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Psychoanalysis and Trauma: September 11 Revisited

M. Gerard Fromm

On the 9th day of the 11th month of 2002, a few hundred people, mostly mental health clinicians, gathered at the New York University Medical Center for two days of discussions on the theme, September 11: Psychoanalytic Reflections in the Second Year. *The conference was sponsored by the five New York Societies of the International Psychoanalytical Association. Two days of presentations described various bits of learning that seemed to be emerging from the crisis clinical work with so many traumatized people since the attack on the World Trade Center.*

One year later, a few miles from Ground Zero, at the invitation of two psychoanalytic colleagues from New York, I took up the role of discussant for a panel of three presentations reflecting on clinical work after September 11. I felt both honored and surprised by this request, since I work in a small psychiatric hospital (the Austen Riggs Center), three hours north of the city by car. After I read the presentations, I felt admiring, even in awe of the presenters' work, but I also felt like those people, mentioned in the presentations, who had not come to work that day. I began my assignment feeling the shame and guilt of the survivor. From my insulated spot in the Berkshire mountains of Western Massachusetts, I hesitated to discuss this work. Not having been there, I felt inclined to de-authorize myself from speaking.

But then again, I was invited, and this must have meant something, perhaps relating directly to where I come from: a small hospital-based psychotherapy practice with severely and chronically disturbed psychiatric patients, a long experience of directing the hospital's open therapeutic community program on Norman Rockwell's Main Street, and now a role directing its Erikson Institute for Education and Research. The task of the Institute is discovering and learning about the connections between the intensive psychological treatment done at the hospital and the larger social context of our patients' and our own lives.

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Erikson's[1] work, especially his discussion of identity, focused on the intersection between the individual's emotional development and the historical moment and context of his or her society. Perhaps my place of work – the hospital, its functioning as a community, my having been its doctor for many years, its location in the rural environment in which many New Yorkers vacation or have second homes – was seen by those in New York as a place of refuge, and my invitation was also addressed to that wandering, benevolent, cross-cultural sense-maker for whom my Institute is named.

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On September 11, 2001, at one in the afternoon, we held a special All-Center Meeting to which all patients, clinical staff and support staff were invited. The hospital is a completely open psychiatric facility for patients who have not benefited from other forms of treatment. By open, I mean that there are no locked doors, restraints or privileging systems in our treatment program. Patients take up their own authority to join the treatment enterprise. They accept the responsibility for keeping themselves safe with our support and for helping us manage the hospital. In the process, they examine the ways in which they engage with these tasks in the service of understanding the problems that brought them to the hospital.

All-Center Meetings are held monthly, co-chaired by the Medical Director and a patient elected to lead the community for eight weeks. This particular emergency meeting of course was called by the Medical Director to inform the total community of whatever was known so far – it literally began with his giving a news summary of the attacks and their aftermath – and to be with each other as we tried to take it in. I remember the hastily written, but beautiful and moving prayer offered to the group by a newer male patient who, up to that time, had been regarded as potentially explosive. Whatever anxiety about aggression had been projected into him by others was quietly re-owned as ours or perhaps displaced further onto the attackers. This man was suddenly a known and valued member of the community.

I also remember the actual explosion of glass three days later, when an angry young woman struck the large plate-glass window in the stairwell outside her preoccupied and impatient therapist's office, creating a hole in the building and potentially endangering anyone who might have been walking below. It was as though her behavior was saying unconsciously, as one of the presenters suggested, 'Terrorism is *here*: face it, deal with it'. We did deal with it by seeing her action in the interpretive context of that particular week and raising the question as to what it meant that one of our patients had on a microscopic scale mirrored the New York attack on a building. But, in taking up the primary task of making sense of our patient's behavior, we had to simultaneously attend to this patient's citizenship in our community as well. So we also insisted that she address the community about her action. One of the things she said to the community was: 'I didn't think the glass would break'.

It struck me again that the 'borderline'[2] patient – the one we work with and the one who in some way must be in each of us – lives in what Lacan[3] would call the Imaginary Order: inside a bubble of wishfulness. She both takes for granted that the glass will not break and yet needs to know that it will – in fact needs, if she is

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ever going to live in the only world we have, to find the 'borderline' between wishfulness and reality.

Two months later, after the broken glass of 9/11, we held an open meeting for people in the local community to talk with each other about the impact of terrorism on their daily lives. To our surprise, 55 people came on a bleak November evening and spoke without pause for two hours. It began with a young woman who had guiltily fled New York with her children, and who sobbed about her fear and her disloyalty; it continued with the World War II generation, despondent about the world they had hoped to make safe for their grandchildren; and it included the teachers who saw their young students' efforts to process the disaster but didn't feel authorized within the politicized climate of their school systems to facilitate or even observe that.

And two months later, a patient of mine discharged himself from the hospital roughly according to plan. What had not been planned was the shift within his family. In the spring of 2001, this college student said 'goodbye', not 'goodnight', to his visiting mother and jumped from his seventh-floor apartment – and lived, carried off to the hospital of which his father was CEO. His father had reacted to this horror with a stiffening of his defensive remoteness and rigidity – until 9/11, until the unforgettable image of people leaping from those towers, at which point this powerful man broke down into a life-changing depression and needed his son's help. He gave it – to his long-term gain or cost, I don't know.

Even in the Berkshires, 9/11 reverberated. Recently, two long-time friends of the hospital, Françoise Davoine and Jean-Max Gaudillière, both psychoanalysts in Paris, presented the clinical work that will be published next year in a book called *History Beyond Trauma*.[4] They are convinced that psychosis and trauma go hand-in-hand, and that the psychotic patient is madly conducting a research into the rupture between his family and the social fabric, a rupture brought about through trauma and betrayal. This work powerfully links the clinical arena with the historical and the political. One of their patients said recently, referring to her actual experience with the Middle Eastern Mafia and her psychotic experience as a Middle Eastern goddess: 'I was in hell; now the United States is.'

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The first presenter at the 9/11 conference, Dr Martha Bragin,[5] described the hell of Lacan's Real, the hell of unthinkably horrific raw experience that destroys not only the glass of the Imaginary but the Symbolic Order as well – the order of mediation, language, law, metaphor. She illustrated what Christopher Bollas,[6] in his paper 'The Trauma of Incest', called a 'topographic reversal', that is, the mind's terrified undoing of its ordinary processing of wishes and impulses in the face of their already being real. As Bollas puts it, the actualization by the other of one's own forbidden drives 'electrifies the dream process' and therefore terrifies the person about sleep. The traumatized person cannot rest.

Dr Bragin noted the 'terrible resonance' between the actions of terrorists and our own childhood fantasies, feelings and impulses, arguing that this resonance is essential to what makes something traumatic. What is done to us touches upon what we

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ourselves might wish to do, and we can't bear to think about it at all. She and Bollas implicitly raise a question, at a much broader level, about the fate of repression in our society and the consequences of de-repression for it. For example, how much of the Catholic Church's problems with sexual abuse by priests has to do with the impossibility of sexual repression in today's western culture? In the same way that the attacks assaulted our safely repressed aggressive impulses, a sexualized culture acts traumatically upon the necessary sexual repressions of priests – and of other religious cultures as well.

Dr Bragin argued that the inability to sustain what Melanie Klein[7] called the depressive position – that is, to own one's own violence in the face of the extreme violence of others – pushes us toward the greater dangers of the paranoid-schizoid position – that is, to a splitting in which we see in ourselves only the good, and we act to purify the world of the evil 'out there'. As Erikson[8] commented: 'Where the human being despairs of an essential wholeness, he restructures himself and the world by taking refuge in totalism. . . . (A)n absolute boundary is emphasized . . . nothing that belongs inside must be left outside; nothing that must be outside should be tolerated inside.'

How are we to live in a world in which we all now know 'the guilty secret' that, as Dr Bragin put it, 'no nightmare is too terrible to be enacted'. (Or filmed: the selling of nightmares by the media was a sub-theme within the three presentations.) About the treatment task, Dr Bragin wrote: 'The one new thing I could add (for therapists) was encouragement to evoke the unconscious meaning (related to one's own feelings and impulses) of external events'. This may be both easier said than done and potentially disorganizing for the traumatized person. It raised for me a concern about how much we need the security of the therapeutic setting and relationship to do therapeutic work. In the face of 'random destructiveness', organization is a natural tendency of the mind, even if splitting into the good-internal and the bad-external is indeed a regressive and dangerous form of organization. Locating the danger in a single group or idea or image is in fact organizing.

Dr Bragin reported a true story about teenage boys forced to fight by one, then another warlord in Afghanistan. They were exposed to extreme violence and sometimes made to do the gruesome work of collecting the broken bodies for burial. But the only image that terrified these boys was that of a lion prowling in the wilderness and menacing them in their work, a lion that almost certainly did not exist. They debated whether the lion was Muslim and thus prohibited from eating people, but decided that the lion was 'ignorant' and ate anything. 'That is why we like to go to school.'

The story suggested that the 'lion' of Islam, as represented by the warlords, could degenerate into eating its young under the impact of such massive societal trauma. The actual human beings in authority – themselves immersed in random violence – betrayed their principles in any number of ways, including religiously proscribed abuse of the boys, and the boys felt this betrayal. They could not admit this consciously, however, and instead felt that their own entrance into the afterlife was lost because of the bad things that they had seen. But they also clung to the hope that they might become able to read the word of the Prophet and escape the ignorance that had licensed such brutality. The Koran for these boys may have been what my

French friends would call a 'password', a closely held hope for a signifier through which one might somehow find one's way into the Symbolic Order of law and meaning, necessary for human life and destroyed by exposure to extreme violence.

This story reminded me of Jonathan Shay's book *Achilles in Vietnam*.[9] He treats traumatized veterans by reading them *The Iliad*, and he notes, as a major factor in their traumatization, their abandonment and betrayal by the legitimate authority on whom they depended. The treatment implications of this might move us beyond interpretation of internal life toward something like the act of witnessing, and then, as perhaps suggested by Dr Bragin's final story, to the writing of a foreclosed or officially disavowed history.

Dr Bragin's discussion of Paul illustrated clearly the loss of boundaries of the traumatized person: Paul felt that he was 'breathing the bodies' in the post-9/11 New York air. An angry African-American teenager before 9/11, after the attacks he broke down emotionally. He could neither eat nor sleep, but instead became obsessed with the 'evil' of the attackers. He seemed determined to declare that these terrorist-avengers were 'not me', feverishly disavowing in the process not only his own rageful feelings but an unconsciously assigned historical role as well.

Paul's mother had witnessed the near lynching of her own father and had unconsciously filled her son with longings to avenge this horrifying injustice. The real loss of boundaries that threatened Paul was between the part of him who might want to take up this unconscious task and the foreign avengers in those planes who actually had. Paul's psychologically adaptive effort in his obsession was to turn rage into outrage and vengeance into justice. From a societal angle, this was the quest of the civil rights movement. I wondered if Paul knew that he was, in effect, a member of that movement, and why, in the history of his own family, it would be an honorable fight? To the extent that he does not, to the extent that his family history is simply enacted unconsciously, Paul is vulnerable to the 'terrible resonance' between the trauma of 9/11, his own disavowed feelings of rage, *and* the historical context in which those feelings have meaning.

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The next presenter, Dr Susan Coates,[10] took up my concern about the developmental setting for the child's growth and the therapeutic setting for treatment. This is the question of what Winnicott[11] called the 'holding environment' and its relationship to trauma. 'Children whose parents *did not know* how their child was responding after 9/11 are eleven times more likely to have behavior problems at ages 6–11 and four times more likely at ages 12–17,' according to one of the studies she reviewed.

Dr Coates and I were both reminded of the 1942 study by Anna Freud and Dorothy Burlingham[12] called *War and Children*. In the bomb-shelters of London, the children whose mothers said 'Don't worry; we'll be alright' survived the experience with far less trauma than those children whose mothers could not contain anxiety enough to be convincingly reassuring. From one angle, that reassurance was completely delusional. From another, it makes perfect Winnicottian sense; what Freud called the protective shield became for Winnicott the child's necessary illusion of omnipotence within a responsive maternal environment, a creative experience

essential to the developmental challenge of bearing the strain between the inner and outer worlds.

Dr Coates reported a heart-wrenching story of a little girl whose father had died on the 104th floor of the World Trade Center and who said that her grandmother 'saw something in her room. She saw an angel. It looked like a butterfly. So that's what made me want to draw a butterfly. I think I will call it a butterfly angel. I think the butterfly was Dad.' A Daddy-butterfly-angel: alive, good and able to fly; the creativity of a child keeping her father alive and with her, in the context of a loving grandmother. It reminded me of an image that sustained me after 9/11. Another little girl, whose across-the-river kindergarten class was doing a Statue of Liberty project, made a drawing two days after 9/11: Liberty holding two baby twin towers in her arms – a Winnicottian Madonna whom I not only will never forget, but, I hope, will never lose touch with. It is this sense of restored union that protects and cures.

In their work with children, Dr Coates and her colleagues emphasize normalizing the child's reactions, containment of the child's feelings rather than exploring them, and, at the right time, promoting identification with the lost loved one. The phenomenon, which she and her colleagues saw so frequently, of the child's knowing and not knowing at the same time seems like the child's natural creation of an intermediate area between the objective fact of loss and her subjective experience of possible presence. This is what Winnicott[13] called a transitional space for both the child *and* the adult who himself cannot yet bear the pain of what has happened.

In a later work, Winnicott[14] made a paradoxical comment: 'This thing of the past has not happened yet because the patient was not there for it to happen to'. Can we modify this to suggest that the child's actually experiencing what he or she, at a different psychic level, knows to be true and to already have happened depends on the emotional presence of the other person, and, until that time, the potential experience is held by the child *in trust* as it were – not only the trust that a parental figure will arrive as a facilitating developmental presence for the child, but also that, if that person has not arrived yet, then he or she too must need a person with whom to experience what the child is holding.

Dr Coates's story of Maria illustrated so clearly the way a child holds for her parents, not only her own terrifying experience, but theirs too. This 3-year-old, suffering through nightly nightmares, scrawled bright reds, yellows and blacks on the drawing pad, describing the buildings that had burned and fallen. The family had seen the destruction on TV and initially had thought that they were watching Maria's father's death. But her father was alive, and Maria emphasized how he had escaped, inhaling smoke and having pieces of the fiery building fall on him. 'He has marks from the fire on his arms,' she said.

In fact, Maria's father had not been at the World Trade Center that day. He was indeed a cook at its top-floor restaurant, but had exchanged shifts with a colleague so that he could do a number of errands. The burn marks on his arm were old ones from splattered grease. He was shocked to realize that Maria believed he had nearly died in the disaster and to realize that he had lost touch with his daughter. His agonizing survivor guilt had led him to ruminate over powerful but lonely imaginings about how his friend must have died that day, images that found their way into his own nightmares.

'So your daughter is drawing your dreams', Dr Coates's colleague, Dr Schechter, said to him, thereby putting father and daughter back into emotional touch with each other. At a simple but profound level, Dr Schechter functioned as a 'Third'[15] to a parent–child couple in unconscious resonance with, but dangerous isolation from, each other. This led me to recall a comment by a Fifth Avenue sidewalk Santa about the change in attitude he noticed during the 2001 Holiday season:

> The normality is not there. The parents will not let the hands of their children go. The kids sense that. It's like water seeping down, and the kids feel it. Their reactions to Santa are not natural. There is an anxiety, but the kids can't make the connections.

This astute man was noticing a powerful double message in the parents' action. Consciously and verbally, the message was 'Here's Santa; love him'; unconsciously and physically, it was 'Here's Santa; fear him'. The unnamed trauma of September 11 was communicated to the next generation by the squeeze of a hand, and it took someone in the position of the Third, like this Santa, to see and name the trouble.

Dr Coates and her colleagues illustrated this unconscious attunement powerfully. Children naturally and irresistibly synthesize the information that matters. That their sense of themselves can become entwined with their parents' unconscious projection – for example, the child's functioning as a symbol of the parents' wish not to know and to stay innocent about such horror, or the child's breaking that unnegotiated contract with emotional reminders of loss that disturb, and even open up the trauma of, their parents – was but one of the suggestions within Dr Coates's paper about the mechanisms by which one generation transmits the legacy of trauma to the next.

Parents *mind* children. That verb connotes the holding-in-mind of the total child, including the developing mind of the child. When parents lose their minds under circumstances of extreme distress, the data from Dr Coates's report suggested that *children mind their parents*. The critical question is whether the parent can hear the child's interpretation, an interpretation delivered in a drawing, a nightmare or disruptive behavior. The therapist's role, as a Third – perhaps replacing another Third if the second parent has been lost – is to help the parent do so and then speak to his or her child about it, thus restoring the holding environment for the whole family.

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The final presenter, Dr Lauren Silverman,[16] continued to develop the theme of what holds a person's sense of internal cohesion and stability after trauma. She and her colleague compared and contrasted their experience of offering psychotherapy services to survivors of the US Embassy bombings in East Africa and their experience with survivors of 9/11. Dr Silverman highlighted the challenge of providing structures and processes that contain people emotionally in the midst of chaotic feelings, and how these structures and processes can be brought to bear responsively in unusual situations by 'protean therapists'. To some extent, these were questions of applied theory and program design.

The preceding January, four months after the attacks, I was on the staff of a Group Relations Conference. One structure within these powerful and unusual conferences is the Institutional Event in which members (in this case, 40 of them) are invited to break up into small groups according to interest, for the purpose of studying aspects of the total conference process (for example, how leadership is being exercised or how gender and race are being dealt with in the conference). After the initial instruction about the task, the members are left to their own authority, and ordinarily, this event begins with a period of silence, confusion, anxiety, frustration, laughter, leadership struggles, power gambits, and a fragmented and sometimes impulsive move into smaller groups. This year was different; within minutes, members exploded out of the room into smaller groups – as though the public space were unconsciously 'Ground Zero'. The seven or so people left in what felt like the debris spontaneously decided to study the effects of 9/11 on the conference. Clearly, this was an impulse experienced on behalf of everyone.

In such conferences, it is the design structure and the sustained emotional processing of the staff that contains the anxiety of the members and allows them to join and learn at a startling emotional depth. The body of work produced by the A. K. Rice Institute, which sponsors these conferences, and by its mother organization, the Tavistock Institute[17] in London, might provide guidance with the kind of methodology questions Dr Silverman raised, especially as these involve the need for dependable structures, the careful negotiation of task and role, and the power of unconscious group dynamics.

Dr Silverman pointed out the illusory nature of differential 'tiers' of victimization when such categorization is based on something like geography (how close or distant one is from the 'center' of the trauma) rather than on more individualized subjective variables (like the meaning of the traumatic experience within one's own life history). She highlighted 'narrative coherence' – the ability of the survivor to tell his or her story clearly and with feeling – as a 'marker' of the traumatized person's psychological integrative process. This is an interesting hypothesis though I hesitate about its validity across gender and cultural groups. Dr Silverman noted that African men were culturally discouraged from verbalizing the effect of trauma on their lives. Their reports showed less narrative coherence than those of women survivors, but might this not simply reflect different culturally sanctioned methods of processing traumatic experience between African men and women?

I also hesitate about the presenter's emphasis on a survivor's coming to a place of integration, control and mastery over the traumatic experience. After his mother's death, Roland Barthes[18] wrote:

> It is said that mourning, by its gradual labor, slowly erases pain; I could not, I cannot believe this; because for me, Time eliminates the emotion of loss . . . that is all. For the rest, everything has remained motionless. For what I have lost is not a Figure (the Mother), but a being, and not a being, but a quality (a soul): not the indispensable but the irreplaceable.

Barthes could seem like one of those people Dr Silverman mentioned as 'most in need of help' and yet completely 'resistant' to treatment. But Dr Silverman also

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recognized the 'ego-preservative' efforts within her patients' resistance, that is, the person's effort to maintain some basic psychological equilibrium and not to be further traumatized by remembering, even if that new possibility of trauma were brought about by someone's wish to help. Perhaps, with Barthes, we see a person's other-preservative efforts as well, their effort to hold onto the person they have lost in as full a way, with as much individualized meaning, as possible. Pertinent to the abandonment threat within the mourning process, Dr Silverman described traumatized people in a 'trance-like' state 'channeling' an 'un-owned history' to 'invisible listeners'. To be sure, this represents massive dissociation as a psychological defense against unbearable emotional pain – especially the pain of irretrievable loss and the end of a living attachment. But it is first of all to be accepted. Contact with the dead is often more important than getting on with the living.

One of the members of the 9/11 group at the Group Relations Conference was of Middle Eastern origin. In the service of studying the effects of 9/11 on the conference, he allowed himself to be 'profiled' by other members – that is, to be imagined, projected into, and related to as containing dangerous and alien characteristics. Later, in a Review Group, other members were shocked that he had permitted this with such equanimity. I asked him what his name meant. With a shy smile, he said it meant 'Resurrection'. It seemed as though he could allow himself to be buried by the projective fantasies of others because his lineage saved him, and perhaps could save others as well. He was securely in touch with his deep emotional connection to preceding generations.

Dr Silverman recognized the need for some kind of a Yes from those she hoped to work with, and the problems of 'a systemic program that was initiated on behalf of the victims, albeit without their knowledge or input'. Without negotiating our authorization, we risk 'doing to' rather than 'doing or being with'. Getting to Yes involves careful negotiation and, to use another set of Winnicottian[19] ideas, a 'phase of hesitation' in a context of proximity. This is a time dimension in which an 'available but not intrusive' therapist makes an offering – 'an intervention in itself' said Dr Silverman – and the other person, no matter how much he or she may be in objective need, *authorizes* the contact, or at least recognizes the future possibility of help, and therefore the possibility of the future.

While Dr Silverman and her colleague experienced a considerable and disappointing amount of rejection from the traumatized people they hoped to help, she also suggested that different forms of help might have been used. For example, the structure of the East African program, which took place in New York coincident with the trial of the bombers and which included the psychotherapy service, provided ordinary communal activities (eating meals together) and time for experiencing oneself as a tourist rather than only as a victim.

Dr Silverman also recognized her own needs for a therapeutic community as she and her colleague were exposed to the trauma of their clients, especially the trauma of 9/11, which occurred in their home city: 'Our identification with these victims potentially compromised our ability to endure the pain of taking in their shattered affective states and dissociated verbal narratives . . . We were not neutral outside professionals.' This self-awareness is of course exceedingly important and must be sustained by one's own professional community. Otherwise, we risk losing our

boundaries, losing our ability to manage our own feelings, and the potential for projectively pushing our own needs for cure into our patients.

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I would like to approach this last question of the therapist's involvement from a different angle for a moment. The word 'therapist', as Gaudillière and Davoine note in *History Beyond Trauma*, comes from the Greek; it means 'the second in combat'. They describe the work of a military psychiatrist of the First World War, Dr Thomas Salmon, who outlined four principles for the therapist's treatment of traumatized soldiers: simplicity (no jargon), proximity (being with the traumatized person's raw experience), immediacy (depending on intuition) and expectancy (the dimension of hope).

As a soldier, you get better because those back at the front wait for you. In the kind of work described by all the presenters, psychoanalytic neutrality, important in its proper circumstances, is neither possible nor an ideal. Given the context of 9/11, we are all *in* it, even if the 'it' may seem far away. The shame and depression of many survivors had to do, we are told, with their not having come to work that day. In other words, they are 'seconds' in combat too. My French friend's psychotic patient, at the successful close of her treatment, said to her: 'What cured me was your ferocity'. Trauma from intentional human actions must differ in significant ways from trauma as the consequence of natural disasters. Along with our containing and nurturing capacities as therapists, I want to suggest that we need this ferocity to be in a working commonality with this particular group of traumatized people.

The first meaning of trauma is a physical one. It refers to a severe blow or wound to the body. Psychological trauma also assaults the organism, overwhelming the mind's capacity to process reality. Psychic numbing occurs immediately as a massive organismic defense against the experience of overwhelming pain. Societal trauma ruptures the 'skin' around a culture and throws the collective into pain-driven mindlessness. If sudden helplessness is at the heart of the traumatic experience, the natural tendency of the mind is to turn this passive imprinting of the horrific into something active. Thus, trauma can beget trauma as vengeance is sought as a form of recovery.

Recovery does indeed involve an active relation to the traumatic experience, though not necessarily a vengeful one. Trauma dreams return the person to the scene of the disaster in the mind's effort to face and master, bit by bit, what happened before, as Winnicott argues, the person could be there for it to happen to. The trauma must be re-experienced in manageable doses; otherwise, a part of the self is missing. It has been the wisdom of those clinicians working in New York after September 11 to understand that such a return has the best chance of success if done in the company of another person. But a return to the front lines, to the scene of war, to the horror of a hole in the social fabric, requires the company of a warrior. Ferocity has to do with the courage and determination to go there fully, with all of one's capacity to experience, and yet to insist on the possibility of making it through as a whole person.

Such company can occur on a cultural level as well. American popular culture

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can be so foolish and destructive, but, in rare instances, it can be curative. It can occasionally produce a work that 'goes to the front' at the edge of the Real and finds, through an act of empathic imagination, the human experience of what it is like to be there. In doing so, it contains and makes endurable the painful experiences of so many people, providing a collective sense of togetherness and binding the rupture to the symbolic order. I shall close this essay with reference to a person whose ferocity, and whose ability to work from it, brought traumatic emotion fully into language, leading to a post-9/11 cultural phenomenon and illustrating how culture, even popular culture, can provide a structure that holds people through trauma.

In 2002, Bruce Springsteen released his CD, 'The Rising'. Its enormous success speaks, I believe, to its being used, on a massive scale, to process the trauma. It is an astonishing set of stories – emotional narratives – of 9/11. He takes us into the feelings of an accidental hero who cannot bear that 'everybody acts like nothing's changed; the sky's still the same unbelievable blue', and is going to kill himself. Into stark, intense, contradictory emotions: 'I want a kiss from your lips, I want an eye for an eye, I woke up this morning to an empty sky'. Into the quiet grief of a spouse: 'The evening falls, I got too much room in my bed, too many phone calls. You're missing.' Into an anguished plea that 'My City of Ruins' will 'rise up' again. Even into the mind of a confused child-suicide-bomber exploited by visions of paradise.

And amazingly, the straightforward rock-and-roll songs metamorphose into litanies that build to emotional climax and outpouring. The title song, *Come on up for the Rising*, refers to the duty of rescue and the adrenaline of going up the stairs of those towers together. Here is part of that song's prayerful call and response:

Sky of blackness and sorrow (a dream of life)
Sky of love, sky of tears (a dream of life)
Sky of glory and sadness (a dream of life)
Sky of mercy, sky of fear (a dream of life).

In listening to these presenters, and their passionate and thoughtful involvement with their work, I felt that they too had 'come on up for the rising', and had held ferociously and lovingly for all of us 'a dream of life'.

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