The COVID-19 pandemic has created a traumatogenic environment across our country and the globe. This unfolding and unpredictable public health crisis has reverberated throughout our society and communities, upending institutions and challenging social and cultural norms. Early on, van der Kolk (2020) shared his view that the pandemic’s traumatic impact upon the American public is exacerbated by leadership’s failure to provide predictability and trust, thus contributing to one’s feeling of vulnerability and helplessness. In exploring the impact of this collective trauma, it is necessary to consider the sociocultural and political environment in which this devastating health crisis is unfolding.

This chapter assumes a relational lens to explore how this pandemic and the ensuing upheaval in our major institutions and daily lives affect the practice of clinical social work. Several clinical concepts facilitate this examination: therapeutic frame, holding environment, embodiment, self-object functions, self-regulation, and intersubjectivity. The purpose is to explore how the traumatogenic context of COVID-19 challenges the structure and process of the treatment relationship and how this challenge benefits or undermines the treatment experience of client and clinician.

This chapter reflects several practice issues that have emerged and challenged me during this period of collective trauma. These include the following: How does the shared trauma experience of my patients and me affect the therapeutic relationship? What does it mean and how does it affect our work that our bodies are not in the same room due to meeting via telehealth? Is the holding environment holding and...
containing as well over a screen as it does in the office? I will explore each of these issues through case material, personal reflection, and discussion.

The trauma literature provides a framework to navigate these uncertain times and this new territory. These include compassion fatigue (Figley 2002), shared trauma (Tosone et al. 2012), collective trauma (Hirschberger 2018), secondary traumatic stress (Stamm 1995), vicarious trauma (Saakvitne 2002), and shared traumatic reality (Baum 2010). The current pandemic shares many characteristics described by Tosone et al. (2012) and Baum (2010). Most notably, we share with our patients the threat of illness and death. Further, with public health recommendations and executive orders prescribing stay-at-home orders and self-quarantining, we share the loss of social connection, anxiety about the future, and significant upheaval in the rhythm and routine of our daily lives. When conducting psychotherapy with our patients, we are likely to experience subjective states and countertransference feelings that are affectively charged and dysregulating.

The current collective trauma has characteristics that distinguish it from other experiences, disasters, and catastrophes. First, while the pandemic has reached into all our communities, its impact is mediated by sociocultural factors such as race, age, and socioeconomic status (Centers for Disease Control and Prevention [CDC] 2020). The disproportionate risk to Black and Brown individuals has exposed major health, social, and economic inequities. These revelations have become part of our shared traumatic reality. Second, this pandemic is not an event as much as it is an unfolding, unpredictable threat to our safety and security. The impact of living with a continuous threat such as the coronavirus seems more akin to chronic trauma or the threat of terrorism. Third, there is no end in sight.

My Personal Trauma Narrative

My experience of this health crisis has been mediated by my age, a risk factor, and my status, a protective factor. I feel quite grateful to be healthy and economically secure. This pandemic has underscored the power and privilege of my whiteness. Concurrently, anxiety regarding my risk status and that of those dear to me is chronic. The continual warnings regarding the risk of COVID-19 for those over 60 years of age confronted me with my mortality and physical vulnerability for the first time. This age-related self-consciousness was and is exacerbated by the now increased reliance on technology that has entered my professional and personal life. The generational divide between the young and old is quite apparent in this age of Zoom meetings, Doxy sessions, and FaceTime calls. Conducting any type of relationship over a screen is alien to me personally, let alone as a professional caregiver.

Given these stressors, I found myself questioning life choices and doubting my commitment to continued work. I asked myself, “What am I doing with my remaining years? Am I too old for this?” Despite decades of experience, I feel like a novice. These feelings of vulnerability, questions regarding my worth professionally, and anxiety about a forestalled future have become the backdrop of my personal and
professional self. The last several months have been a personal exercise in managing grief and social isolation. The loss of connection and intimacy with others has been challenging. I especially miss being with my patients face to face. Little did I realize how much our shared embodiment gratified me! Yet, these subjective experiences are now part of what I bring to the treatment relationship.

The Therapeutic Frame

Cherry and Gold (1989) elaborate the importance of the therapeutic frame for the clinician. I have found the disruption to my usual way of working a challenge. I have learned, to my surprise, how reliant I am on the structural aspect of conducting my practice. Activities such as driving to the office and having that 20 min of travel time to prepare psychologically and to transition from my personal self to my professional self and vice versa are very grounding. I continue to maintain my routine of time, space, and separateness from my personal life, though I am now in my office alone with my screen. Apparently, these rituals serve as an important component of my holding environment by supporting my self-regulation and sense of agency. In addition, I miss the simple rituals of waiting for, greeting, and meeting patients in the waiting room. These have been exchanged for the sending of Zoom and Doxy invitations and a click of the mouse upon beginning and ending the hour.

The conceptualization of the therapeutic frame, the relational context in which psychotherapy occurs, has undergone considerable analysis, reconsideration, and adaptation since its original formulation by Freud (Cherry and Gold 1989). Widely embraced by therapists representing a variety of clinical approaches, the concept of frame includes both structural and relational components. Structural components include timing, payment, setting, and mutually agreed upon expectations regarding the parameters of the relationship. Relational components include confidentiality, ethics, and self-disclosure as components of one’s therapeutic stance. The structural and relational components of the therapeutic frame provide safety, predictability, and continuity for both patient and clinician. Well-established elements of the frame include neutrality, abstinence, and anonymity (Cherry and Gold 1989). In the last several decades, therapist interpretation of these therapeutic attitudes has shifted and evolved to include a variety of practices and reinterpretations to allow for increased self-disclosure and flexibility.

Given the shelter at home order, psychotherapists and their patients were required to co-create a structure that enabled the work of the therapeutic dyad. For most therapists who had been conducting an office-based practice, this required an administrative redesign. We shifted from meeting with clients face-to-face to a tele-health meeting format within a few days. The anxiety, confusion, and insecurity of this shift was well illustrated by the hundreds of e-mail messages, webinars, and informational alerts filling our in-boxes from colleagues, professional organizations, and third-party payers. As professional helpers, we were driven and preoccupied by our commitment to our patients. On a personal level, I and others found
it grounding and reassuring to continue our work— one shred of the normalcy of pre-pandemic life. Even so, the necessary administrative adaptations were accompanied by feelings of insecurity and uncertainty. Would patients continue? Would insurance companies pay equitably? Can I do this?

As van der Kolk (2020) observed, in this accommodation to the pandemic, we lost agency and control over our professional lives, while simultaneously managing a threat to our health and those of our loved ones. Once the structural dimension of the therapeutic frame was established and agreed upon, our attention shifted to mastering a new medium through which the holding environment could be sustained. Flexibility and humor have been essential. I have reevaluated the therapeutic frame with many patients, attempting to accommodate their developmental, relational, and social needs. I have met with clients who are in their cars parked at a Wi-Fi hot spot, with adolescents whispering because they’re afraid their parents will hear them, and with an adult woman who let me know that there were rainbows (pixels) over my head as I shared (what I thought was) a very wise interpretation.

Impact Upon the Holding Environment

Several scholars (Baum 2010; Tosone et al. 2012) have identified shared trauma as contributing a unique dimension to the relational world of the therapist-client relationship. During the pandemic, I have experienced shared trauma as an added real and psychological dimension to the holding environment of the therapeutic relationship. The concept of holding environment (Winnicott 1986) is derived from the archetype of the early maternal-child relationship and the provision of good-enough parenting. Throughout my career, I have found this concept to be a guiding principle in my work with children, adults, and families. In considering the relevance of this concept as a guide for practice during the pandemic, I was and am heartened that the Winnicott’s thinking about this relational dimension of development and healing emerged from their work during a collective trauma, World War II (Applegate 1997). Though their writings do not explicitly explore the impact of the war upon them, they were managing a dual exposure to trauma.

Winnicott’s (1986) early conception of a holding environment portends the need for change and adaptation. Winnicott describes how the infant’s needs are met and adapted to by the mother: The care “is not mechanical… It is reliable in a way that implies the mother’s empathy” (p. 245). Ogden (2004) stresses the changing functions of holding as a means of accommodating and facilitating the individual’s emerging sense of self. These principles have guided me through this pandemic.

Tosone (2011), in describing her clinical experience post-9/11, refers to a “leveling experience” (p. 26) within the therapeutic relationship. The experience of a shared trauma exposes one’s vulnerability and fears both to oneself and one’s patients. Saakvitne (2002) noted that the frame of psychotherapeutic works shifts when the therapist’s vulnerability is revealed to the patient. Anonymity is not
possible with this change. Boundaries are loosened, and therapist neutrality seems withholding and inauthentic.

**From the Office to the Screen: Furthering the Mind-Body Split**

The opportunity to meet with patients over a video platform or audio call has allowed the therapeutic work to continue uninterrupted. The chance to maintain the connections with our patients, and for our patients to be able to access treatment during this crisis, has been an extraordinary benefit to both therapist and patient. Many clinicians have recently extolled the benefits of working on a screen: improved access, convenience, a lens into patients’ personal lives, and inclusion of other family members, including pets.

Challenges are imposed upon the intersubjective sphere of the treatment when the relationship is mediated through a computer screen. In a recent interview, Sherry Turkle (Chakrabarti and Martin 2020) notes that connection through screen is “efficient;” yet, relationships are “messy.” Todd Essig, in a YouTube video presented by the American Psychoanalytic Association (2020), cautions that “telepresence” is distinctly different from “actual presence.” The following section explores one major aspect of this difference: the absence of shared embodiment.

**Shared Embodiment as a Component of the Intersubjective Sphere of Treatment**

Schore (2012), a developmental researcher, enjoins clinicians to “get the body in the room.” Drayson (2009) identified embodiment as an essential component of clinical practice. Clinicians have embraced the observation that the mind is embedded in a body that communicates nonverbally and nonconsciously. Body language is no longer a communication only from patient to therapist; rather, the bodies of the patient and the therapist communicate reciprocally through gesture, subtle shifts in gaze, and head nods. With the discovery of mirror neurons, Lehrer (2018) has shed light on the neurobiological basis of embodied communication. Bodies communicate with each other, and this unconscious synchrony contributes to feelings of well-being (Galbusera et al. 2019). As clinicians, we are trained to take it all in, the posturing, the facial tensions, and the subtle shifts. We respond with our own unconscious movements that communicate understanding, empathy, and interest. The Boston Change Project (Boston Change Process Study Group 2018) describes this dimension of our intersubjective connection with our patients as living “in the bodily experiences of others as we interact with them or even merely observe them” (p. 301).
America is a body-conscious society. The pandemic has affected our experience of our own and others’ bodies. Pre-pandemic, our bodies were easily categorized: healthy or ill, able or disabled, old or young, attractive or unattractive, and white or non-white. The pandemic has leveled this playing field (Tosone et al. 2012). We are all physically at risk, albeit some more than others. Others’ bodies are now perceived as threatening, so we must socially distance. Do not get too close and no touching. A cough and throat clearing have assumed new meaning. Where once these involuntary acts invited others to lean in with concern, now they move away.

In this context, our inability to invite our patients’ bodies into our offices and to sit with each other’s bodies represents a loss and a challenge to the intersubjective sphere. While we are capable of “holding” the patients’ minds, we are not able to hold their bodies. An 8-year-old patient brought this challenge to my attention during a telehealth session. As we were meeting on a video chat, the screen began to move around her room. When I asked what was happening, she explained that she decided to do some pushups while we talked. I joined her, doing pushups while we talked.

Children’s relationship to their bodies is quite different than adults’. This child’s body, quite directly, was a means of self-regulation and mastery. Eventually, during the pandemic, we transitioned to outdoor walks while wearing face masks. As she climbed on a stone wall, she explained that by engaging in these somewhat challenging activities, her mind was occupied and she did not have to think about her worries.

An Actual and a Virtual Holding Environment

In late February I began assessing D, a 17-year-old Caucasian male who presented with depressive symptoms, ruminating thoughts, low self-worth, and depressed mood. After two in-person sessions, we shifted to telehealth sessions, a very comfortable medium for him given his proficiency with computers and technology and interest in becoming a software designer. In late March I received a referral for J, a 20-year-old Latinx-Caucasian male who experienced low self-worth, poor sleep, low energy, and depressed mood. This young man chose to wait until we could meet in person. Our first in-person meeting was delayed until mid-May, when phase II of coronavirus shelter-in-place orders allowed for offices to open with precautions.

Working with these two young men who present with similarities developmentally, share symptoms, and struggle with the social losses of the coronavirus has provided an opportunity to consider how the differing delivery systems of psychotherapy mediate both the therapeutic relationship with each and the therapy experience for both of us.

\[1\] All clients’ names and other personal identifiers in this chapter have been altered to protect privacy and confidentiality.
Both young men are bright and introspective. D relies on intellectualization to manage his feelings and has difficulty letting me in to his inner world. Instead, he independently processes his difficulties and shares the metabolized analysis with me. I can intrude on this and join him in this processing, but he ultimately feels quite dysregulated and withdraws from our work. As the younger of two successful boys, his early development seemed to lack appropriate mirroring and idealizing from his parents. He presents as isolated and psychologically cutoff from them and their “holding.”

J, a very sociable and sensitive young man who writes poetry and is pursuing an art degree, has failed to meet his expectations for social acceptance, belonging, and leadership. He sees himself positively but is disappointed that he was not as successful socially and romantically at college as he “should” have been. He is the older of two children in a family where he is clearly the apple of his mother’s eye.

In retrospect it seems quite understandable to me that J needed to be in the office. He is a very physical young man. He is very connected to his body as an expression of his identity. He is aware that he is attractive and views himself as a good athlete. He needed to be seen and heard in his entirety. Our actual presence provides an enlivened holding environment that supports his sense of self and where his need to be mirrored positively facilitates his self-reflection and growth. I believe that he rightly knew that a virtual environment would not hold him adequately.

D’s relationship to his body is quite different. He sees himself as fat, unattractive, and unathletic. This negative self-perception fuels his poor self-esteem, self-consciousness, and social isolation. Without an embodied component to our work, I have only been able to know how he thinks about what he had been feeling. And, I have no ability to respond to the physical dimension of his self. I cannot even see his body. There is an absence of intimacy in this virtual relationship that I feel would have benefitted from having both our bodies in the room. As I have come to know D as a bright, very appealing young man, I believe that the holding environment provided cannot hold all his needs, longings, and wishes. This deficiency undermines the safety of the relationship, and he is left feeling overwhelmed and affectively dysregulated by our sessions.

These two young men are managing painful affect, complicated family, and social relationships and trying to construct a healthy sense of self. J seems clear that his self is represented through his body and mind and both need to be experienced in his therapy. D’s experience of his body is full of pain and loathing, and the treatment frame has mirrored his overvaluing of his intellect over his body and a seeming devaluing or lack of integration of his physical self in his attempt to construct a healthy sense of self.
Boundary Alterations with an Ongoing Psychotherapy Patient

Baum (2010) describes the impact of a shared trauma upon patient-therapist dyads when a collective trauma occurs within the context of an ongoing therapeutic relationship. Boundaries may be blurred (Tosone 2011; Tosone and Bialkin 2003). Patients may experience and express concern for the therapist’s well-being (Gelso 2002). The following case material represents one of the most intimate therapeutic encounters that I have experienced with a patient. My increased vulnerability due to health concerns as well as the sociopolitical context enhanced our connection, causing me to think about her outside of session and to anticipate her reaction to unfolding events.

T is a middle-aged, African American woman, a retired police detective. She is married to a man, raising two sons, and very involved in her grandson’s life. She began treatment approximately 1 year prior to the pandemic for help with her depression and suicidal thoughts. T is a highly intelligent, compassionate individual who joined the police force to provide service to her community. While she loved the role of helping others and solving problems, she holds much resentment toward the force, where she witnessed corruption, and was the victim of sexist and racist treatment and biased policies. Her inability to trust her fellow officers and the system is best evidenced in her decision to work alone, without a partner. In this way, she shielded herself from other officers’ unacceptable behavior and their expectation that she would support them unquestioningly.

Her retirement after 23 years on the force was the result of injuries incurred on the job that left her with chronic medical problems, as well as a significant history of trauma. Because of these physical problems, her body is a frequent topic of our attention. Pain, the inability to get out of bed some mornings, the loss of physicality and strength, and the side effects from medications represent significant losses to her. Her discomfort is quite visible to me in the sessions.

She had experienced several quite frightening events as a police detective. She described unflinchingly running “toward the danger,” explaining, “That’s what we’re trained to do.” She described dangerous patrol assignments in housing projects where there was only one entry and exit, thus increasing one’s vulnerability when a problem arose. She described a particularly painful and sad experience that occurred early in her career. This event has emerged as a “model scene” (Lichtenberg 2001) because she and I would return to this event as an exemplar of her real and subjective experience representative of her helplessness, isolation, and oppression.

She was called to assist another officer who had apprehended a suspect. When she arrived, the officer in charge and two other officers had subdued the suspect. The suspect, a young African American male, was face down with hands handcuffed behind his back. The officer in charge had his knee on the suspect’s neck, and the suspect was yelling that he “couldn’t breathe.” T registered the officer’s disregard for this young man and intervened, telling the officer, “You can take your knee off his back. He’s cooperating.” The officer responded with expletives and accused her of interfering. This scene led to a series of complaints by T of the arresting officer
and by the arresting officer about T’s interference. Ultimately, neither were reprimanded, and there was no finding of wrongdoing for either of them. In her telling of this story, she directly expressed limited affect. It was an event – one of many. However, her body revealed her despair and anger.

T entered treatment wondering, “What should I do with my life?” Yet, her caretaking of her family and devotion to their safety consumed her. Her well-practiced need to dissociate and deny her needs compromised her ability to care for herself emotionally and physically. Her need to caretake extended to her neighbors and community.

She shared many early and current experiences with racism, though she did not label them as such. However, her awareness of and concern for her son’s and grandson’s safety were an ongoing theme. She worked hard to equip them with the language and skills to manage their worlds. An avid consumer of news, she often arrived at session in a fury about something that the president proposed. I struggled not to join her in her anger, while validating her fear and anger.

At one point she shared that she feared that there would be another “civil war.” In early March, at our last in-person session, she stood up and approached me. We hugged. Despite public health advice, I could not deprive us of this ritual. Our in-person sessions had promoted an intimacy, mutual respect, and positive regard that would form the frame for our telepresence sessions. We brought a holding environment into the telehealth world that absorbed the impact of the collective trauma that we were about to share.

The pandemic’s exposure of the disproportionate impact upon Black and Brown individuals provided a context to explore her concerns for her own and her family members’ health. After a few weeks of lockdown, her husband had to return to work, where safety measures were in place, but loosely. She worried about his health and perceived that he was “not well.” We discussed the reality of his health and ability to access health care. I moved the conversation a bit deeper. Did she trust the medical provider and the healthcare establishment? We were able to acknowledge the extreme vulnerability and risk that her husband, as a Black man, carried and the burdens she experienced trying to keep everyone safe and healthy.

An opportunity to share and hold her experience of racism emerged following the shooting of Ahmaud Arbery. Having heard about this on the news, I was prepared to hear T’s experience of this event. She was despondent as she described having watched the video and seeing him “gunned” down like an “animal.” Her despair and frustration with the authorities were palpable. I was able to link her grief to her identification with Ahmaud’s mother and her experience of being the mother and grandmother of Black boys. She wept openly. My heart broke.

Several weeks after this session, news of George Floyd’s murder hit the news. I learned of this several days prior to a scheduled session with T. I felt immediately attuned to her experience of this shooting. After all, Floyd’s death was painfully reminiscent of the situation that had occurred in her police work over 20 years earlier. My instinct was to reach out to her and call and to engage in a conversation. But I held back, thought about it, and sent a text expressing my shared grief and
acknowledging the impact of this upon her. She let me know that she and her family were “hanging in.”

In the following session, she stated that she had found the complaints that had been written about that long-ago incident. Could she read them to me? Of course, I listened as she read the officer in charge’s complaint about her. He was describing a woman who did not in any way resemble the woman I had come to know. She then read her complaint, submitted when she was only 27 years old. During her reading, I felt an intimacy that I had rarely shared with patients.

My work with T illustrates how our sharing of a traumatic reality reduced the asymmetry of the relationship and enhanced the intimacy between us. As Tosone (2012) pointed out, our responses were not identical. These shifts in the therapeutic frame facilitated the discussion of heretofore unspoken issues: race, privilege, injustice, and death. The layers of our shared trauma facilitated our work as individuals and as an intersubjective couple in making meaning of our experience.

The vicarious traumatization (Saakvitne 2002) that I have experienced in this work has served my personal and professional growth. This transformative experience is captured in the recently coined concept of shared resilience (Nuttman-Shwartz 2015).

Several weeks ago, I walked a path alone and saw a police officer on her bicycle. This sight comforted me and created a feeling of safety. I thought of T’s experiences. I was aware that my experience of safety is not shared across the community. This awareness is another aspect of my privilege and another benefit of our sharing the trauma together.

Conclusion

Just as the coronavirus has presented a “novel” challenge to the field of infectious disease, the pandemic and associated upheaval also have provided a “novel” challenge to the practice of clinical social work. This chapter shared my observations regarding how the collective traumas of our external world intrudes upon the clinical encounter and shapes the potential space as described by Winnicott (1971) of the therapist-patient dyad. Relying on familiar theoretical concepts and my experience, I have attempted to make meaning of my professional experiences. It seems ironic that in a time of such social isolation, distress, threat, and loss, opportunities for growth and intimacy emerge.
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