Being in the Body: Finding reconnection after 9/11

Laurice D. Nemetz, MA, ADTR

Laurice is a dance/movement therapist who spent two years post Sept. 11th, working with a FEMA (Federal Emergency Management Agency) grant in New York's Westchester County as a crisis counselor and dance/movement therapist helping those affected by the events of that day. She has additional experience working with trauma including creating D/MT groups for Holocaust survivors and abused children. She currently teaches a variety of movement classes including yoga and creative choreography, as well as working as a D/MT with special needs children and private clients. She is a special consultant to a crisis grant, awarded to Westchester and Putnam County schools in New York, which is concerned with education and skills building for traumatic events.

The article below is based upon the work that Laurice experienced. Names and some details have been changed to protect the identities of those who reached out for help with the understanding that their privacy would be protected.

Introduction

In William Shakespeare's Macbeth, he wrote of the need to "give sorrow words; the grief that does not speak knits up the o'er wrought heart and bids it break." Perhaps if Shakespeare had been a dance/movement therapist, he would have included the need of the body to move its grief as well, speaking the most profound and primal language of our expression through movement. Throughout the two years that I worked helping people cope post 9/11, I was repeatedly struck by how normal responses to trauma have a clear movement component. If that area is not addressed, the trauma will continue to live in the body, whether it appears as repressed breathing, or in abusive behaviors such as sexual acting out, or substance abuse.

Most of the world is familiar with the date of Sept. 11th, 2001, when the Twin Towers of New York were struck by and later collapsed due to the impact of two separate passenger planes that had been hijacked. Connected to this event is the crash of a flight (United flight 93) on route to Washington D.C., but diverted by passengers, and another flight, American Flight 77, which struck the Pentagon. The initial world-wide response to support those emotionally impacted by this event was great, but as time has gone on, world-wide opinion of America in general has become complicated due to ongoing war and even within the immediate impacted area of New York, where there is the general desire to forget, or at least move on from these events.

For millions of television watchers, the events took place in front of them, as the mid-morning collapse of the World Trade Center towers was witnessed live. For those living in the immediate tri-state area (known as New York, Connecticut and New Jersey) the events were particularly devastating as this area is focused economically and emotionally around New York City. Westchester County, NY, situated north of the city along the Hudson River, is home to many who work in the city. On Sept. 11th, this included both a large percentage of the professionals working in the Twin Towers, as well as a large percentage of the firefighters and police officers who responded to the events. The patients portrayed in this article all live in the immediate county of Westchester NY, as does the author and her family.

The presented material underlines the importance of recognizing the aspect of movement behaviors after a traumatic event. Being in the body, we are faced with the reality and trauma of life, but also remain able to experience its many wonders.

The reactions to trauma

After any trauma, there are several different reactions which may occur. The first, called critical incident stress reactions or CISR are the normal responses to a traumatic event, with reactions usually occurring around 6-12 weeks following an incident. More significant is post traumatic stress disorder or PTSD, which has effects that linger for months, or years, and needs treatment and attention. Symptomatic of PTSD is avoidance of the traumatic experience, or a numbing response, increased arousal response, and persistent re-experiencing of the aspects of the trauma (APA, 1994). While there is an overutilization of the term in current pop literature, the concept of PTSD is a relatively new one, not even formally recognized in the DSM until the 1980's. The psychotherapist, Bessel van Der Kolk, often credited with advocating the inclusion of the PTSD diagnosis, has spent a career studying the effects of the mind/body connection in trauma patients. In many of his studies, throughout the past two decades, he observed that on neuro-imaging scans of the brain, the functioning verbal sections of the brain became impaired as people try to verbally process their trauma. Simply stated, trauma is in the more primitive regions of the brain - the amygdala, hippocampus, hypothalamus and brain stem. This
means that reaction to trauma is felt at the body level, and therefore must be healed through movement, as language fails to access reactions and feelings. (Wylic, 2004) Understanding even common reactions as rooted in the body is an important step in preventing the downward spiral of drug abuse and sexual dysfunction that often comes with trying to rid the body of this stressful event.

As dance ethnographer Judith Hanna has noted, “It is noteworthy that the term ‘stress’ is not as common in the literature of dance therapy as other concepts that can be subsumed under stress. Dance therapy is used to help individuals to overcome and resist stress-related problems. The therapeutic process is especially helpful to people who have difficulty in verbalization.” (Hanna, 1988) Above all, it appears that part of the stigma of individuals that have experienced traumatic stress is that they come from previously “normal” environments in which verbalization is easy. However, as we are already beginning to see, the effects of trauma produce an abnormal amount of primitive movement reactions that are non-verbal in nature.

Thus, after a trauma such as Sept. 11th, many experienced reactions in their bodies that felt uncomfortable and manifested in various forms. Reactions to stress can largely be categorized under physical symptoms (headaches, sweating, rapid heart rate etc.), cognitive changes (forgetfulness, confusion), emotional reactions (guilt, frustration and loss of pleasurable interest in life) and behavior responses (such as change in sleep behaviors, substance abuse and food responses). Even the simple act of having someone recognize some of their behaviors can help to create the sense of universality of symptoms that Yalom highlights as a useful technique in preventing the sense of isolation that comes with psychological stress (Yalom, I. 1970). This is also useful in countering the reaction of anger and prejudice, often also seen early in the grief process. “Margaret”, (see self portrait) was typical of an early reaction of fear, anger and hatred seen throughout the New York area. Even though she had been the target of racial slurs about New York Jews while she was growing up, she immediately reacted to her fear by an extreme hatred and distrust of anything Arab. Her main work was through recognizing her own postures and feelings in her artwork, and slowing being able to re-integrate her feelings within her own body.

**Reactions of rage and hatred can be part of the grieving process. This woman expressed her own racial distrust of people of Arabic descent, a growing problem in communities post 9/11. She wrote, “This picture is meant to represent my sorrow and hopelessness of the events of 9/11/01 and the birth of my rage.” Note the defensive posture, rigid breath, lifted shoulders and concave chest.**

**Self-portrait of Margaret**

In the program, for which this author worked, a government grant was established to provide free, confidential counseling services to anyone affected by the events of September 11. The official definition of this program, under the United States government is that Disaster Crisis Counseling Programs provide, “for short-term interventions with individuals and groups experiencing psychological sequelae from Presidentially-declared disasters. This type of intervention involves classic counseling goals of helping people to understand their current situation and reactions, assisting in the review of their options, providing emotional support, and encouraging linkage with other resources and agencies who may assist the individual.” (Nordboe, D. 1999, p.3) Under this model we saw large volumes of people, often for only a few sessions before a referral to another mental health agency, if needed. As such, there was relatively little time but an important need to create a therapeutic relationship, and impart some coping skills much needed for long-term health.

Common reactions to stress usually manifest in over- or under-doing a normal function. For example, in times of stress many people react through sleep difficulties. As was noted in an AP Science Writer report shortly after 9/11, “almost
seven out of 10 Americans experienced some sleep disturbance after the terrorist attacks of Sept. 11th.” (Reecer, 2002) For most people, this translated to a loss of total sleep time, but others reported experiencing the desire to oversleep, such as is common with depression. Likewise, eating changes, usually resulting in binging or overeating, but occasionally showing a loss of interest in food manifests as well. This reaction has its roots as a direct biological response to the body in stress.

The main purpose of stress is to enable a being to cope quickly with a threatening situation. Classically known as the fight or flight syndrome, this "involves a rapid switch of priorities from long-term to short-term survival. Biological resources are channeled to systems that might be needed to cope with imminent challenges. Whether you must run away or stand and fight, your body will need extra energy, and fast." (Martin, P. 1988, p. 126) The problems arise because some of these responses were much better for coping in a primal world (where sweaty palms could grip things). In addition, the replay of traumatic events by television and media can create greater anxiety, even when an immediate threat is over.

In another interesting relationship, the effects of stress from 9/11 had their impact on the hormones of new parents, as well as on a sub-section of the population of nursing mothers. It is common knowledge among lactation experts that breastfeeding mothers will experience a decrease of milk production, or a delay in the “let-down” response of milk during times of high stress. (Mohrbacker and Stock 1997) In an interesting article that came out post Sept. 11th, author Kathleen Whitfield explored the topic of breast-feeding in times of terrorism. While acknowledging the fears after the attack could impede some milk production, experts from countries such as Israel acknowledged a need to place coping skills at a priority so that constant stress does not impede long-term functioning. In addition, the actual act of nursing can help the mother. “The relaxing hormone, prolactin, increases in the bloodstream while babies feed and can help bring a feeling of normalcy to an unusual situation” (Whitfield, 2001)

Other common reactions include lack of concentration (for example balancing a checkbook), loss of interest in pleasurable activities, physical manifestations (teeth grinding, sweating, etc.) and startle reactions. An increase in substance abuse, while rarer in the general population, is usually a sign that coping skills are further breaking down. Bradshaw (1988) labeled a condition called “toxic shame” to discuss the breakdown of self-acceptance which is often key to addictive behaviors.

For children, these responses played out slightly differently. In young children, there is a tendency to regress quite clearly to earlier behavior problems. For example, a child who is toilet trained may suddenly regress to wetting his/her pants and baby-like behaviors. We had many desperate parents who were upset by their children wanting to sleep with them, and became re-afraid of the dark. Young children often confuse reality on television, and the constant replaying the towers falling made it appear as if the entire city was collapsing. Several children worked out their confusions through play, whether rebuilding New York with blocks or crashing planes into toys. One boy “Michael” drew planes (see below) over and over in our session, much to the discomfort of his parents, who had lost some personal friends in the collapse. Michael, however, wanted to fly a plane again, and his repeated obsession with the image was partially due to his own desire to take a trip to Florida that his parents had cancelled. The plane had great symbolism, and was both an object of fear and death for his parents, as well as one of hope and voyaging. Michael was brought in because his parents were concerned about his well-being but, like many families we saw, the parents consciously or subconsciously projected their fears and anxieties upon their children, finding it easier to seek help for them, than to admit that they themselves may need the actual assistance.

“Plane” by Michael.

One of hundreds he drew post September 11th to show his own desire to travel despite his parents’ fear.

Other children, like “Jarred” became focused on the potassium pills that were distributed in all of Westchester County, post 9/11. These pills are supposed to prevent thyroid cancer in the event that Indian Point, a nearby nuclear power plant, was attacked. Jarred was most concerned because he still had difficulty swallowing aspirin tablets, and was fearful that he would be helpless, like a baby. The reality for most adults who mentioned Indian Point was the fear of terrorists striking the plant, which if
damaged, could release enough radiation to kill thousands of people. Which fear is more valid? Both are reasonable fears, and Jarred showed the reality for his age of what would be comprehensively frightful to him. In reality, the plant remains a difficult terrorist target, but fears in the area remain quite elevated. Even this author had a dream shortly after 9/11 of watching a mushroom cloud explode, and believing the release of nuclear radiation had occurred in plain view.

The fear itself of a potential event can have a detrimental effect on physical well-being, and can produce additional psychological stress. After the Three Mile Island incident in the United States, in which a nuclear power plant suffered an accident that was contained with little significant release of radioactivity, scientists performed a study which showed that even six years after the incident, residents living near the reactor suffered measurable changes in immune cell function compared to a test group living elsewhere. Dr. Paul Martin, a researcher who studied extensively the connection between immune function and stress noted, “The Three Mile Island incident demonstrated quite clearly that irrespective of whether or not there is a release of harmful radiation, the psychological stress which attends a nuclear accident can still have a major impact on mental and physical well-being...prolonged stress can produce a prolonged depression in immune functioning”. (Martin, 1997, p. 84) While studies have yet to test Westchester residents, it seems likely that continued stress of living near two potential terrorist targets (New York City and Indian Point) have the potential to interfere with the body’s most basic functions.

In addition to the common reactions to stress and trauma outlined above, there is another noted phenomenon in trauma work: trauma easily re-triggers past traumas. Basically any work in the body that has not been fully resolved will reappear with significant stress. This is similar to the way that a person with a skin disorder, or any other disease for that matter, will demonstrate the strongest symptoms during times of stress. In my work, there were two women who exhibited this the clearest. The first was “Irene” who was also the very first person I was assigned to work with. An elderly woman who was housebound, I came to visit her at her home. Like many, she did not know anyone directly in the building, but had grown increasingly fearful of breathing the air outside, as well as opening any of her mail, which she had taken to depositing outside of her home directly into a trash bag. Neither of these behaviors was that unusual for the time. Many living within sight of New York could easily witness a dark cloud that hung over the city for days. Many speculated that asbestos and other pulverized matter would be harmful to breathe. While unlikely this was harmful outside of the direct area of the city, many were fearful. In addition, the anthrax scares of contaminated letters arrived soon after 9/11, and many feared their own mail and communications.

“Irene” was charmingly pleasant, but held herself quite guarded, and would repeatedly mention the quality of air. As we talked, she mentioned a love for European folk dance, and we began to move to a Hungarian csardas. She still took little breaths and I asked if she could take a breath. “I am afraid to breathe.” I simply questioned, “Why?” and she revealed that she had been a Holocaust survivor, and remembered watching people being incinerated and the smoke and ash darkening the sky. “How many are dead?” she wanted to know. The fear of death was shutting down her own ability to take in breath. Her doctor examined her often, and found tremendous muscular tension, but little reason for the lungs to be underutilized. As I continued to visit Irene we would repeatedly work on breath and movement. The csardas was a happy, positive dance for her. This dance, which is the national dance of Hungary, and has its roots as both a peasant dance, and stylized couples dance (Buday, 1950) builds slowly and gradually into an almost frenzied swirling movement, ideal for open up to emotion gradually. It was through breathing fully during this movement that she could begin to breathe comfortably again while seated.

As noted in numerous sources, the breath and emotion and quite closely connected. Richard Miller, PhD is one of many doctors whose practice in psychology and yoga therapy closely examines the breath. As he notes, “Our physical existence depends upon breath. Breathing plays a fundamental role in our every activity and is critical in all the physiological functions of the human body. But breathing is not merely a physical process; it is also closely connected with the functioning of the mind and emotions. When we are upset, agitated, depressed, or even excessively happy, our breathing patterns change. When our breathing rhythms are altered, our state of mind and emotions are affected, and repressed feelings, thoughts, and emotions may be released. Conversely, if we regularize our breathing rhythms, our thoughts and emotions stabilize, allowing us to become more relaxed and at ease”. (Miller in Feurstein, 1993, p. 28) For Irene, the ability to access her breath patterns first allowed her to open up to her traumatic past, as well as to reconnect with the pleasurable aspects of her being alive.

Another example of the effect of Sept. 11th re-triggering past trauma was “Michelle,” a quite
strikingly beautiful woman in her late forties, who had made a very successful business career for herself. She always came immaculately dressed, and without a single item of clothing, or piece of hair out of place. "Michelle" had lost her job in the 9/11 attacks, as well as some business associates. But since she had always remained quite independent, she did not seem to mourn much about the loss of the Twin Towers except for the worry of finding a job and maintaining her finances.

Like many of those that I saw, she rarely appeared to breathe, let alone emit much of anything. Her jaw was firm, and she used bound muscular tension, clear directional movement, but was not always able to connect with any strong use of weight. It appeared as if this bound and angry woman floated into a room. On several occasions, as we discussed pleasurable activities to try, she would only look at me quizzically. Any invitation to move in a freer manner was met with extreme resistance.

It then clearly occurred to me what had been her past trauma, and I asked one day if she had been "hurt or damaged" before, words that she used to describe herself as well as the damaged remains of the Twin Towers. "Yes" was the response, "I was raped in my twenties." She had never told anyone except her brother of her brutal attack. She had repeatedly denied herself any relationships from deepening. We came to discuss where this lived in her body, and where she could let it go. It turns out that the rapist left her a sexually transmitted disease that has continued to haunt her, and that flares up during times of stress. Sept. 11th had opened up a floodgate of emotions for her. Of course she also felt terrible for those lost in the tragedy, but there were parades and outpourings of sympathy for the tragic loss. She had never had anyone understand her trauma.

Together we moved a bit further through this grief, but Michelle refused to ever seek treatment directly for the rape itself. Unfortunately, like the sexual disease that remains with her, she felt that she was a true victim of the rape experience, rather than a complete person. Where we could, we tried to build the positive aspects of herself, but the labels, "damage" "broken" and "hurt" would resurface as often as "strong" "independent" and "lonely."

What to do?

How one reacts to stress has a greater effect on the entirety of the immune system than the actual traumatic event itself. (Locke, 1984) This statement has been observed in past survivors of trauma in which one person exposed to a seemingly small event may have less ability than those who have strong coping skills to deal with a great tragedy. Also important to remember is that the reality of a traumatic event must be honored for each individual. As therapists, we do not have the right to judge the degree of impact any event has for another. The best we can do is provide a path and some pointers to a greater sense of wellness and integration in the body, mind and spirit. As part of the process of dealing with trauma, practitioners are trained both in helping individuals recognize the symptoms of stress, and then giving simple, obtainable things to try. These range from learning how to structure time to gain a sense of control, to turning off media coverage and learning how to reach out to, or find support systems.

One of the known aspects in crisis work is that the very action of someone seeking help, and wanting to talk about their trauma, is a critical first step in moving towards wellness. As dance/movement therapists, we are called to move further into psycho-physical awareness, again bringing consciousness to the body aspect of trauma. In the following, dance/movement therapists Meg Chang and Fern Leventhal are describing the reaction in battered women, but the basic approach is the same for any traumatized patient: "In the course of the abuse, a basic level of trust in herself, in intimate relationships, and in the environment has been lost. An abused woman can, however, be helped to reestablish a trust in her body through gradually building tolerance to the physical and psychologically stabilizing. Psycho-physical awareness can help a woman monitor, and possible manage, her anxiety. If, during dance/movement, an abused woman suddenly becomes conscious of her previously split-off feelings, panic may ensue. Focusing on her breath and immediate body sensations is a way to return to the present while allowing fears from the past to be investigated." (Chang and Leventhal, 1995, p. 65)

In my own experience, I have found it important to make the successful things to try as obtainable as possible. If a task or a general statement is too large or too broad, the body will reject it, and sink deeper into feelings of inadequacy. Imagine being told, "just get over it," a refrain heard quite often after a traumatic event. Again, if the response of trauma lives in the deeper, more primal part of the body, hearing a verbal directive will only produce fear and panic. Goals need to be small and obtainable, so the body wishes to return to the healthy activity. The idea of exercising, for example, is overwhelming to a young mother just widowed during Sept. 11th. However, the suggestion to schedule an appointment with herself every week at 9 a.m. to take the baby out in the stroller is a much more realistic and obtainable goal. When that is accomplished, the effect ripples down to the rest of the day. She can
feel like a small goal was accomplished, both for herself and the care of her child. The movement, even as pedestrian in the literal sense as walking, is reaffirming that she is still functioning as a person.

The use of walking alone as meditation and healing has a precedent in thousands of years of history, and should not be taken lightly. In an article on walking meditation, an example is quoted of Buddha teaching walking meditation in the ancient text, The Great Discourse on the Foundations of Mindfulness: “in the section called ‘Postures’, he said that a monk knows ‘I am walking’ when he is walking, knows ‘I am standing’ when he is standing, knows ‘I am sitting’ when he is sitting, and knows ‘I am lying down when he is lying down.” (Silananda, 1995) This may seem esoteric, but the implications are quite simple and profound. Even the act of emphasizing a common movement to a traumatized person will help to bring awareness in the present moment to the actions of the body. By asking this widow to focus for a short time on just the awareness of one movement activity, it allowed her to feel connected to her body (as well as to her baby) and be aware of the present, and to cut the cycle of fear reaction.

I will interject a personal story here for example. When I first learned meditation, I was told that the reason most people fail to establish their practice is that they think they must be able to meditate for a half hour or more the very first time they try. The body panics, and the practice seems impossible. If one begins with a practice of a few minutes, the body and mind have some success, and wish to return to the practice again. In the same manner, one must make even simple acts of daily functioning attainable and enjoyable, by first reintroducing these movements in small amounts.

For “John” this process took months, and revolved around finding some simple gains in mobility, as well as re-discovering pleasure in simple activities. John had worked at a high-level job at one of the major publishing companies in New York. His office was in one of the adjacent areas and he, like many, fled that day from the Wall Street area of NYC, walking several miles to reach mid-town Manhattan. He described witnessing bodies jumping off the towers before they collapsed as well as the black veil of debris dropping, and the general sense of panic that others echoed that day. When I met him, he had been through a coma, several surgeries and was still on various types of support systems. His doctors believed that in the collapse of the building, he had directly inhaled human protein from those who were immediately destroyed. John presented as a rational, middle-aged man who enjoyed his intellect, and liked learning new things. He could not rationalize what had happened to him, nor later understand the loss of several colleagues and friends.

John was greatly intrigued by the idea of dance/movement therapy, and his wife was quite willing to try anything that might help his recovery in any way. However, John also prided himself on his intellectualism, and was quite happy when we could discuss literature or other fine arts. He was quite sure that he wanted to express himself on such a personal level.

For John, I found it easiest to approach him through yoga movements which complemented his physical therapy exercises. In fact, this became our routine when I came in: first the general greetings, news and hellos, and then the work of our exercises together. He knew as well as I did, that these “exercises” always led into deeper discussion, but it was a safe means to respect his fear of entering a body that had literally breathed in other people’s death.

We gradually began to expand his range of motion from his own personal preferences, to what his current condition allowed. Interestingly, he had to be a barometer for what that movement quality was, because as he reflected many times to me, “when we met, I wasn’t myself at all. I wasn’t even in a body that resembled me at all.” Due to his coma and several surgeries, this was quite literally and metaphorically true – his body weight and movements did not match the descriptions from his wife, nor the photos I saw at their house. Over time, in many ways he truly transcended his movement range, taking on quite a few shaping qualities, and light movements, in addition to regaining the quick, directional movement qualities that had always been familiar.

We ended our work during the first year, but he called me to check in around the second year anniversary. He had resumed his job, and talked about how his body felt. More significantly we talked about his ever-expanding garden, a true reflection of the nurturing and care he could experience again. This was symbolic of his ability to live in the present moment as well as envision the future.

Additional case examples

As Dr. Van der Kolk has noted, the real contradiction in trauma work is that traumatized people, “see and feel only their trauma, or they see and feel nothing at all; they’re fixated on their traumas or they’re somehow psychically absent.” (Van der Kolk in Wylie, MS, 2004) Either way, the body connection is missing, and balance of body/mind and spirit is disrupted so that the quality of life becomes injured. Throughout the two years post 9/11, the demographics of those we saw changed from initial
Elizabeth was open to mixing any creative expression into our sessions. A discussion on re-finding small, pleasurable moments in her morning walk would yield a roll of photographs the next week, and discussion about people she knew would yield a small sketchbook. When we worked in movement, she had to literally “face” herself – a visualization she could not fully comprehend. While her movement was quick, and directional, she kept all use of her spatial awareness in near reach space, rarely venturing far from her immediate self. We began to dance her movement every week. I would ask her how she felt, and we would express that not only in our faces but also through the whole of our bodies. She was used to being quite unexpressive with her body, as if it was just a larger extension of the face she couldn’t see. It bothered her that she didn’t really know what the woman in the Twin Tower’s coffee shop looked like, but she knew her nevertheless.

We focused more on the movements that were known, owning them in our bodies, and letting the different qualities produce their different effects. She greatly enjoyed humor, especially in movement qualities, so we built upon this. I would often copy small gestural movements, the easiest for her to read as well. This technique is well outlined in Schmais’ work, “For most patients, the accretive process begins with a simple motion, perhaps a flick of the wrist. The therapist repeats the movement, adding descriptive phrases and poetic images to enhance the meaning and crystallize the action. As the energy level rises, the gesture of a single joint can become a postural motion spreading through the entire body, cutting through tension and engaging inert areas. The facial expressions, sounds and words become congruent with the body actions. Body parts connect, discordant rhythms disappear...” (Schmais, 1985, pp. 27-28) Like many, post 9/11, she was unsure if she should allow herself to feel pleasure. The first time she gave a large belly laugh, she quickly covered her face, as if to hide that it had come from her at all.

In another interesting scenario of missing identity is an artist from the city, whom I shall name “Alice” after the character she closely identified with from Lewis Carroll’s children’s book, Alice in Wonderland. She claimed to be a secret spy, but “on the side of good” as she phrased it. We only worked together briefly, but we discussed at length the image of the mirror, an extremely easy method for me to engage her in the therapeutic process. Not only did we use the term of the metaphorical mirror but I could also mirror her movement in my own body. She would find it amusing that she appeared “light” and “child-like” quite an opposition to the spy and intellect that was a part of her other persona. For her, I worked to ground her movement, to
literally have her stand on her feet and be connected to some of the emotionality she escaped through the young Alice identity.

Many of those who I began to see towards the second year came in stronger with clear substance abuse problems and difficulties in boundary and relationships. "Brian" was a New York City firefighter who, like many, lived in Westchester County and worked in the city. He came in often to see another counselor during the early stages of the grant, but then he would routinely cancel meetings and disappear for months at a time. He was handsome and had an engaging personality, but did everything to avoid dealing directly with the grief process. He admitted freely to cheating on his wife and, to a lesser extent, his ongoing battle with alcohol abuse. While I was aware of his case history, I came to work eventually with his wife "Lisa."

Previously a firefighter, Lisa had a small daughter and was working towards an advance degree in service administration. When I first met Lisa, she would spend a lot of time wondering about her husband, and whether his latest night out was another one-night stand or a drinking bout. Either way, it began not to matter, as Lisa started to move through her own story. At first, her movements always went back to the twenty-something year old that she was when she met Brian. As our sessions went on, she began to focus more on what she was feeling as losses about Sept. 11th. Although her husband went down to Ground Zero, it was Lisa that was in the city that day with their daughter, and it was she that battled her way to mid-town with her child. They had escaped one of the towers collapse by rushing into a delicatessen, and felt the impact of the building collapse as the outside became so black that it reflected the interior of the shop like a mirror. She had kept her daughter calm that day, and had mourned her own personal loss of past colleges and friends.

As part of her personal transformation, she began to wear new clothes and trimmed her long hair into a short, stylish cut. She labeled these acts movements that reflected her inner state, and in a way they were.

Coming from a different background, "Fred" was a chiropractic doctor who had worked heavily on volunteering and organizing first year anniversary tributes, but who also struggled with boundary issues in almost all of his relationships. He was in the middle of a separation from his wife, which he could never fully end, despite an ongoing affair with another woman. He had worked at Ground Zero for weeks volunteering, but at a sacrifice to his children who wanted him at home. In our visits, he would routinely try to circumvent feelings and emotional work through lengthy monologues that needed to be curtailed. We had begun to make some progress with defining his boundaries through movement work, and through simple exercises of having him repeat different movement qualities. He would quickly wish to revert to his own patterns, and his own story, which he felt was the most important to hear. I only saw him briefly, as this was a few weeks before the closing of our own program, and I had to refer him to another agency with a longer-term grant. Unfortunately the new therapist, a young social worker, remained in session with him for two and a half hours on their first meeting, and I understand, did not get a word in edgewise. Despite being a verbal therapist, I felt even more strongly after this that clinicians need to understand the basic non-verbal component of stress in trauma patients, as well as in those like Fred who were experiencing "compassion fatigue."

Fred basically felt uneasy in his reactions to stress. Interestingly, being a chiropractic doctor, he had some experience with the body, but chose to ignore his own breath patterns and growing muscular aches. He would joke about feeling achy, but claimed he just couldn’t work well on himself. Like many trauma patients, he expressed his stress through inappropriate sexual behaviors, and a general lack of boundaries with time as well. His verbalizations were “chatter” to avoid feeling anything. As long as he kept the conversation light, or concentrated on complaining about how others didn’t help his tribute work, nothing could really impact on him. Fred is also an interesting case to note because, by nature, many of his actions appear distasteful, and his inability to engage to verbalize in anything but his monologues could be quite irritating. This too is the nature of trauma; the very behaviors that the individual uses to disassociate with their bodily and emotional experiences have the effect of further pushing others away.

One of my last home visits was one in which I was with another male counselor, who was also a firefighter. We were sent to visit a sixty-year-old man who was hitting severe depression and throwing fits of anger at his wife and college-age daughter who lived with them. "Ted" was obviously drunk when we arrived, his wife slipping in and out of the room, often being yelled at by Ted for not understanding what he was going through. Like many substance abusers, he lacked appropriate spatial boundaries and leaned in repeatedly to both my colleague and I. This was about two years exactly to the events of 9/11. He needed us to see stackfuls of photos that he had taken at Ground Zero. He had been a construction worker at one of the buildings that collapsed near the immediate destruction of the towers. He had gone back to volunteer immediately afterwards, and like many, he stayed for days, fruitlessly searching through the rubble for any remaining survivors. What his
pictures revealed was tangled ruins of the buildings. Occasionally one could identify a shoe or a foot or a hand. The hands seemed to bother Ted the most, and he repeatedly held up his own hand crying. He had picked up some body parts, but had hoped to be part of the rescue of finding survivors. Despite the vast numbers of people that had been killed, most of what was recovered was an odd assortment of mementoes that collected in piles—photographs, paperweights and such.

His sentiments echoed many that were heard by responders who wanted to help, but met with fruitless efforts to uncover any survivors. As explained by a New York Times magazine writer, “We needed bodies. Without them, we were useless. And so we kept waiting, staring south toward the billowing smoke, anxiously tapping our feet, hoping the ambulances constantly pulling up with their sirens blaring had somebody inside we could help. They didn’t.” (Klam, 2001)

As for Ted, we had to refer him directly for a treatment program, but we listened to his anger, and I worked with some of his emotional movements. Although working with someone actively drunk is quite difficult, and our primary concerns were to establish an environment of trust and safety so that he could move into the work that he needed to do.

Fischer (1968) defines body image as referring “to the body as a psychological experience and focuses on the individual’s feelings and attitudes toward his own body” (Fisher, 1968, p. x). In the above cases, it is clear that each of these people at times disassociate from their body. The first two examples are clear, almost pathological examples of disassociating directly from the body to cope with the current crisis. “Alice” was so unsure of her own identity that she had to create an elaborate double identity for herself, and could only associate with herself “through the looking glass.” Others, particularly those who had been involved in the actual witnessing of the trauma, took to disassociation from their own bodily experience, particularly through the use of substance abuse. Even Lisa, who had some of the best coping skills, could not release herself from her identity until she got a haircut and new clothes to signal the internal changes she was going through.

Lessons learned

In the early months post 9/11, it was commonly observed around the city and surrounding counties that New Yorkers were greeting each other more openly, and even making eye contact. However, this response was too opening for a city of thousands upon thousands of people who needed to exist in a very populated and busy city. The return to less intense interaction is a partial necessity of life in a city, but when compounded with the remaining effects of trauma, it can produce a deep sense of isolation. Of course, levels of anger, distrust and prejudice towards the unknown can also arise as a result of a traumatic event, and also need attention to be managed through appropriate patterning of interactions.

The imagery of the two Twin Towers themselves remains important as a symbol of part of the “body” of New York that was lost. It continues to appear in paintings (see below), often highlighted like a ghost limb that is felt by a survivor, but is no longer present. The cultural importance of working through this symbolism will no doubt continue to make its appearances until a new skyline of New York has been assimilated into the immediate culture.

As dance/movement therapists, we serve as guides to the verbal and non-verbal world of the whole person. Because of the nature of trauma, we have seen that it affects lives, but can also be healed through the body. It is important in dealing with this work that a larger community of professionals comes to recognize and support this as part of the healing process. As Bartenieff notes, “The problems of healing and restoring mental emotional health are not confined to pathological extremes. There are differences in degree of mental health, rather than kind. The current exploration in healing oriented toward “restorations” of wholeness – some ancient and some apparently new – are reflections of the wide-spread concern with problems of personal and community wholeness and survival. They are intimately related because what is accepted as appropriate functioning by the individual is
dependent on the society in which the individual lives.” (Bartenieff, 1980, p. 151)

The area of Westchester post 9/11 will continue to struggle with the effects of the day for many years to come. Those that have started work in this dance are already on the road towards healing. Any trauma produces ripples on the body in quite profound ways, both in the gross movement patterning of daily interaction, to a cellular level of coping. In order to continue to heal, we need to encourage that movement and reconnection with the body.

References:

The author welcomes comments at: lauricedn@yahoo.com

INTERNATIONAL DANCE THERAPY INSTITUTE OF AUSTRALIA, Inc.

Dr. Marcia Leventhal, Ph.D., ADTR, CMA.
back in Melbourne to conduct a series of
DANCE THERAPY Workshops

IDTIA’s Founding Director of Training will conduct Diploma graduations and
A Two day Advanced Dance Therapy workshop for Graduates
date: Sat/Sun Nov.27-28

For more info phone Ann Berg 5476 6222

cost: $380 / $405.

Open session Wed 1st December 6-10pm for those who may be new to the work
of Dr. Leventhal.

cost: $70 / $85 non-members.

Experiential Workshop (18hrs training) for IDTIA Certificate Graduates
Or those with equivalent training, who are interested in the Leventhal approach
date: Thurs evening., Friday, Saturday Dec 2-4. cost: $380 / $405

For more information contact: Naomi Richards, IDTIA Administrator
phone 9596 0034 or e-mail: N.E.Richards@hotmail.com