Chapter 8
Reflections on COVID-19, Domestic Violence, and Shared Trauma

Shari Bloomberg

When I first heard about COVID-19 and the devastation that occurred in China and Europe, it seemed implausible that we could face a similar situation and shutdown in the United States. After all, we had faced threatening illnesses in the past 50 years including AIDS, SARS, and West Nile virus, and the country, while living in a more heightened state of fear, had not shutdown. Even in the context of our natural and man-made catastrophes such as Hurricane Katrina, Superstorm Sandy, and September 11, while the regions directly impacted were crippled for a period of recovery, the rest of the country, after a period of shock and empathy, resumed usual activity. Thus, when my counseling agency announced mid-March that we would move to work-from-home on a telehealth platform, I imagined the severity of the illness would pass, and we would be back in the office within a few weeks, limiting our interruption to client services. As I write this, 4 months later, with the pandemic resurging in most of the country and no visible return to our pre-COVID life, I cannot help but consider and reflect on the way our profession has shifted to accommodate the new stressors of our clients, new ways of communicating with them, and the shared trauma experienced between clients and professionals.

As a specialist working with domestic violence victims, the “stay-at-home” orders, intended to keep the general population safe, created new avenues of danger for victims. Financial stressors due to job loss and inability to work, children attending classes from home, and constant exposure to the abuser severely limited her options to leave or seek help. The goal of this chapter is to explore the impact the

S. Bloomberg
Rachel Coalition, Livingston, NJ, USA
Silver School of Social Work, New York University, New York, NY, USA
e-mail: st732@nyu.edu

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The pandemic has had on victims of domestic violence, the programs that serve them, and the nature of the changed relationship between providers and clients due to shared trauma.

The Nature of Domestic Violence

The Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) or domestic violence (DV) as physical violence, sexual violence, stalking, or psychological aggression (including coercive acts) by a former or current intimate partner. Considered a major social and public health epidemic across the globe, there is often a struggle to understand the underlying theories behind domestic violence. Even though victims of domestic violence can be of any gender and that domestic violence can also be seen in LGBTQ+ relationships, at equal proportions to the rest of society, the chapter will focus on violence against women given its wide prevalence. Accordingly, in a study by the US Bureau of Justice Statistics, from 2003 to 2012, 82 percent of domestic, dating, and sexual violence was committed against women and 18 percent against men (Truman and Morgan 2014). More recently, Ali and Naylor (2013) discuss some of the recognized theories of domestic violence as violence against women, including feminist theory and the sociological perspective, both of which exist within the patriarchal framework and elucidate the perpetuation of women as a marginalized population.

The feminist perspective views domestic violence not as a private or family matter but as a deeply embedded social problem that needs to be addressed through social change (Gondolf 1990). Violence against women, in general, is considered to be a social phenomenon determined by the patriarchal structure of most societies that forces women to remain in a submissive state through the use of physical, psychological, economic, and control tactics and permits coercive behavior such as prostitution and forced sex. These theorists maintain that until society sees women as more than subservient, compliant victims, little will change (Ali and Naylor 2013). Tools such as the “cycle of violence” and the “power and control wheel” along with ideas such as “learned helplessness” explain the continuation of abuse against women. The power and control wheel, specifically, addresses male dominance by having a category dedicated to male privilege. Learned helplessness, as explained by Lenore Walker (1977), suggests that IPV negatively affects a woman’s cognitive ability to perceive a successful outcome and enforces the belief that her actions cannot make a meaningful difference. Therefore, she stays in the relationship as she believes there are no other options available (Walker 1977). Restrictions placed on society due to COVID-19 have limited options even further.
Overlaying a Global Pandemic on the Epidemic of Domestic Violence

Early reports of the pandemic spreading focused on China and then Europe. Eager to slow the spread of the virus, many countries initiated lockdowns resulting in people forced to stay at home. Within weeks, reported incidents of domestic violence grew considerably as victims sought relief from the abuse. The Hubei province of China noted a tripling of domestic violence during February 2020, from 47 victims to 162 victims. Both Cyprus and Singapore found calls to police increased by one-third each. France also noted an increase of 30%, and while Italy noted that their calls to police had dropped, they were being flooded with desperate texts and emails from victims who could not safely use the phone. The United Kingdom’s largest abuse charity, Refuge, noted a 700% increase in calls in a single day (Bradbury-Jones and Isham 2020; Taub 2020; Usher et al. 2020). Several months later, an article in the *New York Times* noted that at least 26 women and girls in the United Kingdom had been killed by their abusers during the COVID-19 pandemic. Sixteen of them were killed during the first month of the lockdown, more than triple the number of domestic violence homicides from the previous year (Taub and Bradley 2020).

According to the World Health Organization, during times of crisis—such as natural disasters, wars, and epidemics—the risk of gender-based violence tends to rise (Bradbury-Jones and Isham 2020). Programs across the country enacted emergency plans as they had as many staff working from home as possible. Reported increases became part of the news cycle nationwide. In Portland, Oregon, after their mid-March stay-at-home orders were put in place, there was an increase of 22% in domestic violence incidents. In San Antonio, Texas, there was an increase of 18% in emergency calls between March of 2020 and March of 2019. In Jefferson County, Alabama, there was a reported increase of 27% more calls in March of 2020 than in March of 2019 (Boserup et al. 2020). Locally, at a recent Family Justice Center meeting, the Newark (NJ) Police Department shared that they had a 21% increase in calls from March 2020 to May 2020.

With such an increase in those seeking help for domestic violence, I believed that our programs would become flooded with help seekers. I was very wrong. Instead, the hotline, shelters, and outreach centers remained eerily silent. During weekly meetings at the New Jersey Coalition to End Domestic Violence, program heads from around the state discussed the trends that they were witnessing. Collectively and in line with the literature reported above, we discussed the challenge of clients being safely able to reach out for help. Many reported situations where perpetrators and/or victims had lost their jobs causing perpetrators to spend more time at home and victims to have less ability to leave. In some cases, victims who had left were forced to return due to financial constraints or, due to COVID-19, no longer having a place to stay. Victims were reluctant to call shelters or go to the emergency rooms for medical help, as they were unsure if they would be medically compromising themselves by doing so. The pandemic provided new items to withhold where
perpetrators were hiding masks, sanitizer, and gloves, thus forcing her to stay at home. Perpetrators threatened to expose her to the virus, to force her to leave, or to force her to work in risky environments. Threats to take the kids away increased, especially with the knowledge that the courts were closed and she would have minimal recourse. Her experience, more than ever, was truly one of intimate terrorism and coercive control (Stark 2009). More than ever I felt powerless to support my clients and was restricted by the same collective trauma.

**COVID-19 as a Collective Trauma**

COVID-19 was a traumatic incident different from any that had been experienced in many decades. Often, traumatic work focuses on an individual or family who have experienced something out of the norm. In Judith Herman’s words, “Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life” (Herman 1992, p. 33). Psychological trauma, such as domestic violence, is a type of damage that violates the familiar ideas and expectations about the world of an individual, plunging them into a state of extreme confusion and uncertainty (Aydin 2017). However, collective trauma refers to the psychological upheaval that is shared by a group of people who all experience an event. This type of trauma can affect groups of people of any size, including entire nations or societies (Cherry 2020). As opposed to natural or unintended events such as hurricanes and wildfires, which are regional and limited in scope, or deliberate events such as 9/11, which also more heavily impacted New York City and Washington DC, the COVID-19 pandemic is a new type of mass or collective trauma. The pandemic is truly global, affecting the entire world and infiltrating every part of society. Despite the virus affecting everyone, there is clear discrimination and inequity as to who receives assistance and who is more at risk. Media coverage, both through established sources and social media, has demonstrated a level of unprecedented documentation. Other differences included a focus on isolation for traumatic incidents; we banded together as a society to help and support one another (Horesh and Brown 2020).

With COVID-19, there is a new level of anticipatory anxiety. After other traumatic events, within a week or so after the trauma, healing and rebuilding begin. With COVID-19, there is ongoing uncertainty (Horesh and Brown 2020). It has been over 4 months, at the time of this writing, since the initial stay-at-home order was issued, and there remain more questions than answers about reopening, the lasting impact on jobs and the economy, and a possible second wave of the illness. In many states, the number of people contracting the disease is growing, and there are talks of possibly returning to a lockdown. This would re-endanger victims of domestic violence who are slowly trying to emerge from their abusive strongholds.

In times of trauma, peoples’ nervous systems can become overwhelmed trying to process the experience. In the current pandemic, people are often existing in extreme hypervigilance where they are facing total isolation by staying at home, fearing
their death or the death of loved ones, dreading making a “wrong move,” and griev-
ing the loss of the world as they knew it (Horesh and Brown 2020). If the commu-
nity at large is struggling with these issues, how much harder is it for those also
dealing with home as an unsafe place? How difficult is it for the clinicians that work
with them?

Redefining Boundaries

As my agency mandated the staff to work from home and moved to a telehealth
platform, I began a parallel process with my clients, learning how to best use the
technology. Despite the best efforts, technology has its challenges. Wi-Fi would fail,
sound would not be working properly, or the next-door neighbor would be loudly
mowing his lawn. Some of our clients faced challenges in not having the technology
to use telehealth or not having a safe, private way to have telehealth sessions.
“Offices are the physical containers of treatment, the familiar places where patients
find sanctuary … free from constraints of reality” (Boulanger 2013). No longer able
to use our offices as a safe and contained holding space, where clients were free
from interruptions and able to focus on themselves, improvisation was necessary.
Clients currently participate in therapy from bedrooms, bathrooms (with the shower
running), hallways, laundry rooms (while folding laundry), on walks, in parking
lots, in their cars, and at times when they knew their partners would be out grocery
shopping or in another meeting. Safety, as always, remains the priority.

In addition to the physical boundaries changing, clients appear less formal. I
noticed they dress more casually, no longer apply makeup, and will at times engage
in a comforting activity or continue with an activity that started before the session.
I was taken aback during a pivotal moment in a session when I heard a timer ring
and my client rose from her seat, found her oven mitts, and took a chicken out of the
oven. Boundaries have also loosened as I have seen the inside of my clients’ houses
(except for one client, a self-proclaimed hoarder, who will not use telehealth and
will only speak to me by phone). At times, sessions have been visited by pets, inter-
rupted by a young child, or occurred while eating lunch or having a cigarette. While
these moments have been addressed, the loosened expectations have become part of
the new therapeutic experience.

As with many shared traumatic experiences, not only was the client more vulner-
able, but as a therapist, I was in a similar position. Trained in a setting where the
therapist was to remain a blank slate and the work was done in the office, I needed
to exercise my own flexibility and adapt. It felt inauthentic and intolerable to main-
tain the usual therapy stance (Tosone 2011). Through telehealth, clients saw the
inside of my house, heard my doorbell ring, and witnessed my struggles with tech-
nology. A colleague shared how her cat had leapt on to her mid-session, startling
her, and causing her to scream and jump up (the client laughed, and the cat now
spends the day in the bedroom).
I have also redefined the hours I consider my “workday.” As my clients try to safely navigate this new reality, I have tried to accommodate them as much as possible, while still being mindful of my own work-life balance. Many of my morning clients needed to shift to afternoon sessions as mornings were prime virtual schooling time and they needed to help their children. Together we also developed code words to maintain safety. If one client suddenly gave me the pre-arranged message of “talk to you soon,” it meant she was no longer able to safely speak, as her partner had returned. Providing or reviewing safety planning also presented a challenge and a learning curve to master, as steadfast resources such as the courts had closed and protocols for shelters and other services had changed due to the pandemic.

**Shared Trauma**

Shared trauma is a situation where helping professionals live and/or work in the same community as the people they serve and are exposed to the same traumatic and threatening experiences as their clients (Nuttman-Shwartz 2016; Tosone 2020). This speaks to the dual nature of the traumatic experience, also referred to as a shared traumatic reality by other authors (Baum 2013; Bawens and Tosone 2010; Dekel and Baum 2009; Dekel et al. 2016; Tosone 2012). Shared trauma is defined as the affective behavioral, cognitive, spiritual, and multimodal responses that clinicians see as a result of the same collective trauma as their clients (Tosone 2012). Colloquially, it can be considered as “we are all in this together” or, as Dekel and Nuttman-Shwartz proffered, we are “in the same boat” (Dekel and Nuttman-Shwartz 2009).

In my recent experience, I have noted that my clients have become very concerned about my well-being and the well-being of my family. They are also curious as to how I am managing emotionally through the pandemic and if I can relate to their challenges. In my initial struggles with the level of disclosure, I conceded that the “rules against self-disclosure become difficult to enforce when the asymmetrical nature of the therapeutic relationship was forcibly re-calibrated by the shared trauma” (Boulanger 2013, p. 35). As time continued, I concurred with Tosone’s sentiment where “I found myself engaging on a deeper level and revealing more than usual” (Tosone 2011, p. 26). I think I was also fortunate that, until this point, my clients had all been in treatment with me for at least a year. While the boundaries have been more flexible, the established therapeutic relationship permitted room for growth and change. Still, as I carefully and selectively contemplate what information I am willing to share, I am mindful to ensure that the motivation for the disclosure is for the client’s best interest and not my own personal need (Tosone 2012).

Sharing a traumatic event or reality can become an equaling experience. Tosone noted that the shared experience of September 11 made it difficult to maintain any stance or emotional distance (Tosone 2006). The changing and blurring of roles and
norms that were noted in working with victims of terrorist attacks in Israel apply to the current situation as well. Both the familiar work setting and the walls where we complete this work are gone for now. There has also been a changing and blurring of roles as my clients’ needs have shifted. Many are now facing financial stressors and job losses, problems that lack straightforward solutions, and are looking to me for concrete suggestions and direction (Baum 2013). The blurring of professional and personal boundaries can also become confusing, as I previously mentioned regarding accommodating clients.

One idea that has resonated with me is the differences seen between individuals who have varying levels of responsibility in my agency. As observed by Tosone (2012) in her comparison between student clinicians and supervisors, the latter had added stressors of extra job responsibilities. One of the challenges for me has been not only worrying about my clients but the clients of the people I supervise, my supervisees themselves, and the program. I wonder about the extra stress I am experiencing in the many roles I serve agency-wide and how that may affect my *professional posttraumatic growth*, a term coined by Bauwens and Tosone (2010).

**Posttraumatic Growth**

Posttraumatic growth is defined as a positive psychological change experienced as a result of this trouble with highly challenging circumstances (Tedeschi and Calhoun 2004). It has a quality of transformation or a qualitative change in functioning unlike the apparently similar concepts of resilience, sense of coherence, optimism, and hardiness (Tedeschi and Calhoun 1996). Clinicians working with trauma survivors reported positive consequences such as increased self-confidence, independence, resilience, emotional expressiveness, sensitivity, compassion, and deepened spirituality. Bauwens and Tosone (2010), in their study of Manhattan clinicians post-9/11, similarly found that participants attributed the trauma of 9/11 as the impetus for enhancing self-care, changing clinical modalities, forging new skills, and enhancing compassion and connection in the therapeutic relationship.

Relatedly, shared resilience in traumatic reality allows the therapist to have increased bonding, empathy, and compassion due to the shared experience (Nuttman-Shwartz 2014). As I proceed with my clients and colleagues through this pandemic, I can already see the changes in the therapeutic relationship I have with my clients, as well as with my professional relationships with colleagues. Although I already had positive working relationships with all of them, this shared experience has furthered our connection and therapeutic bond. There is a different ease with our interactions, a different mutual understanding, and room for continued growth.
Conclusion

It is difficult to make overall comments about my experience through the COVID-19 pandemic as I believe we are still fully in the midst of its grip. Anticipatory anxiety and uncertainty as to the immediate future remain. I can see the benefits and challenges that have occurred in my therapeutic work with my clients. Over the next few months, I hope to continue to consider the role of boundaries, shared trauma, professional posttraumatic growth, and the evolving needs of my clients. One cannot yet predict the long-term effects of this global pandemic on the future of the social work profession and the clients we serve.

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