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A Wound Has No Voice

Silence, Emotions, and Community Resilience in the Wake of Collective SARS-Cov-2 Trauma

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Abstract

Derived from the Ancient Greek word τραῦμα (engl. wound, damage), the word trauma refers to either physical or emotional wounds. Nowadays, it is mostly used in the context of psychological wounds, inflicted by an identity-shattering event – an event that causes the traumatised to not be able to reconcile their lived reality with the expectation of a human universal experience anymore. The last decade, the last two years in particular, and the last two weeks ad absurdum, have scarred the global landscape of human existence beyond recognition. From Putin's unexpected reimposition of mutually assured destruction doctrines via the global SARS-Cov-2 pandemic to the lingering threat of climate doom, people all over the globe have been faced with persistent threats to their most basic perceptions of ontological safety. This article seeks to examine the impact of the SARS-Cov-2 pandemic and to which degree it is justified to speak of a pandemic trauma. In addition, it engages with the liminality of pandemic trauma as a shared, collective and an isolated, individual experience, and potential mitigation strategies for building community resilience.

Keywords: trauma studies, collective trauma, SARS-Cov-2, Covid, pandemic, negatively-valenced emotions, Anthropocene Disease.

1 Introduction

When Ma (2018) published her novel Severance, global pandemics were still a far-fetched dystopian nightmare of the future. Like cyberpunk and interstellar colonialization, pandemics felt like a worst-case fever dream, a novel plot, a movie scene, and nothing like a potential reality. It was then that Ma wrote about the Shen Fever, a spore-borne disease eradicating humanity, imported from China, begotten by globalisation. It was then that Ma drew parallels to empty offices, social distancing, the absence of human in so intrinsically human cityscapes. It was then that Ma, unknowingly, provided a pandemic vocabulary, an attempt to articulate the pandemic horrors.

> "Memories beget memories. Shen fever being a disease of remembering, the fevered are trapped indefinitely in their memories. But what is the difference between the fevered and us? Because I remember too, I remember perfectly. My memories replay, unprompted, on repeat. And our days, like theirs, continue in an infinite loop." (Ma, 2018, p. 160)

Much like Emelie St. John Mandel's Station Eleven (2014) and Rory Power's Wilder Girls (2019), Severance became just one example of eerily predictive pandemic literature rising to popularity during the ongoing SARS-Cov-2 pandemic. It appears to be remarkable that in pandemic times, it is precisely pandemic literature that made a whooping comeback. Leaving the dark realm of sci-fi, pandemic literature transcended genres and became mainstream, so much so that it started dominating high-gloss journalism's reading lists (cf. Ciabattari, 2020; Khatib et al., 2020; Meiser, 2020; Time, 2020). While readers turned to stories of post-pandemic dys- or utopias, the non-literary voices remained relatively silent on the elephant in the room: a large part of the population had watched corpses pile up in refrigerated trucks, fought off threats to their livelihood, risk-assessed their way through life, lost loved ones, lost lung function, and lost hope. In year two (and half at the writing of this article), it is yet to be acknowledged that collectively, globally, the population has been subjected to a life-altering, identity-shattering phenomenon that, had it happened in isolation, would have required immediate front line mental healthcare. As a collective, though, we have successfully ignored the implications of threatened ontological safety, isolation, grief, and fear.

This article will first explore what trauma looks like in individuals and collectives, to then further argue why it is justified to speak of a collective pandemic trauma (drawing mainly on studies from the US, UK, and Germany), before offering potential mitigating strategies in turning the pandemic into something traumatic, yet speakable. It is worth pointing out that at the time of writing, the pandemic is still ongoing and therefore the body of research is ever evolving. It is also essential to emphasise that most studies and research have been situated in wealthy, western countries and that the impact of the SARS-Cov-2 pandemic will have, predictably, left a deeper scar on already disadvantaged, yet underresearched communities.

2 Conceptualising Trauma

Trauma has become both a buzzword and a catch-all phrase for moderate discomfort in recent years. Its semiotic content has been cheapened by overuse, often maliciously to re-contest the term and weaponise its elusiveness in order to dismiss concerns. Even when concretely pathologised in the form of Post-Traumatic Stress Disorder, it is still diminutised, with people claiming everything from an overly crowded supermarket to brunch with their mother-in-law has given them Post-Traumatic Stress Disorder - walking the fine line between dismissive conflation and actual psychological infliction.

This comes as no surprise, given the elusive nature of the concept at hand, making it both difficult to define and easy to fill with overbearing meaning. Much of the weight the term holds today still derives from Freudian influences. It

is unbreakably interwoven with psychoanalytical discourse as emerged from Freud's conceptualisation of the human psychosexual development. As characterised in psychoanalysis, traumatic events only become consciously traumatic once they are revisited in the future, such as in dreams, "where subconscious recurrences are seen as inventive and interminable reworkings of the trauma, the main elements of which are concealed somewhere in the language the individual uses to describe the dream" (Bradley et al., 2001, p. 6). The notion of subconscious recurrence still informs modern conceptualisations of trauma: In its most barebones, basic sense, the Diagnostics and Statistic Manual of Mental Disorders (DSM-5) defines a traumatic event as (but not limited to)

> "exposure to war as a combatant or civilian, threatened or actual physical assault (e.g., physical attack, robbery, mugging, childhood physical abuse), threatened or actual sexual violence (e.g., forced sexual penetration, alcohol/drug-facilitated sexual penetration, abusive sexual contact, noncontact sexual abuse, sexual trafficking), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, natural or human-made disasters, and severe motor vehicle accidents." (American Psychiatric Association, 2013, p. 274)

Witnessing any one such events can lead to a traumatisation, pathologised as Post-Traumatic Stress Disorder (PTSD). It is characterised both by recurrency and avoidance; recurring memories and dreams, sometimes disassociative flashbacks that replay the traumatic event and subsequent avoidance mechanisms to avoid setting off any memories, emotions, or thoughts related to the traumatic event (American Psychiatric Association, 2013).

2.1 Experiencing the Unspeakable - Individual Trauma

In the individual manifestation of trauma, the concept of speakability is highly contested. Trauma, in its essence, is mostly marked by an absence: the recurrence of events, coded into the subconscious, until they are triggered back into the conscious by means outside the traumatised individual's control. The trauma, as a locus, is notably absent and hard to grasp, until it violently re-emerges. Caruth (1996, p. 6) writes here

> "The [traumatic event], that is, as it emerges in Freud and is passed on through other trauma narratives, does not simply represent the violence of a collision but also conveys the impact of its very incomprehensibility. What returns to haunt the victim, these stories tell us, is not only the reality of the violent event but also the reality of the way that its violence has not yet been fully known".

This, however, creates a paradox in the traumatised: the trauma must be reprocessed in terms of dreams, flashbacks, or memories; however, the traumatised individual is lacking agency in the retrieval of these memories and, hence, is themselves never capable of producing a reliable narrative of the traumatic event, even though they might have been the only person to bear witness to it in the first place. The traumatised cannot speak their trauma, it remains unspeakable. Luckhurst (2008, p. 79) summarises this paradox as a "challenge to the capacities of narrative knowledge" – it is where words fail the surviving, and they themselves become prisoner to their incomplete ability to articulate. Or, as Caruth (1996, p. 4) summarises:

> "[...] trauma is not locatable in the simple violent or original event in an individual's past, but rather in the way that its very unassimilated nature — the way it was precisely *not known* in the first instance — returns to haunt the survivor later on."

Applying this lack of speakability to medicalised trauma, such as in the case of SARS-Cov-2 sufferers or those bearing witness to their suffering, adds another layer of failed articulation: The unravelling of the human fabric, both quite literally in the deteriorating bodies of the suffering and metaphorically in the societal structures collapsing under mass-scale illness, isolating those incapable of voicing their trauma even further. "Illness is the night-side of life," writes Sontag (1978) in her groundbreaking work *Illness as a Metaphor*. "[...] the nights-side of life", which she describes as another "kingdom" distinct from the "kingdom of the well" – two reigning states humans hold a perpetual "dual citizenship" of (Sontag, 1978, p. 11). It is here that Sontag interweaves the disease(d) with the well and conceptualises illness as an equal part to human life as wellness; as the quintessential dichotomy to be navigated as the most basic function of the human existence. In effect, though, if illness becomes mundane, how can we speak of medical traumata?

"English has no words for the shiver and the headache," writes Woolf (1926, p. 34). "Let a sufferer try to describe a pain in his head to a doctor and language at once runs dry. [...] He is forced to coin words for himself, and, taking his pain in one hand, and a lump of pure sound in the other [...] so to crush them together that a brand new word in the end drops out." (Woolf, 1926, p. 34)

The language of illness is first martial, and then nonexistent. While the speakability of trauma as such is already a highly contested concept, in speaking disease human language falls short of articulating human experiences. As Scarry (1985) points out: "Physical pain does not simply resist language, but actively destroys it. [...] Unlike any other state of consciousness, [pain] has no referential content. It is not of or for anything." (Scarry, 1985, p. 4)

More contemporary scholarship on trauma tends to challenge not the assumption of unspeakability, but its locus as "an unidentifiable, yet infectious pathogen" (Balaev, 2008, p. 152) and therefore intrinsic part of the neuropsychiatric properties of trauma. Instead, the unspeakability of trauma here is situated in a cultural context: "Registration, rehearsal and recall [of trauma] are governed by social contexts and cultural models for memories, narratives and life stories. Such cultural models influence what is viewed as salient, how it is interpreted and encoded at the time of registration and, most important for long-term memories that serve autobiographical functions, what is socially possible to speak of and what must remain hidden and unacknowledged" (Kirmayer, 1996, p. 191). It therefore locates trauma never as an isolated, individual experience, but always in relation to the broader societal context during which it is experienced and relived. It is not the speakability that is up for debate here, it is the cause for the

lack thereof - because both traditional and contemporary trauma theory come to the conclusion that, in the words of Cathy Caruth, a wound has no voice. The question is just whether it is sewn shut at the larynx or silenced by the humming chorus of a culture's collective voices.

2.2 Perpetrators, Facilitators, and Victims – Collective Trauma

Trauma is not necessarily a phenomenon that can be viewed in individual isolation. While that applies to the traumatic cultural context, it also appears to the locus of the trauma itself – when isolated suffering is potentiated to the scale of societies, the locus of trauma does not remain in the individual, but shifts into the collective memory of the traumatised group as well. Here, it is vital to illuminate the fact that trauma, once it has taken hold of the collective conscious, does not just affect those that have been directly affected by a disaster or catastrophe anymore. As Hirschberger (2018, p. 1) points out: "[...] collective memory persists beyond the lives of survivors of the events, and is remembered by group members that may be far removed from the traumatic events in time and space". Collective trauma is much more public than individual trauma: it is weaponised in national narratives, used to justify controversial policies (cf. "You are either with us or against us", as President Bush proclaimed post-9/11 CNN, 2001), and in doing so is recurring on thousands and thousands of screens, phones, and in books; over and over again, offering a secondary traumatic locus and causing secondary trauma to those initially far removed from the traumatic event (Bradley et al., 2001). Collective trauma most evidently manifests in the shifting of social dynamics within the trauma-affected group: for one, social identities require renegotiation based on the salience of trauma as an identity marker: who belongs to the victim-group and, if there is one, who belongs to the perpetrators or dissenting voices? Who has contributed to the gravitas of the traumatising situation, who has been affected by it? Hirschberger (2018) conceptualises the identity of perpetrator groups; however, it is worth extending that group to continue facilitators of initially externally-inflicted situations (such as, for instance, groups that oppose protective measures for the larger victim group, such as mask- or vaccine-opponents) to do the recent surge of natural disasters justice. These have, rarely, a singular cause, which makes the clear allocation of facilitator-groups difficult. "For members of perpetrator groups, collective trauma represents an identity threat [...], as it creates tension between the desire to view the group in a positive light [...], and the acknowledgement of severe moral transgressions in the past" (Hirschberger, 2018, p. 2); it is here that the self-identification in relation to the outgroup (the victimised group) becomes apparent: While both groups can be affected by the trauma, it is the facilitator group that will resort to revisionist rhetoric to mitigate the gap between the trauma inflicted and the role played in the facilitation of that trauma. Hirschberger (2018, p. 2) elaborates that

> "Members of perpetrator groups may deal with the dark chapter in their history by thoroughly denying the events, disowning them and refusing to take any responsibility for them. But, more often than not, reactions to an uncomfortable history will take on a more nuanced form with group members reconstructing the trauma in a manner that is more palpable, and representing the trauma in a manner that reduces collective responsibility. In some cases, the dissonance between current group values and past behavio[u]r are so great that disaffiliation from the group remains the only viable option [...]"

The shifting cultural dynamics post-trauma are only exacerbated by the fact that group membership is not always clear, and members may transcend groups or engage in competition over who gets to claim true victimhood in the nebulous post-traumatic cultural landscape. Concluding, trauma affects collectives on all levels: from shifting intra-family dynamics to more mistrustful communities - trauma seeps into the cracks of the collective (Somasundaram, 2014).

3 Towards a Global Pandemic Trauma?

At the time of writing, the global death toll hovers just over six million deceased, while a total of 526 million people have, at some point, been infected with SARS-Cov-2. Two, almost three years in the pandemic it has unmistakenably materialised that this pandemic is an event unprecedented in the lifetimes of those experiencing it; it is fracturing, defining identities of entire generations, a faultline between the *ante* and *post*. If we assume, therefore, that collective traumata have been instilled, it is vital to place the occuring trauma. Finding the locus traumatae is difficult, it is fragmented, ongoing and not precisely placeable in time. At some point in early 2020, for some even in late 2019, SARS-Cov-2 entered the lived realities of the global population, and in varying degrees it has remained an integral part until this day.

In failing to place Covid-trauma temporally, it is necessary to dissect the abstract spatial paradigms during which traumatisation may occur. In their 2020 paper, Masiero et al. (2020) predict four key situations that could have potentially traumatising effects on different populations. Written at the beginning of the pandemic, the article provides an in-depth play-by-play of what was to follow.

3.1 Early Pandemic Predictors: A Retrospective

Masiero et al. (2020) outline four different instances of pandemic situations that they expected to cause trauma: high-stakes decision fatigue, traumatic grief and bereavement, loss of roles and loss of self, and lastly social despair and division.

The first, **high-stakes decision fatigue**, refers primarily to healthcare providers. As a constant weighing of pros and cons is emotionally taxing, especially if done in multiple instances in short succession, such as when triaging as consequence of lack of beds, equipment, or personnel (Baumeister et al., 2018). Deeply related is the concept of moral injury, where these quick succession decisions force someone to "act (or [...] not act) in a way that contravenes their moral beliefs and ethica principles where they do not have any real control o[r] choice" (Masiero et al., 2020, p. 515). Being forced to act in a way that results in moral injury leaves especially healthcare providers vulnerable for vicarious traumatisation, where traumatic acts witnessed (in the worst case as a direct result of their morally injurious decision) imprint themselves into first order-trauma onto the

provider themselves. While healthcare providers are more prone to suffer from high-stakes decision fatigue (which patient receives the necessary, yet scarce equipment?), it is worth pointing out that all individuals living in pandemic times undergo constant risk evaluation, and are potentially forced to live with the consequences of miscalculated risks. Especially with easing lockdowns, every day is a barrage of subsequent decisions determining potential exposure times, and, by default, secondary exposure of loved ones and day-to-day interactions. Moral injury here arises from social pressure: is it reasonable to visit elderly relatives in a pandemic if they intently ask, even if they are being put at risk? While healthcare providers face the very acute impact of high-stakes decision fatigue, it has become the static background noise in everyday life, in which we are forced to evaluate which situations pose a veritable threat to our ontological safety, and which situations are tolerable in terms of risk mitigation. The human experience has suddenly become a barrage of numbers: every day, people are faced with an onslaught of local incidences, r-values, and death tolls. Especially early on in the pandemic, public communication included primarily numbers, leaving laymen to translate numbers into real lived realities, risk factors, and deciding points. It is here that it must be emphasised that making decision is intrinsically linked to self-control. Wants are at odds with risks, sensible decisions are intrinsically contradictory to fulfilling social desires. Adhering to lockdown rules and mitigating high-stress as well as negative affect take self-control (Muraven & Baumeister, 2000). Various studies show that self-control functions as a depletable resource that needs active replenishing, i.e. temporal distance between the exertion of self-control-related decisions, before allowing an individual to exercise their baseline contingent of self-control yet again (Muraven & Baumeister, 2000; Tyler & Burns, 2008; Vohs & Heatherton, 2000). When placed in a high-stress environment, such as an ongoing pandemic situation requiring continuous risk assessment, it is reasonable to assume that individuals will be negatively affected by their self-control failures and related decision fatigues.

Secondly, **traumatic grief and bereavement** function as another potential locus of trauma (Masiero et al., 2020). In upending the vast majority of socio-cultural rituals, SARS-Cov-2 has subverted cultural safety nets and disengaged societies from the usual cultural scripts assisting in overcoming intensely negatively-valenced emotional situations (Wallace et al., 2020; Zhai & Du, 2020). The

> "impossibility of following loved ones during the disease trajectory until death, and multiple deaths in the family, leave the individual in a sort of suspended time where major events take place but are yet unseen" (Masiero et al., 2020, p. 516)

leads to a perception gap: things have happened, in this case the death of a loved one, but the absence of a person is not enough to signify their death as well, as they too were previously absent if alive. More recent works point to this as being a traumatising experience for frontline workers as well. As Davoine (2022) has pointed out, especially diaspora communities have been severely disrupted because burial rites could not be adhered to and bodies could not be returned to homelands. Healthcare workers are at the forefront witnessing this, all while being coopted into a highly impersonalised death *process*. Emergency doctor Anne Lise recounts

> "[...] we're in our astronaut gear, they can't see any compassion in our eyes, they can't see our mouth or the expression on our face – we look like robots." (Davoine, 2022, p. 8)

In this sense, two trauma loci collide: for one, the individuals and communities directly affected by the loss of a loved one or cherished member, and the subsequent depersonalisation of their death in terms of physical absences and uncoupling of burial rites from the death; and secondly, the frontline workers who not only have to witness death to a much broader extent than during non-pandemic times, but who are also coopted into inflicting trauma onto communities and individuals by participating in the depersonalised death process. Moreover, this participation might not always lead to moral injury, but positions the frontline worker at the intersection of individual and collective damage: following the procedures harms the individual, but benefits the collective, and vice versa.

Thirdly, in addition to the vital health consequences of COVID-19, Masiero et al. (2020) predicted **the loss of roles and the loss of the self** as a potential traumatic locus. The existential threat of unemployment, especially when providing the income for family members or orther people, can "increase the loss of hope and lower optimism, self-efficacy, and self-esteem, which can lead to a concomitant increase of mental health disorders [...]" (Carrion et al., 2020 as cited in Masiero et al., 2020, p. 516). Two years down the line, it becomes evident just how significant the paradigms of (un)employment have shifted during the pandemic: in 2020 alone, 33 million people lost their jobs globally, with another 81 million people terminally leaving the labour market (United Nations Statistics Division, 2021). As Jetten et al. (2017) point out, reliable social security systems can break the economic fall of unemployment or precarious employment, employment also functions as a salient identity marker that contribute to an individual's sense of self. The sudden absence of such an identity marker and its positive proprieties can negatively affect mental health and well-being.

Lastly and fourthly, Masiero et al. (2020) predict that **social despair and division** will act as a site of trauma especially post-pandemically. The authors are pointing to preliminary data in their prediction, pointing to the faultlines of race and class as markers for who they assumed would be hit hardest by COVID-19 fallout, with death rates having been projected to be twice as high for Black people as it is for non-latin whites. They predict that

> "the resulting social distancing will act, similarly to the individual level, as a dissociation mechanism, where the apparent healthy side (the privileged groups) will ignore the troublesome and thorny side." (Masiero et al., 2020, p. 516)

Having progressed further through the pandemic, further research shows that Masiero et al. (2020) were (unsurprisingly) right with their predictions. In terms of race differences, Sandset (2021) found that BAME communities in the UK have been more vulnerable to SARS-Cov-2, while Vasquez Reyes (2020) and Mackey et al. (2021) show higher infection rates in African-American communities. In terms

of class lines, it not only becomes apparent that poverty is a deciding factor for pandemic vulnerability (Patel et al., 2020), but that economic status also has a strong impact on students' educational experiences during the pandemic, with students from lower socioeconomic backgrounds being clearly disadvantaged (Goudeau et al., 2021; Soria & Horgos, 2020).

As an addition to the aforementioned thoughts, it is worth pointing out that women tend to be twice as likely to be diagnosed with (c-)PTSD (Brewin et al., 2000; Hu et al., 2017; Olszewski & Varrasse, 2005; Tolin & Foa, 2006); Yet, Masiero et al. (2020) have inexplicably failed to consider gendered implications of the pandemic. It has become clear that between school closures, lockdowns, and quarantines, women have carried the lion's share of the unpaid care work (Umamaheswar & Tan, 2020; Xue & McMunn, 2021) and therefore have been subjected to additional stressors especially in working-class and low-income families, having to juggle the care work with their pre-pandemic responsibilities.

Another group Masiero et al. (2020) incomprehensibly neglect here is the group of disabled and chronically ill members of a community. While most of the population had to sever physical ties to their communities, it came with the implicit understanding that these limitations would be temporary. However, disabled and chronically ill members have, to this date, been permanently removed from their communities and face existential challenges: with the global retreat of the mask mandate, many disabled or chronically ill people are unable to return to their employment sites, community hubs, or even sustain their life independently in terms of grocery shopping, healthcare, and transport (Lund et al., 2020). Not only are chronically ill and disabled people removed from their communities, but in order to re-gain their participatory rights, they are often forced to bank on the collaboration of their peers or lay their vulnerabilities bare in front of strangers. As activist and university lecturer Dorothee Marx [@Dori_Kiel] (2022) tweets

> "Approached the end of mask mandates by telling students that 'this puts me in the very uncomfortable position of reiterating that I have a chronic illness that shortens my life expectancy. I'd kindly ask you to please keep wearing your masks' and tearing up with humiliation [...]. Neither students nor lecturers should be put in the position of having to openly declare their vulnerability and having to beg fellow students/staff for the simple act of wearing a mask. It's ableist, it's also deeply humiliating."

All of the studies mentioned here in respect to race, class, disability, and gender only encompass a small, geographically-limited sample of a wider body of work that follows the logical implications of the pre-pandemic societal life: those who are not white, not male, not able-bodied, and not economically privileged suffered the pandemic consequences the hardest and are likely to be found not only at the forefront, but also the losing end of Masiero et al. (2020)'s predicted dissociative division.

3.2 Anthropocene Disease

While Masiero et al. (2020)'s work certainly provides highly-relevant touchpoints, it fails to acknowledge the traumatic macrocosm of SARS-Cov-2. The rapid spread of the virus is intrinsically linked to the extensively globalised world, and, more specifically, to the changing global climate. Gupta et al. (2021) conclude that

> "[...] climate change may have contributed to the emergence and transmission and likely even to some of the clinical consequences of SARS-CoV-2 infection. The reasons include evidence that the likely reservoir source of coronaviruses for human infection has increased in number because of climate-induced changes in vegetation, and human activities bringing them into closer contact with bats and animals such as pangolins that could represent the intermediate hosts. [...] Whatever the initial emergence source, we also have made the case that climate change is acting to facilitate transmission between infected and uninfected persons. The case for this largely comes from weather changes causing certain groups to live in more concentrated situations, the temperature and humidity changes to favor viral survival, and the effects of industrial pollution to cause persons to cough and sneeze and create highly infectious aerosols. We contend that climate change is helping set the stage for more severe manifestations of infection." (Gupta et al., 2021, p. 6)

With this damning statement, Gupta et al. (2021) situate SARS-Cov-2 as a manifestation of what is referred to as the Anthropocene: the epoch following the Holocene, during which the planet is shaped by human influence. The beginning of the Anthropocene is contested; Lewis and Maslin (2015) situate it in the context of colonialism, global trade, and the onset of fossil fuels, though others (such as Steffen et al. (2015)) argue that only the second half of the 20th century brought about fundamental changes to the earth system. The beginning of this new era, coming to head in the fundamentally system-changing notion of climate change, has given way for what has been coined the Anthropocene disorder, the "psychological affliction that emerges from the reali[s]ation of the destructive incongruity between the human scale of daily life and the vast spatio-temporal scales of the Anthropocene" (Clark, 2015 as cited in Craps, 2020, p. 277). While the Anthropocene Disorder is more typically applied in the context of climate grief, it emerges analogously in the context of SARS-Cov-2. The most prevailing aspect here is the incongruity between the slowly unfolding catastrophe and the perception of steps taken to counter its effects as insufficient (or, as Clark (2015, p. 140) writes "the sneering voice of even a minimal ecological understand or awareness of scale effects"). UK healthcare provider Salisbury (2021, p. 1) writes

> "[...] a chorus of medical and scientific Cassandras was ignored. We watched in horror as the consequences of government delay and inaction played out as spiralling covid admissions and deaths. I'm trying to be mindful, to contain my anger, as it's of no benefit to anyone. I almost succeed, but then I have another consultation with a desolate bereaved patient trying to understand why her relative died."

What Salisbury expresses here is the consequence of the Anthropocene Disorder: intensely negatively-valenced emo-

tions such as rage and despair and the very conscious perception that the mainstream discourse views such emotional reactions as reactionary, alarmist, or generally disproportionate (Craps, 2020). It is what Clark (2015, p. 140) describes as "the gap between the human sense of time and slow-motion catastrophe and, [...] a sense of disjunction between the destructive processes at issue and the adequacy of the arguments and measures being urged to address them".

4 Making Sense of Trauma and Negatively-Valenced Emotions

Left with a global collective traumatised to varying degrees by the same cause, the first step is to overcome what is coined a "denotative hesitancy" – the phase after which a new social or cultural phenomenon has arisen, but before a common vocabulary has been established (Clair, 1993). Early studies having explored these sensemaking processes have investigated the use of metaphors in the denotatively hesitant period and have derived implicit emotional pictures from the used metaphors (Stanley et al., 2021). The mental models of participants derived from those metaphors revealed four key emotions felt during Covid-19: grief, disgust, anger, and fear (Stanley et al., 2021). It is then that we can, unsurprisingly, establish that most emotional reactions to Covid-19 will be intensely negatively-valenced. As the pandemic is ongoing, collectively we continue to overcome that denotative hesitancy by coining new terms (such as "zoombombing", the hijacking of a zoom call), but as we progress further through the pandemic more and more of our emotions are shaped by the pandemic and the medial discourse around it. An analysis of 2020 UK newspaper headlines revealed that over half of all headlines (52%) invoked negative emotions, while only 30% invoked positive sentiments (Aslam et al., 2020). Globally, Metzler et al. (2022) have shown a strong upsurge in anxiety-related terms in digital traces at the beginning of the pandemic, with most countries also experiencing an uptick in sadness-related terms.

Establishing the emotional baseline here is vital: collective emotional expression and social emotional exchange prove to be one of the most reliable methods of mitigating collective trauma and building community resilience with respect of the pathological aftermath of traumatic exposure (Berry & Pennebaker, 1993; Garcia & Rimé, 2019; Kennedy-Moore & Watson, 2001; Rimé et al., 2010). However, the expression of negatively-valenced emotions also tends to be heavily sanctioned through social norms and therefore is subjected to intense processes of emotional self-regulation (Fischer et al., 2004; Howell & Conway, 1990). Finding ways to enable the expression of negatively-valenced emotions is, therefore, critical for the mitigation of collective trauma.

5 Discussion - A Silence Quite Loud

Both the emotional response to Covid-19 as well as the accurately fulfilled predictors and paralells to climate grief and the Anthropocene Disease warrant speaking of a pandemic collective trauma.

Globally, measures have been launched to alleviate the impact of Covid-19. In the OECD countries, traumatic mitigation has largely focused on attempting to increase job retention and stabilising the labour market and most countries developed new ways to deliver informational content as well as telephone lines for acute crises (OECD, 2021). It appears, therefore, that governments are acutely aware that SARS-Cov-2 has affected all segments of society and all facets of daily life, yet their responses indicate that they intend to engage in these measures without providing space for emotional output. That is to say: in acknowledging that trauma exists, government actors nonetheless suppress the collective expression of that trauma. No or very few measures designed to encourage the public expression of negatively-valenced emotions have been taken and, in the same sense, very few measures to improve community resilience have been taken. Specifically, it appears that the public discourse was notably absent of any trauma-related discourse, nor where spaces created for those affected to express their emotions (de Rosa et al., 2021).

Trauma remains unspeakable in the public discourse. Neither the UK, nor the USA, nor Germany deployed any specific healthcare measures to unburden their citizens from the traumatic consequences of SARS-Cov-2 or take advantage of potential community building mechanisms. While negatively-valenced emotions are generally policed, in terms of the pandemic traumatic discourse further obstacles were employed: one, the acute awareness of the self being perceived as alarmist or hysteric, which in return increases negatively-valenced emotions (Craps, 2020); two, significant pushback from facilitator group communication in terms of fake news and their aggregation (Koch & Denner, 2020); and thirdly, the witnessing of the public discourse surrounding the climate movement in the preceding years, whose activists have publicly voiced their negatively-valenced emotions about a similarly Anthropocene phenomenon and, in turn, were infantilised and decried as alarmists (Bergmann & Ossewaarde, 2020). Moreover, the language of trauma has been coopted by facilitators as well – speaking of trauma also means using the language of those that claim that having to wear masks would be *traumatic* for children, like author Naomi Wolf has loudly proclaimed to her 140.000 followers before eventually getting banned by twitter (BBC News US & Canada, 2021; Onion, 2021). In these shifting goal posts, it becomes hazardous to use language that is yet to be clearly denoted, for fear of incorrect articulation landing the speaker on the wrong side of the ideological fence they intended to be on. Most worryingly though, by limiting mental healthcare initiatives to offering phone lines and websites and leaflets, trauma is confined into the realm of the private, individual again. The government responses we have seen so far do not utilise mechanisms of collective emotional expression for community resilience building. Instead, the mental fall-out from the pandemic is to be fixed by the sufferer themselves: picking up on the martial language, the agency is shifted into the void. The sufferer is forced to take agency where they are incapable as they are sick, and yet, governments unburden themselves by setting up these virtue-signalling offers. The sufferer could get help, if they wanted to, but it is up to them to seek that help, and it is to be confined into the limits of individuality. Amidst the physical isolation of lockdowns and social distancing measures, the individual is robbed of the possibility for collective emotional expression in a systemised, safe context, often leaving the harsh communicative sphere of social media as the only outlet to unite with other sufferers. Speakability is not encouraged,

it is confined to the back alleys of social lives: the looking up information in silence or the phone call for help at the darkest hour.

It is up to governmental institutions to not only up the general mental health care resources, but to counter these inhibitors and actively invite a public mental health discourse, which actively encourages the expression of negative emotions. While the collective is still swallowing thoughts in the denotative hesitancy, incapable of voicing recurrence they do not quite understand yet, a systemised mental healthcare approach is needed to provide that safe space for collective emotional expression. Indeed, this does not necessarily mean that (though desirable) a governmental response must include actual, physical expression for these spaces: much more, the primary healthcare intervention tool here is governmental communication that is clear-cut and denotatively legitimises the traumatic discourse. Here, it is that official communication must assume a role model function to help overcome the denotative hesitancy and drag trauma out of the liminality between individual and collective right into the publicly conscious discourse.

6 Conclusion

Acknowledging the trauma is the first step to mitigating the consequences of that trauma. Stuck in the denotative hesitancy, the collective discourse remains in the trap of recurrency and reproduction, unable to precisely articulate the mental health fall-out of the Covid-19 pandemic. While individually, we have to negotiate the impact the last two years have had on us, it is also here that we must overcome the barriers connected to expressing negatively-valenced emotions. However, as long as the mental health discourse is shifted into the liminality of loneliness, something that needs to be fixed individually, there cannot be a collective expression of the last two year's worth of emotions. It is necessary that space for those emotions is created, even if just discursively, to encourage their expression. With studies like Stanley et al. (2021) pointing towards socially shared and collectively expressed emotions as a veritable means to build community resilience and mitigate the individual aftereffects, it is our best bet to have those uncomfortable conversation and share the burden of the traumatic events, the traumatic witnessing of suffering we have collectively engaged in during the last two years. It is also a step towards seizing agency - with the vast temporal and spatial dimensions of a global pandemic and the burden of finding congruence with our comparably insignificant daily life, expressing emotion can mitigate the feeling of helplessness. It is perhaps then that we can explain the surge in pandemic literature during a global pandemic: in the unspeakability of the trauma coming alive, while we are still lacking the words to describe the absolute absence of referential content in suffering, the authors let us borrow theirs for a little while.

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