Chapter 33
Teaching Social Work Practice in the Shared Trauma of a Global Pandemic

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Shared Trauma

Unique clinical dynamics occur when both clinician and client are exposed to the same community trauma, whether a natural disaster or act of violence. These dynamics are referred to as shared trauma (Bell and Robinson 2013; Tosone 2011), defined as “the affective, behavioral, cognitive, spiritual, and multi-modal responses that clinicians experience as a result of dual exposure to the same collective trauma as their clients” (Tosone et al. 2012, p. 233). The term shared traumatic reality is also used, particularly by Israeli scholars, to describe ongoing experiences of collective terror with chronic effects on individuals and communities (Lavi et al. 2017). Many clinicians describe these experiences as “uncharted territory” (Boulanger 2013, p. 32). In a global pandemic, social work educators encounter similar uncharted territory; this reflection explores the relevance of the concept of shared trauma for the teaching relationship in a crisis.

Following a shared trauma, both clinician and client are involved in mourning the same loss at the same time (Bell and Robinson 2013), even as their experiences of the disaster may vary considerably (Dekel and Baum 2010; Tosone et al. 2012). Clinicians struggle to manage their own personal reactions of shock, worry, and sadness while continuing to work in a professional capacity (Boulanger 2013). Unique countertransference reactions are common, whether clients’ anxieties mirror those of the clinician or diverge considerably (Boulanger 2013; Tosone et al. 2012). Experiencing a disaster and navigating its aftermath force clinicians to confront their own vulnerabilities, leading some clinicians to feel deskilled, ashamed, or unsure of their ability to help clients (Saakvitne 2002).
Clinicians working in the context of shared trauma inevitably make changes to long-standing practice guidelines (Boulanger 2013; Rao and Mehra 2015). Following a traumatic event, clinicians may proactively contact vulnerable clients and inquire about their well-being, rather than wait for them to contact the therapist (Boulanger 2013; Tosone 2006). When the therapy office has been damaged or rendered inaccessible, clinicians find themselves working in temporary spaces or conducting teletherapy; this requires creativity and flexibility to create and maintain a holding environment in a temporary space (Boulanger 2013). Some clinicians report intensified emotional reactions in themselves, which may lead to increased self-disclosure and greater transparency in the clinical relationship (Boulanger 2013; Rao and Mehra 2015; Tosone 2006). For some, this increased therapeutic intimacy bolsters their sense of connection to clients and heightens their appreciation for the intersubjectivity of therapy (Rao and Mehra 2015; Tosone 2006); others may feel shame when their own emotional reactions are apparent to clients (Lavi et al. 2017). In either case, clinicians report a blurring or crossing of professional boundaries, as emotional distance becomes harder to justify (Bauwens and Tosone 2010; Bell and Robinson 2013; Rao and Mehra 2015). In the aftermath of a traumatic event, the traditional asymmetry of the clinical relationship becomes slightly more symmetrical (Boulanger 2013; Tosone 2006).

The impact of shared trauma on clinicians can be both negative and positive (Dekel and Baum 2010). Negative impacts include the challenges for clinicians of managing their own feelings of loss, fear, pain, sorrow, grief, and helplessness, alongside those of their clients (Dekel and Baum 2010). Symptoms of direct or vicarious trauma exposure can include difficulties with concentration, memory problems, dissociation, flooding, and numbing or avoidance (Bell and Robinson 2013). In some cases, clinicians may struggle to differentiate their own reactions from those of their clients (Day et al. 2017). Some clinicians report feeling a decrease in their sense of professional competence (Dekel and Baum 2010; Saakvitne 2002).

In addition, some also report positive impacts on their practice in the context of shared trauma. Nuttman-Shwartz (2015) coined the term “shared resilience in a traumatic reality” to describe the ways that both workers and clients can experience posttraumatic growth from this work. Clinicians report feeling deepened identification with clients as a result of working in a shared traumatic reality (Lavi et al. 2017). Others appreciate the possibility for mutual learning and mutual growth in the therapeutic relationship (Rao and Mehra 2015; Tosone 2006), when both clinician and client are open to being changed as a result of participating in the relationship (Miller and Stiver 1997). Some report that clinical work provides a sense of pride in professional purpose, a sense of meaning, and an antidote to feelings of helplessness following a traumatic event (Lavi et al. 2017; Saakvitne 2002).

Self-care and effective supervision are particularly essential for clinicians navigating shared trauma (Bell and Robinson 2013). Clinicians draw on their circles of support (Dekel and Baum 2010) from family, colleagues, supervisors, and the broader society. Lavi et al. (2017) found that clinicians who felt emotionally and instrumentally supported by supervisors and administrators reported a strong sense
of group cohesion and resilience. In contrast, a lack of clear institutional support aggravates an already intensely challenging situation (Tosone et al. 2012).

Shared trauma also poses unique challenges for students and teachers (Tosone et al. 2003). Nuttman-Shwartz and Dekel (2009) note that students are uniquely vulnerable in shared trauma situations, because they are still learning the knowledge and skills to use in practice and are anxious about being evaluated in the classroom. Tosone (2011) described the challenges in staying committed to the course syllabus as she and her students struggled in the aftermath of 9/11. Her solution was to invite students to write reflections on their experiences and connect them to the literature on trauma and coping, which were ultimately compiled into an article (Tosone et al. 2003). Students may experience role ambiguity in a shared traumatic reality, since it can be challenging for students to maintain a clear perspective on their role as helpers when they are also affected by the situation (Nuttman-Shwartz and Dekel 2009). In these situations, the class must provide containment for students, so that they can maintain their roles as both helpers and students (Nuttman-Shwartz and Dekel 2009; Saakvitne 2002).

Teaching in a Pandemic

The COVID-19 global pandemic has affected nearly every aspect of life in the United States. The rapid spread of the virus in the northeast United States led to an abrupt lockdown and shelter-in-place orders for millions of residents in March 2020. Unemployment numbers skyrocketed, while those who were employed in essential positions struggled with a lack of access to protective gear and worries about contracting the illness and infecting loved ones. In March and April 2020, the death toll from the virus rose exponentially in the region. Institutions of higher education cancelled in-person classes and closed student residence halls, requiring students to move home and both students and faculty to make an emergency pivot to remote instruction. Worries about food shortages, sick loved ones, reduced income, and difficulties accessing unemployment benefits formed the backdrop for the second half of the spring 2020 semester. Similar to clinicians returning to work following a disaster, it was clear that teaching during a pandemic could never be “business as usual” (Boulanger 2013, p. 38).

Several aspects of my own experience teaching undergraduate and graduate social work students invite parallels with the conceptual framework of shared trauma. Perhaps most prominent were feelings of grief that both I and my students experienced in response to multiple dimensions of loss, including the loss of normalcy as a result of the closure of public life; loss of autonomy as a result of shelter-in-place regulations; loss of a predictable future; loss of connection with others in the classroom; loss of rituals to mark transitions, such as graduations; loss of work and predictable income; and loss of private space for living, working, or learning (Berinato 2020). The daily news reports of rapidly escalating death tallies left me feeling numb with grief. I also found that I was easily distracted and had difficulty
concentrating on tasks. Finally, the news of the disproportionate toll the pandemic was taking on communities of color as a direct result of structural racism left me feeling furious, sad, and horrified.

In addition to mourning these losses, both faculty and students had to adapt to new technologies, unfamiliar ways of working, and lack of access to our familiar workspaces. The rapid spread of the virus meant that many of us were preoccupied with worry about loved ones who were ill or at risk, if we were lucky enough to be healthy ourselves. There was widespread concern about the economic fallout of the pandemic and immediate concern for everyone whose livelihoods disappeared in an instant. The collapse of distinctions between home and work led to a disorienting sense of time. The mandates to practice physical distancing and avoid contact with others created a profound sense of isolation, a source of considerable psychological distress (Miller and Stiver 1997).

Similar to clinicians and clients who experience a shared trauma, I found the mutuality of the teaching relationship heightened in the context of COVID-19. Intimacy in a teaching or therapeutic relationship involves exposing our imperfections (Tosone 2006). Self-disclosing to my students, I was honest about my unfamiliarity with online education for social work practice and that I was learning a new medium. I found that, like me, they were also anxious and disoriented by the sudden shift to remote instruction. In one of my first online classes, my computer kept freezing and crashing, interfering with my efforts to facilitate class effectively and leaving me frustrated and frazzled as a result. Later on, during small group discussions in this online class, a student offered me a compliment, saying “We were just saying what a great job you’re doing.” This graceful gesture initially caught me by surprise and made me self-consciously question my efforts to appear competent as a teacher. Had the student sensed that I was feeling vulnerable in an unfamiliar setting and needed a boost of encouragement? Ultimately, I saw this unsolicited compliment as one of the ways that relationships become more symmetrical in the aftermath of disaster. The professional distance that normally exists in the teaching relationship shrank as both teacher and students had to figure out how to navigate uncharted territory together. The boundaries of the teaching relationship, like other professional relationships, can sometimes be crossed in ways that facilitate connection and mutuality (Rao and Mehra 2015).

Both containment and validation are important in trauma treatment, as well as in classrooms following a shared trauma (Boulanger 2013; Nuttman-Shwartz and Dekel 2009). This is especially true when students and clients have encountered empathic failures elsewhere (Saakvitne 2002), as some of the students had. In all of my classes, I encouraged students to reflect on the challenges of this moment and connect their experiences and their clients in the pandemic to our course material. I noticed in myself a heightened emotional investment in my teaching, with stronger affective reactions on my part to student behavior in the online classroom. When students were honest about their struggles and able to reflect on their reactions either with peers in class or in written assignments, I felt strong waves of pride, admiration, and gratitude for their engagement and participation. At the same time, when students retreated into silence and participation was a struggle, I found myself
feeling exhausted and frustrated. To me, my reaction felt like a response to the ongoing isolation imposed by the pandemic, even as I recognized the many valid reasons for silence in an online class.

After a traumatic event, some clinicians choose to reach out to clients rather than waiting for clients to contact them. I identified this dynamic in my teaching as well. When students referenced their own struggles with mental health challenges, I debated whether or not it was inappropriate to proactively reach out to students and ensure they had access to mental health support. I struggled with my own role clarity, aware of my role as a teacher and not a social worker for the students. At the same time, I felt it’s necessary to acknowledge the emotional context of our learning during the pandemic and wanted to ensure that students with concerns knew how to access campus mental health support services. This gesture could be perceived as a boundary crossing but was also a form of affirming connection and care (Rao and Mehra 2015).

In spite of these numerous ways that my teaching experience reflected the concept of shared trauma, by the end of the semester, I recognized the many ways that my experience was not shared with the students. Compared to many of the students, I was lucky to retain employment and was able to work in a safe environment, protected from exposure to the virus. Shared traumatic realities take place in a political context (Nuttman-Shwartz and Dekel 2009); indeed, the impact of the COVID-19 pandemic is inextricable from the pandemic of anti-Black racism in the United States. The racial trauma and racial terror (Comas-Diaz 2007) resulting from police brutality and the weaponizing of White supremacy constitute a different kind of shared traumatic reality in this country. Trauma scholars describe how a traumatic event can shatter previously held assumptions that the world is a safe and benevolent place (Janoff-Bulman 1992; Saakvitne 2002). Experiencing unexpected and invisible threats to health and well-being, a loss of perceived safety, restricted freedom of movement, and in some cases loss of life are certainly destabilizing and disorienting in this moment, but they are sadly not new experiences for many people of color in the United States. The grossly unequal physical, emotional, and economic toll of these pandemics on communities of color in the United States means that it is disingenuous to describe the coronavirus pandemic simply as a shared or equalizing experience.

**Implications for Educators**

Experiencing a shared traumatic event changes the frame of the work (Saakvitne 2002). The literature on shared trauma has recommendations with relevant applicability for social work educators. Self-care is essential for both clinicians and educators who are struggling to regain a sense of equilibrium while maintaining a caring and responsive presence for clients or students (Bell and Robinson 2013). The reality of the pandemic continues to pose challenges to our physical, emotional, and social well-being, and living in a chronically stressful and isolating environment
requires intentional efforts to stay healthy and nurture the self (Saakvitne 2002). Additionally, effective professional and administrative support of all kinds – technical, emotional, and informational – is necessary for teachers to adapt quickly to new and unfamiliar demands and avoid burnout.

Reflecting on the dynamics of shared trauma in the teaching relationship illustrates that teaching, like therapy, is ideally a growth-fostering relationship that leads to mutual empathy and mutual empowerment (Miller and Stiver 1997). In some cases, strategic self-disclosure can enhance mutuality in a relationship and reduce isolation (Rao and Mehra 2015). Feminist theorists have long observed the importance of authenticity and mutuality in healthy, growth-promoting relationships (Miller and Stiver 1997). In times of crisis, judicious boundary crossings can help foster connection between teacher and student, without leading to a dilution of the professional role (Rao and Mehra 2015). As educators, being authentic and empathic with our students can help us identify both the disproportionate vulnerabilities wrought by structural inequities, as well as our experiences of shared humanity.

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