TRAUMA AS A METAPHOR: THE POLITICS OF PSYCHOTHERAPY AFTER SEPTEMBER 11

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ABSTRACT *This paper explores the links between mental health practice and politics by examining the implications of turning persons harmed by an act of mass violence into patients with psychiatric disorders, and of prescribing psychotherapy to treat reactions to terrorism. It first considers the interpretative aspects of diagnosis, the social and political implications of particular diagnostic categories, the history of PTSD, and the phenomenon of medicalization. It then looks at the ways psychotherapists privatize social and political experience by emphasizing the personal consequences of community catastrophes, and by helping individuals transform collective history into personal narratives. In closing, it asks whether mental health discourses depoliticize experience, thereby discouraging political engagement and the development of political consciousness.*

Key words: 9/11, psychotherapy, medicalization, trauma, PTSD

Shortly after 11 September 2001, the New York State Office of Mental Health commissioned the Department of Epidemiology at Columbia University's Mailman School of Public Health to conduct a 'rapid assessment' of the mental health needs of New York state residents. This assessment estimated that more than 527,000 persons in New York City and its 10 surrounding counties would develop post-traumatic stress disorder (PTSD), and that scores more would suffer depression, anxiety, and other forms of mental distress, as a result of the terrorist attack on the World Trade Center (Herman et al., 2002).

To manage the widespread outbreak of mental disorder that public health officials had predicted, within weeks of 9-11 the New York State Department of Public Health unveiled Project Liberty, a mental health programme designed to help those who had been psychologically wounded by the terrorist attack. With more than $150 million in funding from the Federal Emergency Management Agency – the largest grant the American federal government has ever awarded for mental health services – Project Liberty had two primary aims. First it sought to educate the public about PTSD, so that people could recognize its most common symptoms if they appeared in themselves, or in their children, spouses, friends, and colleagues. Second, it sought to provide anyone who experienced emotional distress due to the attack with free psychological treatment. Project Liberty's brochures, which were widely distributed after the attack, offered mental

health services 'wherever you wish to have them – in your home, school, business, office, or church' – as well as in designated Project Liberty sites. Its advertisements, which soon blanketed New York City buses, subways, and airwaves, urged the public to 'feel free to feel better' by speaking with a psychological counsellor 'trained to talk with you about your concerns'.

As of March 2003, over 643,700 residents of New York State had made use of Project Liberty's mental health services. Many of them received crisis counselling or other short-term mental-health treatments, and were referred elsewhere for long-term psychotherapies. In addition, since 11 September 2001, uncounted numbers of New Yorkers, some of whom were undoubtedly influenced by Project Liberty's publicity campaigns urging psychological treatment as the best remedy for the emotional distress triggered by the attack, began a new course of psychotherapy, or extended an existing one, outside of the project's auspices. This new influx of psychotherapy patients meant that the Bush administration, which before the terrorist attack had paid scant attention to mental health treatment, was suddenly promoting it on a grand scale. It is likely that never before had so many people sought psychotherapy to relieve the adverse emotional consequences of a major disaster, let alone a terrorist attack.

Those who see mental health treatment as a good thing may be pleased that after 11 September 2001, the government chose to endorse it. Yet there are reasons to wonder about the implications of providing free mental health treatment on such a large scale, at this particular historical moment. What happens when persons harmed by an act of mass political violence are turned into patients with psychiatric disorders? What does it mean to prescribe a course of psychotherapy to treat individuals' emotional reactions to terrorism?

DIAGNOSIS

Before any kind of treatment can be administered a diagnosis must be made and, although diagnosis may seem to be an objective activity, it is fundamentally an act of interpretation, 'a thoroughly semiotic activity' (Kleinman, 1988, 16). Bodily and behavioural signs may be read in a number of contrasting ways, and thus may suggest a variety of disorders. A pain in the head, for example, may signify a headache, heartache, a toothache, or a tumour. To make sense of such signs requires first converting them into known symptoms and then matching these symptoms to the diagnostic category that best contains and explains them. Just as medical doctors examine patients' bodies for symptoms of physical diseases, mental health professionals examine patients' mental states and behaviours for symptoms of psychiatric disorders. Not only is diagnosis an act of interpretation but the diagnostic categories mental health professionals employ, and the conceptions of mental instability on which they are based, have proven highly susceptible to change. As the anthropologist Ruth Benedict wrote in a famous 1934 article entitled 'Anthropology and the abnormal', forms of emotional instability, like haircuts, hats, and handbags, go in and out of fashion. A quick look at successive editions of the mental health field's central text, the *Diagnostic and Statistical Manual* (DSM), the first of which was published in 1952, confirms that every mental disorder has a history and that notions of mental illness undergo continual revision. The DSM – the fifth edition of which is now in preparation, or perhaps more accurately, under negotiation by panels of mental health professionals – shows extensive and

substantive changes from one edition to the next. These changes pertain to the kinds of behaviours and states of mind that qualify as mental disorders; the distinctive symptoms and features of each disorder; the kinds of persons who are most vulnerable to particular disorders; and the reasons why such disorders occur. For example, homosexuality was formerly considered a mental disorder but is no longer, whereas premenstrual syndrome was not formerly considered a mental disorder but now is. Bipolar disorder, which used to be called manic depression, was previously thought not to emerge before early adulthood, but is now diagnosed in children. Multiple personality disorder, which was diagnosed in epidemic numbers only 20 years ago, is not only out of fashion but entirely out of sight. After an intense controversy featuring allegations that therapists had planted memories of abuse (including memories of satanic ritual abuse) in their patients' minds, and had coached them to display multiple personalities in therapy sessions, this disorder was left out of the fourth and latest edition of the DSM.

Changes in psychiatric diagnosis over the past 50 years suggest that emotional disturbances are social and historical as well as psychological and biomedical phenomena. New diagnostic categories and criteria reflect more than advances in scientific understandings of mental disorders; they also reflect shifting conceptions of normality, morality, and reality. Diagnostic categories thus have social as well as medical implications. Like labels for physical diseases, the labels for mental disorders tell us how to evaluate the ills and ill fortunes of others. They help us distinguish the normal from the deviant and the distressed from the diseased; they tell us what to think of them, how to behave toward them, and what will become of them. Susan Sontag's (1977) claim that illnesses are metaphors, in that they stand for, call up, and play out dominant social anxieties, inequities, and moralities, applies to mental disorders as well. Because mental disorders tend to be more intangible, intractable, and mysterious than physical disorders – because the brain, consciousness, and the processes of thinking and feeling have proven more complex and less knowable than the workings of a kidney or a spleen – they may be even more freighted with cultural meanings.

Just as every mental disorder has a history and a range of cultural meanings, it also has a politics. Diagnostic categories are created, revised, and invoked in response to prevailing political currents. They are applied selectively and instrumentally, to justify both the power and privilege of certain segments of the population and the disadvantage and containment of others. Nowhere are the political features of psychiatric diagnosis clearer than in disorders related to trauma.

TRAUMA

The lack of a centralized bureau of mental health statistics in the US has made it impossible to calculate the precise number of persons diagnosed with PTSD since 9-11, but several studies conducted after the terrorist attack have found elevated rates of PTSD among New York City residents (Schuster et. al. 2001; Galea et. al., 2002; Goodnough, 2002). In response to these findings, to the traumatic reactions they observed among their own patients, and to concerns about responding more effectively to future acts of terror, New York mental health professionals have held numerous conferences, lectures, courses, workshops and training seminars on PTSD in the past 3 years. Trauma has become the hottest topic in the field of mental health.

Recent attention to trauma in connection with 9-11 obscures the fact that psychological theories linking mental disorders to traumatic experiences have gone in and out of fashion a number of times over the past century or so. Freud fervently argued that trauma was the cause of neurosis in his 1896 paper, 'The aetiology of hysteria', before rejecting his own argument with equal fervour a few years later. As Judith Herman (1997) noted in her book, *Trauma and Recovery,* twentieth-century therapists repeated this pattern, first claiming that traumatic experiences were the primary cause of psychopathology and then losing track of such notions. In Herman's (1997, 7) view, therapists' 'episodic amnesia' mirrored society's wish to deny the unspeakable atrocities to which the category of trauma refers, including sexual assaults, natural disasters, all kinds of violence, and now terrorism. Due in part to this collective amnesia, trauma did not appear in the DSM until 1980, when the category of post-traumatic stress disorder first appeared (American Psychiatric Association, 1980).

Psychotherapists' ambivalence toward trauma also may be due to the fact that conceptions of psychic trauma contradict conventional theories of psychopathology. While these theories commonly attribute mental disturbance to deficiencies in the character, physiology, or genetic makeup of individuals, trauma-related disorders afflict even the most sound and sane. Although classical psychoanalysis links psychopathology to the unconscious conflicts and fantasies of the intrapsychic world, trauma refers to the damage done by real assaults and disasters in the external world; indeed, PTSD is among the very few psychatric diagnoses that cannot be made in the absence of an external event. Because theories of trauma focus on the devastating psychic impact of actual catastrophic occurrences, and because they identify mental disturbances as direct outcomes of earthquakes, floods, mass shootings, and wars, they highlight the interplay between social experience and the mind. In the process, to a greater degree than other psychological theories, they bring the world at large into therapists' clinical consulting rooms.

As a result of its connection to outsize events in the outside world, the diagnostic category of PTSD frequently has been attached to a specific politics. In the late 1970s and early 1980s, the widespread diagnosis of PTSD within particular groups in the US drew attention to their suffering and also galvanized public support, advancing their interests and aims. The diagnosis of PTSD was first widely applied to American soldiers who served in the war in Vietnam. To claim that Vietnam veterans had been traumatized by their experiences in combat was to make several political points. Diagnoses of PTSD not only legitimized the suffering of individual veterans who had been reviled for fighting an increasingly unpopular war, but also exonerated them, shifting public anger and blame to the government that had sent them to battle. For a growing anti-war movement, citing the high rates of PTSD among returning soldiers exposed the atrocities of the Vietnam War, and by extension, of all wars; it made a statement that was anti-military, anti-establishment, and anti-imperialism all at once.

Shortly thereafter, many women who had been physically, emotionally, or sexually battered were diagnosed with PTSD. In connection with that era's feminist movement, these diagnoses provided evidence that American society's institutionalized sexism damaged women's mental health. To diagnose women with PTSD was to protest the everyday violence that turned

women's lives into scenes of danger, disadvantage, and harm, and to support women's liberation and empowerment (Herman, 1997).

What common threads connected these two groups – males who had been wounded in a distant war and females, many of whom had been violated at home? Before being diagnosed with PTSD, many of them had kept their horrific experiences a secret. When they had told their stories, few had believed them; even when their misery had been acknowledged, they had been blamed for it. Paradoxically, being diagnosed with a mental disorder, and having their troubles framed in the language of mental illness, actually improved these sufferers' social positions, moving them from the ranks of the devalued to the deserving, and helping them win legal rights and protections.

Mental health professionals played central roles in both of these political movements. For many psychotherapists, as for others of that era, the personal was political. Allying themselves with patients who had been abused, subjugated, and silenced – with those who had been devastated in war or degraded at home – therapists encouraged them to speak. They also encouraged patients to trace their difficulties to societal pathologies rather than to individual psychopathology, to display their psychic injuries as proof of the damage caused by socially sanctioned violence, oppression, and injustice, and to transform their personal suffering into political action. Leaving the confines of their clinical consulting rooms, many therapists became activists, working for social rather than individual change.

TRAUMA AS A METAPHOR

The terrorist attack on the World Trade Center occurred at a very different historical moment. Liberation movements, for the time being, appeared to have run their course. The atmosphere of social crisis and ferment characteristic of earlier decades had evaporated, replaced by what seemed to be an unshakeable national stability, built out of a self-congratulatory, if unexamined, domestic prosperity and international dominance.

Nor did all of those who survived the attack on the World Trade Center, and who were diagnosed with PTSD, resemble the major groups who had received this diagnosis before them. Unlike war veterans and battered women, some of whom inhabited society's margins, many of the new survivors were among the successful, powerful, and privileged. Although veterans and battered women had been chastised for exaggerating episodes of violence and abuse, and for daring to speak of them, the suffering of those who were wounded on 9-11 was unquestioned. These survivors were celebrated, and their stories of injury and terror were told and retold like modern myths.

Despite such marked differences, Vietnam veterans, battered women, and survivors of the terrorist attack have something in common; all were victims of unspeakable, incomprehensible, and undeserved acts of violence. Indeed, if illnesses are metaphors – if, as Sontag (1977) claims, cancer is a metaphor for the repression of violent feelings and AIDS is a metaphor for deviance and indulgence – then PTSD has become a metaphor for victimhood, referencing notions of innocence, blamelessness, and of unprovoked assault. In the case of 11 September, the metaphor of victimhood has been extended. Not only has it been applied to the innocent civilians who were wounded by the attack, but it also has been made to stand for the victimization of the US. The widespread diagnosis of PTSD

speaks to both the individual victims of the attack, who neither provoked nor deserved their fate, and to the suffering of an ostensibly innocent, peace-loving nation, which, in its view, was struck by horrific acts of violence for no apparent reason.

Notions of national victimization are evident in the dominant narrative of 11 September 2001. Like other narratives of trauma, it features a violent, catastrophic assault that seems to come out of nowhere, as if nothing provoked or preceded it. Other narratives of trauma portray such assaults as turning points in the lives of individuals, for whom nothing will ever be the same; here, the terrorist attack is portrayed as a turning point for the nation, which now faces a world that has fundamentally and irrevocably changed. Although the dominant narrative of 9-11 unhooks the assault from the nation's political past, this event, like all traumatic events, haunts and inhabits its present, and carves the shape of its future.

To claim that trauma also functions as a metaphor is not meant to dismiss the profound suffering caused by the terrorist attack on the World Trade Center any more than Sontag's claim that cancer is a metaphor was meant to minimize cancer patients' pain. There is no denying that, since 11 September 2001, hundreds of thousands of Americans have experienced the nightmares, emotional numbing, and intrusive memories that are characteristic of PTSD, and that millions more have been deeply anguished, desperately anxious, and deathly afraid. Yet because illness labels signify the crises that threaten societies as well as the diseases that weaken individuals, conceptualizing trauma as a metaphor allows us to examine the social and political implications of reading the bodily and behavioural responses to the attack as evidence of mental disorder.

THE MEDICALIZATION OF 9–11

While the emotional consequences of the terrorist attack have been described in various ways, the language of mental illness has been invoked repeatedly to characterize them. Project Liberty's advertisements, which listed the symptoms of PTSD, effectively trained New Yorkers – whether they were physically present during the attack, witnessed it from a short distance, or watched it on television – to frame their distress in the language of mental disorder. Although many mental health professionals believed that no existing diagnostic category fitted their patients' emotional reactions to the attack, and although psychiatrists who developed the current diagnostic criteria for PTSD 'can recall no discussion of situations like September 11', public health officials legitimized the connection between 9-11 and mental disorders, warning that high rates of PTSD, depression, anxiety, and substance abuse would follow the attack (Herman et al., 2002).

Once individuals' responses to the terrorist attack were framed within existing categories of mental illness, and especially of PTSD, mental health treatment was designated as the appropriate response. At the urging of public health officials, the Federal Emergency Management Agency agreed to fund mental health treatment for all those psychologically wounded by the attack (Felton, 2002). The attack produced a collective crisis, but treatment related to 9-11, like most psychological treatment, was delivered to individuals. The injured soon found that certain kinds of help were available free of charge. In order to receive it, all they had to do was to label their reactions as psychological symptoms and contact a mental health professional. In many cases, they then would become patients in psychotherapy.

The process by which persons with a wide range of relational, behavioural, moral and existential difficulties are turned into patients with psychological disorders – a process that Arthur Kleinman (1988, 26) calls 'medicalization' – did not originate on 11 September 2001. Over the past 100 years, the parameters of psychiatry have been radically expanded, medicalizing an ever larger portion of the human behavioural repertoire. In the nineteenth century there were only a handful of recognized mental disorders; today, more than 300 varieties of mental illness are meticulously catalogued in psychiatry's latest diagnostic manual. The second edition of the *Diagnostic and Statistical Manual,* which was published in 1968, had less than 150 pages; *DSM IV*, published in 2000, has nearly 1,000. As the number of illness categories in psychiatry has multiplied, behaviours previously attributed to eccentricity, evil, passion and possession have become viewed as symptoms of mental disturbance. Even grief has been medicalized, so that those who lose loved ones, particularly in circumstances of violence or disaster, are commonly seen as in need of professional help.

Edward Linenthal observed this phenomenon in the wake of the 1995 Oklahoma City bombing. As he notes in his book, *The Unfinished Bombing: Oklahoma City in American Memory,* the abject grief of Oklahoma City residents, including many whose friends and relatives perished in the bombing, was often regarded as a symptom of PTSD rather than as an appropriate reaction to a horrifying, earth-shattering loss. In Linenthal's view, the medicalization of grief had clear advantages for mental health professionals, especially those with expertise in trauma, as it expanded the category of patient to include not only persons with imbalanced chemistries or unbalanced families, but also persons upended by political violence. Medicalizing grief had the additional advantage of transforming the whole range of human reactions to catastrophe, even the most intractable, into an illness that was known, circumscribed, and treatable. Unlike mourning, which can last a lifetime, a diagnosis of PTSD raised the hope that, if properly treated, anguish could be put to an end.

Further, because PTSD, like other mental disorders, is conceptualized increasingly as physiological, a diagnosis of PTSD lends an otherwise intangible emotional experience a concrete, scientific dimension. Prominent trauma researchers Bessel van der Kolk and Onno van der Hart (1995) emphasize trauma's neurobiological basis. They argue that trauma is fully embodied; that it literally gets under the skin and is 'engraved' on the brain. In this view, although those who are traumatized have been biologically transformed by indelible experiences that are literally written into their minds and bodies, biomedicine holds the promise of an eventual cure that will erase or undo this damage.

Like the Oklahoma City bombing, the terrorist attack on the World Trade Center involved not only the medicalization of grief, with some of the bereaved still in psychotherapy more than 3 years later, but also the medicalization of terror. The result in both attacks has been the provision of psychological treatment for persons shaken by acts of mass political violence. Because such treatments have been designated as the appropriate remedies for such acts, the wider implications of advancing medicalization are frequently overlooked. Yet it is important to consider what happens when human reactions to international political events, including acts of terror, are reduced to discrete sets of psychiatric symptoms, for which a course of mental health treatment is prescribed.

PSYCHOTHERAPY AND POLITICS

Just as politicians, with few exceptions, have kept mental health issues off of their agendas, contemporary psychotherapists, for the most part, have kept national and community political issues out of their consulting rooms. This makes a certain amount of sense, given that therapists view their clientele as psychological patients rather than as political subjects. Yet many therapists discourage conversations about domestic and international affairs, even where they may be relevant. Some therapists, especially those who strive to maintain the traditional analytic stance of neutrality, fear that in the course of such conversations they will reveal their own political views, interfering with the transference and inhibiting patients' freedom of expression. More to the point, many therapists think that patients who talk politics in session are defending themselves against the turbulence of their inner worlds by discussing material that is comparatively impersonal, external, and remote. Like everything else patients say in psychotherapy, their political comments are likely to be analysed for what they reveal about the hidden world of their psyches rather than accepted at face value.

However, the period immediately after 9-11 was an exception. In the weeks of crisis that followed, many therapists temporarily abandoned clinical conventions. Thousands of New York City mental health professionals left their offices to volunteer their services, working lengthy and emotionally gruelling shifts with survivors, rescue workers, and the families of the deceased at the Armory, at Family Service Centers, and at Ground Zero. When therapists returned to their consulting rooms, these spaces, which they previously had considered inviolable, were invaded by warnings of further attacks. Working in the shadow of unimaginable violence, and with global politics suddenly close to home, therapists could not always distinguish patients' fantasies from reality, nor could they separate patients' internal and external worlds. The boundaries between therapists and their patients also became blurred. Unlike most clinical situations where the distinction between the patient who needs help and the professional who provides it is clear, after 9-11, many therapists were as frightened and as fragile as their patients. Like other New Yorkers, therapists were desperate to make sense of the attack and to share the latest news. Some were determined to bring a greater political consciousness into their work. Given the horror of 9-11, the idea that patients' political comments represented resistances to exploring their inner turmoil suddenly seemed absurd. In a departure from their usual practice, many therapists seemed to tolerate, and even to welcome, political conversations in session (Seeley, 2005).

But as the period of crisis receded, and as therapists regained their bearings, they began to relegate the political story to the sidelines. Once again, therapists – even those who had become politically active outside of the clinical consulting room – were less interested in patients' views of the international situation than in the ways these views reflected ingrained psychological patterns. Some focused not on the actual terrorists who carried out the attacks but on patients' imaginary, internal terrorists. In this vein, the *Journal of Psychohistory,* which, according to its advertisements, aims to 'put the world on the couch', published an article after 9-11 connecting patients' 'bad feelings toward the enemy' to their 'old hurts'.

For therapists who were inclined to analyse the unconscious, the meticulously

planned and wildly violent assault on the World Trade Center offered an interpretative bonanza (Seeley, 2005). The destruction of the towers was dream and fantasy made real. It symbolized the defeat of the parents and the collapse of authority, as well as patients' intrapsychic chaos, fears of violation, and desires for unfettered aggression. Unlike those who saw the burning towers as a commentary on American political history – Joan Didion (2003, 54), for example, wrote that they 'concentrated the complicated arrangements and misarrangements of the last century into a single image' – these therapists made sense of them in terms of each patient's inner world. Other therapists helped patients weave this event into the stories of their lives by assimilating 9-11 to previous experiences of violence and suffering. Patients revisited prior emotional injuries, revising them in light of this fresh assault. While some began to see previous incidents of abuse as trivial when compared to this large-scale disaster, others began to conceive of previous events as traumatic, granting them a new psychological importance.

Whatever their approach, after 9-11 therapists encouraged patients to hook this collective experience of catastrophe to their personal stories. As one psychoanalyst explained, helping patients injured by 9-11 was exactly like helping them with any other difficulty, in that it involved analysing their internal conflicts and asking, 'Why are they hurt? What *really* is it pulling up? What is it *really* about, and what are they *really* saying?' Rather than inviting patients to make sense of the attack within the frameworks of community, nation, politics, or globalization, therapists helped them understand their reactions to the attack in terms of their individual, interpersonal, and family patterns. Rather than encouraging patients to think of themselves as citizens capable of political action, they worked to reinforce their individual psychological identities (Seeley, 2005).

THE POLITICAL IS PERSONAL

The practice of reducing social and political events to the life experiences of individuals, and of subjugating political history to personal history, is typical of talk therapies. Although some describe psychoanalysis as a historical practice – as Michael Roth (1987, 9) writes, psychoanalysis is a 'theory of history' that 'makes sense of the present by seeing it as containing the significance of the past' – in psychoanalysis, as in other talk therapies, the history in question is that of a particular individual. Indeed, after 9-11, the work of psychotherapy involved the transformation of a monumental global event, one that occurred in a city of millions and echoed around the world, into thousands upon thousands of self-contained, individual histories.

In privatizing patients' experiences of the terrorist attack, contemporary American psychotherapists chose a clinical course of action diametrically opposed to the one many of their colleagues had employed in the 1970s and 1980s with Vietnam veterans and abused women. Unlike their earlier counterparts, who considered psychological analysis inadequate unless it was accompanied by political analysis and action, many psychotherapists today think otherwise. The view that psychological difficulties are produced by insidious systems of violence, discrimination and disparity has been replaced by the view that sociopolitical problems and ruptures are best understood and addressed through the categories of psychology and through the psyches of individuals. In contrast to therapists of earlier eras who believed that the personal was political, for many therapists today, the political is personal.

This perspective has significant implications for individual and community well-being following terrorist acts. If the political is personal, then even in cases of national catastrophe, recovery is best accomplished through mental health treatments that return a wronged and wounded nation to its natural state of health and strength, one person at a time. Further, if the personal is political, then changing the conditions that produce acts of mass violence becomes less important than changing individuals' responses to these acts to mitigate their harmful psychological consequences. The persistence of psychological injuries does not suggest the need to rethink the policies that give rise to them, but rather the need to produce more research on PTSD, more effective psychological treatments, and more efficient delivery of mental health services.

Such activities are now under way. Various mental health agencies and organizations are currently readying themselves to respond more efficiently and effectively to future terrorist attacks. Changes in conceptualizations of PTSD are also in progress, as mental health professionals now debate whether, and how, to revise the definition of this disorder so that it might better accommodate new kinds of events – especially acts of mass violence – in an altered political reality. In contrast to the current edition of the DSM, which only peripherally connects terrorism and trauma, the next edition of the DSM is likely to emphasize terrorism as a possible precipitant of PTSD, and to identify PTSD as a common reaction to terrorism. The links between political violence and diagnoses of psychological trauma will become naturalized and routine. Indeed, because trauma is a metaphor for victimization, we can expect diagnoses of PTSD to be applied whenever questions of personal or national innocence are at stake.

VIOLENT EMOTIONS

Terrorist attacks, like other acts of violence, give rise to violent emotions. When these emotions are turned into mental disorders, and those who experience them are advised to seek psychological treatment, psychotherapists stand to benefit. The medicalization of 11 September has provided therapists with a new area of expertise, a new public role, and a new clientele. Who else might stand to gain from having a citizenry that conceptualizes its injuries, and that seeks their repair, in medical rather than political terms; a citizenry composed not of engaged political subjects, but of psychological patients too wounded to feel, too disoriented to think, and too demoralized to act?

In writing a history of madness, Michel Foucault (1965/1988) noted the brilliance of Freudian psychoanalysis, which managed to consolidate the myriad structures of the asylum within the simplicity of the doctor-patient couple. As of 11 September 2001, with the designation of mental health settings as the appropriate spaces in which victims might recoup from a global act of terror, the doctor-patient couple has come to consolidate the complex structures of national and international politics as well. After the attack, the public was repeatedly discouraged from critically analysing American foreign policy, and from openly expressing political dissent, by an administration that considered such actions traitorous. Yet even as they were being silenced, New Yorkers were invited to discuss their psychological reactions to the attack on the World Trade Center, free of charge, with a mental health professional; through Project Liberty's programs alone, more than 600,000 New York state residents accepted the invitation. Many New Yorkers have spoken of the terrorist attack hour after hour, month after month, in great emotion

and detail, but in the privacy of their therapists' offices. A tragedy of community and society that belongs on the national stage has been played out instead behind closed doors, with a guarantee of confidentiality, for an audience of one. Unhooked from its political and historical moorings, a collective tragedy has splintered into countless private stories.

The violent emotions produced by violent acts, including acts of international political violence, doubtless will continue to be medicalized. But turning reactions to terror into mental disorders cannot help us understand the roots of political violence or its social consequences; nor can tethering terrorist acts to personal histories of violence and loss help us think critically and collectively about the means of its prevention. By providing their patients with private spaces in which to speak, and by encouraging them to create personal narratives of trauma, therapists have helped their patients drain global events of collective political meaning. Despite their best intentions, therapist may have contributed to the makings of a passive and silent citizenry.

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