case of muscle spasticity. When it does move, it twitches, trembles, becomes exhausted, and shakes, as if in rebellion to stillness, as tremors, painful spasticity, or neuropathy refuse the body rest.

For many with this diagnosis, such a distortion is considered a disease of betrayal and revolt: the contract between the body and its desire for movement has been broken. Yesterday, one might have walked without conscious thought, but today, the right foot does not respond because the efferent message from the brain, “take a step forward,” does not reach the foot. One's body moves forward, unconsciously dancing with gravity and forward momentum, but instead of taking a simple step forward, one trips and falls, seemingly leaving behind a formerly compliant foot. The person with MS, who until that point has lived as an able-bodied person, now enters a dream-

scape of incoordination where the known laws of physicality no longer apply. Physical movement – too little, or too much – is often beyond control. This creates a radical identity shift regarding one's relationship with oneself and the world.

Many with this illness use allopathic pharmaceuticals in the hopes of managing symptoms. The known medications quiet the immune response, smooth tight muscles, calm an overactive bladder, alleviate pain, soothe anxiety and depression, steady vertigo, stimulate fatigue from its stupor, and calm tremors. Many of the immune suppressor drugs have been a great benefit for those with MS, as well as promising new therapies¹ that have become available in the past few years. These drugs keep the immune system from going into overdrive and causing relapses and, subsequently, more brain damage.

While such support is indispensable, what is rarely addressed or scribbled across prescription pads is how to meet the psychological consequences of experiencing a body that betrays one's intentions. Though medication and treatment protocols have immeasurably improved the lives of those with MS, the symptoms themselves are not considered as something worthy of inquiry. In being with the symptom – through active imagination, movement, or other forms of inquiry – those who suffer may find much-needed insight and psychological ease.

There are several studies showing the benefits of mindfulness-based interventions (MBI) for those with MS. Simpson et al. (2014) looked at three different studies conducted in three countries on MS and MBI: they showed positive results in MS patients. There were “Statistically significant beneficial effects relating to Quality of Life (QOL), mental health, and some physical measures” (p. 2). Mindfulness-based interventions empower those with chronic illness to feel they have a sense of control with a disease that often takes away the most basic sense of control.

Authentic Movement as a Mindfulness-Based Intervention

Authentic Movement (AM) is a meditative movement practice that opens a mover to their somatic wisdom. The practice was first explored as movement-in-depth by dance therapy pioneer Mary Starks Whitehouse (Levy, 1992), and later enhanced by Jungian analyst and dance therapist, Joan Chodorow, Ph.D., and dance movement therapist Janet Adler, Ph.D. Adler (1999) writes of the practice:

This could be one way of describing the development of the self. It is interesting to notice in our movement work

¹ Immunosuppressive medications include Avonex, Betaserone, Copaxone, and Rebif, which are subcutaneous injectibles. Monthly infusion drugs have been developed more recently and include Lemtrada, Novantrone, and Tysabri. Some patients have had success with disease-modifying medications in oral form, including Gilenya, Tecfidera, and Mavenclad.

so far that being seen inevitably precedes seeing oneself. 'I can't see myself here. First you see me as I am in this unknown place, then I begin to witness myself anew.' (p. 154)

The practice begins when the mover steps onto the floor and chooses where and how to begin their meditation – standing, lying, or sitting. With their eyes closed, only peeking when making large movements or traveling, the mover awaits an impulse to move and direct them. There is no predetermined or choreographed way to move. The practice allows for the body to move as it wishes, and through these movements, psychic material is accessed, which might come as visions, sounds, words, and emotion.

The witness watches the mover, holding the space in a way that allows the mover to feel physically and emotionally safe. The witnessing part of AM brings the practice its healing aspects. Much like the dyadic relationship that is created between client and therapist, the witness contains and reflects the mover's process back to them. As described by Stromsted (2015):

The attuned, containing presence of the witness/therapist in Authentic Movement allows the mover/client safe access to early, primary process-oriented parts of the self. Engaging this material establishes new neuropathways in the brain, and supports further integration and embodiment. (p. 344)

The witness is vital to the mover's ability to renegotiate and integrate new discoveries. Authentic Movement asks that one be with the body in whatever way that it wants to move, or not move; both are equally meaningful. This moving meditation provides the body the space and time to be with spasticity, pain, and fatigue in a safe, contained way.

Safety is vital in AM so that movers feel comfortable enough to stay present to any emotional material that may arise. Safety becomes more relevant when taking into account that those with IMIDs often have high adverse childhood experience (ACE) scores (Dube & Fairweather, 2009), meaning that those who are diagnosed with IMIDs often have had traumatic events occur during childhood where the ongoing dysregulation of their vulnerable nervous systems created systemic health issues that manifested in adulthood.

It has been found that many of those with MS (Counsell et al., 2013) experience PTSD simply from living with the complications of the illness itself. Providing integration and a locus of control for those with the complex issues of an IMID diagnosis and PTSD is of vital importance to the wellbeing of those with chronic illness. Authentic Movement creates a space that lends itself to being trauma-informed for those with these complex diagnoses. (Shimmin et al., 2017)

Participants and Procedures

From May through July of 2018, three women with different MS diagnoses – relapsing-remitting, secondary-progressive, and primary-progressive – participated in an eight-week study held in Western North Carolina (WNC).

The study was held in a dance studio where the participants, witnesses, and the researcher met for two hours, once a week. It was difficult to find dance teachers with AM experience in the small city in WNC where the study was conducted. Two dance teachers who acted as witnesses were employed because scheduling difficulties required that one teacher participate for the first half of the study, and a second teacher acted as witness for the second half of the study. Ideally, the study would have benefited from having the same witness throughout the study. The space was ADA-compliant. The study ran for eight weeks and included an introductory class, six weeks of AM classes, and one week set aside for interviews. A follow-up interview was conducted six months after the study began. In the six-month follow-up interview, participants were asked about how their AM practice continued to show up in their lives. All participants reported that AM encouraged them to make positive changes in their self-care routines. Each participant reported a deeper connection with their bodies and symptoms.

The National Multiple Sclerosis Society (NMSS) defines the different disease courses. In relapsing-remitting, the patient has relapses: periods when the immune system actively attacks the myelin sheath protecting the nerves in the CNS. These attacks leave scars, or sclerosis. The scars create the many varied symptoms of MS. Once the attack is over, the patient experiences partial to full recovery. For those with secondary-progressive, relapsing-remitting MS has moved into a progressive stage where there is no longer recovery after a relapse, and the patient continually worsens. In primary-progressive, the patient with MS has a disease course where the symptoms never remit but continually worsen.

The participants were addressed throughout by pseudonyms that they chose. Moonflower is a 50-year old white woman with the diagnoses of progressive MS and bipolar disorder, and is also a recovering alcoholic. Lillie Blanche is a 65-year old white woman with secondary-progressive MS. Eli is a 48-year old white woman with relapsing-remitting MS. In the preliminary interviews, each woman expressed a desire to shift her relationship with her MS diagnosis, which was the basis of their inclusion in the study. I asked if they had participated in any other movement or exercise classes. Due to the limited availability of classes designed for those with disabilities in WNC, only one of the participants had had limited experience with yoga. I asked that the participants keep a journal of their experience with AM during their six weeks of practice. Also, during breaks between movement ses-

sions, art paper and oil pastels were provided to help the movers concretize their experiences.

Gathering Data and Procedures

During weeks four and eight, I conducted semi-structured interviews with open-ended questions to allow participants to provide in-depth responses. Some of the questions asked included:

- “Have you noticed any part of your body needing extra attention during your movement practice?”
- “How has noticing your body and symptoms shifted since beginning AM?”
- “Have there been any changes in your self-care routine since beginning the study?”

I adjusted the interviews from one-on-one to group after I realized that as a group, the participants had an easier time providing answers. I kept notes during classes, while the teacher/witness took over the AM portion of the class.

Analyzing Data

This study was designed using interpretive phenomenological analysis (IPA) methodology. The question posed to the participants, “How does your relationship to symptom and diagnosis change by practicing Authentic Movement?” could not be answered by the participants. It was discovered that the research participants had trouble accessing their interoception. Those with chronic illness and trauma are often unable to access their bodies. Instead of being able to answer direct questions about their bodily sensations and experiences, the participants instead shared their access to active imagination while in meditation. This led to shifting away from IPA methodology toward a multiple case phenomenological study. The participants’ experiences defined emergent phenomena. In examining meaning, I looked for themes that arose among the movers in the data they provided about their lived experience as movers. I also addressed their difficulty in understanding what we were doing, and also noted how they experienced shifts in their self-perception of body and symptom. When assessing the journal entries and the interviews, I attempted to parlay the participants’ lived experiences of AM into the greater body of research on MBIs for those with IMIDs, as well as offer a new perspective to the practice of AM.

The classes had a rhythm and structure contributing to the sense of safety and allowing psychic material to arise. At the start of each session, the movers, the witness, and I walked around the dance studio three times before settling in. The witness asked each of us to share a few words about how we felt in our bodies that day.

After this share, I moved to the side of the room to observe and take notes. The witness made eye contact with each of

the movers. Then, she rang a bell. The movers would close their eyes and allow for movement or stillness, as their bodies chose, for 20 minutes.

At the 18-minute mark, the witness asked the movers to bring their awareness back to the room. When 20 minutes had passed, the witness rang the bell. The movers took 20-minute breaks to go to the bathroom, write in their journals, or draw with oil pastels on art paper. Then, the movers gathered into a circle with the witness. Each mover shared her experience and then received reflection from the witness. The movers returned to their places on the floor for a second 20-minute session.

Ethical Considerations

The participants’ journals and the research notes were kept in a lockbox. The electronic data, including voice recordings of the interviews and the transcriptions, were kept on a secure server. The study presented minimal risk, as the participants did not encounter any discomfort beyond that of an MS yoga class. Danger of injury was further minimized as their movements were self-directed. The potentiality of psychoactive material being activated was addressed in the consent forms, with assurances that the participant would be referred to a mental health professional if needed.

Using the participant-centered perspective, I provided anonymity for the participants, asked them to sign an informed consent form, and requested that they be under the care of a neurologist for the duration of the study. I provided contact information of licensed therapists for participants if they chose to explore therapy during or after the study. Participants were given the ability to opt out of the study at any time, for any reason. I shared the class plan with participants, and asked for their input for their needs and desires within the class structure. I invited guest witnesses so that I could be present as researcher, and allow the process of the movers to have reflection with a witness who had no bias or expectation of their process.

Peer Review

As this was a study conducted for a doctoral dissertation, the study was approved by the university Internal Review Board (IRB). There were also three subject matter experts advising and supervising the study.

Participants’ Experience of Authentic Movement

Moonflower

Moonflower joined the study because she wanted to feel emotion again. During our short time together, Moonflower quickly went from walking with a walker to having to be pushed in a wheelchair. She had a urinary tract in-

fection (UTI) for the first three weeks of the study, which worsened her MS symptoms. This flare-up presented as cognitive difficulties that included dysarthria (slurred speech), losing the thread of a thought mid-sentence, and having trouble following directions for moving, sharing, and receiving reflection from the witness. She had profound muscle weakness, which prevented her from walking or standing. Moonflower did much better in group shares and interviews than in one-on-one interviews. I attributed this to her years of participating in Alcoholics Anonymous. I shifted the interviews to group interviews for the eight-week interview and the six-month follow-up interview. Having her fellow movers present helped Moonflower report about her experience more easily. The other two participants reported that they preferred group interviews as well.

Working with Moonflower deepened my understanding that a person who has little ability for movement can still benefit greatly from an AM practice. Rarely moving during sessions, she often seemed to be sleeping, curled into the left side of her wheelchair, her chin lowered toward her chest as if in deep rest. The witness perceived emotion and movement in Moonflower's face that was startling for Moonflower to have reflected back to her. Despite her minimal movement, Moonflower experienced intense imagery during the practices.

The images that Moonflower reported became the themes of her journey with AM and MS: quicksand, neglect, and relaxation. Moonflower's vivid imagery created a powerful metaphor – being stuck in quicksand and disgusting smells – for her fatigue and inability to walk. Authentic Movement provided the space for her psyche and body to help her sort through her fear and anger in a way that she had not been able to access in talk therapy or EMDR sessions. She shared that being in community and being witnessed helped her access images and feelings she hadn't felt in a long time. From this practice, she developed better self-care habits and returned to journaling as a regular practice. By listening to her symptoms, she decided to switch her medications, which she discovered had been causing many of her cognitive issues.

Lillie Blanche

Lillie Blanche was surprised to hear from witnesses that she often tapped her forefinger on her thigh during movements. She did not realize that she had many unconscious movements when she believed she was sitting still. Throughout the AM study, Lillie Blanche felt too self-conscious to move beyond gentle stretching. She shared that her partner often teased her about her muscle spasticity, and dissuaded her from expressing her extroverted personality.

Discovering that her body moved involuntarily helped her explore her muscle spasticity with more awareness, and

also began an exploration of how others perceived her. Being compassionately witnessed with spasticity helped her address the internalized critic in her psyche.

Lillie Blanche shared profound shifts that arose from her AM practice that she felt were leading her back to her authentic self. Her most powerful moment of transformation came when she rescued a dog. She exclaimed in our interview: "And, I mean the trucks were zooming by, big huge trucks, and she had no place to go! Guard rail, little strip of green grass, busy, busy road. And she had no place to go! And this old woman can still run! This old woman who has MS! I don't know if I was running. I could have been crawling. I don't know. But when I got to her, she knew I was coming for her (starts to cry). She starts running towards me, and when I got to her, she jumped in my arms and she covered my face in kisses! That was me! That was truly, truly me that day who did that. (Cries hard.) I authentically moved that day!"

The phenomena of being witnessed had great significance for Lillie Blanche. During the study, she found a dead Luna moth that had what resembled an eye on each wing. She studied the wings, and later drew them during our practice breaks. She shared that there had always been a critic watching her every move and internally chastising her. From her experience of being witnessed in AM, the critical eyes upon her transformed into eyes that held a "loving gaze."

Eli

At first, Eli was reluctant to join the study because the summer heat often prevented her from leaving the one room in her home that had an air conditioning unit. She expressed how much anxiety she feels now that she has MS, and that agreeing to come to the study was an effort for her. Often, knowing she had an obligation to meet others created too much anxiety for her to follow through with plans. The themes that arose for Eli included discomfort about being watched using a walker, paying attention to her body and symptoms in a different way, isolation, and interacting with those who are insensitive to invisible disabilities.

Eli explored movement more so than Lillie Blanche or Moonflower. Eli chose to explore where exactly in her body the burning sensations (Grierson-Gopalan Syndrome) started and ended, and where the MS hug gripped her shoulders and back. This attention to symptoms led her to realize that while she lives daily with these symptoms, she rarely took time to be with them. Eli shared that painful emotions arose during her one of her movements. She was determined to continue exploring them.

The time spent with her symptoms led her to a deeper sense of how to provide self-care. As a medical practitioner who always cared for others, Eli often stepped into

help her fellow research participants. Eli was expert at taking care of others. Through AM, she was learning how to care for herself.

Six-Month Follow-Up Interview

In the time between the final AM class and the six-month interview, the participants had integrated some of the discoveries they made in their movement meditations. Each woman expressed that they were paying closer attention to their bodies and had shifted their daily self-care practices. Many of the questions asked were repetitions from previous interviews. Lillie Blanche said that because of her AM practice and the reflection from the witness that she was better able to pay attention to her gut reactions, and speak her truth in a way that was thoughtful and compassionate, rather than reactionary.

Eli took the self-care practice that she began in AM, and expanded upon it. She reported that she was feeling much better than she had in months. She also had continued journaling, and had returned to physical therapy. The daily practice of physical therapy had improved her mobility and mood. She credited AM with helping her decide to go back to daily physical therapy. She said, “Now, I make a daily appointment to check in with my body. I’d never done that before. I just pushed through and ignored my symptoms.”

Moonflower expressed surprise that the witness mirrored her experience so accurately. The containment of the space and the integrity of the witness held Moonflower in such a way that it allowed her to explore her symptoms and the attendant images and feelings. In the time since participating in the study, Moonflower had changed her medications, and many of her symptoms improved. All three women made positive changes in their diets and exercise routines. Two participants entered therapy.

When participants were asked how they felt about being disabled, all three women said that they disliked the term “disabled.” Eli and Moonflower shared that they felt “broken.” Lillie Blanche decided that a better term was “alter-abled.” All three participants agreed that rather than be considered disabled, they would instead consider themselves alter-abled.

Emergent Themes

The themes that arose came from my notes, electronically recorded interviews, journal entries, art, and the conversations that took place among participants in the spaces before and after AM sessions, and during breaks. Authentic Movement provided a connection between the women that went deeper than their experience of MS support groups. Moving together and having witness reflections deepened the movers’ connections and intimacy with one another.

- **Community.** In defining an internal locus of control and stronger sense of self, it is integral that someone with chronic illness have community to validate their lived experience of a difficult diagnosis. From the mirroring and kinesthetic empathy that grew within each participant, a spontaneous support group developed that allowed them to go deeper into self-discovery. Moonflower shared, “*We can sit in silence and I can actually let myself see all these visuals. This provides the space and the understanding that we have MS.*” Lillie Blanche shared that she felt safer among her fellow movers and the witness than she ever had in a traditional MS support group because “It is more intimate.”

This concept of community and its impact on our somatic experience, or interoception, is reflected by Rae Johnson (2018): “*In short, our nonverbal communication patterns, beliefs about body norms, and feelings of connection and identification with our bodies are all deeply affected by our assigned membership in different social groups and the privileges associated with that membership*” (p. 1). The feeling of belonging creates ease in the body and psyche when one is in the company of others who struggle with similar issues. For the first time in their lives, someone was asking the participants how it felt to be in their bodies in a way they had never explored on their own. Dibbell-Hope (2007) writes of the findings in her study of AM with breast cancer survivors:

For these women, the Authentic Movement group can provide an experience of communality and social support, an increase in positive feelings of physical well-being, and unique opportunities for restoring an internal sense of strength, control and trust in the ability to return to the body as the site of the wound to find the source of the healing. (pp. 358-359)

Authentic Movement provides a place for the chronically ill to deepen their healing through movement, meditation, and community support. Adler (2002) writes, “*The individual body and the collective body overlap, becoming interdependent as we learn to know ourselves as part of a whole*” (p. 95). In the mirroring and kinesthetic empathy that developed within each participant, the witnesses and the researcher, participants created a support group that allowed them to go deeper into self-discovery.

- **Trauma.** Trauma is a complex topic and, while not the main focus of this study, could not be ignored within the container of the movement practices or in the interviews. With Moonflower’s inability to feel her emotions, Lillie’s feelings of defeat under her partner’s criticisms, and in Eli’s shattered confidence and feelings of being broken, I witnessed women whose bodies and psyches struggled with unresolved trauma. Each of the participants reported experiencing childhood trauma that ranged from physical and sexual abuse to shaming and neglect. They each expressed

that as children they had to pretend to the rest of the world that things at home were okay.

- **Abandonment.** Each woman told stories of being abandoned by parents, being left by life partners when they were diagnosed with MS, or being threatened to be left when the symptoms became too difficult for the partner to tolerate. Moonflower said of her husband, *"If I get much worse, he told me he was going to put me in a home, and that scared the hell out of me."*

Women disproportionately suffer abandonment from their partners when diagnosed with serious illness versus men. Glantz et al. (2009) found that in those who received cancer diagnoses, *"Female gender was found to be a strong predictor of partner abandonment in patients with serious medical illness. When divorce or separation occurred, quality of care and quality of life were adversely affected"* (n.p.) These added stresses that women endure after an MS diagnosis reinforced my desire to keep the study open to the unique experience of women.

- **Symptoms.** The participants had trouble moving from impulse. Two participants rarely moved at all, and the third was able to explore her body with curiosity, but did not wait for impulse to direct her movements. Those who lack interoceptive awareness are unable to know when there is an impulse from the body to move. Despite this, each woman accessed her active imagination, learning deeper truths about herself and her journey with MS. By being with their bodies in a focused way, and in the presence of a compassionate witness, the participants were able to "search for intelligence in a symptom" (Hillman, 1999), and develop a new relationship with their bodies. Each participant had greater interoceptive literacy by the end of the study by making connections between their symptoms and their psyches.

Limitations

I was diagnosed with relapsing-remitting MS in 2000. In acknowledging the transference and countertransference between the participants and me, it could be possible that the study would have been better conducted by someone who didn't have MS. The transference and countertransference would have still occurred, but perhaps to a different degree and with different results. As Romanyshyn (2013) writes of the wounded researcher, *"The wounded researcher is a complex witness who, by attending to not only the conscious but also the unconscious subjective factors in his or her research, seeks to transform a wound into a work"* (p. 111). As researchers, many of us are driven by our impulse toward healing – ourselves and other.

Non-performers, and those who don't exercise regularly, often feel self-conscious about doing movement with their eyes closed while being watched. Once the movers

acclimated to being watched, however, they expressed a desire for more AM classes beyond the study.

Conducting the study in a small town in WNC where there were few somatic resources made it difficult to find ADA-compliant studios and engage experienced witnesses who could be available for the duration of the study. Having the same witness every week would have made Eli more comfortable and perhaps she would have gone deeper into her meditations. The witness is integral to the practice, and it cannot be emphasized enough how important it is to have a witness who herself has had years of experience with AM. In the case of witnessing for underserved and disabled populations, the witness must also have knowledge and understanding of the particular challenges of the movers.

At the conclusion of future studies, it would be beneficial to have a continuing AM practice for the participants. Conducting a study over many months instead of weeks would provide rich data and help participants more fully access interoceptive knowing through AM.

Conclusion

Subject Matter Experts

It was soon discovered that the participants often did not have enough experience with movement meditation practices to fully engage with AM in the way that those with experience in dance and other movement meditation practices have.

The participants were not always able to access their interoceptive experiences and communicate about them in interviews and journal entries. The study uncovered ways to approach the reality that interoceptive literacy is a form of acceptance. If there isn't yet acceptance, which can be challenging when new symptoms develop, accessing repressed emotions can be quite overwhelming, which impacts becoming somatically literate of one's body.

Somatic studies, and trauma studies in particular, are burgeoning in psychology, medicine, and education. As a culture, we are experiencing a much-needed paradigm shift to include trauma awareness in our approach to healing. I offer a suggestion that beyond looking to those with chronic illness as a population to serve, those of us immersed in these fields look to those with IMIDs as subject matter experts.

It is vital that the psyche and soma of the chronically ill be one of the first places researchers and practitioners study interoceptive awareness and the benefits of MBIs for underserved populations. Those who live with an endless list of symptoms provide rich data because they are already dancing with psyche and soma in ways the abled rarely experience.

It is a worthy endeavor to explore the benefits of AM for those with IMIDs. Unlike other movement meditation modalities, AM gives the mover agency in that they are moving in a self-directed way and within the limitations of their disability. Through AM, the mover psychologically renegotiates her experience of disease as a coping strategy, deepens and begins to trust her interoceptive knowing, and strengthens her sense of self and community. These data provide insights for practitioners and researchers in how to work with those who have IMIDs and are part of underserved communities.

Future Applications

There are numerous ways in which AM could be researched as it applies to health concerns. Based on the findings of this study, I recommend more studies using AM as a way to bring ease to those with IMIDs. It would be beneficial to conduct a much larger study including more movers and more experienced witnesses over a greater span of time. Working with an underserved population in Appalachia provided a snapshot of how AM can benefit a more diverse population. Questions that arise from this study include:

- Would participants in larger metropolises who have had access to other movement practices access interoception differently?
- How do ethnic, sexual, and socioeconomic differences affect participants' interoception?
- Given more time in an AM practice, would participants develop stronger interoception?
- How would a control group, perhaps one that practiced only yoga, or attended only a support group, add another dimension to the outcomes?

Further, a mixed-methods study exploring measurable benefits such as biofeedback (Tantia, 2012) would provide quantitative data that could be instrumental for health care providers. Instruments that measure resiliency, cop-

ing, and psychological wellbeing would provide data on the psychological benefits of AM. Working intentionally with a small group of women and focusing on their lived experience provided rich data; however, a mixed-methods study with a more diverse population would enhance the benefits of self-directed movement and the healing benefits of the dyadic relationship between witness and mover.

Authentic Movement is a relatively inexpensive way to provide healing to others and to one's self. I hope that as AM becomes more widespread, it will be as accessible as yoga classes are today. I would caution, however, that those who become witnesses have some training, and have themselves moved in a class for the recommended year before witnessing. It is paramount that a witness fully understands the power in the process of seeing and being seen in a way that is compassionate, boundaried, and healing.

I also propose that those who currently practice AM explore ways to be more inclusive of those who would not be traditionally drawn to the practice, especially those who are "alter-abled." It would be beneficial to design classes that accommodate those with disabilities, particularly ADA-access, temperature controls, and time before and after the practice for community building. It is vital that those who would wish to work with this population have a basic understanding of their students' unique issues and sensitivities.

This study design did not allow time for the movers to act as silent witnesses, as is often done in longer-running AM classes. All of the participants shared that being able to witness would have helped them better understand AM. For future research and classes, I believe AM providers should introduce silent witnessing early in the process to aid the movers in developing kinesthetic empathy (Pallaro, 2007) so as to deepen the resonance in a mover's body as they witness and attend to their own reactions to witnessing another mover.



Elyn Selu, PhD, is an SEP in training. This article is based upon the study she conducted for her PhD dissertation at Pacifica Graduate Institute. Selu began her studies in Chinese medicine, and switched to Somatic Depth Psychology to further explore the connection between psyche and symptom. Diagnosed with multiple sclerosis in 2000, Selu is committed to helping those with autoimmune diagnoses renegotiate connection to their bodies so they may find ease in their symptoms and disease course.

E-mail: elynmsele@gmail.com

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