WHEN THE TRAUMA IS TERRORISM AND THE THERAPIST IS TRAUMATIZED TOO: WORKING AS AN ANALYST SINCE 9/11

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Tuesday, September 11, 2001, was a brilliantly sunny, late summer day. As I drove up the Palisades Parkway (about 15 miles northwest of Manhattan) to drop my daughter off at preschool, I smiled, reflecting on the summer just past as one of the best in recent memory. As we pulled off the highway, my daughter began to sing "Frere Jacques" just as the news radio station interrupted itself with a bulletin that a plane had struck one of the World Trade Center towers. Like so many people, my first reaction was, "Why do they let those little private planes buzz around New York? They are accidents waiting to happen."

I tickled my daughter as I freed her from the car seat, checked that she had her lunch and show-and-tell item, hugged her tight, and kissed her twice before watching her scamper into her new school. Getting back into the car, I marveled at her confidence and sense of security, especially given that she had spent her first two years of life in a Chinese orphanage. Not for the first time, I thought of her intellect, humor, and engaging little personality and was grateful that she was safe in the United States rather than growing up in the uncertainty of China.

My thoughts shifted as I guided the car back onto the parkway. It was just about nine o'clock and my first patient was not due until 9:45 a.m. I would have time for another cup of coffee and decided that I would enjoy it on the patio, grabbing every remaining opportunity to relish that outdoor space.

Again the radio announced a news bulletin. A second plane had hit the other World Trade Center tower, and the voice filling my car and sensorium reported that both planes appeared to be commercial jetliners. As is emblematic of trauma, I now find it difficult to convey linguistically my reactions in a way that sufficiently expresses their somatic and affective wallop. Words seem altogether too trite, but here goes.

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Cognitively, I immediately apprehended that there had been a deliberate attack of some kind on our country, or at least on New York. I experienced a sense of something vital flowing out of me, an involuntary evacuation of buoyancy and forward movement. At the same time, I gasped, taking in something vague, nauseating, and pernicious. I was afraid but riveted, wondering what would happen next. I also knew profoundly, deeply, in my bones, that great suffering was on its way. I was aware of being shocked, shaken to my core, and perhaps because of my clinical experiences with childhood trauma survivors, had an instantaneous sense that many people's lives had changed forever. I visualized the dark psychological ripples that would extend out from this event to touch thousands of people. I was also keenly aware of bubbling rage and despair at having to "deal" with this, although at the time I had no idea what "this" was or what would be involved in "dealing" with it.

Back home, I flipped on MSNBC and watched events unfold as I called family and friends to let them know that my immediate family members were safe. I was both relieved and frustrated that my husband was out West on business. I was so glad that he was safe but wanted him home and correctly sensed that he would not be able to get back anytime soon. My Bosnian foster son, Igor, had been a frontline soldier defending his hometown from the Serbian Army from age sixteen to age twenty. Now he is a graduate film student at NYU. I was worried about his physical and psychic integrity and was concerned that he would get into the thick of things. At some point, I began to sob, overwhelmed by the formulated and the yet inchoate meanings of what was still happening. By then, the Pentagon had been hit and the newscaster was saying that a fourth plane might have crashed in Pennsylvania. I was crying, already drained, while simultaneously much too full, and was facing my first patient of the day in just a few minutes.

The horrific events of 9/11 imposed then and continue to impose uncharted clinical challenges. We can turn to the trauma literature (Kardiner, 1941; Lifton, 1967; Burgess & Holmstrom, 1974; Figley [Ed.], 1978, 1986; Krystal, 1978, 1988; Terr, 1979, 1990; Baum, Gatchel, & Schaeffer, 1983; Card, 1983; Green, Grace, Titchener, & Lindy, 1983; Adams & Adams, 1984; Kestenberg, 1985; Kolb, 1987; van der Kolk [Ed.], 1987; Ulman & Brothers, 1988; Herman, 1993; Davies & Frawley, 1994; van der Kolk, McFarlane, & Weisaeth [Eds.], 1996; Gartner, 1997) to glean insights into the immediate and long-term sequelae of catastrophically traumatic events. In addition to depicting the cognitive, affective, somatic, interpersonal, and psychophysiological consequences of severe

trauma, some of this literature also presents the transference and countertransference paradigms common to clinical work with trauma survivors. We are also able to access helpful literature on the secondary or vicarious traumatization of therapists working with patients who have been exposed to serious trauma (Pearlman & Saakvitne, 1995; Frawley-O'Dea, 1997). But this is different. It is different because analysts have been coping with the same traumatic events impinging on patients, and we have been attempting to do it right alongside them.

Boulanger (2002a) cogently points out that psychoanalysis has not developed a sophisticated theory of treating adult onset trauma, particularly because historically we have been more or less disinterested in the impact of "real," external events on the psychological lives of our patients. In this paper, therefore, I will offer some perspectives on the clinical impact of 9/11. These draw on the trauma and psychoanalytic literatures, on the personal accounts and clinical reports of colleagues, and on my own work with patients as I began and continue to experience various reactions to the terrorist attacks and to all that has succeeded them in this country and overseas, including the war in Iraq.

The Analyst Is Traumatized

On September 11, 2001, every American—and particularly every New Yorker—was confronted with the same crisis at the same time. Like the jets smashing into the twin towers and the Pentagon, the attacks brutally broke into and entered our real time and psychological experiences with maximum force. Nina Thomas (2002), in fact, compares the impact of 9/11 to 5,000 volts of electricity administered suddenly to an appliance designed to run on 100 volts; our psychological and psychobiological systems were fried. Therapists, their own analysts, supervisors, peers, and patients, as well as family members and friends, were exposed simultaneously to the same constellation of traumatic stimuli, the same voltages. Clinicians, many of whom had just returned to their practices after summer vacations, were faced with work quite literally before they knew what had happened to them. There was no one sufficiently distant from the trauma to turn to for holding or advice. Depended-on containers overflowed or collapsed, as Shadick (2002) poignantly illustrates in his discussion of trying to supervise traumatized therapists treating traumatized patients in lower Manhattan when he himself was attempting to absorb and process the 9/11 events.

At the same time that patients were reacting to the events, analysts were confronting their own acute stress responses. As for our patients, our traumatogenic experiences differed according to our proximity to the attack

site, the loss of family or friends, and our characteristic adaptive and defensive coping strategies. Similarly, our responses to the trauma, like those of patients, rested on and evoked other traumatic situations or relationships from our own histories and reflected the degree to which those experiences had been worked through. Each of us developed unique responses to 9/11, some of which were similar to and some of which diverged markedly from those of our patients. The challenge we faced, especially in the early weeks after 9/11, but continuing still and exacerbated by ongoing terror threats and war in Iraq, was to cocreate with our patients good enough therapeutic environments for them while, like them, we were immersed in and overwhelmed by death, fear, grief, and brokenness. Another challenge was to muster self-acceptance when we failed to be good enough.

At 9:45 a.m. on September 11th, I greeted my first patient, Suzie, a tall, willowy redhead I had been seeing for a little over a year. Prior to beginning twice-weekly psychoanalytic psychotherapy with me, Suzie had worked with a series of New Age spiritual healers, body workers, Reiki practitioners, and other alternative treaters. Suzie was also active in Alcoholics Anonymous, but tended to use the program in a superficial way, glibly throwing out platitudes rather than deeply exploring constructions of her own experience.

As a child, Suzie had been the sole "adult" in her family, serving to contain and interpret the physical and emotional needs of her alcoholic mother, depressed and periodically hospitalized father, and epileptic younger sister. Later in life, Suzie adopted two older, severely emotionally disturbed siblings. Her husband left her within a year of the adoption, leaving Suzie alone to raise these two chaotically organized, wildly acting out children. She worked during those years as a hospital oncology nurse, thus spending about fifteen years caring for desperately needy people twenty-four hours a day. A much repeated theme in her treatment was her stated intention to care for no one but herself, although she tended to surround herself with exceptionally dependent friends and romantic partners whom she then grew to resent and eventually dropped precipitously from her life. The therapy had lasted as long as it had in part because Suzie perceived me as neither needy nor willing to be used. Lurking out of her awareness, however, I detected envy of my apparent professional success and family life as well as defensive contempt for my apparently traditional lifestyle.

On that morning, we took our respective seats in my consultation room and Suzie asked me if I knew about the planes. I nodded, "yes." She had listened to the news reports in the car and had heard people discussing

the attacks at Starbucks, where she had stopped for coffee on the way to my office. Suzie said that she was baffled by people's reactions. "People were crying in Starbucks, for heaven's sake. Crying–like it happened to them," she snorted. She went on to say that "everything happens for a reason," that "there was a lesson to be learned here," and that instead of getting hysterical, "people should try to figure out what the universe is trying to tell us."

As Suzie spoke, I experienced a cascade of emotions all tumbling into a pool filled mostly with horror, shock, and rage. I tried to gain an "analytic" foothold but could not. Instead, I began to cry. I told Suzie that my reactions to the events of the morning were very different from her own. With tears still rolling down my cheeks, I interpreted that her feelings made sense in terms of all that she had faced in her life and suggested to her that she could feel only what it was possible for her to feel at that moment. Then I said that it was clear to me that I was too distraught to be helpful to her that day and that we could talk more about this session in the next one, two days later. I ended the session with some inane comment about there being no charge for the 9/11 meeting.

Perhaps it is not surprising that I never saw Suzie again, receiving a phone call the next day that she had decided to end treatment to pursue more fully a spiritually based healing program. She did not return the several phone calls I made over the next few weeks. Apparently, Suzie was not about to work through the 9/11 session in which she undoubtedly felt that, among other things, her therapist was just one more person who fell apart in a crisis and needed to be cared for. Added to the emotional potpourri I experienced that week was guilt and shame over losing this patient who had appeared to be working well through the relationship we had formed prior to that day.

After Suzie left that Tuesday morning, I had about twenty minutes before my next patient and used the time to call other patients to cancel the appointments for that day. Although I felt quite guilty about abandoning patients who were suffering with their own reactions to the attacks, I decided that I did not trust myself to work effectively that day. In fact, when I checked my answering machine, a number of patients had already canceled, wanting to remain at home with their families. Several requested that I call them just to let them know about the safety of my family members, and I complied with those requests, asking similar questions of them.

Unable to reach the 10:30 a.m. patient before she arrived, I greeted her. LuAnn was a relatively new patient, whose life history included sadistic physical battering by her mother, the early death of a father she adored, and two years of sexual abuse by an uncle immediately following her

father's death. This patient, like Suzie, also was in A.A. after years of serious alcoholism. In our early work together, LuAnn talked about trusting no one, expressing her conviction that most people took care of themselves first, no matter the cost to others in their lives.

After exchanging greetings with LuAnn, I asked her if she had heard about the planes crashing into the World Trade Center towers and the Pentagon. She replied that she had and was shocked and confused by it. I told LuAnn that I also was shocked by the news and unsure of all my feelings about it. Therefore, I said, I did not feel able to work well as a therapist that day and would like to cancel the session. She was welcome, however, to stay for some time if she felt it would be helpful to put words to some of her reactions. Again, I mumbled something about there being no charge for the time.

LuAnn and I sat together for a number of moments. We asked about the safety of each other's families and friends. Like Gensler's (2002) patient, LuAnn used my phone to call a cousin she had been unable to reach yet and I excused myself to answer a phone ringing in another room. That call was from a friend and colleague whose neighbor had been at work on the hundredth floor of one of the towers and who had not yet been heard from. His wife was distraught, and my friend was trying to comfort her while also caring for the couple's equally frightened eleven-year-old son. At some point, LuAnn left, confirming that we would meet at the same time the following week. Given her history and the newness of our relationship, I wondered about that.

In LuAnn's session the following week, I inquired about her experience of our 9/11 meeting. She began to cry and said that I was the first doctor she had ever encountered who seemed to be a real person with real feelings about the world and other people. She could not believe that she was saying it, but she thought she might be able to be helped by working with me. Ushered into the therapy was an idealized transference that, although predictably fraught with its own problems, indeed has seemed to facilitate LuAnn's ability to engage in very meaningful and, according to her, unprecedented, therapeutic progress.

These vignettes exemplify the confusion of roles and blurring of typical analytic boundaries common during the first few days of the 9/11 events (Gensler, 2002; Goldman, Dodi, 2002; Rosenbach, 2002). Many therapists called patients they knew might be directly involved in the crisis, allowed patients to use their phones during sessions, waived fees for canceled sessions, hugged and were hugged by patients, expressed their own feelings about the attacks, and shared information about the fate of their

own family members and friends. Most patients seemed to have responded positively to these boundary violations, and it may be worthwhile for analysts to consider the value of such increased openness even when there is not a shared crisis (Schreiber, A., personal communication). Other patients reacted poorly, and several colleagues have reported premature terminations like Suzie's that may have been in part related to the analyst's untimely imposition of her own subjectivity. One colleague was in tears about a patient's termination and was filled with shame about that outcome. Others have been almost euphoric about the seemingly magical progress some patients made right after 9/11 and attributed to their therapists' emotional availability and vulnerability during that time. Ongoing collegial consultations and published literature provide all of us with an opportunity to revisit and process our own and our patients' self-expressions on and since 9/11.

As the week of 9/11 passed and the immediacy of the horror receded somewhat, it remained noticeable that treatment issues, transference and countertransference paradigms, and therapist self-care efforts stayed in flux. The rest of this paper addresses four topics that have been consistently raised in collegial discussions since 9/11: consideration of normative versus particular responses to this trauma, clinical handling of the real versus the metaphoric meanings of the 9/11 events, the entry of politics into the analytic space, and issues regarding therapist self-care. They represent first brushes with the clinical impact of 9/11 and point to the need for ongoing reflection and dialogue about the role such a shared external trauma plays in clinical work. As Boulanger (2002b) notes, analysts, no less than patients, may tend to dissociate the ongoingness of the 9/11 tragedies when, instead, it behooves us to continue to engage with this material and with its personal and professional meanings for each one of us.

The Normative Versus the Particular

Analysts and patients were confronted with the same traumatically disruptive stimuli on 9/11. Although each of us reacted according to our own pre-9/11 character structure and coping capacities, many of us and many of our patients exhibited and may even continue to exhibit symptoms consistent with an acute traumatic-stress reaction (Shalev, 1996; Solomon, Laor & McFarlane, 1996). In addition, individuals who seemed to recover from their response to 9/11 experienced the flare-up of symptoms when the government raised the level of potential terrorist threat, at the first anniversary of 9/11, and/or as war in Iraq approached and was launched. Sleeplessness and/or disturbed sleep, increased anxiety, difficulty concentrating, anhedonia, a sense of helplessness, heightened irritation or rage,

and emotional lability all are normative traumatic stress reactions reported by many patients and also by clinicians. For many clinicians and patients unfamiliar or only superficially acquainted with traumatic-stress reactions, it has been enormously helpful to normalize their symptoms as expectable responses to an event of the magnitude of 9/11 and its aftermath. Education about and normalization of acute stress reactions, in fact, is part of the accepted model of critical-incident-stress debriefing (Raphael, Wilson, Meldrum, & McFarlane, 1996). For example, I found it useful, especially in the months directly following 9/11, to provide friends, family members, colleagues, and patients with symptom lists and suggested coping mechanisms to which they could refer when they were ready to take in that information and/or when they began to notice changes in their functioning.

Dodi Goldman (2002) eloquently points out that there was a rush by the media and by some members of the mental health community to speak prematurely about PTSD when, in fact, the initial trauma was still unfolding. As the immediacy of the crisis passed, however, a percentage of analysts and patients continued to experience or just began to notice symptoms developing into a post–traumatic stress disorder (Herman, 1993; van der Kolk, McFarlane, & Weisaeth [Eds.], 1996), the configuration of which differed from person to person. Here, too, it is important to normalize as consistent with PTSD those symptoms and experiences of self and others that are assessed to be associated with a person's response to 9/11 and to the sociopolitical realities emerging after that day. This is the valuing of the impact of external trauma in and of itself that Boulanger (2002a) finds too often lacking in psychoanalysis.

At the same time that there are species-specific, normative responses to trauma, it is equally true that the traumatic events of 9/11 were processed by unique human beings. Our own and our patients' histories and current internal and external stressors, pre-9/11 cognitive schemas, affective range and organization, defensive repertoires, internal and external relational worlds, psychobiological vulnerabilities and strengths, senses of safety and efficacy, all influence how each of us integrates or dissociates the impact of 9/11 and its aftermath in conjunction with the preexisting tapestries of our beings. It is crucial that we allow space for ourselves, for friends and family members, and for patients to identify and process associations to 9/11 and to the changed world in which we now live without assuming that everyone is feeling about the same way at the same time.

This seemingly rudimentary clinical tenet may be more challenging to follow than it first appears. Since many of us consciously and unconsciously continue to react to and work through our own experiences of 9/11

and afterward, it is possible that we unintentionally and unconsciously assume patients are about where we are in their reactions and symptoms. It may increase our own sense of ongoingness and sanity, in fact, to feel that society is moving as a united bloc through the sequelae of the 9/11 attacks. In so doing, we can inadvertently apply pressure on our patients, as well as on others in our lives, to comply with our expectations. In addition, each of us may find ourselves with unexpected and shameful countertransference reactions, e.g., envy toward a patient who seems further along in symptom relief than we are, or impatience with a patient who is still suffering and thereby is experienced by us as threatening to our own perhaps recently reclaimed "normalcy." Especially challenging can be the profoundly narcissistic patient who never expressed much interest in or affect about the 9/11 attacks or the ongoing threat of terror. My own hostility toward and contempt for these few patients have been echoed by others (Goldman, Dodi, 2002; Gordon, 2002; Prince, 2002). It has been helpful for me in working with these patients to consider my own possible envy of their ability to remain so untouched by tragedy. At the same time, I have wondered whether the rage I experienced with them then was warranted even before 9/11 and should be made available to them in some way.

Dodi Goldman (2002) suggests that, although it is important to be alert to traumatic-stress reactions in both ourselves and our patients, it also is worthwhile to balance that awareness with recognition of the amazing resiliency, courage, and hope many of us have mustered. The "big heroes"–rescue workers, firefighters, volunteers, families of the Pennsylvania flight's passengers–have received well-deserved accolades. There have been, however, legions of "little heroes" whose resiliency and determination have allowed them to continue to love relatively well, work relatively well, and play relatively well even when beset by terror, rage, and profound grief. Further, some patients have been able to use the 9/11 tragedies to propel them into deeper and more productive therapeutic work. One patient said to me in December 2001, "You know, I always knew intellectually that life is both short and fragile. But, since September 11th, I've known it in my gut and in my bones and in my soul. I know now that I want to live my life as fully as I can. As much as I like you, I have decided that I don't want to grow old with you! I never told you before but I used to think I would–that I would just keep coming here until one of us died. Now, I want to make every session count as much as it can so I can make every day count too." And she has.

It was particularly moving to note that a number of patients who were severely abused as children, who had been in treatment for some time,

and who successfully had worked through many sequelae of their early traumas prior to 9/11 coped especially well with the events of that day and what has come after. Stripped long ago of their expectations of a just world; betrayed early on by other humans, who used them to contain their own rage, emptiness, and need; having had their young minds and bodies blasted to pieces, they have been able to approach this latest series of assaults with remarkable affective depth and coping resiliency.

Similarly, Igor, my Bosnian foster son about whom I was so worried that Tuesday, has been a resilient hero in our family. He did indeed end up in the thick of things on 9/11, spending over eleven hours as a volunteer on the bucket brigade at what came to be known as Ground Zero. Over the next days and weeks, I obsessively checked in with him about how he was doing, until he finally said: "Look, I know you love me and are worried. But you are having a much harder time with all this than I am. Remember where I lived. I already know that the world is totally fucked up and that people who lived next door to you all your life can pick up a gun and start shooting at you as their enemy because someone in power tells them to do it for some great cause. I don't expect what you do from life or from people. I honestly think that there is a good chance that something else will happen here. I believe that there's a decent chance that I could get blown up on the way to school tomorrow or next week or next year. I also think just as much that I'm going to win an Oscar someday for cinematography or directing. And, in case I don't get blown up tomorrow, I have to go upstairs right now and write a paper that's due."

This was not said in despair, defensiveness, or anger; for Igor, that worldview just represents the "facts" around which he has constructed an otherwise optimistic life replete with goals, accomplishments, love and hope.

Unlike Igor and some patients, other childhood trauma survivors who still live in symbolic bondage to early abusive and neglectful objects and who had not effectively worked through the post-traumatic sequelae of their early experiences prior to 9/11, became increasingly dissociated and symptomatic. In these cases, the new trauma collapsed into the earlier ones, leading to intensified internal and external chaos.

As we and our patients continue to process the aftermath of 9/11, we strive clinically to sustain an effective oscillation between addressing traumatic responses normative to our species and developing a narrative regarding individually unique reactions to 9/11, including those of remarkable resiliency. Associated with that clinical challenge is a similar attempt to maintain a dialectical tension between the intrusive and undeniable

reality of the 9/11 tragedy and all that followed it and its symbolic, metaphorical meaning for each analyst and patient.

Reality and Metaphor: How the Twain Shall Meet

A recurrent theme in collegial discussions of the clinical implications of 9/11 is the challenge to balance acknowledgement and validation of the reality and impact of the attacks and subsequent world events while addressing the unique psychological significance and constructions of the events for each individual patient, and for ourselves. Boulanger (2002b), Gensler (2002), Prince (2002) and Rosenbach (2002) all offer perspectives on this issue. Boulanger (2002a), in particular, stresses that psychoanalysts are much better prepared to deal with the symbolic and the metaphoric and may give destructively short shrift to the nonnegotiable reality of traumatic events occurring in adulthood.

For some patients, especially but not limited to those who lost family or friends during the attacks, and/or who were in downtown Manhattan that day and bore witness to the devastation, attempting to explore the metaphorically meaningful aspects of 9/11 too soon was experienced as yet another betrayal and assault. While "too soon" differed from person to person, there was for each a point before which reality simply was too real and too impinging to be treated as "material" to be analyzed. For other patients, often but not always those less directly affected by the crisis, the multiple levels of meaning for them of the 9/11 events were more readily accessible for analytic work. Because clinicians were sorting out the real and symbolic threads of 9/11 for ourselves in the same time frame as our patients, our personal analytic processing of the attacks could muddle countertransference responses and clinical interventions. And they still might, even this "long" after the events of that day. For instance, we may inadvertently push a patient to consider the psychological familiarity of the 9/11 events because we are more comfortable with focusing on those aspects of our own reactions. It can be stabilizing for us to work on our own and our patients' traumatic responses as metaphor rather than unwaveringly to stare in the face current dangers and uncertainties. In addition, engaging with patients in trusted clinical ways reassures us that life really is not so different than it was on September 10, 2001, thus helping to restore shattered illusions of safety and security on which we depended prior to 9/11 (Boulanger, 2002a). Because of our own need to focus on the symbolic meaning of these horrible events and their aftermath, we may unconsciously try to truncate a patient's immersion in the all too real, ongoing disruptions of their lives.

Geraldine is a 45-year-old woman whose husband has been a New York City firefighter for over twenty years, and whose son began training at the fire academy shortly before 9/11. Most of Geraldine's social network is comprised of firefighters and their families. She and her husband spent many autumn 2001 weekends attending memorial services for longtime friends confirmed dead or still missing at Ground Zero.

This patient is also a survivor of horrendous childhood sexual abuse by her uncle, who also abused his own four daughters and Geraldine's two younger sisters. The victimizations were severe, including rape, sodomy, fellatio, and cunnilingus; they lasted for over ten years. Often, the patient's uncle surprised her in stairwells and on rooftops where she thought she was safe. Although it is inconceivable that the adults in her family did not know about or suspect the abuse, no one intervened to protect these children. Geraldine works very hard to shield herself from surprise, arranges her life so that she is in control of most aspects of it, and struggles to tolerate even the gentlest physical or psychological penetration.

Clearly, Geraldine's current "real" life was enormously disrupted by 9/11. Also as clearly, the W.T.C. events struck profound psychological chords as they symbolically repeated surprise attacks on her integrity, the loss of any semblance of control over her safety, and devastating penetration of seemingly secure boundaries.

For weeks and weeks after the attacks, Geraldine spoke mostly about current events and strategies she was using to cope and to help her husband, son, and friends. She exhausted herself caring for others and even took on additional responsibilities at her already demanding healthcare job, in part because that was one area of her life she felt able to master and control.

During these weeks, I occasionally suggested to Geraldine that the 9/11 events might feel familiar to her in important ways and that they might be evoking experiences of herself and others that were reminiscent of earlier times. I wondered if she might be ready to talk about these possibilities with me. No, she was not ready and she had quite enough to deal with every day without getting into what else it might mean for her mind or for our work together. Although her enactment of timeworn defensive efforts to be in total control of her life was clear, I agreed that the current stress on her was all that she could handle. A longtime patient who had worked well in her treatment, Geraldine, I was confident, would "get back to work" when she could. Moreover, I gleaned that even my gentle attempts to turn her attention to the psychic meanings for of 9/11 were experienced

subjectively as pernicious reenactments. Rather than helping her focus on and cope with current disruptive trauma, I, like earlier figures in her life, was ignoring her present suffering, instead urging her to "think about something else."

Then, one night in December, 2001, I was driving over the George Washington Bridge into Manhattan and got stuck in unmoving traffic. It seemed to me that there were more National Guardsmen than usual on the bridge, and I began to get anxious. I looked over to where the twin towers once stood just as a plane, outlined against the nearly full moon, passed over lower Manhattan and headed up the Hudson River towards the bridge. I began to cry as all that had happened since 9/11 hit me again and, simultaneously, I felt rising panic as the irrational certainty took hold that the bridge was about to be blown up. Terrified and in tears, I mustered my analyst self and calmed down by approaching the current situation as metaphor for earlier experiences in my life. As I regained control, I could find some humor in the chronic tendency I have to believe the sky is about to fall. Now busy examining well-worn threads of my psychological fabric, the terror subsided and the tears dried. Dissociated for now was the now, the real-time, real-life danger and vulnerability to another attack with which we all are faced.

Back in the consultation room with Geraldine the next day, she spoke about her anxiety every time her husband went to back to Ground Zero where he was supervising the recovery of bodies. With contacts in the public health field, Geraldine knew the air quality was quite bad at the site and wondered if she should not try to dissuade her husband from going there. Maybe she should insist that he ask for a new assignment. She felt responsible for his safety and guilty that she had not been more forceful with him about the dangers of working at Ground Zero. I interpreted to Geraldine that she might well feel that she was not doing enough to protect her husband from being harmed by knowable danger. I suggested that she experienced herself as silently sending him off to work much as once she was sent by her parents to her uncle's home when the danger at that site was knowable. My interpretation was made in a pushier, less tentative voice than I had been using with her since 9/11 and I did not ask her first, as I had been doing since the attacks, whether she was ready to consider alternative meanings to her anxiety and guilt.

Geraldine let me have it in no uncertain terms. She felt that I was devaluing the present day, very good, very normal, very real reasons for her concern about her husband's safety. She insisted that these were appropriate and would be in play even if she never had been sexually abused and

had instead grown up at the Cleavers'. She reminded me that she knew how to be a patient, stated that she was not an idiot, said that one did not have to be Freud to know that everything about 9/11 brought up other things for her, and repeated that she would get there quite literally when the air had cleared. Why couldn't I just be a little patient? Indeed, six-plus months later, Geraldine began sorting through various meanings for her of 9/11 and all that had happened in her life since.

What is obviously crucial here is that my stance with Geraldine in the session after I experienced myself as trapped and in danger on the bridge derived not from the organic unfolding of our work together, but rather from my own need to distance from the very real dangers and uncertainties confronting me. Similarly, another analyst, or this analyst on another day, might engage with a patient in an extended discussion of New York's current vulnerability to attack because the clinician was obsessed with those issues and not able to consider their psychological meanings. Finally, it is possible that some of us, at least on some days, unconsciously exert pressure on our patients not to talk at all about 9/11 or all that has happened since. Weary of working through our own reactions and/or yearning to embrace the illusion that all has returned to normal, we may subtly silence patients who continue to struggle with real life and symbolically meaningful responses to this trauma.

Politics Enter the Analytic Space

Since 9/11, the political views and cultural biases of many patients have entered the treatment dialogue with unusual force and frequency. In addition, patients' curiosity about their analysts' political positions is heightened at a time when many of us are struggling to think more consciously about newly emerging or previously disavowed assumptions regarding ourselves as Americans and citizens of a wider world. For many patients and analysts across the political spectrum, then, the events of 9/11, the wars in Afghanistan and Iraq, and the frequent reminders of terror threats against the U.S. have set in relief political and sociocultural beliefs formerly located well in the background of daily life. For instance, it has been quite startling to realize that, in the past, I seldom heard from patients for whom they were voting or why. Further, I suspect that a significant number of patients are careful about openly sharing racial, ethnic, or religious prejudices, fearing to transgress unspoken norms of "political correctness." Likewise, most analysts would consider it inappropriate to place consciously and directly into the therapeutic dialogue their own political and sociocultural philosophies, although most certainly these

beliefs influence our patients in subtle and unspoken ways.

The dissociation of politics from the consultation room in itself has been a convention of our work. In part, this may reflect the American emphasis on the right to secrecy about one's political leanings. It also often is simply taken as a given of good practice, an unquestioned tenet of the psychoanalytic community with which we all consciously and unconsciously affiliate and whose expectations we assume we know. Exceptions to the general case of keeping politics and cultural bias out of the analytic space have been specific treatments in which there are obvious differences between patient and analyst in terms of race, ethnicity, or religion. There is a body of literature guiding us through the shoals of the transference-countertransference issues arising in these instances (Zaphiropoulos, 1987; Herron, 1995; Leary, 1997; Moncayo, 1998; Yi, 1998; Tang & Gardner, 1999; Altman, 2000). There is, however, little to my knowledge that speaks to a conservative working with a liberal, a capitalist in analytic relationship with a socialist, an Anti-Semite working with a Zionist, or an atheist working with a devout Catholic. Those topics and other like them, unless embedded somewhat peripherally in a particular case illustration, remain unvoiced and even taboo within psychoanalysis and, until 9/11, within most treatments. Since 9/11, however, patients have been much more open about their sociopolitical allegiances and biases, both in ways that are impressively sophisticated and well considered and in ways that seem "knee-jerk" and malicious. The latter can disrupt, disorient, and hurt the therapist, especially if the views of a specific patient come as a surprise to the analyst who thought they "knew" the patient well. A number of Jewish colleagues, for instance, have been aghast to hear long-term patients for the first time offer up virulent anti-Semitism, blaming the Jews and United States support for Israel for the 9/11 tragedy.

Whatever unique relational implications such remarks have for a given analytic dyad, their expression at this particular point presents the therapist with yet more shock, stress, and clinical challenge when s/he may already be traumatically stressed. Like many Americans, analysts may be confronting complacently espoused or barely noticed attitudes about race, ethnicity, political parties, religion, war and peace, globalization, nationalism and nation building, and may find ourselves disrupted in this process. In addition, national and international politics have assumed a more critical, literally life-or-death significance for many of us, even those of us who were already passionate about political and cultural ideals. Since 9/11, our own political, religious, and social policy "hot buttons" may be hotter and/or we may find ourselves thinking or feeling something quite alien to

the persons we pride ourselves on being. For example, many of us have been horrified to find ourselves staring coldly at an Arab family shopping in "our" grocery store, an experience unimaginable to most of us prior to 9/11.

Analysts already struggling with emotional and intellectual hyperarousal about their own and others' political beliefs may find it difficult to think, to process, and to respond to patients who present offensive or upsetting political views. Our tried-and-true analytic tools may seem insufficient to guide us when the treatment space suddenly is electrified with passionately expressed sociopolitical positions with which we disagree, now more passionately than ever.

Ultimately, of course, how one responds to a given patient's expression of his sociocultural and political views, or to his interest in those of the analyst, rests with the psychodynamics of each member of the dyad, other issues alive in the treatment at the same time, the state of the analytic relationship, and the analyst's position on self-disclosure of any kind. The point here is to highlight the post-9/11 intrusion of politics into the consultation room at a time when patient and analyst alike are likely to be hypersensitive to political issues and when the analyst may find it unusually difficult to marshal her typically reliable analytic functioning. The following vignette illustrates the problem.

George is a 48-year-old man I had been seeing for about 18 months before 9/11. The son of very proper and emotionally distant WASP parents, George attended an Ivy League college and prestigious graduate architectural program. His career has been spent as an architect in a large firm where he has performed well but not spectacularly. Once having dreamed of designing buildings in a league with I. M. Pei, George's position offers him a high salary but little challenge or excitement. He is definitely "second tier" at his firm, primarily executing the creative ideas of more successful partners. A presenting problem when George began treatment was his frustration with what he perceived to be "golden handcuffs" chaining him to a boring, predictable career. He also talked about being a failure for not following an even earlier dream of becoming a photojournalist, a desire derided by his parents.

From the beginning of his treatment, George had described rages he associated with a "depressive swamp" he entered into from time to time, but I had neither seen nor felt the swamp or the rage in sessions. About seven weeks after the 9/11 attacks, however, George withdrew into uncharacteristic silence. After several moments of quiet during which I imagined him slowly sinking into quicksand on my couch, George said

almost inaudibly that he was going to leave. I urged him to stay and to try to let me know about his experience at that moment. Growing very red in the face, he shook his head "no." I pressed him, saying that together we might be able to bear whatever he was experiencing.

At that point, George grew extremely tense and "exploded" in a tight-lipped, rigidly postured manner. He launched into a very quiet but unmistakably vicious narrative about all the brokers working in the World Trade Center on 9/11, contemptuously railing against them for caring only about "money, money, money, money, money–things and money, things and money, money and things." He spit out that he was glad they were dead, hoped they had been terrified and had burned slowly, wished more had died, and heartily congratulated the terrorists on their success, expressing the hope that they would strike again soon and "get more of them." Following that was a diatribe about the immorality of capitalism; the greed, complacency and arrogance of most Americans; the imperialism of globalization; and his desire to reduce the United States to a Third World country. Finally, George sank back into the couch pillows, exhausted.

As I sat in my chair, struggling to collect myself and wondering what to say, I was relieved that the session was almost over. In part, my shock and my uncertainty about what to say or how to say it were not unlike my reactions to other patients' newly expressed aggression, no matter the content. In large part, however, my countertransference responses here rested on aspects of my own experience of 9/11.

The Saturday before the Monday session with George, I had attended a memorial service for Joe, the nephew and beloved godson of a dear college friend. At 22 years old, Joe had been wildly proud of and excited about his first job out of college as a trainee at Cantor Fitzgerald, located at "the top of the world" at the W.T.C. They had hired Joe in June, 2001, despite the economic downturn, because they had sensed in him a fire and an instinct for the world of finance. On the morning of 9/11, Joe had time to leave a message on his parents' answering machine telling them how much he loved them and assuring them that he had enjoyed a wonderful life. He told them to take care of themselves and his younger brother, Phil.

The country club reception held after the packed memorial service included so very many young people, several of whom had lost more than one relative or friend in the W.T.C. attack. As I gazed at them nibbling finger sandwiches and sipping wine on the rolling lawn behind the clubhouse, time seemed to slip out of gear and the scene, viewed through the unseasonable heat and humidity, shifted into the surreal. Colors appeared to brighten and fade and the foreground kept shifting with the background. I

felt tearful and markedly disoriented, as if someone had dropped a tab of LSD into my Diet Pepsi. The repeated thought running like a ticker tape through my mind was that this should be Joe's wedding, not his funeral.

With memories, affects, body sensations and thoughts related to Joe's funeral coursing through me as I tried to focus on George's therapy, I found myself wanting to cry and to rage back at him at the top of my lungs. I wanted to tell him about Joe, to throw Joe's passion about his new career in the face of the decrepit old failure that George now appeared to me to be. I wanted to eviscerate my patient for his hypocrisy in decrying the capitalist system that provided him with his treasured antique music boxes and toy race cars, some of which cost nearly as much as the real thing. I wanted to use my power as an analyst–as his analyst–to berate and humiliate and psychically destroy him in some perverted sacrifice to the memory of Joe. I saw myself offering George's head to Joe's parents on a platter, saying, "I couldn't get them for you but I did get him." Almost immediately, I was horrified to recognize the "them" in me; the hate-filled terrorist analyst bent on killing my patient as only I could. It was my turn to sink into my chair.

Eventually, I found some words. I simply observed to George that he looked exhausted. He agreed and said that we would have much to discuss in the next session. In subsequent sessions, we analyzed many aspects of George's outburst, both in terms of the content and in terms of the process of entering into that state with me. Included in our work was an analytic examination of George's political beliefs, their psychological meaning, and his enactment of them or lack thereof, in his daily life.

Again, what is crucial here is that my countertransferential reaction to George that night had as much to do with my experience of one aspect of 9/11 and its impact on me as it did with George and the material he presented. While the analyst's subjectivity always influences her response to the patient, the intensity and immediacy of 9/11 in this case rendered the usually bearable less tolerable and the usually stimulating more so as patient and analyst were engaged in very different ways with the same set of traumatic events.

9/11 ushered an unusual and sometimes intense political climate into many treatment relationships. As analysts, we have been presented with new opportunities to consider the typically unformulated mutual influence on patient and analyst of each other's politics and sociocultural beliefs. Unfortunately, that opportunity arrived at a time of maximum strain and stress for many clinicians. Combined with the other dimensions of clinical work set in play by 9/11 and its aftermath, analysts have been

confronted with unfamiliar, and perhaps in too many cases ignored, needs for mindful self-care.

Analysts, Heal Thyselves ... And Keep Doing It

As the events of 9/11 fade further into the past, analysts–like so many others–are tempted to feel as if "it" is "over." Boulanger (2002b), in fact, points out that survivors of adult-onset trauma frequently insist to themselves that, "I should have gotten over this by now. I'm not in danger anymore. What's the matter with me? (p. 46)." Our very isolation of 9/11 as a discrete, boundaried event, rather than as one day in a terrifyingly dangerous and unfamiliar worldwide series of hostile engagements with uncertain ultimate outcomes, is itself symbolic of our yearning to split off and dispose of 9/11 as "over."

For many of us, however, and for many of our patients, it is not over, and the sequelae of 9/11, including wars and threatened terror attacks, will be felt for some time. There were anecdotal clinical reports surfacing over weeks and months after the attacks that a significant number of people just then were recognizing the need for treatment as they noticed and came to terms with the fact that they were not functioning as well as they had prior to 9/11. As analysts, therefore, we need to stand fully in the reality that the traumatic events set in motion on 9/11 will affect our personal lives and our work for some time. It is also important to examine our individual responses to 9/11, as well as those of the wider mental-health community, in order to prepare effectively for the potential next time, an eventuality this country's leaders remind us is likely.

In the immediate aftermath of 9/11, most of us felt a deep desire to "do something." Many members of the mental-health community donated hours and hours of their time, volunteering to be trained for and to administer critical-incident-stress debriefings, visiting local firehouses to help in any way possible, or passing out water and donuts to rescue workers. All the analytic institutes quickly compiled lists of members willing to offer pro bono sessions to people directly affected by 9/11. In part, these efforts reflect the generosity and optimism of the American character cited so enthusiastically by Alexis de Tocqueville (1840/1961) when he said, "I have often admired the extreme skill with which the inhabitants of the United States succeed in proposing a common object to the exertions of a great many men, and in getting them voluntarily to pursue it" (p.129). Historically, Americans, with their barn-raising heritage, have met national catastrophes with an unyielding optimism.

At the same time, there was a disturbing, manic quality to the rush

to put our professional skills to work. To what extent were we invested in a group illusion that we could quickly intervene in and repair that which can be fixed only very slowly, over time and, in some cases, not at all? As more and more groups enlisted more and more mental health professionals to participate in more and more hastily implemented programs, it seemed possible that helpers might be helping as much to restore their own shattered core sense of an inviolable and efficacious self (Boulanger, 2002b) as to meet carefully evaluated needs of the ostensibly more deeply psychologically wounded. It seemed possible that many of us were not giving ourselves enough time to absorb the impact of 9/11 on ourselves and our families before locating the damage, the woundedness, the brokenness "out there" where we could heal it rather than be it. Through our Herculean efforts to do good, we may have contributed to a professional group fantasy that we could be voyeurs of and attendants to great suffering rather than full victims of the traumatogenic psychic earthquake rippling across our communities from the epicenter of Ground Zero, a trauma still producing significant aftershocks. Hoffman (1979, 1998) might suggest that the analyst rushing out to volunteer hours and hours a week was, in part, defending against the experience of her own annihilatory anxiety and the nonnegotiable reality of her own eventual mortality by acting rather than being. Finally, some clinicians sheepishly acknowledged later that, as awful as the events of 9/11 were, there was an excitement, a "rush" to being in the middle of the initial mental health response. Such a "high" also served as a further distraction from the terror, rage, and sadness professionals might otherwise have been immersed in. After the rush, the resulting release of endogenous opioids helped to tranquilize the anxious helper, initiating a welcomed numbing.

In discussing these aspects of the massive effort to "do something," I do not intend to denigrate or minimize the generosity and profound humanity of our professional community. As was said so often in those early days, the best of personkind shone forth in beacons of human-mediated hope and compassion in the midst of unimaginable human-mediated horror and annihilation. My concern here stems from a sense that some clinicians moved from high activity and arousal in ministering to others to dissociatively declaring 9/11 "over" without fully experiencing and processing the real and psychological meanings of the attacks and their ongoing aftermath. To the extent that we have not facilitated an analytic consideration of the various meanings this trauma has for us, we may not be sufficiently available to patients to do the same. On the other hand, when psychoanalysts are able to stand fully in the personal reality and

metaphoric meanings of 9/11 and the changed world that followed, we create the possibility of a new epicenter, one sending out through our communities ripples of reflection, meaning, and affective depth.

Each of us will form our own relationship with 9/11 and all that has happened in our world since. We will work through some of it, split it off, refind it, and work through more of it in an ongoing process of discovery, dissociation, and rediscovery. Continued, regularly scheduled collegial discussions of 9/11 and its impact, even when it seems that there is nothing more to say, would be helpful and eventually could be broadened into consideration of analytic approaches to other adult-onset traumas. Coming together as professionals reminds us that 9/11 is neither a discrete event, nor is it over for us or for our patients. It challenges us to remain mindful of the continuing effects on us, our patients, our families and friends, not just of 9/11 but of the ongoing war in which the country is engaged, one which may well explode within our borders again.

In addition to continued professional dialogue about 9/11, trauma experts would counsel being gentle with ourselves. Far from doing more, the time period following trauma is a good time to do less. Fewer clinical hours, more play time, more exercise, extended relaxation hours just before bed, more enjoyable time with family and close friends, more contemplative time to reflect on our own well being, all, in the end, enhance our ability to work as effectively as we would like to in our consultations rooms.

The events of 9/11 offer analysts and patients alike opportunities to grow, to visit the unexamined and unformulated corners of our internal and external lives, to review and perhaps alter priorities, and to think about new perspectives on clinical work with adult-onset trauma. The catastrophe of 9/11 and the fear of catastrophes yet whispered about in the corridors of terrorism confront us with our ever-hovering mortality, as well as that of our patients and our loved ones. As Hoffman (1979, 1998) teaches us, the richness of each life very much depends on the individual's capacity to love, to work, and to play in dialectic tension with the nonnegotiable reality of our always-impending death. 9/11 challenges each of us to engage with that tension so that we may live as well as survive.

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