Introduction

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It seemed to happen overnight or at least over the course of a week. Even though these events occurred during 1 week in March, it feels like a lifetime ago when I was at a Rangers game in Madison Square Garden, dining at a packed, near impossible-to-get-reservations Manhattan restaurant; running a race; seeing a Broadway play; and meeting with clients and students face-to-face. The following week, coinciding with the first day of spring, I was sheltering in place with a friend in his rural Pennsylvania farmhouse, the nearest neighbor a mile away, wondering if I should prepare my will in the event that I had already contracted COVID-19.

I miss my old life. For this die-hard New Yorker and those of my ilk, the COVID-19 pandemic has many of the features of a traumatic event: sudden, unexpected, and potentially life-threatening (van der Kolk 2014). While a persuasive argument could be made contradicting these factors—COVID-19 was a known entity anticipated to impact the United States, and only a fraction of those who contract the illness die—subjectively, it felt traumatic. And as we know, trauma is a subjective experience, such that what one person perceives as traumatic may not be construed the same by another (Herman 2015).
Theoretical and Research Contributions to the Understanding of Shared Trauma

My experience, coupled with a steady diet of hearing the fears, anxieties, and major adjustments that my clients are undergoing, lends itself to the development of shared trauma. Shared trauma, defined previously, is the “affective, behavioral, cognitive, spiritual, and multimodal responses that mental health professionals experience as a result of primary and secondary exposure to the same collective trauma as their clients” (Tosone 2012, p. 625). Experienced on multiple levels—intrapsychic, interpersonal, community, and societal—shared trauma can impact the clinician personally and professionally in a myriad of ways (Tosone et al. 2012). Shared trauma has sometimes been misunderstood as the clinician and client having the same experience in relation to collective trauma (Kaplan 2020) or as “emotional contagion” from the client’s affective state to that of the clinician, such that the clinician understands exactly what the client is feeling (Seeley 2008). In fact, the clinician may be projecting their reactions onto the client; the emotional contagion may be bidirectional if the client and clinician are both sufficiently anxious and the boundaries between them are permeable.

Rather, the dual nature of the clinician’s trauma—primarily as citizen of a traumatological environment and secondarily through exposure to the trauma narratives of one’s clients—does not imply that the clinician’s response is identical to that of the client. Deprived of the clinical distance usually afforded them by having a different set of external experiences from their clients, clinicians may overidentify with a particular client, self-disclose, or offer an interpretation better suited to themselves, potentially traumatizing the client further. Clinicians and clients can be variably affected by the same catastrophic event, and given the potential blurring of boundaries, it behooves the clinician not to assume that their experience is the same as that of the client.

Although the term was initially used in response to the September 11th disaster by psychoanalysts (Saakvitne 2002; Altman and Davies 2002) and social work educators (Tosone et al. 2003; Tosone and Bialkin 2003), it is important to note that, while not named as such, the phenomenon may have begun with Freud as he was known to treat patients during World War I (Zilcosky 2018). Baum (2010) traces the phenomenon to a brief report by Schmidenberg, a psychoanalyst, writing about her experience treating patients during the World War II London Blitz. Schmidenberg (1942) described the impact that the prolonged bombing had on her personally and on her psychoanalytic work. In other parts of the world, notably Israel, the same phenomenon is referred to as shared reality and shared traumatic reality (e.g., Dekel and Baum 2009) as the terms are believed to better capture the chronic nature of a traumatogenic, terrorist-prone environment rather than a single terrorist event, such as 9/11, or any number of natural disasters, most recently Hurricane Laura.

Shared trauma differs from existing clinician-based trauma concepts such as compassion fatigue, secondary trauma, and vicarious traumatization in that these latter terms individually and collectively describe the deleterious effects of working...
with trauma survivors, but do not consider the dual impact of the traumatic experience. Following 9/11, there was a call to develop a construct that adequately captures the ramifications of the clinicians’ direct and indirect exposure to collective trauma (Eidelson et al. 2003). And while the reactions may be similar to those associated with the secondary trauma constructs—such as an enduring alteration of one’s self-perception or world view, or symptoms that mirror those of the client—shared trauma suggests that the responses are attributed to the dual nature of the traumatic exposure. That is, as a result of interacting directly in a traumatogenic environment and serving as witness to the trauma narratives of their clients, these clinicians are potentially more susceptible to the blurring of professional and personal boundaries, increased self-disclosure with clients, and the development of posttraumatic stress.

I have written about my own 9/11 experience (Tosone 2002; Tosone et al. 2003) and its influence on my practice (Tosone 2006) and research (Tosone 2011). Suffice it to say that my experience sitting with a client as the first plane flew over the building on route to crash into the North Tower of the World Trade Center changed my personal and professional life in profound ways. The experience spawned my curiosity as to how other Manhattan clinicians dealt with the potentially traumatizing event. Did the experience increase clinician self-disclosure and/or increase therapeutic intimacy? What are the personal and professional characteristics of clinicians who fared better post 9/11?

My quest to answer these questions began in earnest as I undertook the Post 9/11 Quality of Professional Practice Survey (PQPPS) which examined the long-term impact of 9/11 on 481 Manhattan social workers living and working in Manhattan at the time of the disaster. The PQPPS consisted of several established measures for PTSD, compassion fatigue/secondary trauma, compassion satisfaction, resiliency, and adult attachment styles, as well as demographic, practice, supervisory, training, and 9/11-related professional and personal experience questions. Secure attachment was found to serve as a protective factor against the development of compassion fatigue and as an enhancement to resiliency; fostering secure attachment in agency settings through identification of vulnerable workers, and provision of peer supervision and self-care, might help to decrease the development of compassion fatigue (Tosone et al. 2010).

While an important start, compassion fatigue alone did not address the primary nature of exposure to the trauma, thereby necessitating the development of a measure for shared traumatic stress. The construct was operationalized by the mean scores for the PTSD and compassion fatigue/secondary traumatic stress, rescaled to give equal weight to both components. Risk factors for shared traumatic stress include insecure attachment styles, exposure to potentially traumatic life events, and enduring stress attributed to the events of 9/11. These findings underscore the relational nature of trauma in that clinicians may attribute their traumatic responses to direct exposure, work with clients, or both (Tosone, McTighe, Bauwens, & Naturale, 2011). A noteworthy finding from a thematic analysis of open-ended questions on the PQPPS was that respondents described professional posttraumatic growth following the 9/11 disaster. Specifically, they noted having a greater ability and urgency
to care for themselves (e.g., reduce number of patient hours, take on fewer trauma cases), as well as a renewed appreciation for the profession. These are aspects of posttraumatic growth (Tedeschi and Calhoun 2004) but focus on the nature and context of practice. Other themes emerged consistent with their dual exposure to the disaster, including (1) an increased sense of vulnerability and living in fear of another terrorist attack; (2) past traumas served as either preparation for or complicating recovery from 9/11; (3) traumatic reactions persisted long after September 11; and (4) blurred client-clinician roles, increased clinician self-disclosure, and a sense of a shared traumatic experience with their clients (Bauwens and Tosone 2010).

Would shared trauma manifest similarly in a natural disaster as it did in the September 11th terrorist attack? The *Post Hurricane Katrina Quality of Professional Practice Survey* (PKQPPS) replicated the PQPPS, with the addition of an instrument to measure posttraumatic growth. Findings from this study of 244 social workers from New Orleans indicated that insecure attachment, greater exposure to potentially traumatic life events in general, and distress related to the events surrounding Hurricane Katrina specifically were predictive of higher levels of shared traumatic stress (Tosone et al. 2015). The *Shared Traumatic and Professional Posttraumatic Growth Inventory* (STPPG), a 14-item, Likert-type scale composed of three subscales (Technique-Specific Shared Trauma, Personal Trauma, and Professional Posttraumatic Growth), developed as a result of this study to further understand the nuances and nature of clinicians’ dual trauma exposure (Tosone et al. 2014). The STPPG correlates well to existing measures for posttraumatic stress and secondary trauma and supports the reciprocal nature of shared trauma, such that personal traumatic experience can impact professional practice and client trauma narratives can influence one’s personal trauma responses.

Others (Faust et al. 2008; Boulanger 2013) have applied the concept of shared trauma to the understanding of the dual impact of Hurricane Katrina on psychotherapists living and working in New Orleans and more recently to psychiatric residents in New York City during Hurricane Sandy (Rao and Mehra 2015). Increased self-disclosure and the blurring of professional and personal boundaries were also found in these reports. Shared trauma has been studied in counselors working on campus during the Virginia Tech shootings, with results indicating the need for counselors to practice self-care to better help their clients, in addition to the blurring of boundaries between the counselors and clients (Day et al. 2017). Bell and Robinson (2013) note that when exposed to the same collective disaster as their clients, counselors are at an increased risk for retraumatization, as well as decreased objectivity, empathy, and professional engagement. In examination of the long-term impact of the Troubles on social workers living and working in Northern Ireland during the 30-year period of sectarian violence, Duffy et al. (2019) found themes of increased therapeutic intimacy and self-disclosure and a renewed appreciation for the social work profession.
Shared Trauma and the COVID-19 Pandemic

By contrast to the other collective disasters, both natural and man-made, which have been restricted by location, the COVID-19 pandemic is worldwide and negatively impacting nearly all aspects of everyday life for everyone, clinicians included. We, along with our clients, have had to contend with quarantining, isolation, social distancing, fears of contagion, possible or actual loss of loved ones to COVID-19, disruption to work and transition to teletherapy, and remote learning/teaching/working. In trying to make sense of the impact of the COVID-19 pandemic on their personal and professional lives, some clinicians considered the literature on shared trauma. I received numerous calls for virtual speaking engagements from local, national, and international professional organizations; there was curiosity for the research of those working in the area. As an example, a podcast on shared trauma and the COVID-19 pandemic received over 40,000 downloads in 3 months (Singer 2020).

Shared Trauma, Shared Resilience During a Pandemic: Social Work in the Time of COVID-19 came to fruition as a result of the renewed interest garnered by the coronavirus pandemic. Importantly, shared trauma needs to be discussed in relation to shared resilience, a term coined by Nuttman-Shwartz (2014) to describe the positive experiences that clinicians derive from exposure to traumatic events, both directly and through their work with clients; the term suggests a reciprocal mutual aid that can take place between client and clinician. Throughout this volume there is an emphasis on shared trauma, but it would be remiss not to acknowledge the silver lining of shared trauma, and many of the chapters do discuss positive attitudes, experiences, and sentiments that result from interactions with clients exposed to the same collective trauma as themselves. Shared resilience differs from vicarious resilience (Hernandez et al. 2007) and compassion satisfaction (Figley 2002) in that the resilience and satisfaction derive respectively from work with clients and the clinicians and clients are “not in the same boat” (Nuttman-Shwartz 2014, p.467) as with shared resilience.

Understanding the Impact of the COVID-19 Pandemic on Practice: An Outline

Many of the contributors to the book are members of the New York University Silver School of Social Work community—full-time or adjunct faculty, students, and graduates—who write courageously about their clinical work with clients, including the adjustments they have made and the innovations they have undertaken during the pandemic to maintain the continuity of the therapeutic process and an ethic of care. They write openly about their experiences related to the pandemic, including several contributors who contracted COVID-19 and had to contend with the illness, along with the fears and reactions of their clients. As an editor, I didn’t
want to impose too much structure to the content of the chapters. Rather, I wanted the contributors’ voices to be clear, strong, conversant in their areas of specialization, and as if you are in conversation with them. The resulting 36 chapters are an embarrassment of riches in the populations and topics covered, especially the intersection of the COVID-19 and racism pandemics. The number of hospitalizations and deaths related to COVID-19 among Black and brown persons is disproportionate to that of their white counterparts and confirms the racism inherent in access to and utilization of health care in the United States.

The book is organized into six parts, beginning with reports from those on the front line of health care during the COVID-19 pandemic, followed by chapters pertaining to special populations impacted by the pandemic—such as intimate partner violence (IPV)/domestic violence (DV), eating disorders, addiction, veterans, LGBTQ, autism, adolescents in school settings, and job loss. Part III includes reflections and practice perspectives from seasoned clinicians on theories, adaptations to teletherapy, innovative therapeutic techniques, and the necessity for self-care. Part IV addresses the convergence of the COVID-19 and racism pandemics; Part V includes reports from social work educators, followed by Part VI, a guide for self-care practices consistent with the Centers for Disease Control and Prevention (CDC) guidelines for social distancing.

More specifically, Part I begins with an intimate interaction between a therapist, Patricia Hecht, and her patient, a hospital nurse on the front line of the COVID-19 pandemic. We next hear from a clinical social worker and supervisor, Victoria L. Cerrone, who in the midst of mourning the loss of a loved one discusses the moral distress and anguish experienced by patients and their families, many of whom did not have the opportunity to say goodbye before the patients’ deaths. Sophia Tsesmelis Piccolino addresses the critical role that healthcare social workers play in supporting patients and families, while she herself confronted COVID-19 directly. As a leader in social work health care, she discusses the importance of meaning-making for both the workers and patients. Lastly, Leslie Cummins offers candid reflections as a psychoanalytic supervisor to residents who are working in hospitals that were converted into COVID-only facilities.

Part II considers the populations most disrupted by the pandemic, beginning with the severely mentally ill. David Kamnitzer, Elisa Chow, and Jeanine D. Costley examine our profession’s Code of Ethics and the applicability of its six core values at a nonprofit human service organization delivering mental health and supportive services remotely during the pandemic. Three chapters address the increase in intimate partner and domestic violence as a result of the COVID-19 pandemic: Catherine Hodes discusses the role of advocates in providing safety options other than leaving for survivors of intimate partner abuse and their families, especially those living with, or in close contact with, an abuser. Shari Bloomberg reflects on both shared trauma and shared resilience in her work with survivors of domestic violence and the innovative ways she found to communicate with clients as they were forced to shelter in place with their abusers. Christine M. Cocchiola also addresses sheltering in place, but from the standpoint of college students returning home and the coercive control that may intensify in post-separation abuse. She
argues that these young adults are primary, not secondary, victims of intimate partner violence, alongside their victimized parent. In addition to IPV, concerns also have been raised about the exacerbation of addictions during the pandemic. Cassandra Lenza examines the social norms about gaining weight and using food to control one’s anxieties or for comfort, as clinicians navigate their own experience of pandemic life while providing known and novel resources and interventions to their eating disorder clients. Anna Wilking draws on her own experiences to help clients deal with addictive behaviors during the pandemic and argues for harm reduction rather than abstinence. For her, shared trauma provided an opportunity to deepen client relationships and help her to accept and heal her own behaviors. Howard Leifman discusses his work coaching increasing numbers of unemployed clients to find jobs during the coronavirus pandemic while helping them increase their sense of agency and self-worth. Jillian Tucker discusses her clinical work with veterans and how their crisis response military skills (e.g., social isolation and long-term separation from loved ones) can help manage aspects of COVID-19; on the other hand, veterans also can experience a reactivation of posttraumatic stress symptoms, survivor’s guilt, and moral injuries. Nicholas Santo also addresses reactivation, but as it applies to LGBTQ individuals who lived through the AIDS epidemic. Also included in this part are two chapters on school social work, one by Dayna Sedillo-Hamann, Jessica Chock-Goldman, and Marina A. Badillo comparing their experiences in different school settings and the other by Cierra Osei-Buapim describing the challenges of transitioning to teletherapy with adolescents previously seen in a residential school setting and the importance of maintaining a holding environment in the virtual space. The final chapter in this part by Samantha Fuld argues that shared experiences of loss associated with the COVID-19 pandemic may foster greater empathy and awareness for clinicians working with autistic clients.

Continuing the discourse on practice, Part III offers perspectives that speak to a more general discussion of therapeutic work and inclusive of theoretical applications, case material, innovative approaches, and the need for self-care and reflective practice. With rich case illustrations, Constance Catrone invites us into the intersubjective sphere of the therapeutic relationship and holding environment with clients deeply impacted by the racial disparities revealed through the COVID-19 pandemic. Jill Zalayet, also working from a relational frame, reminds us of the value of applying Karen Horney’s theory of wholeheartedness to an understanding of the mutual anxiety generated by the coronavirus, and the need for clinicians to be fully present for patients, while attending to our own fears and conflicts. Similarly, Meredith Hemphill Ruden applies Irvin Yalom’s concept of friendship in therapy to the virtual realm, noting its potential to foster strong therapeutic engagement and positive outcomes in a new, co-created therapeutic space. Next in this part are three chapters that offer innovative approaches to enhancing connection and decreasing anxiety during the COVID-19 pandemic. Starting with Michelle Willoughby’s ecosocial work approach to practice, she asserts that the natural world is part of human development and an expansion of the “person-in-environment” perspective, one which places the natural environment at the heart of anti-oppressive practice and environmental justice. Following which, Stacey Gordon, Ernest Gonzales, and Jillian
Hinton describe the development of the Neighbor to Neighbor Volunteer Corps as a civic engagement program to assist neighbors with basic needs, mental health, and social isolation during the pandemic while building resilience among neighbors and enhancing productive aging on a community level. Next, Katherine Compitus, a COVID-19 survivor, clinician, and director of a nonprofit animal sanctuary, discusses the value of animal-assisted therapy (AAT) adapted to conform to the current CDC guidelines for social distancing, as well as how to adapt AAT when working remotely with clients. These chapters are followed by two that address adaptation to teletherapy for Dialectical Behavior Therapy (DBT) and Eye Movement Desensitization and Reprocessing (EMDR), respectively. First, Madelaine Ellberger ponders the challenges of providing DBT remotely to patients at potential risk for suicide during the pandemic and emphasizes the importance of the treatment team and peer supervision to mitigate the impact of shared trauma. Then through a composite case, Gillian O’Shea Brown discusses adapting to the use of mobile health applications in virtual EMDR. The final two chapters in the part address the impact of trauma on clinicians and the important role that organizations can play to mitigate the development of shared trauma and burnout. Deirdre S. Williams posits the need to provide institutional support to public child welfare workers who face cases complicated by pandemic-specific stressors, such as quarantine and economic instability that can heighten the risk of abuse for children in precarious situations. In the final chapter of the part, Julian Cohen-Serrins suggests that the COVID-19 pandemic has underscored the limitations of self-care; he shifts the primary responsibility for reduction of burnout and shared trauma from the individual worker to the organization.

As mentioned previously, the coronavirus pandemic has highlighted the disparities in health care for African-Americans and Latinx. This, coupled with the brutal and hate-filled murder of George Floyd by a police officer, has ignited awareness of the racism hiding in plain sight in the United States. This book would not be complete without addressing the convergence of these two pandemics. Part IV begins with a spiritual perspective on the “pandemic within the pandemic of 2020” by Terry S. Audate who proffers a spiritual framework to provide meaning and purpose to these specific events and to one’s life in general. Kirk “Jae” James offers an Abolition Social Work framework to combat the perpetuity of Black trauma evident in overrepresentation in the carceral system and COVID-19 pandemic hospitalization and death rates. Adopting such a framework, he asserts, is an actualization of social work’s core values. Relatedly, Anna Morgan-Mullane addresses the impact of parental hyper-incarceration on children and adolescents amid the COVID-19 pandemic and lays the groundwork for the implementation of Relational Cultural and Attachment Theory to treat this population in community-based settings. Raashida M. Edwards describes the emotional impact of shared cultural trauma in the psychotherapeutic interaction between Dana, a Black cisgender female sex worker and her therapist, also a Black cisgender female. Because of the clandestine nature of the sex industry, voices such as Dana’s have been largely absent in the professional literature to date; shifts in the sociopolitical climate are creating spaces for persons of color engaged in sex work to procure appropriate representation, protection, access
to resources, and support. This part concludes with a chapter by Diana Franco, who addresses the negative impact of the COVID-19 pandemic on the lives of Latinx transgender migrants in detention, including the challenges they face in accessing mental health care and establishing credible fear in seeking asylum.

Turning to the future of the social work profession, Part V offers four chapters describing the experience and strategies of teaching in the midst of the coronavirus pandemic. Beginning with Beth Sapiro, who offers an intimate account of shared trauma with her students, keeping in mind that trauma is not shared proportionately in environments of persistent racial and economic inequality, she emphasizes the importance of self-care and administrative support in the context of shared trauma teaching environments. Peggy Morton and Dina Rosenfeld describe the shift in emphasis for service-learning courses necessitated by the suspension of in-person service, such that learning went from “SERVICE-learning” to “service-LEARNING” depending upon which goals are primary, with the hyphen symbolizing the process of reflection. Abigail Nathanson presents an intimate account of navigating shifts in multiple roles: doctoral student, professor, social worker, and COVID-19 patient. Themes of shared trauma, object relations, grief, and parallel process are described from a first-person narrative of the first few months of quarantine. My students and I conclude the part with a chapter describing our personal and professional reflections on the coronavirus pandemic, touching on the challenges of both social isolation and living with others, the role of social media, the uncertainty of the future, and the need for the social work profession to focus more on macro-level issues of social injustice and racial inequality highlighted by the COVID-19 pandemic.

No book on trauma would be complete without a chapter devoted to clinician self-care. While in a previous chapter Julian Cohen-Serrins argues cogently that the primary responsibility for the infrastructure to support self-care strategies resides within the organizations employing mental health practitioners, in this chapter he acknowledges the state of practice administration and the limited resources available in most social service agencies. He offers a guide for workers to access self-care procedures that are relevant now and consistent with CDC guidelines for social distancing, including various forms of mindfulness-based practices. While it does not inoculate clinicians from the effects of the COVID-19 pandemic, it helps clinicians to sustain their crucial services in the absence of structural resources.

Conclusion

It is difficult to conclude an introduction, especially about shared trauma when in the midst of a global pandemic and without any clear-cut remedy in sight. I applaud the authors whose work I describe in this chapter for recognizing the need to add their voices to the discourse on social work practice during the COVID-19 pandemic. You, the reader, have your own shared trauma narratives to tell, and we encourage you to add your voices to this discourse. The paradox of shared trauma,
particularly now, is that in the isolation of quarantine and life in the virtual world, we are building a strong sense of community, shared resiliency, and promise of a future with more intimacy, both personally and professionally.

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