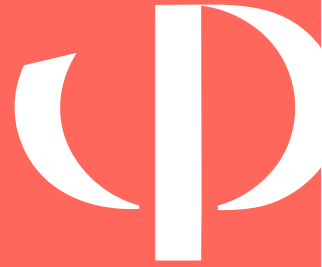


# Feminism and Philosophy

Special Issue: Feminist Responses to COVID-19 and Pandemics



SEPTEMBER 2020

VOLUME 20 | NUMBER 1

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APA NEWSLETTER ON

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LAUREN FREEMAN, EDITOR

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## EDITOR'S INTRODUCTION

Lauren Freeman  
UNIVERSITY OF LOUISVILLE

I am delighted to present to you this special issue of the *APA Newsletter on Feminism and Philosophy* on the topic of **Feminist Responses to COVID-19 and Pandemics**. I hope that you enjoy all of the marvelous contributions. Let me give you a small taste of what you'll find in this issue.

In **"Analyzing COVID-19 Sex Difference Claims: The Harvard GenderSci Lab,"** Marion Boulicault and Sarah Richardson summarize some of the groundbreaking work that they're doing at the [Harvard GenderSci Lab](#). Since March 2020, their lab has been analyzing, interrogating, and critiquing sex essentialist explanations of COVID-19 outcome disparities that are fairly ubiquitous in news media. Using interdisciplinary tools from feminist philosophy, science studies, and critical public health, they work collaboratively with two goals: (i) to critically examine COVID-19 sex difference research and (ii) to explore and elevate the role of social variables in driving biological disparities. They argue that in public health research, media, and messaging, data on sex disparities must be contextualized both to avoid reinforcing harmful sex essentialist assumptions and also to help the public understand the complex ways in which social factors influence these patterns. They argue that within the context of COVID-19, doing so can both clarify risks and save lives. Their contribution to this issue describes their methods and shares some of their findings.

Carol Hay's essay, **"How Privilege Structures Pandemic Narratives,"** responds to platitudes that we hear over and over again, namely, that the pandemic is "the great leveler" and that "we're all in the same boat." She argues that the pretense that we're all equally vulnerable across lines of gender, race, and class is at best a comforting lie. Instead, social privilege has protected the advantaged from suffering the worst consequences of the pandemic. Analyzing popular media talking points from the past few months, Hay argues that social privilege continues to structure the narratives we use to process life under the pandemic, while, unsurprisingly, material conditions are far worse for those who are not in control of the narratives. At the same time, however, she suggests that the pandemic might be opening the door for genuinely new collective responses to social inequalities, including the long-overdue uprisings inspired by the Black Lives Matter movement.

In **"Thoughts on the Loss of Ethical Goods: Perplexity and the Pandemic,"** Helen De Cruz complicates the standard narrative about the pandemic, namely, that it's disrupting—tragically altering and oftentimes even devastating—the lives of individuals. While this is undeniably true, she shifts the discussion to the broader question of ethical goods—those things that contribute to a flourishing life, like friendship, connection, a good relationship with family, and romantic attachments—and how they're affected by the pandemic. As she notes and as all of us know well, the pandemic is forcing us to lose out on many of these goods and this is no trivial matter. In fact, De Cruz argues that these losses pose a "crisis for ethics." In considering the topic of ethical goods and how to balance them in the pandemic, De Cruz draws upon American pragmatism, which is particularly well suited to help us adjust our ethical lives in challenging and uncertain circumstances given that it has long understood morality to be inherently social. Like Hay, De Cruz presents a cautiously optimistic conclusion, namely, that if we allow the moral perplexity brought on by the pandemic to be transformative, then we can examine which ethical habits and institutions hold up, and which require change. If anything, the pandemic might compel us to reconsider what we value as good features in our society, and how we can form habits that are conducive to them.

Miranda Pilipchuk brings to the fore an important and difficult consequence of the pandemic in **"A Crisis Ignored: Domestic Violence and the COVID-19 Pandemic."** Taking as a point of departure her own experiences, she considers the harms and needs of survivors who are simultaneously living in an abusive relationship and a pandemic. She begins by outlining various ways in which the pandemic has exacerbated situations of domestic violence. She then zooms out to explore the harms caused by the failure of the United States government to address the problem of COVID-related domestic violence. In response, she lays out some policy recommendations for how the government can immediately rectify its failure to address COVID-related acts of domestic violence. She concludes by taking a step back and reflecting on ways to effectively respond to domestic violence beyond the context of the pandemic.

In **"Pandemic Parenting,"** Ami Harbin and Alice MacLachlan reflect on their own experiences of (the ups and difficult downs of) parenting during the pandemic. They focus on four characteristics that have been cast into relief by pandemic parenting. The first, *the contingency of plans*, refers to a newly deepened surrendering of parents' control over their own time, combined with no guarantee that they will have any protected alone time, apart from children, to

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work or to care for themselves. The second, *the assumed self-sufficiency of the nuclear family*, speaks to the almost impossible expectation that individual families will be able to take care of themselves under the current circumstances: that is to say, the assumption that these families are entirely self-sufficient emotionally, financially, and otherwise. The third characteristic, *the hyper-individualization of risk management*, refers to a newly pronounced and seemingly never-ending imperative for parents to manage their own families' risks in the absence of clear, consistent, and oftentimes trustworthy messaging from government, state, and local authorities. The final characteristic of pandemic parenting discussed by Harbin and MacLachlan is *the potential conflicts between the emotional and epistemic needs of parents*. Here, they call attention to the ways in which in the last six months, parents have been working more than ever to create and bolster relationships of care among ourselves, but meeting these needs often comes with complicated epistemic costs. In each area, Harbin and MacLachlan draw out the complex gendered dimensions of the problem.

In **"Planning in the Void: Autonomy amid Pandemic Constraints,"** Jennifer Szende considers the passage of pandemic time over the last six months: navigating the changing terrain of her own personal and professional life with two young children amidst so much uncertainty. Within this context, and drawing on feminist philosophers like Simone de Beauvoir and Diana Tietjens Meyers, she considers what the good and meaningful life could mean under the present circumstances and how to carve out the possibility of autonomy and authenticity when so many background conditions are not only out of our control, but are forever changing. Amidst all of the uncertainty, Szende tries to take one day at a time, holding her breathe until things, maybe, hopefully sooner rather than later, return to resemble what they once were.

**"Surviving and Getting Your Life Back Are Two Different Things': COVID-19, ICU Psychosis, and the Coming Mental Health Crisis"** is a harrowing, prescient account of what is to come as more people survive their COVID-19 ICU experiences and are faced with the resulting trauma. Anna Gotlib, a bioethicist and ICU patient survivor, reflects upon the time (pre-COVID) that she spent on a ventilator. She discusses how she dealt with and continues to deal with the distress and fallout of ICU-induced post-intubation PTSD that resulted and that continues to unmoor her. Her account is graphic. It flies in the face of standard American narratives of independence, autonomy, and individual choice. It gives us a frightening look into what lies ahead. Her aim in offering us a glimpse into these mostly unknown phenomenologies is to motivate much-needed conversations about what happens behind ICU doors—and, importantly, what comes after. She concludes with some informed suggestions for how health-care providers and others can better respond to ICU discharges.

In **"What Does It Mean To Be an Empathetic Leader? Lessons from COVID-19"** Riana Betzler critically analyzes the observation that in the wake of the COVID-19 pandemic, countries led by women seem to be faring better than countries led by men. Think, for example, of New Zealand's

Jacinda Ardern, Germany's Angela Merkel, and Taiwan's Tsai Ing-wen. Using feminist-informed approaches from health and psychological sciences, Betzler argues that we should be wary of this finding, its implications, and, in particular, of how both have been reported in news media. In her fascinating and wide-reaching analysis, Betzler specifically considers what empathy is; how it tends to be a gendered emotion, often to the detriment of women; and how it should be distinguished from epistemic humility. Her point is to draw attention to the ways in which the concept of empathy at work in everyday discussions of empathic leaders, but especially within the context of the pandemic, is richer than the reductive concepts often in use in psychology.

In Ian James Kidd's contribution, **"Pandemic, Pessimism, and Misanthropy,"** he thoughtfully interrogates all of the silver-lining-speak that has become ubiquitous in the last six months. He concedes that "such cheery sentiments are tempting, amid the daily counts of 'excess deaths' and anger at governmental failings and acts of public selfishness and recklessness." Indeed, they offer emotional solace and even the hope for moral rejuvenation. But Kidd's worry, following medical writer and cultural critic Barbara Ehrenreich, is that such optimism and hope can both reflect and reinforce "bright-siding," described by Kidd as "an array of psychological and cultural mechanisms that aim to turn us away from the darker sides of life—our adversities, disappointments, frustrations, resentments." In his thoughtful remarks, Kidd wonders how much of our response to the pandemic that aims to initiate a moral transformation of humanity for the better is in fact a collective exercise in bright-siding. Bright-siding, he shows, can reflect a set of vices—from dogmatic optimism to absurd hubris to willful self-deception—and not all of them are easy to spot. Specifically, and from a feminist perspective, he elaborates on a kind of politically charged *naïve myopia* that should be of concern to all. He also offers some suggestions for how we might begin to offset it.

In **"Ordinary Women in Extraordinary Times,"** Nanuma Subba discusses her experience as a graduate student at the Centre for the Study of Law and Governance at Jawaharlal Nehru University in New Delhi. In response to the pandemic, Subba had to return home to live with her family in the small state of Sikkim at the corner of the Indian subcontinent, nestled at the foot of the Himalayas. In her essay, and by adopting a feminist perspective and situating herself within a long tradition of gendered expectations, she juxtaposes her professional and personal lives both before and during the pandemic. Being home with her family while trying to pursue a graduate degree is pulling her in a number of conflicting directions that she grapples with in this contribution. Her studies of feminism and privilege have allowed her to hold up a new lens to her family life.

This issue was put together very quickly and under very nonideal conditions. I would like to thank all of the authors who not only wrote their contributions with little lead time and with many constraints, but who also got their revisions to me with a turnaround time of often only a few days (and in some cases, a few hours!). I would like to thank all of the reviewers who read papers with little notice and who,

in the midst of everything, got their comments to me with lightning speed. Thanks to Kate Norlock and Amy Ferrer for giving the green light to go ahead with this project. Finally, my greatest thanks to Erin Shepherd, the managing editor of this newsletter (and all of the *APA Newsletters*) who tirelessly works behind the scenes to bring all of the newsletters to reality. Erin agreed to go above and beyond what she's required to do by adding this extra newsletter to her endless list of jobs. Not only that, but she prioritized this issue to publish it in a timely manner. This newsletter (and all of the *APA Newsletters*) could not be published without Erin's masterful editing and supreme speed and efficiency. Erin, I'm so grateful for what you do for the newsletter and I feel so lucky to work with you. A heartfelt thanks!

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## ABOUT THE NEWSLETTER ON FEMINISM AND PHILOSOPHY

The *Newsletter on Feminism and Philosophy* is sponsored by the APA Committee on the Status of Women (CSW). The newsletter is designed to provide an introduction to recent philosophical work that addresses issues of gender. None of the varied philosophical views presented by authors of newsletter articles necessarily reflect the views of any or all of the members of the Committee on the Status of Women, including the editor(s) of the newsletter, nor does the committee advocate any particular type of feminist philosophy. We advocate only that serious philosophical attention be given to issues of gender and that claims of gender bias in philosophy receive full and fair consideration.

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## SUBMISSION GUIDELINES AND INFORMATION

**1. Purpose:** The purpose of the newsletter is to publish information about the status of women in philosophy and to make the resources of feminist philosophy more widely available. The newsletter contains discussions of recent developments in feminist philosophy and related work in other disciplines, literature overviews and book reviews, suggestions for eliminating gender bias in the traditional philosophy curriculum, and reflections on feminist pedagogy. It also informs the profession about the work of the APA Committee on the Status of Women. Articles submitted to the newsletter should be around ten double-spaced pages and must follow the APA guidelines for gender-neutral language. Please submit essays electronically to the editor or send four copies of essays via regular mail. All manuscripts should be prepared for anonymous review. References should follow *The Chicago Manual of Style*.

**2. Book Reviews and Reviewers:** If you have published a book that is appropriate for review in the newsletter, please have your publisher send us a copy of your book. We are always seeking new book reviewers. To volunteer to review books (or some particular book), please send the

editor, Lauren Freeman ([lauren.freeman@louisville.edu](mailto:lauren.freeman@louisville.edu)), a CV and letter of interest, including mention of your areas of research and teaching.

**3. Where to Send Things:** Please send all articles, comments, suggestions, books, and other communications to the editor: Dr. Lauren Freeman, University of Louisville, [lauren.freeman@louisville.edu](mailto:lauren.freeman@louisville.edu).

**4. Submission Deadlines:** Submissions for spring issues are due by the preceding November 1; submissions for fall issues are due by the preceding February 1.

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## ARTICLES

### *Analyzing COVID-19 Sex Difference Claims: The Harvard GenderSci Lab*

Marion Boulicault

MASSACHUSETTS INSTITUTE OF TECHNOLOGY AND UNIVERSITY OF ADELAIDE

Sarah S. Richardson

HARVARD UNIVERSITY

Men seem to be more susceptible to the coronavirus, said Dr. Deborah Birx, the coronavirus response coordinator for the White House. . . . 'To all of our men out there, no matter what age group, if you have symptoms, you should be tested,' Dr. Birx said.

– *The New York Times*, April 9, 2020

Men are more likely to die from COVID-19 than women. Research into sex disparities began early in the outbreak, before it was declared to be a global pandemic. In February 2020, the Chinese Center for Disease Control and Prevention analyzed the records of 72,314 COVID-19 patients and reported that men are nearly twice as likely to die as women.<sup>1</sup> In April, researchers in Italy found that men in their fifties had mortality rates four times higher than women in that age group.<sup>2</sup> To explain these sex disparities, many researchers looked to biology. Do women have "more exuberant" immune systems than men?<sup>3</sup> Is androgen-linked baldness a risk factor for COVID-19?<sup>4</sup>

Since March 2020, our group at the [Harvard GenderSci Lab](#) has been critiquing sex essentialist explanations of COVID-19 outcome disparities. Using interdisciplinary tools from feminist philosophy, science studies, and critical public health, we work collaboratively to critically examine COVID-19 sex-difference research and to explore and elevate the role of social variables in driving biological disparities. We argue that, in public health research and messaging, data on sex disparities must be contextualized to avoid reinforcing harmful sex essentialist assumptions and to help the public understand how social factors influence these patterns. In the case of COVID-19, doing so can clarify risks and save lives. Here, we describe our methods and share some of our findings.

## THE HARVARD GENDERSCI LAB

Founded in 2018, the Harvard GenderSci Lab is a collaborative, interdisciplinary research lab dedicated to generating feminist concepts, methods, and theories for scientific research on sex and gender. Through research, teaching, and public outreach, we work to advance the intersectional study of gender in the biomedical and allied sciences, to counter bias and hype in sex-difference research, and to enhance public discourse surrounding the sciences of sex and gender. Our work is intended to reach across audiences: we publish not only traditional academic papers, but also editorials, public-facing blog posts, teaching tools, and media and communication guidelines.

The lab is made up of junior and recently tenured faculty, as well as graduate and undergraduate students. We are a home for scholars from a wide range of disciplines; our members are trained in philosophy, public health, history of science, anthropology, biology, and psychology. We use a mentor-mentee model for integrating new members of the lab (with more senior members acting as mentors). Our working model focuses on process and values including equity, solidarity, and consensus-building, inspired by pioneering feminist labs such as the Civic Laboratory for Environmental Action Research Lab (The CLEAR Lab n.d.).

## CRITIQUING SEX ESSENTIALISM IN THE CONTEXT OF COVID-19: OUR APPROACH

Though the magnitudes vary by location, men in aggregate are dying at higher rates from COVID-19 than women.<sup>5</sup> Observed sex differences across diverse populations are often assumed to have a biological cause, such as higher average testosterone in men or hormones associated with reproduction in women. This assumption is reflected in media headlines like “BUGGIN’ OUT: Coronavirus – Men more likely to catch deadly bug thanks to weaker immune systems, experts fear.”<sup>6</sup> There are reports that some researchers have even begun clinical trials on the use of estradiol patches or progesterone injections for men suffering from COVID-19.<sup>7</sup> As one researcher put it, “everybody is chasing a link between androgens . . . and the outcome of COVID-19.”<sup>8</sup>

Essentialist explanations of biological sex differences are familiar terrain for feminist philosophers and science studies theorists. Researchers like Rebecca Jordan-Young (2011, 2019) and Cordelia Fine (2010, 2017) have tackled essentialist claims in neuroscience and endocrinology. Sociologist Steve Epstein has analyzed sex-difference research at the policy and advocacy levels (2007). Here at the GenderSci Lab, we’ve contributed to this line of research both individually<sup>9</sup> and collectively. For example, we’ve co-authored analyses of claims of [sex differences in the incidence of Alzheimer’s disease](#),<sup>10</sup> and of biological theories of the [underrepresentation of women in STEM](#).<sup>11</sup>

Our approach to COVID-19 research draws on this experience and expertise and is grounded in feminist research methodology. When we began focusing on COVID-19 in March of 2020, our lab members (like so many others) were struggling with changes in work schedules, childcare obligations, homelife disruptions, travel and

immigration issues, and illness. Building on feminist work models and on our existing lab values and procedures, we developed a work structure with a particularly strong emphasis on support, flexibility, and empathy. In practice, this meant creating mechanisms for adapting to changing schedules and needs, focusing on supporting early career researchers and other more professionally vulnerable lab members, and integrating new members into the lab to bolster our team. This investment in working practices felt particularly urgent in a context where women academics are disproportionately affected by COVID-19 in terms of publishing, grants, and other professional metrics, with projected long-term consequences.<sup>12</sup>

## LOOKING TO HISTORY

As a lab, we approached our analysis of COVID-19 sex-difference claims from multiple angles. First, we looked to history. What can previous epidemics tell us about sex disparities in respiratory infectious diseases? Examining the 1918 influenza epidemic and the recent SARS-1 and MERS coronavirus pandemics, we found evidence that gender and other factors, not biological variables, largely explain sex differences in outcomes. We published our findings, which we outline below, in a [New York Times editorial](#).<sup>13</sup>

During the 1918 flu pandemic, men were 80 percent more likely to die than prior to the pandemic, while women were only 70 percent more likely to die. The principal causes of this disparity were preexisting conditions—in particular, far higher rates of the respiratory illness tuberculosis among men compared to women—and occupational gender segregation, particularly among the poor and members of the military. Men were disproportionately represented in the military and in certain nonskilled labor sectors, and military personnel and members of these labor sectors experienced a disproportionately higher death rate because of higher exposure levels in crowded conditions. In contrast, upper-class and nonmilitary men died at rates similar to women.<sup>14</sup>

The SARS-1 and MERS epidemics exhibited similar patterns. While the SARS-1 case-fatality rate differed between men and women (21.8 percent vs. 13 percent), that difference disappeared in analyses that controlled for other variables, such as age and occupation.<sup>15</sup> The MERS epidemic overwhelmingly affected men, but again, there was no sex difference in case-fatality rate between men and women when controlling for age and comorbidity status.<sup>16</sup> MERS is primarily transmitted through camels, and in Saudi Arabia, which experienced the world’s worst MERS outbreak, camel-handling and slaughtering are occupations dominated by men.

If COVID-19 also follows these patterns, then the overwhelming focus on biological sex is misguided at best, and a major threat to public health at worst. The *Times* editorial concluded with a call to action: “If gendered behaviors and gender-segregated occupations are responsible for greater COVID-19 vulnerability, we owe it to people of all genders to address these urgent, controllable risk factors.”<sup>17</sup>

## DIGGING INTO THE DATA

Based on our historical research and on our experiences as scholars working at the nexus of gender, sex, and biology, we posited that understanding gender/sex disparities in COVID-19 outcomes will not come from simple comparisons between all females and all males in aggregate. Instead, gender/sex variables must be analyzed in interaction with other socially relevant variables, allowing for robust intersectional analyses.<sup>18</sup> To tackle COVID-19 disparities, researchers will need to consider subsets of men and women, specific gender-related occupational exposures, lifestyle behaviors, age, race, ethnicity, and associated comorbidities such as heart disease, diabetes, liver disease, or cancer.

## DOES THE DATA EXIST?: A REPORT CARD

The first question we asked was this: Does such data exist? Is there data available on COVID-19 case and death rates of not only men and women in aggregate, but also on Black women, or men with comorbidities, or Hispanic men and women under 50?<sup>19</sup> Starting in April 2020, we began tracking and scoring US states on the comprehensiveness of their reporting on four socially relevant variables (gender/sex, race/ethnicity, age, and comorbidity status) and on interactions between these variables.

Our findings revealed that US state COVID-19 surveillance reporting is dangerously inadequate. As of July 2020, the mean score across the US is a “D,” or failing grade. Data on interactions is particularly limited: as of July 2020, only sixteen states are reporting on interactions between variables for cases, and only thirteen are doing so for deaths (and only two report the interaction between race and sex for deaths).

The paucity of data on interactions profoundly hinders investigation into the drivers of gender/sex outcome disparities. Consider, as an example, North Carolina, one of the few states reporting data on interactions between gender/sex and race/ethnicity. On June 11, 2020, 50 percent of COVID-19 cases in North Carolina occurred among men and 50 percent occurred among women. However, when restricted to African Americans, the percentage of cases among men dropped to 42 percent, while that among women rose to 58 percent. In other words, amongst African Americans, more women than men were testing positive for COVID-19. These data indicate a need to investigate how social variables linked to race/ethnicity, such as economic status and housing density, influence COVID-19 gender/sex disparities. This need cannot be met without comprehensive data from across the US on interactions between socially relevant variables.

We created a map and a “Report Card” to visualize these findings, published on the *Health Affairs Blog*,<sup>20</sup> and maintained and updated monthly henceforth on our *blog*.<sup>21</sup> We see this Report Card as a tool for accountability, bringing to light serious deficiencies (particularly with respect to data on interactions), but also showcasing successes, tracking improvements in reporting practices across time, and spurring (we hope) the creation and sharing of best practices for data reporting.

## THE US GENDER/SEX COVID-19 DATA TRACKER

Of the four socially relevant variables analyzed in the Report Card, we found relatively extensive reporting of sex disaggregated data on COVID-19 cases and deaths. On April 13, 2020, we began tracking this data for the fifty US states; Washington, DC; Puerto Rico; and the US Virgin Islands. We made this data freely available in an online *Data Tracker* that allows researchers, journalists, and the general public to compare data across states and examine trends over time.<sup>22</sup> Our Data Tracker, with seventeen weeks of data to date, demonstrates that there is great variability in the gender/sex disparity in COVID-19 case and mortality rates across US states, and over time. It also shows that in the United States, the gender/sex disparity in fatality has narrowed since tracking began in April. As such, we see the tracker as a tool for reexamining and critiquing broad generalizations about sex differences and facilitating more granular geographic and temporal analyses of gender/sex disparities.

## ANALYZING SEX DISPARITIES ACROSS RACIAL GROUPS

Next, we turned our attention to data that is far less extensively reported: data on interactions. As noted above, data on interactions is essential for developing robust intersectional analyses of COVID-19 risks and outcomes. Based on our Report Card research, only two states report on interactions between sex, age, and race: Georgia and Michigan. So as our next step, we analyzed how mortality rates between men and women differ by race (and age) across these two states. We found that the sex disparity in COVID-19 mortality rates varies dramatically between Black, white, and Asian/Pacific Islander populations in Georgia and Michigan. Our findings indicate that blanket claims about greater male than female vulnerability are misleading. For example, while men in these states do have higher mortality rates than women overall, Black women have significantly higher mortality rates than both white men and Asian/Pacific Islander men (Rushovich et al., unpublished). This is a powerful affirmation of the importance of thinking intersectionally about race and gender as social variables.<sup>23</sup>

## ACCESSIBILITY, OPENNESS, AND ENGAGEMENT

Our analytical work on COVID-19 sex disparities emphasizes transparency, accessibility, and public engagement. We make all of our data (both for the Report Card and the Gender/Sex COVID-19 Data Tracker) publicly available on our website.<sup>24</sup> We’ve also published a *guide* for reporters, researchers, and members of the public on how to communicate ethically and responsibly about COVID-19 gender/sex disparities (e.g., in ways that avoid reinforcing harmful sex essentialist claims).<sup>25</sup> This guide was inspired by another feminist group, the Berkeley Media Studies Group, that published an excellent guide on “Communicating about Racial Inequality and COVID-19.”<sup>26</sup> We are now in the process of creating a resource for teaching about gender/sex in the context of COVID-19, and hope to have this available in the coming weeks.

## CONCLUSIONS

Our work at the Harvard GenderSci Lab provides one model for putting critical feminist theory into action in the context of COVID-19. We show how resources from feminist philosophy of science and science studies can be marshalled to provide a corrective to prevailing sex essentialist assumptions in biomedical science and in the public translation of that research. Alongside other crucial feminist COVID-19 interventions,<sup>27</sup> critical and engaged analysis of sex-difference claims in biomedicine constitute an important component of the COVID-19 feminist toolbox.

## ACKNOWLEDGMENTS

We would like to thank all members of the Harvard GenderSci Lab for their tireless work on the projects described in this paper, especially the members of the Summer 2020 GenderSci Lab "COVID Coven": Alex Borsa, Joe Bruch, Ann Caroline Danielsen, Capri D'Souza, Annika Gompers, Nicole Noll, Mimi Tarrant, Tamara Rushovich, Heather Shattuck-Heidorn, and Helen Zhao.

## NOTES

- China CDC, "Vital Surveillances: The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19) — China, 2020."
- Epicentro, "Epidemia COVID-19."
- Rabin, "Why the Coronavirus Seems to Hit Men Harder Than Women."
- Wadman, "Why Coronavirus Hits Men Harder: Sex Hormones Offer Clues."
- Global Health 5050, "COVID-19 Sex-Disaggregated Data Tracker—Global Health 50/50"; Harvard GenderSci Lab, "US Gender/Sex COVID-19 Data Tracker."
- Mullin, "BUGGIN' OUT Coronavirus – Men More Likely to Catch Deadly Bug Thanks to Weaker Immune Systems, Experts Fear."
- Nachman, "Estrogen Patch for COVID-19 Symptoms—Tabular View—ClinicalTrials.gov"; Ghandehari, "Progesterone for the Treatment of COVID-19 in Hospitalized Men."
- Quoted in Wadman, "Why Coronavirus Hits Men Harder."
- See, for instance, Lab Director Sarah Richardson's work on sex chromosomes, *Sex Itself: The Search for Male and Female in the Human Genome*.
- Reiches et al., "Theory Matters: Sex, Gender, and Alzheimer's Disease."
- Richardson et al., "Is There a Gender-Equality Paradox in Science, Technology, Engineering, and Math (STEM)? Commentary on the Study by Stoet and Geary (2018)."
- Gabster et al., "Challenges for the Female Academic during the COVID-19 Pandemic."
- Shattuck-Heidorn, Reiches, and Richardson, "Opinion | What's Really Behind the Gender Gap in Covid-19 Deaths?"
- Viboud, et al., "Age- and Sex-Specific Mortality Associated With the 1918–1919 Influenza Pandemic in Kentucky."; Paskoff, "Sex- and Age-Based Differences in Mortality during the 1918 Influenza Pandemic on the Island of Newfoundland."
- Chan-Yeung, "SARS: Epidemiology"; Jia et al., "Case Fatality of SARS in Mainland China and Associated Risk Factors."
- Yang et al., "Impact of Comorbidity on Fatality Rate of Patients with Middle East Respiratory Syndrome."
- Shattuck-Heidorn, Reiches, and Richardson, "Opinion | What's Really Behind the Gender Gap in Covid-19 Deaths?"
- Agénor, "Future Directions for Incorporating Intersectionality Into Quantitative Population Health Research"; Bowleg, "The Problem With the Phrase *Women and Minorities*: Intersectionality—an Important Theoretical Framework for Public Health"; Gkiouleka et al., "Understanding the Micro and Macro Politics of Health: Inequalities, Intersectionality & Institutions - A Research Agenda."

- State-level public health agencies use binary categories for reporting sex. This significant limitation in data reporting practices isn't included in our Report Card as it doesn't vary by state, but constitutes a crucial avenue for further improvement.
- Boulicault et al., "Socially Relevant Variables in US State COVID-19 Surveillance Reporting: A Report Card | Health Affairs."
- Harvard GenderSci Lab, "US State COVID-19 Report Card."
- Harvard GenderSci Lab, "US Gender/Sex COVID-19 Data Tracker"; Hawkins, "Covid Kills More Men Than Women. Experts Still Can't Explain Why."
- Agénor, "Future Directions for Incorporating Intersectionality Into Quantitative Population Health Research"; Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics"; Ryan and Ayadi, "A Call for a Gender-Responsive, Intersectional Approach to Address COVID-19."
- Harvard GenderSci Lab, "US State COVID-19 Report Card."; Harvard GenderSci Lab, "US Gender/Sex COVID-19 Data Tracker."
- Danielsen and Noll, "Communicating about COVID-19 and Sex Disparities: A Guide for Media, Scientists, Public Health Officials, and Educators."
- Berkeley Media Studies Group, "Communicating about Racial Equity and COVID-19: Connecting Data to Context."
- See, for example, research on the inequitable distributions of carework during the pandemic. Power, "The COVID-19 Pandemic Has Increased the Care Burden of Women and Families."

## REFERENCES

- Agénor, M. "Future Directions for Incorporating Intersectionality Into Quantitative Population Health Research." *American Journal of Public Health* 110, no. 6 (June 2020): e1–e4. <https://doi.org/10.2105/AJPH.2020.305610>.
- Ali, M. A. "Gender Dynamics and Socio-Cultural Determinants of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in Saudi Arabia." *University of Toronto Medical Journal* 94, no. 1 (2017): 32.
- Bengtsson T., M. Dribe, B. Eriksson. "Social Class and Excess Mortality in Sweden During the 1918 Influenza Pandemic." *American Journal of Epidemiology* 187, no. 12 (2018): 2568–76. <https://doi.org/10.1093/aje/kwy151>.
- Berkeley Media Studies Group. "Communicating about Racial Equity and COVID-19: Connecting Data to Context." May 1, 2020. Accessed August 19, 2020. <http://www.bmsg.org/resources/publications/communicating-about-racial-equity-and-covid-19-connecting-data-to-context/>.
- Boulicault, Marion, Ann Caroline Danielsen, Joe Bruch, Amelia Tarrant, Alexander Borsa, and Sarah S. Richardson. "Socially Relevant Variables in US State COVID-19 Surveillance Reporting: A Report Card | Health Affairs." *Health Affairs Blog* (blog). July 14, 2020. Accessed August 18, 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20200710.964611/full/>.
- Bowleg, L. "The Problem With the Phrase *Women and Minorities*: Intersectionality—an Important Theoretical Framework for Public Health." *American Journal of Public Health* 102, no. 7 (2012): 1267–73. <https://doi.org/10.2105/AJPH.2012.300750>.
- Chan-Yeung, M., and R. H. Xu. "SARS: Epidemiology." *Respirology* 8 (2003): S9–S14.
- Channappanavar, R., C. Fett, M. Mack, P. P. T. Eyck, D. K. Meyerholz, and S. Perlman. "Sex-Based Differences in Susceptibility to Severe Acute Respiratory Syndrome Coronavirus Infection." *Journal of Immunology* 198, no. 10 (2017): 4046–53. <https://doi.org/10.4049/jimmunol.1601896>.
- Crenshaw, Kimberle. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." *The University of Chicago Legal Forum* 140 (1989): 139–67.
- Danielsen, Ann Caroline, and Nicole E. Noll. "Communicating about COVID-19 and Sex Disparities: A Guide for Media, Scientists, Public Health Officials, and Educators." *GenderSci Blog*, June 24, 2020. <https://www.genderscilab.org/blog/covid-communication>.
- Epicentro. "Epidemia COVID-19." April 2020. [https://www.epicentro.iss.it/coronavirus/bollettino/Bollettino-sorveglianza-integrata-COVID-19\\_23-aprile-2020.pdf](https://www.epicentro.iss.it/coronavirus/bollettino/Bollettino-sorveglianza-integrata-COVID-19_23-aprile-2020.pdf).

Epstein, Steven. *Inclusion: The Politics of Difference in Medical Research* (Chicago Studies in Practices of Meaning). Chicago: University of Chicago Press, 2007.

Fine, Cordelia. *Delusions of Gender: How Our Minds, Society, and Neurosexism Create Difference*, 1st ed. New York: W. W. Norton, 2010.

Fine, Cordelia. *Testosterone Rex: Myths of Sex, Science, and Society*, 1st edition. New York, NY: W. W. Norton & Company, Inc., 2017.

Gabster, Brooke Peterson, Kim van Daalen, Roopa Dhatt, and Michele Barry. "Challenges for the Female Academic during the COVID-19 Pandemic." *Lancet* (London, England) 395, no. 10242 (2020): 1968–70. [https://doi.org/10.1016/S0140-6736\(20\)31412-4](https://doi.org/10.1016/S0140-6736(20)31412-4).

Ghandehari, Sara. "Progesterone for the Treatment of COVID-19 in Hospitalized Men." *National Institutes of Health - Clinical Trials*. April 28, 2020. <https://clinicaltrials.gov/ct2/show/record/NCT04365127>.

Gkiouleka, A., T. Huijts, J. Beckfield, and C. Bamba. "Understanding the Micro and Macro Politics of Health: Inequalities, Intersectionality & Institutions - A Research Agenda." *Social Science & Medicine* 200 (2018): 92–98. <https://doi.org/10.1016/j.socscimed.2018.01.025>.

Global Health 5050. "COVID-19 Sex-Disaggregated Data Tracker—Global Health 50/50." Last updated August 7, 2020. Accessed August 18, 2020. <https://globalhealth5050.org/covid19/sex-disaggregated-data-tracker/>.

Harvard Gender Sci Lab. "US State COVID-19 Report Card." Accessed 19, 2020. <https://www.gendersciab.org/data-report-card>.

Harvard GenderSci Lab. "US Gender/Sex COVID-19 Data Tracker." Accessed August 19, 2020. <https://www.gendersciab.org/gender-and-sex-in-covid19>.

Hawkins, Grace. "Covid Kills More Men Than Women. Experts Still Can't Explain Why." *Wired*, July 9, 2020. Accessed August 19, 2020. <https://www.wired.com/story/covid-kills-more-men-than-women-experts-still-cant-explain-why/>.

Jia N., D. Feng, L-Q. Fang, et al. "Case Fatality of SARS in Mainland China and Associated Risk Factors." *Tropical Medicine & International Health* 14 (2009): 21–27. <https://doi.org/10.1111/j.1365-3156.2008.02147.x>.

Jordan-Young, Rebecca M. *Brain Storm: The Flaws in the Science of Sex Differences*. Reprint edition. Cambridge, MA: Harvard University Press, 2011.

Jordan-Young, Rebecca M., and Katrina Karkazis. *Testosterone: An Unauthorized Biography*. Illustrated edition. Cambridge, MA: Harvard University Press, 2019.

Mullin, Gemma. "BUGGIN' OUT Coronavirus – Men More Likely to Catch Deadly Bug Thanks to Weaker Immune Systems, Experts Fear." *The US Sun*, February 13, 2020. <https://www.the-sun.com/news/398152/coronavirus-men-more-likely-to-catch-deadly-bug-thanks-to-weaker-immune-systems-experts-fear/>.

Nachman, S. "Estrogen Patch for COVID-19 Symptoms—Tabular View—ClinicalTrials.gov." National Institutes of Health - Clinical Trials. April 24, 2020. <https://clinicaltrials.gov/ct2/show/record/NCT04359329>.

New York Times. "Jobless Claims Surpass 16 Million; Aid Package Stalls in Senate." *The New York Times*, April 9, 2020, sec. US. <https://www.nytimes.com/2020/04/09/us/coronavirus-us-news.html>.

Paskoff, T., and L. Sattenspiel. "Sex- and Age-Based Differences in Mortality during the 1918 Influenza Pandemic on the Island of Newfoundland." *American Journal of Human Biology* 31, no. 1 (2019). <https://doi.org/10.1002/ajhb.23198>.

Power, Kate. "The COVID-19 Pandemic Has Increased the Care Burden of Women and Families." *Sustainability: Science, Practice and Policy* 16, no. 1 (2020): 67–73. <https://doi.org/10.1080/15487733.2020.1776561>.

Rabin, Roni Caryn. "Why the Coronavirus Seems to Hit Men Harder Than Women." *The New York Times*, February 20, 2020, sec. Health. <https://www.nytimes.com/2020/02/20/health/coronavirus-men-women.html>.

Reiches, Meredith, Marion Boulicault, Joseph Bruch, Nicole Noll, Heather Shattuck-Heidorn, Brianna Weir, and Sarah Richardson. "Theory Matters: Sex, Gender, and Alzheimer's Disease." *GenderSci Blog*, October 10, 2018. <https://www.gendersciab.org/blog/theory-matters-sex-gender-and-alzheimers-disease>.

Richardson, Sarah S. *Sex Itself: The Search for Male and Female in the Human Genome*. Chicago; London: The University of Chicago Press, 2013.

Richardson, Sarah S., Meredith W. Reiches, Joe Bruch, Marion Boulicault, Nicole E. Noll, and Heather Shattuck-Heidorn. "Is There a Gender-Equality Paradox in Science, Technology, Engineering,

and Math (STEM)? Commentary on the Study by Stoet and Geary (2018)." *Psychological Science* 31, no. 3 (2020): 338–41. <https://doi.org/10.1177/0956797619872762>.

Rushovich et al. "Sex Disparities in COVID-19 Mortality Vary across US Racial Groups." Unpublished manuscript, typescript.

Ryan, Nessa E., and Alison M. El Ayadi. "A Call for a Gender-Responsive, Intersectional Approach to Address COVID-19." *Global Public Health* 15, no. 9 (2020): 1–9. <https://doi.org/10.1080/17441692.2020.1791214>.

Shattuck-Heidorn, Heather, Meredith W. Reiches, and Sarah S. Richardson. "Opinion | What's Really Behind the Gender Gap in Covid-19 Deaths?" *The New York Times*, June 24, 2020, sec. Opinion. <https://www.nytimes.com/2020/06/24/opinion/sex-differences-covid.html>.

The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team. "Vital Surveillances: The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19) — China, 2020." *China CDC Weekly* 2, no. 8 (2020): 113–22. <https://doi.org/10.46234/ccdcw2020.032>.

Viboud, C., J. Eisenstein, A. H. Reid, T. A. Janczewski, D. M. Morens, and J. K. Taubenberger. "Age- and Sex-Specific Mortality Associated With the 1918–1919 Influenza Pandemic in Kentucky." *Journal of Infectious Disease* 207, no. 5 (2012): 721–29. <https://doi.org/10.1093/infdis/jis745>.

Wadman, Meredith. "Why Coronavirus Hits Men Harder: Sex Hormones Offer Clues." *ScienceMag.org*, June 3, 2020. <https://www.sciencemag.org/news/2020/06/why-coronavirus-hits-men-harder-sex-hormones-offer-clues>.

Yang, Y-M., C-Y Hsu, C-C Lai, et al. "Impact of Comorbidity on Fatality Rate of Patients with Middle East Respiratory Syndrome." *Scientific Reports* 7, no. 1 (2017). <https://doi.org/10.1038/s41598-017-10402-1>.

## How Privilege Structures Pandemic Narratives

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A common early narrative that arose as people struggled to cope with their new lives under COVID-19 centered on a platitude about the pandemic being "the great leveler." But the pretense that we are equally vulnerable—or that we're "alone together" across lines of race, gender, and class—was a comforting lie. Social privilege protected the advantaged from the worst of the pandemic's wrath. What is true is that while the pandemic has been feeding the downward spiral for those who've been suffering all along, it has also made things bad enough that even the privileged can no longer avoid or ignore many problems.

Chronicling the timeline of media talking points seen over the past few months, in this paper I'll argue that social privilege continues to structure the narratives many people use to process life under the pandemic, even while material conditions are much worse for those not in charge of these narratives. At the same time, however, I'll argue that the pandemic might be setting the stage for genuinely new collective responses to social inequalities, including the long-overdue uprisings inspired by the Black Lives Matter movement.

### 1. A COMFORTING LIE

Shortly after the many lockdowns and stay-at-home orders intended to curb the spread of the COVID-19 virus went into effect, we saw a lot of feel-good platitudes about this pandemic being "the great leveler." We're all in the same boat now, the thought went. We were supposed to think of



ourselves as “alone together” across the social lines that might have separated us in more ordinary times. Viacom and the American Ad Council put out a representative PSA in early April, replete with an #AloneTogether hashtag, communicating the importance of social distancing and encouraging us to think of our new routines that subsisted chiefly of staying home and watching TV as pro-social behavior. Memes on social media contrasted the great sacrifices required of people during WWI and WWII with the relatively minor patriotic duty people now had to keep their collective butts on the couch.

The scope and pace of the pandemic’s changes to everyday life shouldn’t be undersold, and folks are hardly to be faulted for grasping at ways to make sense of what was happening to them. But I want us to notice the pretense here that the couch and TV were already paid for, or were somehow going to start paying for themselves. This pretense is representative of a willful ignorance of how privilege softens the blow of the restrictions imposed by COVID-19, and it would continue to pick up steam as time went on. This ignorance was no accident, nor was it isolated to glib memes on social media.

From the beginning, privilege has structured how we’ve been processing the unprecedented things that have been happening to us in this pandemic. In what follows, I’ll argue that if we pay attention to the stories we’ve been telling ourselves about what we’re living through—those reflected in and constructed by the talking points coming down from the media and opinionati; those circulated in conversations and memes on social media—we’ll see that what we care about and why we care about it too often reflect the priorities and viewpoints of those who are insulated from the worst of what the pandemic has wrought.

Many of the problems the pandemic is creating aren’t really all that new.<sup>1</sup> COVID-19 is merely exacerbating social problems that have always been there, making them such that even the socially privileged can no longer avoid them, and of course making them even worse for those who have been suffering their brunt all along. From the beginning, homeless people, low-income people, undocumented immigrants, disabled people, and people of color have been getting severely ill and dying in much greater numbers. Underprivileged people who are lucky enough to escape getting sick from the virus itself are still disproportionately vulnerable to other effects of the pandemic. Marginalized people have borne the brunt of the economic and social impacts of the coronavirus. They shoulder much of the mental health burden as well.

As the pandemic took hold, we kept emphasizing the importance of sheltering in place—but you can’t shelter in place if you don’t have a place. We kept telling people they’d be safe if they stayed home, but home isn’t a safe place to shelter for women and children at risk of domestic violence and for many LGBTQ+ people who are at risk of abuse, or who are not yet out to their families.

Nonwhite, LGBTQ+, and low-income people are more likely to experience worsening mental health and difficulty coping with the upheavals of the past few months. These

same populations are also least likely to have access to mental health care and other support services, particularly now. According to a recent Canadian study, people with preexisting mental health conditions were three times as likely to have had suicidal thoughts as the overall population since the pandemic began.<sup>2</sup> People with disabilities, low incomes, or Indigenous people were more than twice as likely to have had these thoughts. Only 16 percent of people with preexisting mental health conditions reported accessing in-person or online mental health care. Low-income and LGBTQ+ people, and those with disabilities, were also more likely to report worsening mental health—at rates between 43 and 47 percent. These groups were about twice as likely to report having trouble coping, compared with the 14 percent rate in the general population. Indigenous and racialized respondents also reported more trouble coping at 26 and 22 percent, respectively. And 18 percent of people of color reported heightened concerns about physical or emotional abuse in the home, compared to 7 percent of the general population.

The pandemic’s economic effects are also affecting marginalized people disproportionately. Responding to the realization that women account for a disproportionate number of the workers who have lost their jobs due to the coronavirus pandemic, some economists are calling this recession—the worst since the Great Depression—the “Shcession.”<sup>3</sup> Women of color—overrepresented in low-paying service and sales jobs—have been particularly affected.<sup>4</sup>

As the lockdown took hold across the US, wealthy urbanites were escaping to their summer homes, potentially endangering the locals in those small towns whose hospitals weren’t equipped to deal with so many off-season residents. Suburbanites complained about teleworking while trapped in their tiny plastic castles with their stir-crazy kids, but things were of course immeasurably harder for big families crammed into tiny apartments whose children didn’t have a safe backyard to play in. COVID-19 rushed through many of these multigenerational households, many of whose members were deemed “essential workers” and thus ineligible for unemployment benefits, who had to risk their lives at their minimum wage jobs.

The people who were already vulnerable in our society are now even more vulnerable in the pandemic, and people who were privileged are still privileged. The pandemic exposes these inequalities so starkly that it’s hard to look away.

## 2. HOW SOCIAL PRIVILEGE STRUCTURES OUR NARRATIVES

It’s undeniable that the pandemic has been much harder on those who could least afford it. But, as I’ve said, social privilege has been structuring our narratives about the pandemic from the beginning. What follows is merely a sampling of these narratives. This list isn’t meant to be exhaustive, but rather representative of our continued collective failure to give a damn about the lives and experiences of those Rawls’s difference principle would have us put at the center of our deliberations about justice.

## 2.A. HEALTH-CARE RATIONING

The first narrative I want us to look at came in the early days of the pandemic, when there was much fuss about the possible impending need to ration health-care resources. Bioethicists' inboxes were full and phones were ringing off the hook with media requests for a hot take to placate the worries of a public newly concerned about their access to health care. For perhaps the first time for many people of means in this country, money alone wasn't necessarily going to be enough to buy your way to the front of the queue. Poor people, whose access to health care has never been guaranteed, were in a sense no worse off than they already had been. They would, in the end, continue to get the short end of the stick. But the prospect of wealthier people also possibly dying from lack of resources made people freak out—and this freak-out should be instructive. I suspect many wealthier Americans are horrified by crass utilitarian calculations such as the QALY assessment because they've never really had to consider the possibility that they or their loved ones wouldn't be able to throw everything possible at whatever was threatening their lives.<sup>5</sup>

The point here isn't that these questions—questions about whether and how age, or disability, or insurance status, or quality of life should be factored into deciding who gets a ventilator or other limited resource—aren't interesting philosophical questions. The point is that it's instructive that these were the questions at the forefront of so many people's minds, that they were what the media was flocking to bioethicists to have answered. Instead of worrying about how the pandemic was going to amplify existing inequalities, or about what the state's lack of preparedness for this predictable disaster said about the precarious state of our democracy, too many people's primary concern smacked of a need to be reassured that privilege would continue to protect them from what was coming down the pipe.

## 2.B. AGEISM AND ABLEISM IN PANDEMIC MINIMALIZATION

Another early narrative marked by privilege was the not-even-thinly masked ageism and ableism implicit in a common early strategy we heard from people looking to deny or minimize the severity of the pandemic. Proponents of this view insisted that this was a disease affecting only the old and the sick, not something regular healthy people had to worry about. It wasn't worth upending our collective lives, or decimating the economy, if this disease was something that was only going to affect those already at the margins of society, proponents of this narrative kept insisting. That those not lucky enough to be blessed with youth or good health had to (rightly) insist that their lives were no more expendable than anyone else's illustrates the privilege lurking behind this narrative.

Of course, not everyone fell prey to this explicitly ageist and ableist rhetoric. Texas Lieutenant Governor Dan Patrick was rightly roasted by many progressives, for example, for suggesting that "lots of grandparents" would be willing to sacrifice themselves for the good of the economy. But notice that this progressive indignance papered over the reality that when the economy crashes, people—

particularly those who are already struggling to make ends meet—suffer immensely. I don't mean to suggest here that we should be willing to sacrifice *anyone* so that investors can keep lining their pockets. But it's important to recognize that implying that concerns about the tanking economy are somehow limited to how recessions affect the stock portfolios of the 1 percent reveals a privilege of its own: the most vulnerable members of society don't tend to have the assets or savings necessary to weather economic downturns. And so not only did we see privilege informing the ableist narrative that looked to minimize the severity of the pandemic's impact, we also saw privilege lurking behind the progressive criticism of this narrative that accused anyone concerned about the economy of caring only about protecting the wealth of those at the top.

## 2.C. QUARANTINE-SHAMING

Another privileged narrative that came on the scene once precautionary measures such as mask-wearing and social distancing became the new normal was when social media was quickly overrun with people—sometimes colloquially dubbed "Karens"<sup>6</sup>—quarantine-shaming those members of the so-called unwashed masses they deemed insufficiently good at social distancing.

Some of these criticisms were likely on point. I don't mean to suggest we defend the partygoers looking to blow off steam and blithely ignoring basic common sense, nor the politicized insistence on portraying mask-wearing requirements as an infringement on civil liberties. But many of these Karens' attempts to paint the noncompliant as either selfish or stupid ignored or minimized the very real difficulties of social distancing when you don't have an enormous house to hole up in, when you don't have a credit card to buy or a massive pantry to hold big Instacart orders, when you don't have a private backyard for your kids to play in. Others failed to consider the costs of mask-wearing, such as the difficulty it imposes on people who rely on lip-reading because they're deaf or hard-of-hearing, or the dangers to which it can subject Black and brown men who are perceived as threatening when they hide their faces in public. Still others downplayed the devastating effects social isolation can have on mental health, or the increased risks of domestic violence and harms to LGBTQ+ folks that it can be responsible for.

And, of course, all of this virtue-signaling might have made the Karens feel better, more in control of the uncontrollable situation imposed by the pandemic, but behavioral economists agree that posting pictures of people on social media, or even lecturing them to their faces, is unlikely to actually change anyone's behavior. And anti-racist activists point out that this tattling comes with significant risks to groups who are already suffering more than most from the virus and its effects. "When there's a mandate to snitch or to shame, that's going to disproportionately affect black people," says Damon Young, author of *What Doesn't Kill You Makes You Blacker*. "When you call the police on a group of black people, you are threatening their lives."<sup>7</sup>

## 2.D. RESPONSES TO BACKSLIDING ON GENDERED GAINS IN THE DOMESTIC SPHERE

Another set of privileged narratives are found in the many pieces that have called attention to the backsliding on the slight amounts of progress that some women had made in the domestic sphere over the past few generations. As the pandemic progressed, we saw a lot of opinion pieces about how the stay-at-home orders during the pandemic forced women back into domestic roles that they thought they'd managed to shed by working outside the home full time: about how even with two straight parents working at home, it was still the women who were multitasking like no tomorrow, while the men would hop on and off Zoom calls and then veg out on the couch to "decompress." We also saw discussions of a few studies suggesting that men were "doing a bit more than usual around the house" or at least, by being home all day, realizing for the first time just how much domestic and emotional labor their partners had been doing.

Of course, these problems are far from new; feminists have been going on about these issues for literally decades. The sociologist Arlie Hoschild coined the phrase "the second shift" in 1989 to describe what's expected of those women who work outside the home. Studying the time women and men put into their paid jobs, housework, and childcare, she found that women work on average fifteen more hours each week than men; this means that in a year, women work an extra month of twenty-four-hour shifts. Thus, the wage gap between men and women in the workplace is mirrored by a "leisure gap" between them at home.

More than thirty years after Hoschild initially published this research, in married heterosexual couples where both partners work full time women still provide close to 70 percent of childcare during standard working hours.<sup>8</sup> This burden has increased exponentially as schools and other activities shuttered and help from babysitters and housecleaners has been all but eliminated.<sup>9</sup> Before the pandemic hit, bemoaning these asymmetries had become basically a feminist bromide that working women used to bitch about their husbands over drinks with their girlfriends. They've taken on a new urgency now that the pandemic is threatening to undo decades of progress for working mothers.<sup>10</sup> And while these problems aren't new, I don't think it's overly cynical of me to suggest that the reason they've risen to the top of our collective radar screens has less to do with a sincere feminist concern for women's flourishing than with the reality that when the pandemic lockdown hit even the wealthiest men were forced to reckon with how much work it takes to raise a child, how hard it is to do this work well, and how much our society had been exploiting those previously tasked with this work (either mothers or paid caregivers).

A related pre-pandemic narrative had us celebrating the progress we've been making on these fronts. Men of this generation are doing unprecedented amounts of domestic work. While most men of our grandfathers' generation couldn't boil an egg and had never changed a diaper in their lives, we liked to congratulate ourselves about the dads these days who are strapping on their babies for

walks in the park, taking parental leave, and involving themselves in their children's lives like never before. But, please, let's not pretend that men don't expect cookies for dirtying their hands with this stuff. A disproportionate amount of the work involved in raising children still falls to women, no matter their background, class, or professional status. Even in those households with two full-time working parents who agree that tasks should be equally shared, mothers' household management, mental labor, and childcare contributions still outweigh fathers'. Psychologist Darcy Lockman suggests that our egalitarian values don't map onto our lived experiences in part because many progressive men are totally fine with not doing as much as women *as long as they see themselves doing more than other men.*<sup>11</sup> And we all know how low the bar is there.

Much of this boils down to the issue of salience. By the time we reach adulthood, women have internalized a whole passel of norms about the amount of domestic work that's expected of us—the grooming starts early, with baby dolls and toy kitchens, so that by the time we're old enough to take this work on, it doesn't even register as work, but rather just the occasionally annoying but still necessary responsibilities of adulthood (on par with flossing our teeth and paying our taxes). Men, on the other hand, have been made to know that their real job is to earn a living and that all this "women's work" is fundamentally beneath them, so that by the time they're faced with it, any contribution to the household beyond the financial feels heroic. (How many times have you heard a man valiantly boast about "babysitting" his kids? Fathers don't "babysit." They *parent*.)

Years of sociological research using time diaries have consistently shown that men often overestimate the amount of time they spend on household chores, even while women actually *do* more.<sup>12</sup> The pandemic has exacerbated these preexisting holes in our collective consciousness. Homeschooling, the new parental chore brought about by coronavirus lockdowns, was foisted disproportionately onto women. Despite this, nearly *half* of fathers with children under twelve reported spending more time on homeschooling than their spouse, while only 3 percent of women agreed that their spouse was doing more. Similarly, 20 percent of men said they were fully or mostly responsible for housework and childcare during lockdown, while only around 2 percent of women agreed.<sup>13</sup> (In case there's any doubt, time diary research is on women's side here.)

Married philosophers and parents Serene Khader and Matt Lindauer point to another explanation for why men so consistently overestimate their household contributions: a background culture of microcompliments and other socially affirming gestures where men regularly receive praise from strangers for publicly performing basic parental duties—"taking their children places, feeding them, changing their diapers, talking to them, and so on"—that they deem "the Daddy Dividend."<sup>14</sup> Because traditionally gendered distributions of domestic labor dole out very different household and parenting duties to fathers and mothers,

any engagement by fathers in the duties associated with mothering is therefore supererogatory—

beyond the call of fatherly duty. . . . In praising fathers for doing what is simply required of mothers, strangers reinforce the attitude in men that the fatherly duties assigned to them by the traditional gender division of labor are all that should be expected of them." Given all this, "aiming at equality may not be the appropriate framing to guide men's action," they argue. "When you're faced with such a system of social rewards, the better strategy," they say, "is to overcompensate in some domains of household labor. Perhaps egalitarian men should do "more" of the cleaning, diaper-changing, laundry, clothing turnover and organization, and other unappealing tasks in the household. Because the perception that a man is doing "more," when so much in our society is telling him that he has done more than his share already, is likely to just be a reflection that things are a little bit closer to equality.

Feminist economists have long been making clear that the gendered asymmetry of domestic labor has significant consequences outside the home: it's a major reason for women's lower pay and stunted career paths.<sup>15</sup> Now that they're spending even more time on these chores because of the pandemic, the repercussions are likely to worsen. These repercussions could last a lifetime, reducing women's earning potential and work opportunities long after the pandemic subsides.<sup>16</sup>

Again, I don't mean to suggest that these problems surrounding the division of domestic labor are unimportant. But I do think we should admit that a major reason they're only now getting so much attention in the culture at large is that they're now impacting those with the cultural capital to decide what are the issues we're supposed to care about. The pandemic has made it impossible to ignore these gendered asymmetries of domestic labor because it's no longer possible for even the most privileged to outsource enough of this work to make life even slightly manageable. This is no longer a problem you can just throw money at, no matter how deep your pockets, and so it should come as no surprise that it's suddenly become a problem of grave national concern. There's a direct analogue here to the other examples discussed earlier, where, for example, rich people have to reckon with rationing of health-care resources: the pandemic makes it impossible for the privileged to ignore the deep social problems that everyone else has been living with all along.

## **2.E. WHITE RESPONSES TO GEORGE FLOYD'S MURDER**

While a perusal of the many ways privilege has been informing our pandemic narratives might inspire a certain degree of hopelessness or despair, I actually think there's reason for optimism buried in all this. The final privileged narrative I'll look at has to do with responses to the protests that took place across the world in the wake of George Floyd's murder. This long-overdue reckoning with America's sordid history of race relations saw people flocking to the streets in numbers not seen in more than a generation. But too many white people seemed more concerned about the

effects of these mass gatherings on the rates of pandemic spread than about admitting there were serious, legitimate problems motivating these protests.<sup>17</sup> I don't know about you, but my Facebook feed was full of an awful lot of white people tut-tutting, "Who protests during a pandemic??" The answer to this one comes from Audre Lorde: "Sometimes we are blessed with being able to choose the time, and the arena, and the manner of our revolution, but more usually we must do battle where we are standing."

To the great relief of many, it turned out that these protests didn't result in a spike of COVID-19 cases. As anyone who was out in the streets could attest, most protestors actually paid attention to the advice from medical experts. There was almost complete compliance with mask-wearing directives, the gatherings were outdoors, there was extreme conscientiousness from protestors who came prepared with hand sanitizer and masks to distribute to others—all of these precautions contributed to the gatherings' safety.

Here's where I permit myself a degree of cautious optimism. Even while it's true that privilege has protected white people from the ravages of the pandemic far more than members of the Black community, white people finally seem to be waking up to this reality.

In the United States, both the police and the coronavirus endanger Black people disproportionately.<sup>18</sup> Black people don't just suffer higher rates of police brutality, racial profiling, and mass incarceration compared to white people; they also suffer higher rates of medical mistreatment.<sup>19</sup> Even prior to the George Floyd demonstrations, the coronavirus death rate among Black people stood at 50.3 per 100,000—compared to 20.7 for white people, 22.9 for Latinos and 22.7 for Asian Americans. Though Black people comprise just 13 percent of the US population, they account for nearly a quarter of the country's COVID-19 deaths.<sup>20</sup> Americans in lower income brackets are also more likely to catch the virus and die from the disease, indicating that both race and money matter when it comes to the spread of infection and the quality of associated treatments.<sup>21</sup> Racial and economic biases are present in rates of coronavirus testing as well.<sup>22</sup> Even the concern trolls who were initially critical of the protests have been forced to recognize that marches against racism and inequality posed less of a threat to public health than racism and inequality themselves.

Why are white people finally waking up? Surely, the fact that Floyd was killed during the coronavirus lockdown, when there were fewer distractions to national attention and massive pent-up energy to release, must be part of the explanation here. And the ensuing protests were an avenue for people to express their opposition to Trump's increasingly unpopular presidency, whose tanking ratings have been fueled by the economic collapse and the administration's bungled emergency response. This new privileged narrative, one that's beginning to recognize the devastating effects of systemic racism, has unprecedented numbers of white people waking up to a reality that people of color have known all along.

This, then, is why I think there's reason for hope. While privilege continues to structure the stories we tell

ourselves to process the coronavirus's new world order, and while these narratives too often reflect the priorities and viewpoints of those who are insulated from the worst of what the pandemic has wrought, at least one thought might inspire cautious optimism: things might finally have gotten bad enough that they can no longer be ignored.

**NOTES**

1. Sean Valles defends a similar claim. See Sean A. Valles, "The Predictable Inequities of COVID-19 in the US: Fundamental Causes and Broken Institutions," *Kennedy Institute of Ethics Journal* (2020).
2. Moira Wyton, "Pandemic's Mental Health Toll Is Hammering Marginalized People." *The Tyee*, June 25, 2020. <https://thetyee.ca/News/2020/06/25/Pandemic-Mental-Health-Toll-Marginalized-People/>.
3. Amanda Holpuch, "The 'Shcession': Why Economic Crisis Is Affecting Women More Than Men," *The Guardian*, August 4, 2020, <https://www.theguardian.com/business/2020/aug/04/shcession-coronavirus-pandemic-economic-fallout-women>; J. C. Pan, "The Wildly Unequal 'Shcession'," *The New Republic*, August 7, 2020, <https://newrepublic.com/article/158825/recession-coronavirus-women-economic-recovery>; Alisha Haridasani Gupta, "Why Some Women Call This Recession a 'Shcession'," *The New York Times*, May 9, 2020, <https://www.nytimes.com/2020/05/09/us/unemployment-coronavirus-women.html>.
4. Naomi Cahn, "COVID-19's Impact on Women of Color," *Forbes*, May 10, 2020, <https://www.forbes.com/sites/naomicahn/2020/05/10/mothers-day-and-covid-19s-impact-on-women-of-color/>; Jacqueline Rodríguez and Maggie Cordish, "Work-Life Balance for Women, Especially for Women of Color, Is Key to Restarting Economy," *Bipartisan Policy Center Blog*, June 11, 2020, <https://bipartisanpolicy.org/blog/work-life-balance-for-women-especially-for-women-of-color-is-key-to-restarting-economy/>; Marguerite Ward and Tyler Sonnemaker, "All the Visceral Ways Black Women in America Have Been Hurt By the Coronavirus Unemployment Crisis," *Business Insider*, June 1, 2020, <https://www.businessinsider.com/black-women-hurt-by-coronavirus-pandemic-survey-lean-in-data-2020-4>.
5. QALY stands for Quality-Adjusted Life Years, a generic measure of disease burden that assesses both the quality and the quantity of life lived, that is used in economic evaluations to assess the value of medical interventions.
6. Ashitha Nagesh, "What Exactly Is a 'Karen' and Where Did the Meme Come From?" *BBC News*, July 31, 2020, <https://www.bbc.com/news/world-53588201>.
7. Jennifer Weiner, "The Seductive Appeal of Pandemic Shaming," *The New York Times*, April 14, 2020, <https://www.nytimes.com/2020/04/14/opinion/coronavirus-shaming.html>.
8. Kim Parker and Wendy Wang, "Chapter 5: Americans' Time at Paid Work, Housework, Child Care, 1965–2011," in *Modern Parenthood: Roles of Moms and Dads Converge as They Balance Work and Family*, Pew Research Center, March 14, 2013, <https://www.pewsocialtrends.org/2013/03/14/chapter-5-americans-time-at-paid-work-housework-child-care-1965-to-2011/>; Francesca Donner, "The Household Work Men and Women Do, and Why," *The New York Times*, February 12, 2020, <https://www.nytimes.com/2020/02/12/us/the-household-work-men-and-women-do-and-why.html>.
9. Titan Alon, Matthias Doepke, Jane Olmstead-Rumsey, and Michèle Tertilt, "The Impact of Covid-19 on Gender Equality," *Covid Economics 4* (April 2020): 62–85, [https://faculty.wcas.northwestern.edu/~mdo738/research/Alon\\_Doepke\\_Olmstead-Rumsey\\_Tertilt\\_COVID\\_2020.pdf](https://faculty.wcas.northwestern.edu/~mdo738/research/Alon_Doepke_Olmstead-Rumsey_Tertilt_COVID_2020.pdf).
10. Perlita Stroh, "Pandemic Threatens to Wipe Out Decades of Progress for Working Mothers," *CBC News*, August 17, 2020, <https://www.cbc.ca/news/business/women-employment-covid-economy-1.5685463>.
11. Darcy Lockman, *All The Rage: Mothers, Fathers, and the Myth of Equal Partnership* (New York: Harper, 2019).
12. Jill E. Yavorsky, Claire M. Kamp Dush, and Sarah J. Schoppe-Sullivan, "The Production of Inequality: The Gender Division of

Labor Across the Transition to Parenthood," *Journal of Marriage and Family* 77, no. 3 (June 15): 66279, <https://onlinelibrary.wiley.com/doi/abs/10.1111/jomf.12189>.

13. Claire Cain Miller, "Nearly Half of Men Say They Do Most of the Home Schooling. 3 Percent of Women Agree," *The New York Times*, May 8, 2020, <https://www.nytimes.com/2020/05/06/upshot/pandemic-chores-homeschooling-gender.html>.
14. Serene Khader and Matthew Lindauer, "The 'Daddy Dividend': The Gender Division of Labor and Regression Towards Patriarchy," *The American Philosophical Association Newsletter on Feminism and Philosophy* 19, no. 2 (Spring 2020): 6–8, <https://cdn.ymaws.com/www.apaonline.org/resource/collection/D03EBDAB-82D7-4B28-B897-C050FDC1ACB4/FeminismV19n2.pdf>.
15. Claudia Goldin, Sari Pekkala Kerr, Claudia Olivetti, and Erling Barth, "The Expanding Gender Earnings Gap: Evidence from the LEHD-2000 Census," *American Economic Review* 107, no. 5 (May 2017): 110–13, <https://www.aeaweb.org/articles?id=10.1257/aer.p20171065>.
16. Patricia Cohen and Tiffany Hsu, "Pandemic Could Scar a Generation of Working Mothers," *The New York Times*, June 3, 2020, <https://www.nytimes.com/2020/06/03/business/economy/coronavirus-working-women.html>.
17. There was also the myopic insistence that the real story was the "looting" and "rioting," instead of the actual injustices being protested, but that's a criticism for another day.
18. Ed Pilkington, "Black Americans Dying of Covid-19 at Three Times the Rate of White People," *The Guardian*, May 20, 2020, <https://www.theguardian.com/world/2020/may/20/black-americans-death-rate-covid-19-coronavirus>.
19. Radley Balko, "There's Overwhelming Evidence That the Criminal Justice System Is Racist. Here's the Proof," *The Washington Post*, June 10, 2020, <https://www.washingtonpost.com/graphics/2020/opinions/systemic-racism-police-evidence-criminal-justice-system/>.
20. "Weekly Updates by Select Demography and Geographic Characteristics," National Center for Health Statistics, [https://www.cdc.gov/nchs/nvss/vsrr/covid\\_weekly/index.htm#Race\\_Hispanic](https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#Race_Hispanic).
21. Max Fisher and Emma Bubola, "As Coronavirus Deepens Inequality, Inequality Worsens Its Spread," *The New York Times*, March 15, 2020, <https://www.nytimes.com/2020/03/15/world/europe/coronavirus-inequality.html>.
22. "COVID-19 and Minority Health Access," *Infectious Disease Insights*, March 2020, <https://rubixls.com/wp-content/uploads/2020/04/COVID-19-Minority-Health-Access-7-1.pdf>.

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## Thoughts on the Loss of Ethical Goods: Perplexity and the Pandemic

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Public discussions on the ethics of our response to the pandemic often focus on lives. For instance, we discuss the way the virus has ripped through care homes, jails, and immigrant communities, causing a devastating loss of lives. Or, conversely, some argue that deaths aren't such a big deal, or in any case, not big enough to warrant lockdowns (for example, the Texas Lt. Gov. Dan Patrick said COVID-19 social distancing restrictions should be eased because "there are more important things than living").

What often gets forgotten in these discussions is the broader question of *ethical goods* and how they are affected by the pandemic. With ethical goods, I mean things that contribute

to a flourishing life, such as friendship, connection, a good relationship with family, and romantic attachments. Such goods are, as Jennifer Morton pointed out, both particular and not easily replaceable.<sup>1</sup>

Undeniably, my life is impoverished as a result of the pandemic. Soon I will need to decide about my kids' return to school. Even if it is safe enough for them to go back, social distancing measures will still impoverish their lives significantly. As an immigrant living in the US who just managed to make some tentative connections with local people, I am unable to mingle with them anymore. With many flights across the Atlantic canceled and travel from the US to the EU restricted, it is a big question mark when I will get to see my parents and sister in person again.

More broadly speaking, we are losing so many ethical goods: friendship, connection, physical touch. Grandparents are unable to hug their grandkids. There are canceled theater performances, music, and sports events. Family gatherings are unsafe, and religious services have become COVID-19 hotspots. A hair salon near where I live specializes in braiding, and the job takes many hours of close contact between the stylist and her client. As I often walk past the now usually empty window, I think the salon might not survive the pandemic, along with many other small businesses. This loss is not just economic, though economic considerations are important. The loss we are experiencing collectively is the loss of things that make our lives meaningful and happy.

When I open my Google calendar and see the upcoming canceled talk or colloquium on my calendar—the calendar full up until March, then suddenly blank and quiet except for some holidays I do not celebrate—I get a sense of collective missing out. This feeling of missing out has an ethical dimension. The loss of ethical goods, i.e., of things that make our life worthwhile, requires more serious consideration in discussions on the ethics of the pandemic and social distancing. One might be tempted to dismiss beachgoers and family gatherers as people who give in to their selfish, hedonistic desires. But we are not only losing out on the fulfillment of hedonistic desires. Just watch any pre-pandemic show or read any pre-pandemic book, and it's easy to see how an ordinary human flourishing life involves doing things that are now greatly hampered or unsafe due to the pandemic.

To focus the conversation on the broader topic of ethical goods, and how to balance them, I draw on American pragmatism, a philosophical tradition eminently suited to adjusting our ethical lives in challenging and shifting circumstances. Pragmatists have long recognized that morality is inherently social;<sup>2</sup> hence adjusting habits in the face of the pandemic presents a formidable task.

In everyday life, we unthinkingly go through a series of ingrained routines. However, there are situations where our everyday routines break down, where, as John Dewey put it, "there is something the matter";<sup>3</sup> this is a situation where "there is something lacking, wanting, in the existing situation as it stands, an absence which produces conflict in the elements that do exist." When things run smoothly,

we are not motivated to rethink our routines. When our habits are interrupted, we get a felt sense, an emotion that forces us to stop in our tracks, to pay heed to the situation and to seek out ways to resolve it.

Jane Addams, a social reformer and pragmatist philosopher, argued in her *Democracy and Social Ethics* that a lot of what we term "morality" has become automatic and reflexive. Morality is part of the habits that govern our daily lives: "Certain forms of personal righteousness have become to a majority of the community almost automatic. It is as easy for most of us to keep from stealing our dinners as it is to digest them, and there is quite as much voluntary morality involved in one process as in the other."<sup>4</sup>

While within our own private sphere, we feel like we are morally decent people, doing well by our friends and family, and not doing obviously wrong things such as stealing, but given the broader injustices in the societies in which we live, it's clear that such ethical habits are not sufficient. Moreover, being unreflective about our ethical practices means we can get stuck with ethical ideas and routines that may no longer be fit for purpose. As Addams argued, "Each generation, and the problems it faces, poses a new test to judge its own moral achievements."<sup>5</sup>

This is true today. We are faced with a variety of situations that our old, ingrained ethical responses do not live up to, and seem to have little to say about. Examples include climate change, the Black Lives Matter movement and other movements to set right racial injustices, and now the pandemic. Practices that seemed unproblematic before and that were ingrained in our ethical habits, such as flying, attending family gatherings, and going to the gym, are now suddenly imbued with a moral weight they did not have before. For example, is it acceptable to shield oneself and one's family at home, while outsourcing the risk of infection to Instacart shoppers? Is it morally acceptable, or problematic, to form homeschooling "pods" with one's own children and a few select others if the public school system cannot deal with pandemic risk mitigation, particularly as this exacerbates already-existing social, economic, and educational inequalities? How do we deal with the vexing intersections of class, ethnicity, and gender in many of these debates, recognizing that many frontline workers are not able to shield themselves, and consequently, their children and families, the way middle-class professionals can?

In the US, the absence of a coordinated and coherent response at the local, state, and federal levels has left people to their own devices. Ethical decisions are reduced to risk management. Articles galore advise us on the relative risk level of engaging in different everyday activities. This advice is of course valuable, allowing one to conclude, for instance, that playing tennis outdoors would be taking an acceptable risk, whereas sparring indoors would not. The problem is, you cannot DIY an individual response to a public health situation. For example, an individual cannot change her work environment in response to reports of aerosol transmission in poorly ventilated areas if her employer insists she should come back to the office or teach face-to-face. We need more collective risk assessments and collective responsibility to get us through this.

The pandemic thus presents us not only with an ethical crisis, but a *crisis of ethics*: it prompts us to rethink what ethical life requires of us, individually and collectively, rather than relying on old habits. Some of this crisis is grounded in the fact that we have to confront the moral weight of activities we previously thought of as morally neutral or good. Additionally, COVID-19 has thrown into sharp relief that some of our ethical habits are unjust and suboptimal.

In some situations, adequately responding to the public health crisis of COVID-19 conflicts with our ingrained ethical habits that seemed just fine pre-pandemic. Take the example of gatherings of friends and family. When a close-knit Texan family hosted a birthday party where all eighteen people attending the party became infected with COVID-19, there was widespread outrage at their lack of prudence. A recognition of the ethical goods lost with social distancing at a societal level might be helpful in these discussions: in this case, families such as these are faced with the dilemma of adhering to social distancing versus fulfilling social goods that constitute human lives, such as celebration and personal relationships. It may help us to understand why some people (especially those who perceive themselves to be at low risk of severe illness or death) throw caution to the wind. Such understanding is needed if we are to implement sustainable interventions.

For example, opening bars before one opens schools seems ill-advised given the relative loss of ethical goods in each. Schools provide education, opportunity, safety from problematic home situations, nutrition, and some form of equity, as well as a locus for social and emotional development for children. Given the severe loss of ethical goods with the closure of schools and the risks of spread with bars, it makes sense to open schools safely before we can countenance opening bars. Not being able to go to a café might be regrettable, but it does not present us with the same loss of irreplaceable ethical goods as school closures does. In other situations, the pandemic exacerbated habits and institutions that were already ethically problematic. The lack of paid sick leave and universal health care in the US was suboptimal in pre-pandemic times; now it is shaping up to be part of a collective disaster, and it is time to address these structural problems.

In our present situation, we are in what Addams termed a collective state of *perplexity*, “a mental attitude of maladjustment, and in a sense of divergence between [our] consciences and [our] conduct.”<sup>6</sup> Perplexity does not provide us with easy solutions or answers. It is an uncomfortable state to be in. Yet this state of maladjustment, of being removed from ordinary routines and unreflective ethical attitudes, is philosophically valuable. When we are in a state of perplexity, unsure about the contours of our everyday ethical sensibility, we are faced with two choices: try to go on as we were before, or allow the perplexity to help us radically question our ingrained ethical habits. For instance, it may help us understand what the value is of in-person gathering, or how to weigh certain goods against each other. In addition, this perplexity reveals many ethical failures in our societies, in economic inequality between different workers, incarceration rates, eldercare, childcare,

and clearly shows us that we need really deep change—and such change is always, at heart, philosophical change.

There is a danger that in all the confusion and immense challenge that this virus poses, we might focus only on containing the coronavirus without addressing all the issues it has laid bare. As Addams put it, when we are in a transformative situation, “the community may be unable to see anything but the unlovely struggle itself.”<sup>7</sup> However, if we allow perplexity to be transformative, we can examine which ethical habits and institutions hold up in the light of the pandemic, and which require change. Recognizing the loss of ethical goods in, for example, friend gatherings or schools, would help to steer us to ways to protect those goods, to implement policies that make them possible, and allow them to flourish even better post-pandemic. It allows us to shift away from the dichotomy of lives versus the economy, but rather, about what we value as good features in our society, and how we can form habits that are conducive to them.

The future of philosophical thinking in light of the virus is not fixed or predestined; together we can shape it, and—given how societal ideas are always philosophical—also help to shape post-COVID-19 future ethical habits and institutions.

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#### NOTES

1. Morton, “Moving Up Without Losing Your Way.”
2. E.g., Dewey, *Human Nature and Conduct*; Addams, *Democracy and Social Ethics*.
3. Dewey, “Theory of Valuation,” 33.
4. Addams, *Democracy and Social Ethics*, 1
5. *Ibid.*, 2.
6. *Ibid.*, 4.
7. *Ibid.*, 172.

#### REFERENCES

- Addams, J. *Democracy and Social Ethics*. London: MacMillan, 1902.
- Dewey, J. *Human Nature and Conduct: An Introduction to Social Psychology*. New York: Henry Holt and Company, 1922.
- Dewey, J. “Theory of Valuation.” In *International Encyclopedia of Unified Science. Foundations of the Unity of Science* (Vols. 1/2, pp. 1-66), edited by O. Neurath. Chicago, IL: University of Chicago Press, 1939.
- Morton, J. “Moving Up Without Losing Your Way.” Princeton, NJ: Princeton University Press, 2019.

## *A Crisis Ignored: Domestic Violence and the COVID-19 Pandemic*

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This article was both excruciating to write and an exercise in immense gratitude. In the months prior to, and right at the beginning of, the COVID-19 pandemic, I was in an abusive relationship with a domestic partner. One month after I safely ended the relationship, my university closed campus and moved all classes online. I stood in the middle of my apartment the day of the announcement, numb with fear and relief. I had survived the worst periods of abuse by maximizing the amount of time I spent on campus, and minimizing the amount of time I was at home. For weeks I would leave for campus first thing in the morning, and I would catch the last train home at the end of the day. Campus provided me with a safe space to escape the abuse I experienced at home, and to securely work out the details of my escape plan. If my relationship had continued even one month longer, escaping to campus no longer would have been an option for me, and I would have been sequestered with my abuser all day, every day. I don't even want to imagine the harm that would have caused.

I was privileged enough to escape from an abusive situation before the COVID-19 pandemic could make it worse. Not all survivors share this privilege; many survivors are now seeing a substantial worsening in abuse because of the pandemic. This article engages with the harms and needs of survivors who are simultaneously experiencing an abusive relationship and a pandemic. Section I outlines the ways in which the pandemic has exacerbated situations of domestic violence. Section II explores the harms caused by the failure of the United States government to address COVID-related domestic violence.<sup>1</sup> Section III offers policy recommendations for how the US government can immediately rectify its failure to address COVID-related acts of domestic violence. I offer these recommendations with the full acknowledgment that they are incomplete and will not by themselves be enough to fully address the problem of COVID-related domestic violence. I do, however, hope that they will contribute to the project of ending domestic violence and of finding a way forward through the COVID-19 pandemic for survivors and people who are currently suffering and/or being harmed. I close the article by reflecting on effectively responding to domestic violence beyond the pandemic.

### **I. INCREASES IN DOMESTIC VIOLENCE**

As governments around the world enact lockdowns and other social distancing measures in order to minimize the spread of the COVID-19 virus, there has been a corresponding worldwide increase in cases of domestic violence. In China, the domestic violence cases reported to the police tripled after the country went into lockdown.<sup>2</sup> In Spain, emergency calls related to domestic violence increased 18 percent during the first two weeks of lockdown. In France, police have reported a 30 percent nationwide increase in domestic violence. In the UK,

domestic violence incidents have increased 20 percent.<sup>3</sup> In Brazil, the number of survivors seeking resources at domestic violence shelters has more than doubled.<sup>4</sup> In both Lebanon and Malaysia, calls to domestic violence hotlines have doubled.<sup>5</sup> In the United States, YWCA shelters are operating at capacity nationwide.<sup>6</sup>

The COVID-19 pandemic, and the social distancing measures taken to combat the pandemic, have exacerbated a number of factors that create situations conducive to domestic violence. The Centers for Disease Control and Prevention (CDC) identify social isolation, unemployment, economic stress, and lack of access to adequate health care as among the factors that are most likely to contribute to acts of domestic violence.<sup>7</sup> These factors have all been central consequences of the pandemic. The pandemic has led to historic job losses and unemployment claims in the US.<sup>8</sup> Millions of people have also lost health insurance as a consequence of loss of employment.<sup>9</sup> And the US health-care system itself is now under incredible strain as it copes with the increasing demand caused by the pandemic. As social, economic, and health-related stressors continue to rise, acts of domestic violence are rising as well. At the same time, social distancing measures have restricted the opportunities of survivors to escape from acts of abuse. Many survivors use their time at work or school, their time out in the community, and visits to family and friends as breaks from dealing with abusive situations at home. Now that many places of employment and education are either closed or operating remotely, and community gathering places are shut down or restricted, domestic violence survivors are unable to use those options as a respite from abuse. Survivors report being reluctant to turn to their family and friends for support, out of concern for exposing them to the virus. Survivors also report that their abusers are using the specific circumstances of the pandemic to terrorize and control them. In the words of one survivor, "My husband won't let me leave the house. He's had flu-like symptoms and blames keeping me here on not wanting to infect others or bringing something like COVID-19 home. But I feel like it's just an attempt to isolate me."<sup>10</sup>

A related matter is that the pandemic has also created a unique set of stressors for LGBTQ2S people in particular, and most especially LGBTQ2S students who have been forced to return home from college campuses. Many LGBTQ2S students feel safer on college campuses than they do in their home environments, and are able to express themselves in ways that are inaccessible to them at home. LGBTQ2S students returning home to unsupportive environments may now have to choose between either outing themselves or having to live with chronic misgendering and/or misassumptions about their gender or sexual orientation. LGBTQ2S students are more likely to experience "depression, anxiety, and suicidal thoughts," which may be intensified because of the stress of the pandemic.<sup>11</sup> LGBTQ2S crisis centers have reported that the number of young people reaching out for help has "more than doubled since the pandemic began."<sup>12</sup> The experience of chronic misgendering and other aspects of living in an unsupportive family environment are often not included in definitions of domestic violence that focus on stereotypical acts of abuse such as physical and sexual



violence. I have chosen to include chronic misgendering and other aggressive acts LGBTQ2S students experience in my analysis of domestic violence in recognition of how such acts function as part of a system of gender violence that oppresses gender and sexual minorities. As Rebecca Solnit has correctly pointed out, the differences in various manifestations of gender-based harassment and abuse is one of degree and not of kind.<sup>13</sup> Excluding accounts of emotional abuse like misgendering from analyses of domestic violence overlooks the role such acts play in domestic violence, and the harm they cause to survivors. I will elaborate more on how LGBTQ2S people are uniquely impacted by domestic violence, both in general and in regard to the pandemic, in greater detail in the next section.

In response to COVID-related increases in domestic violence, the United Nations has asked governments to directly address the problems of domestic violence. On April 5, UN Secretary-General António Guterres “urge[d] all governments to put women’s safety first as they respond to the pandemic.”<sup>14</sup> The US has failed to do so. Instead, the US government has remained entirely silent on the problem of COVID-related cases of domestic violence.

## II. THE HARM OF INACTION

The official US response to the COVID-19 pandemic is largely encapsulated in the March 27, 2020, \$2 trillion stimulus bill designed to counteract the negative economic impacts of the pandemic. The bill is the largest emergency aid package in US history.<sup>15</sup> The bill includes no funding for domestic violence organizations or resources. The US federal government has also made no attempts to address COVID-related increases in domestic violence outside of the stimulus bill. The US government’s failure to address COVID-related domestic violence is problematic for two reasons.

First, failing to address COVID-related domestic violence increases the likelihood that the negative impacts of COVID-related domestic violence will be worse. Domestic violence has serious psychological, physical, reproductive, and economic consequences for survivors. Psychologically, survivors of domestic violence are more likely to experience depression, anxiety, PTSD, suicidal ideation, self-harm, and sleep disorders.<sup>16</sup> Domestic violence survivors are also more likely to experience a range of physical health complications, including acute injuries, chronic pain, gastrointestinal problems, cardiovascular problems, muscular skeletal problems, respiratory problems, fatigue, diabetes, anemia, STIs (including HIV), and cervical cancer.<sup>17</sup> In a 2018 study by the Institute for Women’s Policy Research, four in ten domestic violence survivors reported that “their partner tried to get them pregnant against their will or stopped them from using birth control.”<sup>18</sup> Domestic violence survivors are more likely to experience pressure or conflict from their partner when deciding whether or not to seek an abortion,<sup>19</sup> and they are more likely to die by suicide or homicide while pregnant.<sup>20</sup> In terms of economic harms, the CDC estimates that the lifetime economic cost caused by medical services, criminal legal services, and lost time from work because of domestic violence is \$103,767 for women survivors and \$23,414 for men survivors.<sup>21</sup>

The Institute for Women’s Policy Research reports that 66 percent of domestic violence survivors experienced their abusive partner disrupting “their ability to complete education or training,” and 83 percent “reported that their abusive partner disrupted their ability to work.”<sup>22</sup> The most serious harm caused by domestic violence is death. The CDC reports that 16 percent of homicide victims are killed by intimate partners.<sup>23</sup>

Domestic violence organizations seek to alleviate these negative impacts by providing survivors with resources to safely escape from abusive relationships, and to heal the harms caused by domestic violence. The resources domestic violence organizations provide usually include emergency housing, assistance with finding longer-term housing, counseling, legal advice, childcare, employment assistance, and translation services. These services provide crucial support for domestic violence survivors, especially survivors who do not have the means to access them independently of domestic violence organizations. Before the COVID-19 pandemic, domestic violence organizations already lacked the resources to adequately meet the needs of all survivors. After the 2008 recession, many domestic violence organizations experienced an increase in the number of survivors seeking help, and a decrease in funding. Seventy-nine percent of organizations experienced decreased governmental funding, 64 percent had fewer contributions from private donors, 57 percent experienced a decrease in funding from nongovernmental foundations, and 49 percent experienced a reduction in corporate funding. Almost 50 percent of domestic violence organizations had to decrease the services they provided.<sup>24</sup> Both the increase in need for services and the decrease in funding continued for years after the economy began to recover.<sup>25</sup> To date, domestic violence organizations continue to be underfunded and struggle to meet the needs of all survivors.<sup>26</sup>

The COVID-19 pandemic has intensified the strain on organizations that have already had to deal with substantial cutbacks and inadequate funding. Domestic violence organizations are currently facing two major problems because of the pandemic. The first problem is an increase in demand for services. The pandemic has not only increased the number of people experiencing domestic violence, it has also seriously decreased the availability of resources survivors need in order to leave abusive situations. As Ellen Friedrichs argues, “This pandemic has exposed gaps in our social safety net, such as substandard wages, minimal paid time off, health care tied to employment, and a lack of affordable housing and childcare, all of which impose barriers to leaving an abusive household under the best of circumstances.”<sup>27</sup> As many people’s social and economic resources and access to health care dwindle, an increasing number of survivors will need to rely on domestic violence services to provide them with the resources they need to successfully leave abusive situations. Domestic violence organizations both in the US and globally have been overwhelmed by the increase in demand caused by the pandemic, and do not have adequate resources to meet the needs of all survivors who are seeking help.<sup>28</sup> Domestic violence services will likely continue to decrease, especially if the pandemic causes an economic recession

that leads to a decrease in governmental funding and private donations—as the 2008 recession did.<sup>29</sup>

The second major problem domestic violence organizations are facing because of the pandemic is that many key domestic violence resources are designed to meet survivor needs during nonpandemic circumstances and may be inadequate or even dangerous during a pandemic. For example, most domestic violence shelters are dormitory-style shared living environments that necessitate a high degree of social interaction and physical proximity between survivors. Social interaction and physical proximity are conducive to the spread of COVID-19, and shared living environments put survivors—and their dependents—at risk of catching the disease.<sup>30</sup> The primary method domestic violence organizations use for connecting with and supporting survivors is now also unsafe for many survivors to use. The phone is often the first point of contact between domestic violence organizations and survivors. Domestic violence services are most easily accessible to survivors through domestic violence hotlines. Most domestic violence organizations require survivors to contact them directly through the phone in order to access survivor support services. Domestic violence websites act as gateways that provide survivors with basic information about their rights, as well as the phone numbers of organizations that can provide them with individualized resources. Survivors who report their abuse to the police or to health-care professionals are also encouraged to call domestic violence hotlines to access survivor support resources. After the initial point of contact, many survivors receive ongoing support, such as counseling or legal advice, through the phone. The danger to survivors tends to increase if their abuser knows they are actively seeking help, so in order to keep themselves safe, survivors often utilize phone services only when they are certain their abuser is not close enough to hear them, which often requires either the survivor or the abuser to be out of the home. Under social distancing guidelines, survivors may not have easy access to safe spaces outside of the home, and they are likely to be trapped at home with their abusers for sustained periods of time. Many survivors will thus be unable to safely access phone resources because they will be unable to physically distance themselves enough from their abuser to do so.<sup>31</sup>

The COVID-19 pandemic has required that domestic violence organizations both increase the quantity of the services they provided before the pandemic, and adapt the type of services provided to meet the unique set of circumstances generated by the pandemic. Domestic violence organizations currently do not have enough resources to maintain the baseline of services they were already providing before the pandemic, let alone implement new services that would more effectively meet the needs of survivors during the pandemic. Since the US government has failed to provide emergency funding for domestic violence organizations, they will be unable to meet the needs of many survivors. The lack of emergency funding means that fewer survivors will be able to successfully leave their abusive circumstances, and more survivors will experience the negative psychological, physical, reproductive, and economic consequences of domestic violence.

Particularly concerning is the fact that the survivors most likely to experience the negative consequences of domestic violence belong to populations that are also the most likely to experience the negative consequences of the pandemic. Research shows that there is a strong connection between structural oppression and individual acts of domestic violence. People who experience structural oppression—such as women from lower socioeconomic statuses, Black women, and LGBTQ2S people—are more likely to be negatively impacted by domestic violence. According to the National Intimate Partner and Sexual Violence Survey, women with combined household incomes of \$25,000 or less are almost twice as likely to experience domestic violence than women with combined household incomes of \$25,000–\$50,000, and they are more than three times as likely to experience domestic violence than women with combined household incomes above \$50,000.<sup>32</sup> Survivors from lower socioeconomic statuses are also less likely to have access to the resources needed to leave abusive situations and to recover from the harms caused by abuse. For example, survivors from lower socioeconomic statuses may not be able to afford therapy or legal representation, they may experience reduced access to affordable health care and housing, and they are more likely to be unable to rely on family members or friends for financial support. The lack of access to resources makes it more likely that survivors from lower socioeconomic statuses will stay in abusive environments for longer periods and that the abuse will have a greater impact on their lives.

Black women are disproportionately impacted both quantitatively and qualitatively by domestic violence. Black women are more likely to be killed by an intimate partner than women of any other race or ethnicity. They are twice as likely to be killed by a spouse than are white women.<sup>33</sup> They are four times as likely as white women to be killed by a romantic partner they are not married to. And for Black women between the ages of fifteen and twenty-five, “homicide by an intimate partner is the second leading cause of death.”<sup>34</sup> Black women living in low-income areas and relying on government assistance “are particularly vulnerable to both physical and emotional abuse.”<sup>35</sup> The intersecting oppressions of race and gender also make the impact of domestic violence different for Black women. Beth Richie argues that the systemic oppression of Black women increases both the kinds of abuse and the severity of effects of abuse Black women survivors experience. Black women survivors who disclose acts of domestic violence are often denied the same access to resources that white women have. White/mainstream domestic violence organizations and discussions about domestic violence often frame survivorship in ways that do not fit with the experiences of many Black women. Black women who do not align with white conceptions of “good” survivorship may be alienated or excluded from the services and resources they need to safely leave abusive situations.<sup>36</sup> Black women are also more likely to experience violence from systems that are supposed to protect them from abuse. Black survivors are more likely to be abused by law enforcement officers, and to be incarcerated or lose custody of their children after reporting acts of domestic violence.<sup>37</sup> Reporting acts of domestic violence or accessing domestic violence resources can thus increase Black women’s risk of experiencing violence.

LGBTQ2S people are also disproportionately negatively affected by domestic violence. LGBTQ2S people experience domestic violence at roughly the same rate as cis/hetero people, with three notable exceptions: bisexual people and trans people are significantly more likely to experience domestic violence, and trans people of color in particular experience the highest rates of domestic violence.<sup>38</sup> However, even for LGBTQ2S groups who experience domestic violence at the same quantitative level, qualitatively their experience of domestic violence is very different from cis/hetero people's experiences. LGBTQ2S people's experiences of domestic violence are strongly impacted by the long history of discrimination and violence against their communities: "Transphobia, biphobia, and homophobia, as well as the intersections of race, poverty, or ability status, exacerbated LGBTQ survivors' experience of IPV [intimate partner violence]."<sup>39</sup> The presence of intersecting oppressions can affect both the kind of domestic violence LGBTQ2S people experience as well as the resources available to them for dealing with experiences of domestic violence. For example, LGBTQ2S people report experiencing forms of domestic violence that relate specifically to their gender or orientation. LGBTQ2S survivors have reported that their abusers outed, or threatened to out them, as a means of controlling or punishing them.<sup>40</sup> Survivors also report incidents where their abusers would psychologically or sexually abuse them by accusing them of not being authentic enough to their sexual orientation or gender identity, and pressuring them to perform sex acts they are uncomfortable with in order to prove their authenticity.<sup>41</sup> LGBTQ2S survivors are also less likely to report acts of domestic violence and less likely to receive adequate help when they do so.<sup>42</sup> The failure of mainstream cis/hetero communities and organizations—including the US government and governmental organizations—to adequately respond to transphobic, homophobic, and biphobic violence and discrimination makes it more likely that LGBTQ2S survivors will remain silent about the acts of domestic violence they experience. Negative judgments about their orientation or identity from family, friends, and law enforcement officials can discourage LGBTQ2S survivors from reaching out for help.<sup>43</sup> This silence is likely to increase in the midst of the COVID-19 pandemic, as the options for seeking help become increasingly more constrained.

In addition to being more severely impacted by domestic violence, people from lower socioeconomic statuses, people of color, and LGBTQ2S people are also the populations most likely to be negatively affected by the COVID-19 pandemic. People from lower socioeconomic statuses, people of color, and LGBTQ2S people are all less likely to have access to adequate health care.<sup>44</sup> People from lower socioeconomic statuses—who are disproportionately made up of people of color and LGBTQ2S people—are "more likely to be exposed to the virus, have higher mortality rates, and suffer economically."<sup>45</sup> They are more likely to work "essential" or frontline jobs that cannot be done remotely, significantly increasing their exposure to the virus. They are more likely to suffer economically and to experience unemployment because of the pandemic, and they are less likely to have savings that can sustain them through periods of unemployment.<sup>46</sup> Thus far, the highest death rates in the US

have been reported in communities of color. In New York City, African Americans and Latinx people are dying at twice the rate of white people. In Chicago, African Americans are dying at three times the rate of white people. In New Mexico, Native Americans make up 11 percent of the population, but account for over half of all confirmed cases.<sup>47</sup>

The increased strain of the COVID-19 pandemic means that the populations that are already the most vulnerable to domestic violence will now be even more likely to experience it and be negatively impacted by it, and less likely to access the resources they need to recover. The US government's failure to provide emergency funding to domestic violence organizations thus directly endangers the well-being of the populations that are most vulnerable both to domestic violence and to the virus. The US government has essentially failed to protect the people who face the greatest danger during the pandemic.

The second harm caused by the US government's failure to address COVID-related domestic violence is that this failure communicates a lack of care about issues of domestic violence and about the populations most impacted by domestic violence. Statutes are one of the primary ways that governments communicate what they value and care about. Joel Feinberg argues that criminal statutes, and, more specifically, the punishment included in criminal statutes, "expresses the community's strong disapproval of what the criminal did."<sup>48</sup> Feinberg's argument specifically addresses criminal law, not economic-oriented statutes such as the COVID-19 stimulus bill, but the sentiment remains the same: the content of government statutes is a strong indication of what the government supports, and what it disapproves of. By investing in businesses that are facing economic hardship because of the pandemic, the US government has communicated that it supports and values the economy and the role businesses play in the economy. By contrast, remaining silent about COVID-related domestic violence communicates the message that the government is not concerned with addressing COVID-related domestic violence.

In addition to conveying a lack of national importance or concern, the US government's silence about COVID-related domestic violence may make it harder for domestic violence survivors to be identified and treated as survivors. Rebecca Wanzo argues that public acknowledgments of suffering "is key if people want to mobilize sympathy."<sup>49</sup> Public acknowledgments of suffering make it more likely that survivors will be acknowledged as victims of a legitimate harm and will be treated as such. By contrast, erasures of suffering make it more difficult for the public, service providers, and even survivors themselves both to identify their abuse and to identify their need and their right to access domestic violence support services. Neglecting to acknowledge the harms survivors experience as legitimate and worthy of support increases the likelihood that both the general public and survivors themselves will minimize or dismiss the seriousness of the abuse, and that the abuse will continue unabated. This erasure of suffering is especially problematic for survivors from marginalized identities. Survivors from marginalized identities are not only more likely to experience domestic violence and

less likely to have access to the resources needed to recover from domestic violence, they are also less likely to be considered legitimate victims. White institutions have largely failed to acknowledge or address gender violence against Black women. White discourses instead overwhelmingly default to negative stereotypes that portray Black women as overly domineering and hypersexual, and therefore incapable of experiencing gender violence.<sup>50</sup> And mainstream discourses that address domestic violence in an exclusively cis/hetero framework automatically render the perspectives and experiences of LGBTQ2S survivors of domestic violence entirely invisible, effectively erasing their victimization. Officially acknowledging and addressing COVID-related domestic violence would make it more likely that survivors will be treated as legitimate and will be able to access the resources they need. Both the increased legitimacy and access to resources are especially important for survivors who are the most vulnerable to both domestic violence and the COVID-19 virus itself.

### III. A CALL TO RESPOND

In order to rectify its failure to address COVID-related domestic violence, I recommend that the US government include support to domestic violence organizations in its official response to the COVID-19 pandemic, and that it immediately provide emergency funding to domestic violence organizations.<sup>51</sup> Providing emergency funding to domestic violence organizations would help alleviate both of the harms discussed above. Emergency funding would directly support domestic violence organizations in increasing the quantity of resources they are able to provide and in adjusting the resources they provide to meet the unique demands arising from the pandemic. Emergency funding would also communicate the message that the US government considers domestic violence and the needs of domestic violence survivors to be an important concern to the country as a whole.

I want to acknowledge that there are (at least) two problems with providing emergency funding to domestic violence organizations. The first problem is that domestic violence funding in the US has historically been linked to law enforcement activities. The Violence Against Women Act (VAWA), which has been the primary source of federal government funding for domestic violence, was originally passed as part of the 1994 Violent Crime Control and Law Enforcement Bill that severely increased the state-based oppression of marginalized communities. VAWA itself is not a crime bill, but the majority of the funding available through VAWA is linked to law enforcement activities. Donna Coke reports that “[m]ore than 50% of the current VAWA allocation is directed to training and support of police and prosecutors.”<sup>52</sup> VAWA has also adopted pro-criminalization policies, such as mandatory arrest and no-drop prosecution policies, that require survivors to directly engage with the criminal legal system—even if they do not want to.<sup>53</sup> My intention here is not to downplay the good that VAWA has accomplished. As Coke notes, the positive changes VAWA has made include “relief for some immigrant victims, expanded tribal court jurisdiction over certain instances of gender violence that occur on Native American land, and the provision that protection orders in one state are enforceable in another state.”<sup>54</sup> All of

these changes are important accomplishments that make substantive differences in the lives of survivors.

Along with these positive changes, however, VAWA has also instituted policies that may further alienate the most marginalized survivors. In particular, VAWA’s reliance on the criminal legal system overlooks the ways in which the criminal legal system has itself been a source of violence and oppression for many survivors. Andrea Ritchie argues that “[t]he proliferation of mandatory arrest policies across the country is leading to increased arrests of domestic violence survivors, who then become subject to further violence in the criminal justice system.”<sup>55</sup> The impact of mandatory arrest policies falls disproportionately on survivors of color. A study in New York City found that 66 percent of domestic violence survivors who were arrested with their abusers were women of color.<sup>56</sup> LGBTQ2S survivors also experience an increased risk of oppression from law enforcement officers and agencies. The National Coalition of Anti-Violence Programs reports that almost one-third of LGBTQ2S survivors who reported a domestic violence incident to law enforcement were arrested instead of their abuser.<sup>57</sup> LGBTQ2S survivors also reported experiencing verbal abuse, physical violence, and sexual violence from law enforcement officers responding to domestic violence reports.<sup>58</sup> And finally, survivors who are arrested are at high risk of being assaulted in prison. According to the US Department of Justice, in 2011 alone there were almost 9,000 reported incidents of sexual harassment and assault in adult correctional facilities.<sup>59</sup> Given that incidents of sexual harassment and assault in correctional facilities are severely underreported, this number is likely inaccurate. An independent survey conducted on incarcerated persons leaving correctional facilities estimates that 80,600 incarcerated persons experienced sexual violence in 2011–2012.<sup>60</sup> For these survivors, the US criminal legal system functions as another abuser instead of an escape from abuse.

The second problem with providing emergency funding to domestic violence organizations is that domestic violence organizations and shelters themselves can be exclusionary to some survivors. LGBTQ2S survivors were not explicitly included in VAWA until 2013, and many domestic violence organizations are not inclusive of LGBTQ2S needs. A 2010 study by the National Coalition of Anti-Violence Programs and the National Center for Victims of Crime found that out of 648 surveyed “domestic violence agencies, sexual assault centers, prosecutors’ offices, law enforcement agencies, and child victim services, 94% of respondents said they were not serving LGBTQ survivors of IPV [intimate partner violence] and sexual violence.”<sup>61</sup> A 2015 report by the National Coalition of Anti-Violence Programs found that 44 percent of LGBTQ2S people who sought help from domestic violence shelters were denied access, and that the most common reason for denial “was barriers related to gender identity.”<sup>62</sup> For those survivors who are able to access shelters, many shelters lack LGBTQ2S-inclusive protocols that would prevent same-sex abusers from also seeking services at the shelter.<sup>63</sup> And while shelters specifically designed to meet the needs of LGBTQ2S survivors do exist, they are very rare, and not easily accessible for all LGBTQ2S survivors.<sup>64</sup> Providing emergency funding to domestic



13. Rebecca Solnit, *Men Explain Things to Me* (Chicago: Haymarket Books, 2014), 32.
14. Neuman, "Global Lockdowns Resulting in 'Horrifying Surge' in Domestic Violence, UN Warns."
15. Clare Foran, Manu Raju, Haley Bryd, and Ted Barrett, "Trump Signs Historic \$2 Trillion Stimulus After Congress Passes it Friday," *CNN*, March 27, 2020, <https://www.cnn.com/2020/03/27/politics/coronavirus-stimulus-house-vote/index.html>.
16. Gina Dillon, Rafat Hussain, Deborah Loxton, and Saifur Rahman, "Mental and Physical Health and Intimate Partner Violence against Women: A Review of the Literature," *International Journal of Family Medicine* (2013): 1–15; Ann L. Coker, Keith E. Davis, Ileana Arias, Sujata Desai, Maureen Sanderson, Heather M. Brandt, and Paige H. Smith, "Physical and Mental Health Effects of Intimate Partner Violence for Men and Women," *American Journal of Preventative Medicine* 23, no. 4 (2002): 260–68; Amy Bonomi, Robert S. Thompson, Melissa Anderson, Robert J. Reid, David Carrell, Jane A. Dimer, Frederick P. Rivara, "Intimate Partner Violence and Women's Physical, Mental, and Social Functioning," *American Journal of Preventative Medicine* 30, no. 6 (2006): 458–66.
17. Dillon et al., "Mental and Physical Health and Intimate Partner Violence against Women: A Review of the Literature."
18. Cynthia Hess and Alona Del Rosario, "Dreams Deferred: A Survey on the Impact of Intimate Partner Violence on Survivors' Education, Careers, and Economic Stability," Institute for Women's Policy Research, October 24, 2018, <https://iwpr.org/publications/dreams-deferred-domestic-violence-survey-2018/>.
19. Jay G. Silverman, Michele R. Decker, Heather L. McCauley, Jhumka Gupta, Elizabeth Miller, Anita Raj, and Alisa B. Goldberg, "Male Perpetration of Intimate Partner Violence and Involvement in Abortions and Abortion-Related Conflict," *American Journal of Public Health* 100, no. 8 (2010): 1415–17.
20. Christine Lancaster Palladino, Vijay Singh, Jacquelyn Campbell, Heather Flynn, and Katherine J. Gold, "Homicide and Suicide During the Perinatal Period: Findings from the National Violent Death Reporting System," *Obstetrics & Gynecology* 118, no. 5 (2011): 1056–63.
21. Centers for Disease Control and Prevention (CDC), "Preventing Intimate Partner Violence," February 26, 2019, <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>.
22. Hess and Rosario, "Dreams Deferred."
23. CDC, "Preventing Intimate Partner Violence."
24. "Truth About Abuse Survey Report," The Mary Kay Foundation (2012): 6, [http://www.ncdsv.org/images/MK\\_TruthAboutAbuseSurveyReport\\_NatFindings\\_2012.pdf](http://www.ncdsv.org/images/MK_TruthAboutAbuseSurveyReport_NatFindings_2012.pdf).
25. Ibid., 2.
26. See Neuman, "Global Lockdowns Resulting in 'Horrifying Surge' in Domestic Violence, UN Warns."
27. Ellen Friedrichs, "Coronavirus Is Making People Stay at Home: What Happens When That Isn't a Safe Place to Be?" *The Lily*, March 24, 2020, <https://www.thelily.com/coronavirus-is-making-people-stay-home-what-happens-when-that-isnt-a-safe-place-to-be/?fbclid=IwAR1zIBHFILV-mDrG2UHVxhFFjCaBDk4mBv5L6jeamwCfFEyCKfRckvovQ>.
28. Neuman, "Global Lockdowns Resulting in 'Horrifying Surge' in Domestic Violence, UN Warns."
29. See Godin, "As Cities Around the World Go on Lockdown, Victims of Domestic Violence Look for a Way Out."
30. See North, "When Home Isn't Safe."
31. Linda Carman Copel, "Domestic Violence Victims Need Crucial Support During the Coronavirus," *The Philadelphia Inquirer*, April 6, 2020, <https://www.inquirer.com/opinion/commentary/coronavirus-domestic-abuse-resources-support-philadelphia-20200406.html?fbclid=IwAR1ISi6rCOIYdku4mCJdmBmK33-4FR7HgWov3gdBhcoOsy2XmZtGP1A7WSI>.
32. National Intimate Partner and Sexual Violence Survey (NISVS), *Intimate Partner Violence in the United States—2010* (Washington, DC: Centers for Disease Control and Prevention, 2010), 31–33. Available at [https://www.cdc.gov/violenceprevention/pdf/NISVS\\_report2010-a.pdf](https://www.cdc.gov/violenceprevention/pdf/NISVS_report2010-a.pdf).
33. Roberta K. Lee, Vetta L. Sanders Thompson, and Mindy B. Mechanic, "Intimate Partner Violence and Women of Color: A Call for Innovations," *American Journal of Public Health* 92, no. 4 (2002): 530–34; Beth E. Richie, *Arrested Justice: Black Women, Violence, and America's Prison Nation* (New York: New York University Press, 2012), 26.
34. Richie, *Arrested Justice*, 26.
35. Ibid., 27.
36. Ibid., 24; Kimberlé W. Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color," *Stanford Law Review* 43, no. 6 (1991): 1241–99.
37. Andrea J. Ritchie, "Law Enforcement Violence Against Women of Color," in *Color of Violence: The INCITE! Anthology*, ed. INCITE! Women of Color Against Violence (Durham: Duke University Press, 2016); Kolleen Duley, "Un-Domesticating Violence: Criminalizing Survivors and US Mass Incarceration," *Women & Therapy* 29, no. 3–4 (2007): 75–96.
38. NIPSVS *Intimate Partner Violence in the United States—2010*; National Coalition of Anti-Violence Programs (NCAVP), *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence in 2012* (New York: New York City Gay and Lesbian Anti-Violence Project, 2013) [https://avp.org/wp-content/uploads/2017/04/ncavp\\_2012\\_ipvreport.final.pdf](https://avp.org/wp-content/uploads/2017/04/ncavp_2012_ipvreport.final.pdf); Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma'ayan Anafi, *The Report of the 2015 US Transgender Survey* (Washington, DC: National Center for Transgender Equity, 2016) <https://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf>.
39. National Coalition of Anti-Violence Programs (NCAVP), *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence in 2015* (New York: New York City Gay and Lesbian Anti-Violence Project, 2015), 12. Available at [https://avp.org/wp-content/uploads/2017/04/2015\\_ncavp\\_lgbtqipvreport.pdf](https://avp.org/wp-content/uploads/2017/04/2015_ncavp_lgbtqipvreport.pdf).
40. Ibid.
41. Danica R. Bornstein, Jake Fawcett, Marianne Sullivan, Kirsten Senturia, and Sharyne Shiu-Thornton, "Understanding the Experiences of Lesbian, Bisexual and Trans Survivors of Domestic Violence," *Journal of Homosexuality* 51, no. 1 (2008): 170.
42. Kevin L. Ard, and Harvey J. Makadon, "Addressing Intimate Partner Violence in Lesbian, Gay, Bisexual, and Transgender Patients," *Journal of General Internal Medicine* 26, no. 8 (2011): 630.
43. Ibid.
44. "US: Address Impact of Covid-19 on Poor," *Human Rights Watch*, March 19, 2020, <https://www.hrw.org/news/2020/03/19/us-address-impact-covid-19-poor>; Catherine Powell, "The Color of Covid: The Racial Justice Paradox of Our New Stay-at-Home Economy," *CNN*, April 18, 2020, <https://www.cnn.com/2020/04/10/opinions/covid-19-people-of-color-labor-market-disparities-powell/index.html>; *Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health* (San Francisco: Gay and Lesbian Medical Association, 2010), [http://www.glm.org/\\_data/n\\_0001/resources/live/HealthyCompanionDoc3.pdf](http://www.glm.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf).
45. "US: Address Impact of Covid-19 on Poor."
46. "US: Address Impact of Covid-19 on Poor"; Powell, "The Color of Covid."
47. Yamiche Alcindor, "'We're Angry and We're Hurting.' Why Communities of Color Suffer More from COVID-19," *PBS*, May 12, 2020, [https://www.pbs.org/newshour/show/were-angry-and-were-hurting-why-communities-of-color-suffer-more-from-covid-19?fbclid=IwAR16EF1r\\_17XLCADY-5UY4BWV-ktmo4WpBizOCDGPMK09vinlwG89g4\\_Lal](https://www.pbs.org/newshour/show/were-angry-and-were-hurting-why-communities-of-color-suffer-more-from-covid-19?fbclid=IwAR16EF1r_17XLCADY-5UY4BWV-ktmo4WpBizOCDGPMK09vinlwG89g4_Lal).
48. Joel Feinberg, "The Expressivist Function of Punishment," *The Monist* 49, no. 3 (1965): 403.
49. Rebecca Wanzo, *The Suffering Will Not Be Televised: African American Women and Sentimental Storytelling* (Albany, NY: SUNY Press, 2009), 3.
50. Darci E. Burrell, "Myth, Stereotype, and the Rape of Black Women," *UCLA Women's Law Journal* 4 (1993): 87–100; Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (New York: Routledge, 2009),

ch. 4; Angela Y. Davis, *Women, Race, and Class* (New York: Vintage Books, 1993); Evelyn M. Hammonds, "Toward a Genealogy of Black Female Sexuality: The Problematic of Silence," in *Feminist Genealogies, Colonial Legacies, Democratic Futures*, edited by M. Jacqui Alexander and Chandra Talpade Mohanty (New York: Routledge, 1997), 170–82.

51. Other countries have already included emergency funding for domestic violence service providers in their official responses to the pandemic. For an example, as part of its official response to the pandemic, the Canadian government has provided domestic violence shelters and sexual assault centers with an additional \$50 million in funding, with \$10 million specifically designated to support Indigenous women and children (for more information, see the Government of Canada's website: <https://cfc-swc.gc.ca/fun-fin/shelters-refuges-en.html>). And the Australian government has included a \$91 million plan to address increasing cases of domestic violence in its official response to the pandemic (see Neuman, "Global Lockdowns Resulting in 'Horrorifying Surge' in Domestic Violence, UN Warns").
52. Donna Coke, "Roll Back 'Prison Nation,'" *CUNY Law Review* 18 (2014): 14.
53. Leigh Goodmark, "Stalled at 20: VAWA, the Criminal Justice System, and the Possibilities of Restorative Justice," *CUNY Law Review* 18 (2014): 48.
54. Coke, "Roll Back 'Prison Nation,'" 14.
55. Ritchie, "Law Enforcement Violence Against Women of Color," 140.
56. Ibid.
57. NCAVP, *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence in 2012*, 21.
58. Ibid.
59. Allen J. Beck, Ramona R. Rantala, and Jessica Rexroat, *Sexual Victimization Reported by Adult Correctional Authorities, 2009–11* (Washington, DC: US Department of Justice Bureau of Justice Statistics, 2014), <https://www.bjs.gov/content/pub/pdf/svraca0911.pdf>.
60. Valerie Bauman, "The Forgotten Voices of #MeToo," *Just Detention International*, December 10, 2018, <https://justdetention.org/the-forgotten-voices-of-metoo-prison-rape-in-america-perpetrated-by-both-inmates-and-staff-remains-pervasive-and-under-reported-15-years-after-the-passage-of-a-law-intended-to-end-crisis/>.
61. NCAVP, *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence in 2015*, 13.
62. Ibid., 10.
63. Ibid.
64. Ard and Makadon, "Addressing Intimate Partner Violence in Lesbian, Gay, Bisexual, and Transgender Patients," 630.
65. See NCAVP, *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence in 2012*, 10.
66. Carolyn M. West, and Kalimah Johnson, "Sexual Violence in the Lives of African American Women," *VAWnet.org* (March 2013): 6. Available at <https://www.nsvrc.org/publications/articles/sexual-violence-lives-african-american-women>.

## Pandemic Parenting

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The authors of this piece are both feminist philosophers, each a parent to two children. Between us, we have a seven-year-old, three-year-old, two-year-old, and one-year-old.

Due to the COVID-19 pandemic, we have both been without childcare or public school since March 13, 2020, and for both of us, at the time of writing this, there is not yet a sense of when or how childcare or school will return. In addition to doing paid work as tenured associate professors, one is also a graduate program director in Canada, the other a director of a women and gender studies program in the US, we are also currently full-time caregivers for our children (together with our partners, both of whom currently work from home). While the virus has dramatically impacted many lives and exacerbated harms of economic insecurity, poverty, and racism, our families are exceptionally fortunate: we, our partners, and our children have been healthy; we have secure employment, housing, and access to food and health care; and we share household labor with our partners. These are not the only ways our lives as parents and professionals are sheltered; as anti-racist rebellions grow in June 2020, we continue to recognize the ways in which our whiteness shields us from many of the most severe harms of this time. In this piece, we reflect on our experiences of pandemic parenting, rather than *the* experience of pandemic parenting—aware that our particular perspectives are shaped by the safety, security, and privileges from which we continue to benefit, even as we encounter new forms of contingency, insufficiency, uncertainty, and discordance.

For both of us, this period has meant more time with our children and has brought significant pleasures. For both of our families, the choice to parent was deliberate and desired,<sup>1</sup> and our children, like all children, are wonderful. During pandemic stay-at-home orders, we have enjoyed more popsicles, backyard bathing suits, family drawing parties, garden experiments, butterfly growing, and temporary tattooing than in past years. These moments are, in part, just what we hoped we would be lucky enough to experience when we sought to become parents.

Yet the pandemic has also introduced a period when we cannot rely on so many of the social and physical structures that scaffold and support our parenting—daycares, babysitters, schools, in-person therapies, play groups, community centres, sports teams, music lessons, friends, neighbors, extended family members, playgrounds, green spaces, museums, libraries, swimming pools, splash pads, and the like. Our relationships with these people and spaces were major parts of our lives and the lives of our children. We are who we are as parents and children because of these relationships. Some helped our kids grow and be happy given their particular social, emotional, and physical needs. Some helped us balance ourselves as adults, giving us time and space to work, exercise, maintain our households, take care of our health, relate to partners and other loved ones outside of parenting, and sustain trusting and mutually influential relationships with other adults. Many did both. For several months now, our relationships with these people and spaces have either been radically altered or cut off completely.

In an April 2020 *Medium* article gone viral, "The Parents are not All Right," Chloe Cooney writes,

Viruses—pandemics—expose and exacerbate the existing dynamics of a society—good and bad.

They are like a fun-house mirror, grossly reflecting ourselves back to us. One of those dynamics is the burden we put on individual parents and families. We ask individuals to solve problems that are systemically created.<sup>2</sup>

The effects of this virus itself combined with systemic failures to respond well to it (particularly at the level of the federal government of the US, but also at the levels of various other national and international institutions), have created a situation where it is unsafe for children and parents to relate to many of the social and physical structures that support us. And so it becomes the task of parents in each individual household to care for ourselves and our families in isolation.

In offering a personal reflection on some of its most salient features, it has seemed to us that pandemic parenting feels in some ways both *like pre-pandemic parenting but amplified* and, in other ways, *like a radically new organization of parenting life*. Disentangling these is an interesting experiment in itself, and it is perhaps best to instead see them on a spectrum. We focus here on four characteristics highlighted by pandemic parenting: (1) the contingency of plans; (2) the assumed self-sufficiency of the nuclear family; (3) the hyperindividualization of risk management; and (4) potential conflicts between the emotional and epistemic needs of parents.

### THE CONTINGENCY OF PLANS

A common and expected part of parenting is that parents' plans come to be fundamentally contingent upon the needs of our children. Of course, any person's plans can be overridden by circumstances outside of their control—for example, anyone can plan to arrive at work on time and be unable to do so because of a car accident or a transit delay. But parenting creates more opportunities for plans to change. Whether or not I eventually become a parent, if I even seek the task of parenting, my other plans may be regularly overridden as I try to become a parent through pregnancy, birth, adoption, or otherwise—even my plan to become a parent may itself be overridden since whether this will eventually happen is not something I fully control. If I do become a parent, my plans for days, weeks, months, and years become contingent on the needs of my children. If they need me to do otherwise, and if their need is serious enough, any conflicting plans of my own will be set aside.

As such, there is a kind of surrender to contingency at the heart of parenting, from the moment we agree or try to become parents. By our own choice, our lives are no longer fully our own, and parents might either respond with acceptance or resistance, or (perhaps most familiarly) vacillate between the two. A related contingency is present for everyone existing in the pandemic and is clearly amplified for parents who have children still in the home. Our plans for what projects we would have taken on during this period, where we would have gone, how we would have done our jobs, are subject to how they can fit around the task of providing round-the-clock childcare. For some parents, this has led to dramatic changes in career paths, including some (and more often, mothers) leaving the paid labor force in order to provide full-time childcare.<sup>3</sup> For

most parents, it means a newly deepened surrendering of control over our own time, and a lack of certainty that we will have protected time, apart from children, to work or to care for ourselves. Indeed, both the surrender to contingency and the uncertainty of maintaining identity are deeply tied to maternal ambivalence, a common, if stigmatized, feeling experienced by professional women. Some parents more than others might feel this pandemic-generated contingency is on a continuum with their pre-pandemic lives: for instance, those who were already the first or only ones on call in cases of ill children, those whose children's particular needs have made more parent-provided care necessary or desirable, those whose children have more appointments or therapies, and those who were already providing childcare some or all of the time leading up to the pandemic. Other parents might have felt their schedules more rarely intertwined with unexpected needs of their children. The adjustment to current contingency may feel different depending on these circumstances—one might feel the new contingency as more or less of a shock to the system.

### THE ASSUMED SELF-SUFFICIENCY OF THE NUCLEAR FAMILY

Parenting in pandemic is further like an amplified version of pre-pandemic parenting in that it reveals the untenability of the nuclear family as a fundamental way of organizing care labor in society. The boundary between the family and the rest of the world is now drawn more firmly and sharply than ever, as is the expectation that individual families will (be able to) take care of themselves. This is reflected in the language that emerges in discussions of families seeking ways to interact with others through creating "double bubbles" or "quarantine pods." Before the pandemic, the expectation that nuclear families would be self-sufficient (emotionally, financially, and otherwise) was already clear. This expectation was never meetable, but was perhaps more deniable or even partly subvertable given parents' abilities to cultivate and rely on a "village" (of other paid or unpaid caregivers, family members, friend networks, therapists, educators, afterschool programs, and so on). In locations where in-person social interaction outside the household has been prohibited or discouraged, families are now apart from these villages, and it becomes clear that nuclear families are, and in some sense always were, expected to be self-sustaining in the absence of social and structural supports. While our households are assumed to be self-sufficient, of course we have all along been depending on so many workers who produce and sell food, collect garbage, ship and deliver goods and mail, and work in medical fields to care for our bodies. All of the work of nuclear families and any of the ways we are able to sustain ourselves depends on this (still insufficiently appreciated) labor. For many middle-class families, childcare and many other household tasks (food and supply buying, cooking, cleaning, laundry, emotional labor, educational labor) have always been largely privatized—either we do it ourselves, or afford to pay others to do so. Now we have not just a responsibility to ensure that these things are done, but also a responsibility to do them all ourselves. And we see starkly now how much our children miss out on when their chief or only interactions are with parents and (where



they exist) siblings, and how much all others (parents and nonparents) miss out on as well. And so parenting in pandemic reveals more strongly what we already knew: when societies treat nuclear families as isolated building blocks, wholly responsible for practices of child raising and family building, everybody suffers. As Sophie Lewis writes in “The Virus and the Home,”

Even when the private nuclear household poses no direct physical or mental threat to one’s person—no spouse-battering, no child rape, and no queer-bashing—the private family qua mode of social reproduction still, frankly, sucks. It genders, nationalizes and races us. It norms us for productive work. It makes us believe we are “individuals.” It minimizes costs for capital while maximizing human beings’ life-making labor (across billions of tiny boxes, each kitted out—absurdly—with its own kitchen, micro-crèche and laundry).<sup>4</sup>

While it has not been our particular experience, for many families with children, the gendered effects of this sudden and forced household self-reliance can be stark, for several reasons. First, in homes with parents of different genders, women are more likely to be the primary caregiver of young children and, if working, are more likely to hold a lower paying or part-time job, more easily sacrificed to take on the sudden need for at-home childcare and domestic work.<sup>5</sup> Also, more women than men are employed in the industries hit hardest by the economic impact of coronavirus: retail and hospitality. These impacts are likely to continue into years to come, as austerity policies, widespread unemployment, and the closure of childcare facilities will make it harder to seek work outside the home.<sup>6</sup> Finally, the loss of social networks and external supports is likely felt hardest by those in contexts of intimate partner and domestic violence (statistically more likely to be women), who have lost direct access to outside supports and may be living in immediate proximity to their abusers 24/7.<sup>7</sup>

And of course, the sudden pressure on nuclear families can have detrimental gendered effects across lines of income level and class. Even for those of us in academia who are privileged enough to enjoy the remarkable freedom and security of tenure, the modern nuclear family—once cut adrift from the networks and communities that sustained it from without—threatens our professional lives in ways we might previously have thought ourselves protected. There are already reports of a gender gap in academic research, with academic journals reporting both fewer submissions by women and greater numbers of submissions by men.<sup>8</sup> The request that university teachers “pivot” to online teaching was made seemingly without awareness of not only the work involved in recreating complex courses in a different medium, but also the fact that parent-academics pivoted while simultaneously continuing to teach and working full time as caregivers and—for older children—homeschool teachers: three full-time jobs, each with its own nonnegotiable commitments. Making this lack of awareness apparent, an email from one of our universities aimed at encouraging a healthy work-from-home life asked that no meetings be scheduled from 12:30 p.m. to 1:30 p.m. (aka nap time, when parents of young children

may be less hindered) and that no email be sent after 6 p.m. (aka bedtime, when most of the work gets done). Regardless of gender, the familiar parenting experience of split attention has been amplified dramatically over the last four months: we are not coping with *time confetti*<sup>9</sup>—a term coined by Brigid Schulte to describe the fragmented bits and scraps of time many women must seize to do housework, email, and other small tasks during ordinary, pre-pandemic life, contrasted with the “chunks” of time needed to truly focus or rest—so much as even smaller fragments of *time glitter* (as if months of at-home crafting had not taught us enough about the impossibility of tracking and organizing glitter).

It is both unsurprising and distressing to see the persistent assumption that *nuclear families will be self-reliant* further revealed and intensified during pandemic, along with accompanying assumptions that the nuclear family will be heteronormative and gendered in harmful ways.

## THE HYPERINDIVIDUALIZATION OF RISK MANAGEMENT

Parenting in pandemic introduces a newly pronounced imperative for parents to *manage their own families’ risks*. As we write this in July 2020, some areas which were once under stay-at-home orders are beginning to reopen or discuss reopening businesses, childcare centers, and schools. This is happening, for the most part, without comprehensive or clear guidance for how individuals should navigate these contexts given that the virus still exists, many people are still infected or newly becoming so (in some areas, numbers of new cases are rising dramatically), and we have neither a vaccine nor reliable treatments. Evidence-based guidance from health experts and states is more available in some areas than in others, but, by and large, what we witness in our circles and in online parenting groups is a sense that individual families are on their own to make decisions about their actions, depending on their comfort level with risk. This is very difficult, particularly since we know that the actions of individuals can have significant effects on the lives and well-being of others. If a parent considers sending their child to an outdoor summer camp, this introduces some level of risk that this child or others within the household may be exposed to the coronavirus, but it also means that all the other children and staff at the camp will be exposed to this child and thus to whatever other exposures this child has had. We have growing but still incomplete information on how exposure is most likely to happen, about the levels of risk associated with different activities and locations, and about the long-term effects of the illness for different people. Every week it seems we learn new things about how we might prevent the illness, but also about new possible vulnerabilities in the population and lasting damages it might cause, including to children. In some areas more than others, the guidance of governmental authorities seems predominantly driven by economic goals and other considerations (e.g., number of ICU beds or stocks of PPE available) and less likely to be based on the recommendations of health-care researchers, public health experts, and scientists about what practices can actually reduce exposure for everyone. This frantic uncertainty sometimes takes the shape of a dilemma: we

must choose between our children's immediate physical health and safety and their longer-term mental health and safety, while being critiqued as either paranoid or foolhardy, depending on which we choose. Parents may or may not already know some about practices involved in trauma-informed parenting—understanding causes and expressions of trauma, and becoming equipped to help children cope with post-traumatic stress—but it is in any case important to remember that the pandemic is genuinely traumatic for all of us, in ways that we cannot yet wholly understand or appreciate. For children, who experience time differently, it will have been dramatically world-changing. So, for all parents, the very real possibility of trauma, and a future shaped by that trauma, lurks behind the big and small dilemmas of the present.

Parents now have the task of making many unprecedented decisions, with incomplete and in some cases rapidly changing information, when the potential risks and rewards for their own families and others could be profound. We are charged with managing our own risks. To be sure, parenting always requires a great deal of decision-making, from the moment of the unprecedented decision to become a parent.<sup>10</sup> Throughout the process of gestating, birthing, awaiting the birth of, adopting, or otherwise coming to parent a child, one already faces innumerable decisions. Parenting infants, toddlers, and children at all ages requires constant decision-making work, and the navigating of often conflicting sources of information on how best to proceed. While parenting often involves the experience of having to navigate *too much* advice from others, picking, choosing, and then defending our choices about which information to follow, we are now in a circumstance where we all could benefit immensely if everyone followed trustworthy, uniform advice—and yet, this advice is not reliably available.

Moreover, the institutional and ideological pressure to make the nuclear family separate and sovereign has especially heinous consequences here, since a certain percentage of parents are susceptible to COVID-19 conspiracy theories swirling around the internet. While some of us are desperate for *more* comprehensive and authoritative instruction around our children's health and appropriate preventative measures, others see *any* such direction as an infringement on parental authority. The rise of anti-science rhetoric and the ideology of the self-sufficient nuclear family combine to make "nobody knows what's best for my children but me" appear—to some—as a legitimate expression of parental rights. Yet we know that so often this attitude works against the best interests of children (e.g., the anti-vaxxer movement or parent-led mobilizations against comprehensive sex education).

### CONFLICTS BETWEEN EMOTIONAL AND EPISTEMIC NEEDS

A final characteristic of pandemic parenting is the way in which parents' emotional and epistemic needs may come to be at odds. We are witnessing the ways parents are worried about each other: parents see and anticipate how the work of parenting in pandemic may take a toll on each other's mental and emotional health,<sup>11</sup> and we may find

ourselves more regularly reaching out to each other with sympathy, humor, or support. We may also be reaching out to each other more than usual with questions, or to see if our own intuitions about right action are aligning with those of others (e.g., are you having your kids wear masks outside? How are you thinking about interactions with friends?). We also find ourselves organically creating space for each other to occupy different moods or different positions of need at different times: some days I express feeling overwhelmed and you are in the position of supportive listener; other days we swap. In many cases, it seems parents are working more than ever to create and bolster relationships of care among ourselves. We very much need the emotional connection to other parents we trust, and this need is valid.

And yet, meeting these emotional needs may also have complicated epistemic costs at this time. Those parents to whom we may be most inclined to turn for emotional support—those who we find like-minded and most trustworthy—are likely also to be those we find ourselves agreeing with on most things related to COVID-19 or otherwise. Just as we see the potential harms of epistemic bubbles in many contexts of health care (e.g., consider vaccine refusal, where vaccine refusing parents may get (mis)information about the dangers of vaccines from other parents instead of health authorities), we can imagine potential epistemic risks associated with turning most towards other parents whom we already trust for their sense of how to act in this uncharted territory. It might be that the other parents we turn to are *insufficiently* attentive to the need to act in ways to prevent viral spread (e.g., they might be more in favor of a return to pre-pandemic social interactions than is prudent). Or it might equally be that the other parents we trust are *too* cautious and that we will mutually promote measures that are *too* extreme and potentially damaging in other ways. This is a real challenge in our context where, as noted above, we do not yet have all of the reliable evidence-based information we need, our understandings of the virus, its effects, and best practices for treating and preventing it are still changing quickly, and the implications for families can vary by geographic and personal context (i.e., what is relatively safe to do in one location or with low-risk family members may be not safe to do in a different location or with higher-risk individuals). It is hard to know what decisions to make as parents, in general. It makes sense that we would turn to other parents we trust to talk through our decisions and to provide and receive emotional support. But it must be noted that doing so can have epistemic costs, and we should be aware of them.

In sum, caring for children during the pandemic amplifies some existing complexities of parenting and introduces others. Parenting right now is a very different experience than doing so in the context of the many constitutive relationships with (currently distant) others. We are no longer who we once were, and neither are our kids. With any luck, this experience has permanently challenged our understandings of what counts as productivity, confronted primary identifications of ourselves as workers, strengthened our relationships to others (including those whose work truly sustains our lives), and clarified what kinds of community and household practices might genuinely support and hearten us and our children. Ongoing needs for

sustaining relations to all the people and spaces described above are clear, and we might see now where changes must—and can—be made to these relationships. Being in the midst of pandemic parenting gives certain access to seeing these complexities. We trust that much more will be learned and recognized about these experiences in the months and years to come.

#### ACKNOWLEDGMENTS

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#### NOTES

1. For one account, see MacLachlan, "Conceiving Differently within the Ethics of Assisted Reproduction."
2. Cooney, "The Parents Are Not All Right."
3. Cohen and Hsu, "Pandemic Could Scar a Generation of Working Mothers."
4. Lewis, "The Virus and the Home."
5. Gunraj, "Gendered Impacts of Coronavirus."
6. Topping, "Covid-19 Crisis Could Set Women Back Decades, Experts Fear."
7. See Miranda Pilipchuk's contribution to this issue (pp. 14–21).
8. Flaherty, "No Room of One's Own"; Frederickson, "Women Are Getting Less Research Done Than Men During This Coronavirus Pandemic."
9. Schulte, *Overwhelmed: Work, Love, and Play When No One Has the Time*.
10. Paul, "What You Can't Expect When You're Expecting."
11. Springer, "Parents in Lockdown Are Quietly Falling Apart—I'm One of Them."

#### REFERENCES

Cohen, Patricia, and Tiffany Hsu. "Pandemic Could Scar a Generation of Working Mothers." *New York Times*, June 3, 2020. <https://www.nytimes.com/2020/06/03/business/economy/coronavirus-working-women.html>.

Cooney, Chloe. "The Parents Are Not All Right." *Medium*, April 5, 2020. <https://medium.com/@chloe.cooney/parents-are-not-ok-66ab2a3e42d9>. April 5, 2020.

Flaherty, Colleen. "No Room of One's Own: Early Journal Submission Data Suggest COVID-19 Is Tanking Women's Research Productivity." *Inside Higher Ed*, April 21, 2020. <https://www.insidehighered.com/news/2020/04/21/early-journal-submission-data-suggest-covid-19-tanking-womens-research-productivity>.

Frederickson, Megan. 2020. "Women Are Getting Less Research Done Than Men During This Coronavirus Pandemic." *University Affairs*, May 20, 2020. <https://www.universityaffairs.ca/opinion/in-my-opinion/women-are-getting-less-research-done-than-men-during-this-coronavirus-pandemic/>.

Gunraj, Andrea. "Gendered Impacts of Coronavirus." Canadian Women's Foundation, March 14, 2020. [https://canadianwomen.org/blog/gendered-impacts-of-coronavirus/?gclid=Cj0KCQjw9IX4BRCCARIsAOD2OB2\\_1NrVtUTcP7vedTJ1-ihoxa0QfoTDzkfm3tIkqnqGudybJyUcaAvgzEALw\\_wcB](https://canadianwomen.org/blog/gendered-impacts-of-coronavirus/?gclid=Cj0KCQjw9IX4BRCCARIsAOD2OB2_1NrVtUTcP7vedTJ1-ihoxa0QfoTDzkfm3tIkqnqGudybJyUcaAvgzEALw_wcB).

Lewis, Sophie. "The Virus and the Home." *Bully Bloggers*, April 1, 2020. <https://bullybloggers.wordpress.com/2020/04/01/the-virus-vs-the-home-what-does-the-pandemic-reveal-about-the-private-nuclear-household-by-sophie-lewis-for-bunkerbloggers-originally-published-on-patreon-reblogged-by-permission-of-the-author/?fbclid=IwAR0dxkGIGmVzvqV41uaYmQ3BUBFspIARkOQBNLauYID2rPik45Fu-kDwA>.

MacLachlan, Alice. "Conceiving Differently within the Ethics of Assisted Reproduction." *American Philosophical Association Newsletter on LGBTQ Issues in Philosophy* 19, no. 1 (2019): 14–17.

Paul, Laurie A. "What You Can't Expect When You're Expecting." *Res Philosophica* 92, no. 2 (2015): 149–70.

Schulte, Brigid. *Overwhelmed: Work, Love, and Play When No One Has the Time*. New York: Harper Collins, 2014.

Springer, Lindsay. "Parents in Lockdown Are Quietly Falling Apart—I'm One of Them." *Today's Parent*, June 12, 2020. <https://www.todayparent.com/family/family-life/parents-mental-health-coronavirus/>.

Topping, Alexandra. "Covid-19 Crisis Could Set Women Back Decades, Experts Fear." *The Guardian*, May 29, 2020. <https://www.theguardian.com/world/2020/may/29/covid-19-crisis-could-set-women-back-decades-experts-fear>.

## Planning in the Void: Autonomy amid Pandemic Constraints

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In early July, our daycare announced that it would be reopening at the end of the month. The daycare had already polled parents about priorities for reopening, and about whether we would send our kids back should a spot become available. I replied, at the time, that the circumstances under which the staff felt safe to return would be the circumstances under which we would be happy to send our kids back, provided there was a space for our kids. My partner wrote to tell them that we would not want to take a spot away from a frontline worker, nor from a child whose family needed it more than we did.

The daycare listened to our concerns. After a few weeks of planning and reorganizing the space for physical distancing, they contacted us again. They emphasized that the health and safety of both children and staff were their utmost concern. They would be reducing the number of places in the daycare by more than half. There would be eight kids with two staff members in each age cohort. The daycare prioritized spaces for children of frontline workers; the next set of spaces would be prioritized based on need; and they would hold a lottery for remaining spots.

They would be removing all carpets and soft or porous toys, and covering all couches with plastic sheeting to help to implement new cleaning protocols. They would seat children at tables with plexiglass dividers for meal and snack times, and set out individual rather than shared art materials or crafts. There would be no singing. No mixing of cohorts. No sharing of snacks. No hugs. Obviously.

Their priorities were our priorities. They had taken great care in coming up with a plan that felt safe enough for both staff and families to consider coming back.

We got the email. They had a spot for each of our kids! Our kids would be returning to daycare. We would be returning to some semblance of our old life. I took a deep breath.

Perhaps I could start applying for jobs again? Maybe do a little bit of writing? Hopefully, working in August wouldn't be the constant stream of interruptions that it has been since mid-March. Perhaps for both of us, our careers would buck the trend and survive the pandemic. Or maybe, for at

least one of us. So many possibilities seemed to open back up with that one email.

We thought about what it might mean for our kids. A chance to see and play with kids their own age, notwithstanding the ban on hugs. Or the limitations on types of play, for that matter. Our kids' bedtime might revert to quasi-normal! Fewer tearful bedtimes. Fewer tantrums. Fewer days spent in the blue or red zone. A chance to spend some time in the care of a trained professional who cares for children, but isn't as invested in everything as a parent. A chance to try to balance work and life once again.

Since March, I now realize, I have been holding my breath, waiting for something to change. At some point, I noticed that I had stopped even checking the weather forecast. What would be the point? We take it one day at a time. One tantrum at a time. One book at a time. One bout of despair at a time. One crisis at a time. Living in the moment. But also stuck in the moment.

I exhaled. It felt good.

Naturally, we started to plan, just a little.

My unexpected reaction to the daycare reopening was to feel the weeks and months ahead opening up to possibility. I started to look forward, after months of looking down, of watching my feet, glued to the ground.

Many philosophies suggest that a good life includes making choices, developing a direction, and plotting a route from here to there. We live a meaningful life by working towards meaningful goals, a meaningless life by working towards superficial goals, or by not working towards any goals at all. First, we are supposed to consider our options; next, we set goals; we make appropriate plans for achieving them; we follow through. Completed goals or "achievements" may be considered and evaluated in an attempt to answer the question "How is my life going?" We judge ourselves, and are judged by others, through an accounting of the quality of these choices.

Many modern philosophers add a condition about living authentically. Not just any plan will do. It has to be our own plan, a reflection of our True Self. Externally imposed goals, even if fulfilled, don't count as "achievements" or don't count in the same way. Death and taxes are not chosen, so they rarely qualify as achievements. For most of us, they are not what makes our lives meaningful. External constraints, such as the pandemic, don't change the underlying calculus. We have to do our own choosing, bounded by whatever constraints the world imposes on us. We have to act for ourselves.

In her book *Self, Society, and Personal Choice*, Diana Tietjens Meyers explains these connections between self and choice. She explains: "to be in control of one's life is . . . to live in harmony with one's true—one's authentic—self."<sup>1</sup> In the pandemic, I am not in control of my life. None of us are. But also—as a result—I am not being true to myself. I am losing my concept of who I am, of who I want to be. To be stuck in the moment is also to be stuck in tension with one's true self.

Although I continue to set goals, my ability to work towards them is extremely limited. In the pandemic context, I am not in control of my life plan. I am not even in control of my daily plan. The pandemic—and pandemic parenting in particular—precludes so many different types of planning. The constant stream of interruptions is so much harder on me than I recognize on a daily basis.

Constant interruptions are a pandemic parenting problem. The closure of schools and daycares—or the ill-thought-out proposals to reopen as though there were no pandemic—are pandemic parenting problems. But the loss of self is a much broader phenomenon.

Meyers continues, "[c]ompleting a part of one's life plan does not simply add an item to a person's roster of accomplishments; fulfilling a particular plan insinuates itself into the individual's personality by weakening or reinforcing some of the individual's traits, by modifying the relations among them, or by engendering new ones."<sup>2</sup> I am no longer the type of person who moves forward. I am stuck, and this is becoming Who I Am. Holding my breath. Waiting. Looking down.

Part of my pandemic problem, then, is that my life plans—and my ability to fulfill them—have been taken completely out of my control. We have collectively spent months worrying about whether, when, or how to reopen schools, universities, restaurants, churches, or barber shops. How can any of us work towards our goals in the context of so much uncertainty?

To the extent that I can still formulate goals, there is one set of goals that continues to take precedence: my children's. Even if I want to wallow in the uncertainty of it all, my kids have other plans. They certainly have up and down days. But their days are my days. Pandemic parenting means that the shapes and contours of my plans are set by the children. Of course, the children's plans are, and always have been, important to me. But under different circumstances, there is a little room for a Me to fit around them. Pandemic parenting certainly means that someone else's wants, needs, desires, and values take precedence. Maybe this is true of pandemic life in general.

Meyers says, "Autonomous people must be able to pose and answer the question 'What do I really want, need, care about, believe, value, etcetera?'; they must be able to act on the answer; and they must be able to correct themselves when they get the answer wrong."<sup>3</sup> Here is the pandemic dilemma. We have time for introspection. We have moments of deep recognition of our wants, needs, desires, and values. But the pandemic makes acting on the answer next to impossible, for too many of us. For those of us unable to leave our homes. For those of us unable to pay rent. For those of us unable to say no to work that feels unsafe. For those of us unable to say yes to help that feels unsafe.

In *The Ethics of Ambiguity*, Simone de Beauvoir wrote: "It is apparent that the method we are proposing [. . .] consists, in each case, of confronting the values realized with the values aimed at, and the meaning of the act with its

content.”<sup>4</sup> What we claim to aim for is important, but what we do—and how it relates to our aims—is fundamental. It demonstrates our true values. What we *really* want. Our true choice, and our True Selves.

What de Beauvoir and Myers agree on is this: what we do affects, or builds, our identity. What we do defines what we want, need, care about, believe, value. In short, what we do is who we are.

Striving for a goal, and genuinely taking steps towards that goal, is part of living a meaningful life. Daycare’s planned reopening allowed us the space to take those steps for the first time in a long time. It helped us see a light at the end of the tunnel, and simultaneously helped us perceive the tunnel.

Three days after daycare offered us a spot, they sent another email. They would not, after all, be reopening. There was not enough interest. Other parents had faced the possibility of sending their kids back to daycare and had decided against it. Many are frontline workers who may worry about the risk they pose to the rest of the daycare. Many have preexisting conditions. There are many layers of vulnerability in each family’s story, and each family has a complex decision to make. All have good reasons for their decisions. We were, nonetheless, heartbroken. The hoped-for August disappeared. The plans evaporated. The self that I was starting to see on the horizon receded back into the fog.

Many of our school districts, states, and provinces have made decisions about whether, or how, to reopen schools in the fall. But no matter how conscientious and well-thought out they may be, they will not address everyone’s concerns. They may be just as conscientious and well-thought out as our daycare’s plans. With any luck, they may be backed up by promises of funding for PPE and physical distancing and masking. But, even with a plan, the pandemic will likely shift the goal posts once again. A second wave, or a sudden surge in cases, will certainly force us to reconsider any plan.

My attempt to form a plan sits in the shadow of our collective efforts at forming a plan. Each plan sits enmeshed with other people’s plans, with institutional plans, with government plans. And that means that each layer of the plan remains out of any individual’s control.

I find myself once again holding my breath. Perhaps you do, too. After all, we are all in this together.

**NOTES**

1. Diana Tietjens Meyers, *Self, Society, and Personal Choice* (New York: Columbia University Press, 1989), 19.
2. *Ibid.*, 60.
3. *Ibid.*, 76.
4. Simone de Beauvoir, *The Ethics of Ambiguity*, translated by Bernard Frechtman (New York: Citadel Press, 1948), 152.

*“Surviving and Getting Your Life Back Are Two Different Things”: COVID-19, ICU Psychosis, and the Coming Mental Health Crisis*

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It is a positive and active anguish, a sort of psychical neuralgia wholly unknown to normal life.

– William Styron, *Darkness Visible*

I have PTSD.

When I say that I have it, what I really mean is that it is my nearly constant companion, sometimes choosing to remain as a manageable background hum, while other times unceremoniously inserting itself into whatever I happen to be doing, thinking, planning, and fearing. I should probably give it a nickname, but I am afraid that it might disapprove.

It is difficult to reduce the source of my PTSD to a single event—I was not suddenly and violently attacked by another like Susan Brison,<sup>1</sup> nor did I bear witness to something similarly scarring and traumatizing, like wartime atrocities. Instead, I became ill—seriously, life-threateningly ill—in February of 2018. While I was not conscious for some of the worst parts of the illness’s progress (awareness fell to my partner, whose witness-and-caregiver trauma deserves its own analysis), what I do remember about my ICU experience seems now to be a permanent part of my internal wiring. That, and what came after, make up a PTSD-constituting process that did not end once I was wheeled through the hospital doors back into the world in which I no longer felt at home. While I appeared to have survived the illness, what came after continues to unmoor me.

A brief digression: As advertised, this is a paper about COVID-19, the life-and-stability-threatening virus currently at odds with American narratives of independence, autonomy, and individual choice (with all evidence suggesting that the pandemic is winning the argument). But I am not going to devote any time to analyzing how, and why, the American onslaught of COVID-19 is so especially severe—these analyses abound, and I am not sure what my perspective would have to add to them. Instead, I focus on the virus’s largely invisible victims—those who endure the worst ravages of the illness behind the curtains of critical care units, and whose deepest struggles remain mostly hidden to outsiders, especially after the fortunate few are celebrated as survivors. That is, because the suffering of those who experience the worst of COVID-19, both *in the ICU* and *post-discharge*, is so significant and life-altering, my focus is on their particular traumas that are largely hidden, and even when known, mostly ignored, even by those in a position to offer assistance. And given the additional failure of many dominant media narratives to directly contend with the reality of these traumas (with some exceptions), I hope that the story of my own (non-

COVID) ICU experiences offers a glimpse into these largely unknown phenomenologies, motivating much-needed conversations about what happens within the ICU doors—and, importantly, what comes after. What happens after all those who have survived, and who will survive, the worst of the virus's onslaught—those in the ICU, intubated, in medically induced comas—come home? Should we not celebrate, as many hospitals do when these patients are discharged, with applause, balloons, and cheerful signs, full of hope that the monster, even if just this once, has been kept at bay?

Yes, of course, we should. How can we be faulted for trying to find some light in the ever-increasing darkness of disease, social injustice, public health disasters, and a federal government whose leadership seems to increasingly engage in a toxic mix of scientific denialism and outright cruelty? These moments of triumph are important both to our mental health and to our ability to persevere. Indeed, when I took my first breath of nonhospital air, I felt euphoric, telling myself that whatever horrors I experienced in the ICU and in the hospital itself were safely behind that sliding door, compartmentalized both in the physical world, and in my mind, as a nightmare that would no longer be mine to endure.

I should have known that medication-induced delusion and the irrational happiness of having “escaped” what seemed for a long time to be inescapable would not last. The truth is much more complicated—and much less bright. The reality to which I returned no longer had the ventilator, the endless IVs and blood draws, the beeping machines that destroyed any hope of sleep, the countless specialists marching into my room at all hours of day and night, the lack of any privacy. But it hid other things.

There it was—our Brooklyn walk-up (and a bit later, a quieter, more isolated house upstate), with all of the familiar things and sounds, all of my books and work and schedules still there on my desk, left untouched since that night when I could no longer recognize them, or much of anything else. But after some fleeting, short-lived joy, what I felt was not relief, not happiness, and certainly not hope. In fact, it was the opposite of hope: for months after my release from the hospital, I quickly and catastrophically fell into the darkest place I knew. My daily thoughts ranged from fear (am I feeling *that* again?), to depression and despair (like many patients post-ICU, I could not walk independently, within a month transforming from a fast-walking New Yorker to someone who could not take a handful of steps without a cane and someone there to help me), to the horror that my career as a philosopher is surely over . . . to the worst part of all: terrifying flashbacks, glimpses of impossible, grotesque images, memories that seemed to me, a horror-film buff, to be B-movie scenes replete with nightmarish images designed to evoke in the viewer a kind of delirium.

The delirium, however, was all mine.

Today, I am writing this essay both as a bioethicist worried about what is to come, and as a person who has, and still is, experiencing the aftershocks of my time in the ICU, sedated, in a medical coma, and on a ventilator. So much has been

said and written about not only the ravages of COVID-19, but about the desperate need for ventilators and other life-saving equipment. Surprisingly little has been written about what comes after the patient, having survived the worst, is taken off the ventilator, declared “healed,” and sent home. And because thousands of the sickest COVID-19 patients require intensive care, what happens to them afterward matters. Imagine, if you can, what being placed on a ventilator is like: while you are already distressed by illness and frightened by a total loss of control, the medical staff have to thread a plastic breathing tube down your throat, past the vocal cords, and into the upper chest. It is unsurprising that patients who are conscious will instinctively fight this frightening, claustrophobia-inducing invasion. As a result, the patient often has to be sedated, sometimes with powerful, hallucination-inducing drugs such as propofol and fentanyl, while their arms and legs are restrained to prevent the kinds of physical struggle that can rip out the breathing tube.<sup>2</sup> In my case, I was not only restrained, but had large, boxing-glove-like mittens on each hand. I would at first remember them as malevolent figures and invisible forces that imprisoned me, preventing me from escaping what looked like a constantly changing combination of an unfamiliar house, a dank basement of some prison, and a weird bar, where funhouse mirror versions of people from my past and present, people in white coats who, in retrospect, were probably doctors—as well as disembodied heads and headless torsos—mingled, occasionally glancing at me, their captive. I could not speak, scream, move. And everywhere, the walls, floors, things, people were covered with ever-increasing numbers of bugs, large and small, moving through and over everything like schools of fish or flocks of birds. And I mean everything, including my body, face, gown. “Why are there so many bugs here?” I apparently kept asking whoever was near. “Why don’t you get rid of them?” And even after I was taken off the ventilator and was vaguely aware of some of my surroundings, I kept seeing those bugs—relentless, directionless, fully in charge in my ICU psychosis-induced universe.

So now we get to my central worry about the post-intubation COVID-19 crisis—the onslaught of ICU psychosis (or ICU delirium) in intubated COVID-19 patients, and the PTSD that follows—a rate comparable to PTSD diagnoses among combat veterans and rape victims.<sup>3</sup> Indeed, a third to more than 80 percent of ICU patients suffer from delirium during their stay, and about one in three ICU survivors who require intubation might develop post-traumatic stress disorder, also known as post-intensive-care syndrome (PICS).<sup>4</sup> The cause of the delirium, of which mine is but one example, is not yet well understood neurologically. It is likely the result of several factors, including hypoxia, the use of sedatives, restraints, and lack of conscious mental stimulation.<sup>5</sup> The sedated brain is not a resting brain: it is a brain strained by the extreme conditions of the ICU, including sensory deprivation and, at the same time, sensory overload of intense pain, bright lights, extended ventilator use, and constant prodding from a rotating cast of nurses and doctors. In response, patients can become confused, paranoid, or completely lose touch with reality. As Jim Jackson, a psychologist at the ICU Recovery Center at Vanderbilt University Medical Center noted, delirium can be understood in part as a patient’s attempt to create a

narrative that not only explains what seems inexplicable, but that

reflects the very real pain and stress of their environment. The problem is that the mind transmogrifies reality into something much scarier.

We've had delirious patients who are taken to an imaging center at the hospital to get an MRI [. . .] As they are being pushed into the MRI machine—quite appropriately—they're convinced that they're being moved into an oven, because that MRI machine bears some vague resemblance in their mind to an oven.<sup>6</sup>

Although the breakdown of a patient's mental health can begin in the ICU, it does not end there. Even when the delirium is over, what remains are false, frightening memories. Because they are based on real-life stimuli, they are so much more vivid than a nightmare. My memories of bugs, shadow monsters, talking headless bodies, and scheming medical staff, intent on injecting me with dangerous poisons, are still with me today. Sometimes, they even pay me unwelcome visits in my dreams—over two years post-discharge. They are, of course, much more contextualized now. Unlike the terror, helplessness, and despair that I experienced while in their grip, I am now aware that they were a part of my ICU delirium. That they did not actually take place in the *real* world.

But, also in a very real sense, they *did*. They happened to me emotionally, biochemically, phenomenologically. Apart from wakeful consciousnesses, in all the senses that an experience can be real, in all the ways that it can alter your life, your understanding of who you are, and your capacities to imagine yourself in the future—these delusions are, catastrophically, genuine traumatic memories. They can alter, and even break, the emotional circuits of the brain. The only kinds of intervention that can lessen the depth and the trauma of the delirium seem to be human contact—touch, soothing words, music—that can somehow get through the chaos, and ground the patient in the real world. The tragedy of COVID-19 lies in part in the impossibility—at least for now, before we have a vaccine—of even these small mercies. The result is that this leaves the intubated patient not only physically, but existentially, alone with their nightmares. And this makes what happens next so much worse.

What happens next, if one is fortunate enough to have survived intubation, is wakefulness, and the onset of post-delirium PTSD. My own recollections of those first few days post-intubation are rather opaque, but the account of another patient rings true: "I don't feel safe anymore," he says, "like there's a low hum of menace."<sup>7</sup> In addition to multiple physical and psychological challenges—in my case, an inability to walk due to muscle wasting, foot drop (rendering my left foot paralyzed), dizziness, nausea, loss of smell and taste, and general confusion—the post-ICU experience is pure, unrelenting fear of being *back there*, or at least of experiencing what it was like all over again. As one patient describes it, "I'm afraid [. . .] after the horrible things I saw."<sup>8</sup> Flashbacks to the delirium visions come

often, unexpectedly, and sometimes triggered by strange and random stimuli: some patients cannot take showers because the shower curtain is too much like the ICU curtain, on the other side of which lies horror; some cannot bear the sounds of sirens, for that is how the nightmare began; some cannot stand to be alone. And some, myself included, are initially too anxious to seek needed medical care. I say "initially" in referring just to myself, since for a number of patients, hospitals trigger PTSD-inducing horrors that continue for years after their discharge. This particular PTSD stimulus is especially problematic for COVID-19 survivors, who often face long and difficult recoveries at home, requiring additional medical treatment.

The psychological distress of ICU-induced PTSD does not end with anguish attributable to traumatic memories. Another factor is what happens when, and immediately after, the recovered patient is wheeled out to the celebratory applause of medical staff and family members. A COVID-19 survivor recalls that

"I felt bizarre because I was sort of being publicly celebrated by friends, family, and the interviews I was doing for having recovered," she said. "But I felt like I had this dirty little secret, which was that I was not fully well at all."<sup>9</sup>

In my own case, I recall not only fear of the nightmares and sadness at my lack of autonomy, but a growing, irrationally triggered anger—apparently not an uncommon symptom of PTSD—at what I interpreted as pressure to *perform survival*. With significant hindsight, what is clear is that those who loved and cared for me were overjoyed at my presence here among them, pushing far back the darker thoughts about what could have been. What was less clear to me then was how to balance what I thought I ought to do for the sake of those who had gone through so much as a result of my illness, and what I wanted to do, which vacillated between hiding in bed with the shades drawn, and screaming my fear, my pain, my physical and psychological limitations for all to hear. Exhausted and confused for quite some time after returning home, I remained mostly silent.

An ICU survivor noted that "surviving and getting our life back are two different things."<sup>10</sup> Those of us who live daily with the truth of this claim know that even after a pandemic, this pandemic, wanes, there will be the walking wounded, the miracle of whose survival is followed by the heavy burden of having to go on. I would like to conclude by asking what is next for them—and how can it be made better? Given the growing number of COVID-19 patients, some of whom survived, and will survive, the worst versions of the illness in the ICU, what can we do to lessen ICU psychosis, and in turn, to reduce the numbers of those facing months, and perhaps years, of PTSD-related trauma? What would it mean to address this new and looming mental health challenge?

There are long-term and short-term possibilities. In the United States, where the worst outbreak in the world is made that much worse by a lack of not only a robust public health response, but of any kind of guaranteed health care at all, the challenges are both most pressing and the outlook the least promising. The lack of care, racial inequalities in both who becomes most ill and who receives

better treatment, and a federal government that not only denies scientific facts but cares very little for the welfare of its most vulnerable citizens, suggest that any immediate large-scale changes, as necessary as they are, would be too slow in coming to those patients who are, or will be, in the greatest need of assistance. And so I turn to some less structurally complicated options that might have some hope of being implemented in the shorter term.

The first suggestion has to do with mental health follow-up after ICU discharge. “Not having any kind of aftercare for the emotional aspect is honestly the hardest part,” one patient notes.<sup>11</sup> When patients leave the ICU, “[e]veryone pays attention to whether patients can walk and how weak they are. But it’s the exception for them to be screened for psychiatric symptoms like post-traumatic stress or low mood.”<sup>12</sup> Indeed, in the United States, there are only sixteen ICU follow-up clinics for the needs of over five million new ICU survivors each year. Two of the largest clinics—at Vanderbilt and Johns Hopkins—are already seeing increasing numbers of COVID-19 patients, with more to come.<sup>13</sup> The result is a kind of medical abandonment: When I was discharged, my patient file could rival a treatise on constitutional law in thickness (and top it in excruciating analyses), but not one word could be found in it, nor in any contact I had with any of my treating physicians, about my psychological aftercare, or even about the possibility that I just might not feel like myself . . . for a while. I was released into the familiar streets of Brooklyn without any guidance or warning that the blocks, stores, and sounds that I once found so familiar and comforting might now be sources not only of terror and panic, but also that their busyness, noise, and speed might contribute to unprecedented feelings of liminality, *otherness*, and isolation. Like others who have gone through prolonged intubation, I no longer fit my former life, and what it required of me was no longer within me to give. All this without a word about what awaits me beyond the hospital doors from the medical professionals who, up until discharge, cared so well for my physical body. It took a long time—too long—to find the kind of compassionate, effective therapy that slowly but surely made the shadow monsters, bug infestations, and other grotesqueries more manageable. And I am one of the privileged ones, with a good job, a supportive partner, and decent medical insurance.

But this is, of course, not just a story about my personal post-ICU nightmare. Indeed, the struggle to find similar post-intubation PTSD care would place unimaginable burdens on someone less fortunate. And, as has become entirely all too clear, COVID-19 has disproportionately impacted the less-privileged, socioeconomically oppressed communities (and especially communities of color)—the very same communities whose access to medical care, including mental health care, is most limited, most insufficient. What faces us in this time of the pandemic—and I mean “us” in the most inclusive sense possible—is a choice: Do we continue discounting the dire need for mental health care for COVID-19 patients in the same dismissive, cavalier manner that ICU patients, like myself, have been treated, or do we choose to do better? Do we begin to view the idea of recovery as not ending once the hospital doors slide shut, and, especially in the case of the most underprivileged

and vulnerable, do we make the necessary efforts to reach out, to offer help, to, at the very least, let patients (and their families) know what “getting better” post-intubation might be like? Given the growing numbers of patients and the virulence of the virus (at least in the United States), I am not sure that we have a morally defensible choice to remain passive. And so I propose that not only should the medical staff never leave a post-ICU patient without clear, understandable, and caring instructions about how to access necessary mental health care while hospitalized as well as once they are released, but that we meet those exiting the hospital doors not (only) with flowers and balloons, but with experienced and caring therapists and psychiatrists as an essential part of COVID-19 treatment.

My second suggestion is much simpler, and has more to do with a patient’s experience in the ICU itself. Given the isolating nature of the disease, the patient is likely to develop memory holes—gaps in the narratives of their life, with nobody to fill them. This, too, adds to an already-traumatized survivor’s challenges: How does one begin to reconstruct a life when so much of what has suddenly and dramatically changed is missing? One strategy that some hospitals are beginning to use is the ICU diary: Family members and health-care professionals write in a personal journal the story of each day the patient spends in the ICU, each adding their own perspectives, thoughts, and observations.<sup>14</sup> After the patient is discharged, this diary serves as a map, or perhaps as a bridge, between the “before” and the “after,” that gives them back their story by helping them to narratively navigate, connect, and try to make sense of, their lives during intubation. None of this is new, revolutionary, or unreasonably demanding of the medical staff. In fact, for over a decade, critical care units in Europe have been turning to bedside diaries as a way to not only record significant medical events, but to tell the kinds of stories that allow patients to trade epistemic lacunas for an unflinching, sometimes difficult reading about their own lives.<sup>15</sup> I suggest that these diaries, and the multiperspectival narratives they contain, can be powerful tools in helping COVID-19 patients recover from ICU psychosis, and thus to alleviate later symptoms of post-traumatic stress. Not only do they offer evidence that one was not as existentially alone as one might imagine, but also that others, either in person, or via video, phones, and other methods “held” the patient as Hilde Lindemann might say, in her personhood—that the patient’s necessary silence did not mean a lack of story, of meaning, or of a self.<sup>16</sup> These insignificant-seeming diaries, then, just might be a way to remind a traumatized post-intubation patient that she was, is, and remains a person, physically and psychologically damaged, but not beyond repair—and that the roots of that repair are already right here in the words of others, in this little notebook. Given the choice between knowing and not knowing what took place in those fragile hours when life and death were measured with breaths and when the idea of tomorrow was just that, these words are the first, and necessary, steps to a place that is more than mere survival.

**NOTES**

1. Brison, *Aftermath: Violence and the Remaking of a Self*.
2. Zhang, “What Life Is Like After Being Taken Off a Ventilator.”



3. Hopkins, "PTSD Common in ICU Survivors."
4. Girard et al., "Delirium in the Intensive Care Unit."
5. Buder et al., "COVID-19 Is a Delirium Factory."
6. Ibid.
7. Zhang, "What Life Is Like After Being Taken Off a Ventilator."
8. Buder et al., "COVID-19 Is a Delirium Factory."
9. Ibid.
10. Ibid.
11. Ibid.
12. Hoffman, "Nightmares After the I.C.U."
13. Buder et al., "COVID-19 Is a Delirium Factory."
14. Buder et al., "COVID-19 Is a Delirium Factory."; Hoffman, "Diaries from I.C.U. Aid Mental Recovery."
15. Hoffman, "Diaries from I.C.U. Aid Mental Recovery."
16. Lindemann, *Holding and Letting Go: The Social Practice of Personal Identities*.

#### WORKS CITED

- Brison, Susan J. *Aftermath: Violence and the Remaking of a Self*. Princeton, NJ: Princeton University Press, 2002.
- Buder, Emily, Annalise Pasztor, and Vishakha Darbha. "COVID-19 Is a Delirium Factory." *The Atlantic*, May 8, 2020.
- Girard, Timothy D., et al. "Delirium in the Intensive Care Unit." *Critical Care* (London, England) 12, Suppl 3. 2008.
- Hoffman, Jan. "Nightmares After the I.C.U.," *The New York Times*, July 22, 2013.
- . "Diaries from I.C.U. Aid Mental Recovery." *The New York Times*, July 22, 2013.
- John Hopkins Medicine, "PTSD Common in ICU Survivors," April 20, 2015. [https://www.hopkinsmedicine.org/news/media/releases/ptsd\\_common\\_in\\_icu\\_survivors](https://www.hopkinsmedicine.org/news/media/releases/ptsd_common_in_icu_survivors).
- Lindemann, Hilde. *Holding and Letting Go: The Social Practice of Personal Identities*. New York: Oxford University Press, 2014.
- Renault, Marion. "ICU Delirium' Is Leaving COVID-19 Patients Scared and Confused." *The Atlantic*, May 5, 2020.
- Styron, William. *Darkness Visible: A Memoir of Madness*. New York: Random House, 1990.
- Zhang, Sarah. "What Life Is Like After Being Taken Off a Ventilator." *The Atlantic*, April 22, 2020.

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## What Does It Mean to Be an Empathetic Leader? Lessons from COVID-19

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An interesting finding has emerged in the wake of the COVID-19 pandemic: countries led by women seem to be doing better than countries led by men. Numerous news outlets report on this observation, and not always without a measure of surprise.

A popular strategy for evidencing this claim is to point to examples of successful female leaders such as New Zealand's Jacinda Ardern, Germany's Angela Merkel, and Taiwan's Tsai Ing-wen.<sup>1</sup> While this makes for a compelling news story, this strategy is susceptible to cherry-picking. We can easily find examples of women at the highest echelons

of governmental advisory teams in countries with disastrous coronavirus responses—case in point: Dr. Deborah Birx, the current Coronavirus Response Coordinator in the US.<sup>2</sup> We can also find highly successful coronavirus responses in countries led by men—examples include Vietnam, the Czech Republic, Greece, and Australia.<sup>3</sup> Simply pointing to examples of effective women leaders is not enough to prove that they are more successful than their male counterparts, whether in this crisis, or more generally.

The *New York Times* columnist Nicholas Kristof takes a different approach, using data to substantiate the claim that female leaders have been more effective than their male counterparts.<sup>4</sup> Based on death rates from twenty-one countries from around the world, Kristof shows that women-led countries lost one fifth as many lives to the coronavirus than did their male-led counterparts. That is a staggering difference.

But we must be careful with these kinds of claims too. We might choose among several different definitions of effectiveness. Is death rate the best measure of success? Or would case rate be better? Or perhaps we should focus on the economic health of the nation (for which there are also many different measures we might adopt). Whether we judge female leaders to be more successful than their male counterparts will depend on the metric we use.

The question of whether countries led by women genuinely fare better than countries led by men is largely an empirical one. Like many other empirical questions, our values affect the measures that we use and therefore the outcome of the analysis.<sup>5</sup> This complicates things, of course, and we should accept a healthy dose of scepticism. But for the sake of argument, let's take the empirical claim at face value.

The next question is what makes women leaders so successful?

News articles again provide a helpful starting place. They point to a number of qualities and attributes that successful women leaders tend to share. *BBC News* attributes Jacinda Ardern's success to her strength, kindness, and empathy.<sup>6</sup> Similarly, blogs from leading management firms and business schools all highlight the virtues of feminine leadership styles and emphasize empathy.<sup>7</sup> *New York Magazine* describes Merkel's coronavirus speech as "direct, honest, and searingly empathic."<sup>8</sup> Empathy comes up again and again. But what is empathy?

Empathy is notoriously hard to define. There is much dispute within the philosophical and psychological literatures over what it is. We don't need to get too mired in this debate. But it is important to be clear about what we mean when we're talking about empathy.

Here's why:

On one popular view, empathy is just the ability to share others' emotions, to feel what another individual feels. Call this "emotional empathy." This concept of empathy has been used to construct numerous studies and build various scales that measure empathy.

But this type of empathy, as many authors have pointed out, has many dangers.<sup>9</sup> It can lead us to be partial and parochial. Perhaps most relevant for our purposes, it can lead to burnout and empathic distress, in which people feel completely overwhelmed by the feelings of others, to the extent that they cannot act. If this is what we understand empathy to be, it seems ill-suited for crisis situations.

But crisis is the situation that we currently find ourselves in. And crisis situations are precisely the ones that world leaders who we recognize as empathetic are excelling in. So what is going on here?

Let's consider a parallel case: medicine. Patients often say that they want their doctors to be empathic. And yet, many doctors rate as very low on empathy based on scales that measure emotional empathy. This is because if you respond positively to items on that scale, such as "I am able to remain calm even though those around me worry"—that is, if you say, "Yes, I am able to remain calm"—you will be rated as low on empathy.<sup>10</sup> But many of us would still consider these doctors to be empathic. They seem to be highly attuned to what their patients are thinking and feeling. And they remain extremely adept at responding well in a crisis.

So it seems that what we're dealing with is not emotional empathy—at least not solely—but something else. Emotional empathy, while helpful for constructing psychological studies, is too narrow a concept to capture what we mean when we talk about empathic leadership during a global pandemic or when we talk about empathic doctors. Both the medicine and leadership cases illustrate mismatches between certain concepts of empathy, the scales used to measure them, and the quality that we are trying to express, target, and understand.

When we identify global leaders as empathetic, what then do we have in mind? We do not seem to mean that these global leaders are particularly good at emotion sharing, despite emotional empathy being the concept favored by many psychologists and philosophers.

Other qualities that people tend to associate with empathy include kindness and care, or the kind of warmth associated with older women, mother figures who wrap you up in the hug you didn't know you wanted. But the female leaders in question are not particularly warm or fuzzy. Angela Merkel is cool, calm, and direct. She approaches her populace with the straightforwardness of a surgeon or a general, levelling with them, and responding pragmatically. Jacinda Ardern does come across as warm—she invites us into her home for chats over Facebook Live, after all—but she also emphasizes the compatibility of empathy and strength.<sup>11</sup>

The idea that empathy is about warmth, kindness, and care perhaps goes some of the way towards explaining why it has long been associated with women (more on this in a minute). But I don't think that warmth is really what people have in mind when they attribute empathy to these women either. There is something else going on here.

Again, the comparison with medicine is apt. People often think of their doctors as empathic when they are able to remain uncannily calm and when they level with us. The essayist Leslie Jamison captures the idea perfectly:

I remember being struck by how the doctor had anticipated a question about the pacemaker I hadn't yet discovered in myself: How easily would I be able to forget it was there? I remember feeling grateful for the calmness in his voice and not offended by it. It didn't register as callousness. Why? . . . His calmness didn't make me feel abandoned, it made me feel secure. It offered assurance rather than empathy, or maybe assurance was evidence of empathy, insofar as he understood that assurance, not identification, was what I needed most.<sup>12</sup>

Empathy, on this view, does not mean simply feeling what the other person feels—though feeling may be part of it. It instead involves inquiry and openness followed by understanding and anticipation.

When we attribute empathy to strong women leaders, we are doing something similar to what we do when we attribute empathy to doctors. What we have in mind has little to do with warmth and fuzziness and everything to do with inquiry and understanding.

This form of empathy has epistemic value—that is, it helps us to gain knowledge about each other and about the world. It has much in common with another quality that has received praise in recent discourse about the coronavirus: epistemic humility.<sup>13</sup> Epistemic humility is basically about knowing your limits—knowing what you don't know and when to consult the experts. Epistemic humility is especially important in a crisis of the sort that we are facing, where there is great uncertainty and complexity, and where we must reckon with multiple (sometimes competing) strands of scientific and technical knowledge.

Perhaps empathy, of the sort that we attribute to world leaders and to doctors, is about epistemic humility, but on an interpersonal level. Leslie Jamison, writing about the medical context, again captures the idea well: "Empathy requires inquiry as much as imagination. Empathy requires you know nothing. Empathy means acknowledging a horizon of context that extends perpetually beyond what you can see. . .".<sup>14</sup> Empathy is, on this view, epistemic humility but about other people, their situations, their contexts, and what they need. We come to understand them through a process of inquiry.

If what we have in mind when we talk about empathy in our leaders is a form of interpersonal epistemic humility, this also helps to explain why empathy is so tightly connected with effective communication, trust, and care. Being able to listen closely, to ask the right sorts of questions and respond with honesty and openness—to level with the people—engenders trust. It also makes room for care that is more tailored to the needs of the community in question, rather than wholesale generalized responses.

Importantly, leaders who present as direct or even cold in the public eye can excel at empathy construed as interpersonal epistemic humility. Angela Merkel is not usually described as particularly warm or feminine and yet she is “searingly empathic.” Hillary Clinton, who was lambasted for being cold and aloof during her presidential campaign, also famously went on “listening tours” while she was a New York State senator, an activity that endeared her to its citizens and gained her high approval ratings.<sup>15</sup>

This brings me to my final questions: Is there anything particularly feminine about empathy? And what are the consequences of continually thinking of empathy as a feminine trait?

Empathy has long been associated with women. As we’ve seen here, it continues to be identified as an attribute of a feminine leadership style. It can also be found at the heart of feminist ethical thought—namely, in care ethics. Empirical work also shows that women and girls tend to be more empathic than men and boys.<sup>16</sup> However, it’s unclear what we should conclude from this research. First, we need to be careful about the aforementioned conceptual disputes. Not all of these scales are measuring the same thing. And many of them may be getting at something quite different from what we have in mind when they talk about empathic leaders. We also cannot conclude from this research that women are by any means more empathic *by nature*. It’s more likely that girls are brought up to be more empathic than boys are and that the difference is largely due to culture and development.

More importantly, however, it can be damaging—for both men and for women—to think of empathy as a particularly feminine trait. It’s bad for women because empathy continues to be associated with warmth and fuzziness. This is not a bad thing in and of itself, but the association nevertheless plays into the stereotype that women are soft, weak, frail, overly emotional, or easily trampled upon. These are hardly qualities that we want to see in our leaders. This is perhaps why Jacinda Ardern feels that she needs to publicly reconcile her strength with her empathy.

It is also bad for men because it feeds into the narrative that they need to be the opposite of empathetic to be seen as strong leaders, even when this leadership style is highly ineffective. They go too far the other way in an effort to be seen as strong. Some of the analyses of coronavirus responses are telling. They attribute the difference in response not to the success of female leadership but to the failure of strongmen, who are all “ego and bluster” and lack both epistemic humility and interpersonal skills.<sup>17</sup>

Thinking of empathy too narrowly also leads us to overlook the ways that men can be empathic in nontraditional ways. Perhaps the most famously empathetic male leader is Barack Obama. He is clearly skilled at communicating emotively and with warmth—at empathy as traditionally conceived.

But focusing on the epistemic dimension of empathy opens up the field of empathic leaders and makes sense of nontraditional empathy attributions. Joe Biden, for

example, identifies his approach to foreign policy explicitly as one of “strategic empathy.” While Biden does come across as skilled in the language of emotion, it is hardly the case that we expect him to emotionally engage with foreign leaders to develop policy proposals. Understanding strategic empathy as involving connection in the service of inquiry makes more sense here. It also helps us to see what we mean when we attribute empathy to Andrew Cuomo, an extremely blunt New Yorker. These leaders are skilled communicators, adept at listening to their populace, establishing a connection, and thereby gaining more detailed information to inform their responses.

I do not mean to say here that empathy *is* interpersonal epistemic humility or that we need to think about it as being completely divorced from emotional engagement. Emotional sensitivity may facilitate the epistemic function of empathy. The point is that the concept of empathy at work in everyday discussions of empathic leaders is clearly richer than the reductive concepts often in use in psychology. But it’s still worth trying to understand what we have in mind and what quality is valuable in our leaders. In leadership, as in medicine, empathy has an epistemic dimension and a strong affinity with humility.

#### NOTES

1. See, for example, Jon Henley and Eleanor Ainge Roy, “Are Female Leaders More Successful at Managing the Coronavirus Crisis?” *The Guardian*, April 25, 2020, <https://www.theguardian.com/world/2020/apr/25/why-do-female-leaders-seem-to-be-more-successful-at-managing-the-coronavirus-crisis>.
2. This is not to say that she is to blame for the disastrous response.
3. Examples from <https://www.theguardian.com/world/2020/apr/25/why-do-female-leaders-seem-to-be-more-successful-at-managing-the-coronavirus-crisis>.
4. Nicholas Kristof, “What the Pandemic Reveals About the Male Ego,” *The New York Times*, June 13, 2020, <https://www.nytimes.com/2020/06/13/opinion/sunday/women-leaders-coronavirus.html>.
5. Science is not value free, as philosophers of science widely accept.
6. “Coronavirus: How New Zealand Relied on Science and Empathy,” *BBC News*, April 20, 2020, <https://www.bbc.co.uk/news/world-asia-52344299>.
7. Examples come from the Oxford Saïd School of Business (<https://www.sbs.ox.ac.uk/oxford-answers/leading-empathy-pandemic>), Yale School of Management (<https://insights.som.yale.edu/insights/leading-through-covid-manage-your-team-with-empathy>), and McKinsey (<https://www.mckinsey.com/business-functions/organization/our-insights/tuning-in-turning-outward-cultivating-compassionate-leadership-in-a-crisis>).
8. Justin Davidson, “The Leader of the Free World Gives a Speech, and She Nails It,” *NYmag.com*, March 18, 2020, <https://nymag.com/intelligencer/2020/03/angela-merkel-nails-coronavirus-speech-unlike-trump.html>.
9. Jesse Prinz and Paul Bloom are perhaps the most forceful critics of empathy. See Jesse J. Prinz, “Is Empathy Necessary for Morality?” In *Empathy: Philosophical and Psychological Perspectives*, ed. A. Coplan and P. Goldie, 211–29 (Oxford: Oxford University Press, 2011); Paul Bloom, *Against Empathy* (London: The Bodley Head, 2016). See also his article in the *New Yorker* for a short summary of his argument (<https://www.newyorker.com/magazine/2013/05/20/the-baby-in-the-well>). Of course, these critiques do not mean that empathy always carries these dangers—we need to be sensitive to conceptual and measurement essays and put forward a more contextualized account.

10. For a good explication of this issue, see R. Pedersen, "Empirical Research on Empathy in Medicine—A Critical Review," *Patient Education and Counseling* 76 (2009): 307–22.
11. See Geoff Blackwell, "Jacinda Ardern: 'Political Leaders Can Be Both Empathetic and Strong'," *The Guardian*, May 30, 2020, <https://www.theguardian.com/world/2020/may/31/jacinda-ardern-political-leaders-can-be-both-empathetic-and-strong>.
12. Leslie Jamison, *The Empathy Exams* (London: Granta Publications, 2014), 17.
13. See Erik Anger, "Epistemic Humility—Knowing Your Limits in a Pandemic," *Behavioral Scientist*, April 13, 2020, <https://behavioralscientist.org/epistemic-humility-coronavirus-knowing-your-limits-in-a-pandemic/>.
14. Jamison, *The Empathy Exams*, 5.
15. See Ezra Klein, "Understanding Hillary: Why the Clinton America Sees Isn't the Clinton Colleagues Know," *Vox*, July 11, 2016, <https://www.vox.com/a/hillary-clinton-interview/the-gap-listener-leadership-quality>; and Elizabeth Kolbert, "The Student," October 6, 2003, <https://www.newyorker.com/magazine/2003/10/13/the-student>.
16. For a review, see Leonardo Christov-Moore et al., "Empathy: Gender Effects in Brain and Behaviour," *Neuroscience and Biobehavioural Reviews* 46, no. 4 (2014): 604–27.
17. See again Kristof, "What the Pandemic Reveals About the Male Ego."

## *Pandemic, Pessimism, and Misanthropy*

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Every Thursday night at 8 p.m., during lockdown, millions of Britons went outside to "clap for the NHS," the much beloved National Health Service. They were publicly celebrating care workers in a morally expressive ritual. Some gushing commentators talk of an "epidemic of neighbourliness." People admire the community support groups that quickly sprang into action to help vulnerable people. Children put up colorful pictures in their windows to affirm they are thinking of others.

Expressed in all of this is a faith that in times of crisis we show our better selves and overcome our petty biases and sullen self-enclosedness. What's hoped for is a new fellow-feeling and a happy experience of our slumbering compassion-awakening. One of the best-selling books right now is Danish historian Rutger Bregman's *Humankind: A Hopeful History*, an uplifting case for our deep and natural goodness, (which, tellingly, sold out before it was published).<sup>1</sup> In these optimistic moral visions, the message is we can hope that in the "new normal," we're a lot *nicer*.

Such cheery sentiments are tempting, amid the daily counts of "excess deaths" and anger at governmental failings and acts of public selfishness and recklessness. I feel the lure of believing in the inevitability of compassion. Leaning into a quiet spirit of hopeful trust in our latent capacities for mutual concern offers emotional respite. Horrible realities are—like death and the sun—hard to stare at for too long. Many of us feel deeply the temptations to look away by contemplating sunny visions of our morally transfigured future. Such willful self-indulgence in hopeful optimism may serve positive ends too. Perhaps it makes that hoped-

for moral rejuvenation seem a little more plausible. Margaret Walker emphasizes the "action-tendencies" of hope: to believe that an end is possible and to desire that it comes to pass can emotionally nourish us and drive us to act—to plan, to imagine, to collectively organize.<sup>2</sup>

A natural worry about such optimism and hope is that they can reflect and reinforce what the medical writer and cultural critic Barbara Ehrenreich called "bright-siding." In her book *Smile or Die* she describes an array of psychological and cultural mechanisms that aim to turn us away from the darker sides of life—our adversities, disappointments, frustrations, resentments, all the suffering without consolation, all the wickedness without retribution.<sup>3</sup> Ehrenreich describes the many forms of "bright-siding"—the crudest being blanket denial of the reality and inevitability of suffering across its forms. Some of the more sophisticated forms involve acknowledging the dark sides only on strict condition that they be fitted into a triumphal narrative with a happy ending. Sometimes, bright-siding means admitting the facts of painful loss only to insist on a new, better life in which all such pain and loss will be forgotten.

Ehrenreich wrote *Smile or Die* partly in protest at the ways that bright-siding helped to sustain the suffering of millions of Americans, encouraging them to turn away from the realities of their cancer, poverty, or political disenfranchisement. One of the most powerful sections of her book is an account of her effort to be honest about the anger and frustrations she felt during her first experience of breast cancer. In an online breast cancer support forum, she described her anger—at her body, her insurance company, at the people who stare and those who stay away, at the American health-care system. She was almost unanimously met with an automatic chorus of bright-siding content and tone policing—pitying her anger, warning that anger only makes you sicker, and the usual chorus of banal assurances that things will look better tomorrow. Such bright-siding responses are extremely familiar and by now show up in response to a whole range of adverse experiences, even if the experiences of cancer and other serious illnesses are often the most appalling. Indeed, one of the deeper warnings of *Smile or Die* was that American culture has become ensnared by "an ideology of positive thinking."

I wonder how much of the talk of the pandemic initiating a moral transformation of humanity for the better is some collective exercise in "bright-siding." Obviously, it isn't total, since there's plenty of emphasis on our collective bad behavior—selfish acts of stockpiling, willful violations of physical distancing restrictions, and the rest. But bright-siding can reflect a whole set of vices—from dogmatic optimism to absurd hubris to willful self-deception—and not all of them are easy to spot.

I think that one of the main forms of vicious bright-siding in relation to the pandemic is a kind of politically charged *naïve myopia* of a sort that should be of special concern to feminists. The naiveté takes the form of an unsustainable trust that people are working for the better. The myopia involves a failure to see that substantive moral reform for the better typically requires radical structural changes to

the ways that societies are organized. In their compound form, the vice of naïve myopia distorts our perception and understanding of the dynamics of the social world. By presupposing that people typically are clear-sighted and morally concerned, what results is an untenably morally optimistic stance whose ultimate expression is a false hope that the pandemic will reveal us at our best.

Doubtless, challenging naïve myopia requires a whole set of responses, all of them abundantly familiar to feminist activists. I want to emphasize two which might best target the naïveté and the myopia of much contemporary pandemic bright-siding. The first is the imperative to think structurally, which is a core lesson of generations of feminist action and theory. A main claim of Bregman's book *Humankind* is that we are (in his cutesy term) *Homo puppy*—fundamentally gentle, sociable beings, attuned to one other's emotions and needs. Whatever the truth of that anthropological claim, it misses the point that many human evils are generated and enacted, not by isolated villains, but by social institutions and structures. (Tellingly, Bregman makes only one, passing, mention of patriarchy.)

The culturally pervasive exploitation and oppression of the members of so many social groups must be understood as a social and structural phenomenon. Patriarchy is a vital concept for articulating that truth about the world and a corrective to a myopic vision of dispositions to gendered oppression as a feature of bad people, rather than as a system dominated by what Kate Manne called a "logic of misogyny."<sup>4</sup> An inability or refusal to see the structural dimensions of the moral problems of the world is a specific sort of politically charged myopia. Training people to see and think structurally is one way to counteract myopia. Alas, though, also a difficult one, given what we know about the invested need of so many people to turn away from the uncomfortable realities of the social world—a need apt to be amplified by cultural valorizations of traits like autonomy.

A different response is needed to the naïveté displayed in bright-siding confidence in the receptivity of people to radical moral transformation. It cannot simply take the tit-for-tat form of wielding counter-examples to those heartwarming incidences of kindness and thoughtfulness which the optimists broadcast. It requires a different way of thinking about our collective moral condition as it has come to be in the specific forms of the social world that we have inherited. Such transformations of perception have always been central to feminists—both as exercises in lucid perception of the moral realities of the world and as a justification for the radical work needed to transform society. Audre Lorde wrote in her *Cancer Journals* of her abiding "fury at the outside world's viciousness, the stupid, brutal lack of consciousness or concern that passes for the way things are."<sup>5</sup> For many people, it's a slog and a shock to see the world in this grim light.

When the target of moral condemnation is something collective—such as humanity or the current forms of human life—an appropriate if neglected term is *misanthropy*. I don't mean a hatred or distrust of individual human beings, even though some of them are indeed exemplary of our

collective failings (think of Trump's greed, conceitedness, and vanity). Philosophical misanthropy is a systematic moral condemnation of humanity or humankind as it has come to be, driven by a perception of its being suffused by vices and failings that are entrenched and ubiquitous. What the pandemic has exposed are the collective failings deeply built into our ways of life—the callous institutionalized neglect of the vulnerable; the systematic derogation of the socially marginalized; the entrenched greediness which powerfully privileges economic interests over the integrity of human lives. In these cases, the moral criticism is directed at failings integral to the common structures of human life.

An obvious connection exists between structural consciousness and misanthropy. The more carefully and critically one examines the wider structures of the world as it has come to be, the more compelling a misanthropic verdict will become. We start to see in very stark relief the ubiquitously entrenched dogmatism, hate, indifference, and recklessness of our shared form of life. It becomes gradually evermore difficult to entertain the optimistic talk of the pandemic as revealing "the best in humanity." We start to feel discontentment at facile "bright-siding" assurances of the underlying goodness of *Homo puppy*. Any genuine rectification of our collective moral condition requires nothing less than radical changes to the cultures and structures constitutive of our shared ways of living. Nothing less will do for nothing less could do the work.

Ehrenreich's main concern about bright-siding was that it stifles our sense of the need for collective political action. Like all of those fighting against injustice and oppression, she focused on the dark sides of human life—our well-rehearsed capacities for cruelty, dogmatism, indifference, willful ignorance, and other failings. Dismantling structures of oppression requires sustained long and difficult projects of collective action and a virtuous hope rooted in a lucid perception of the scale of the task. It does not need some naïve trust in a forthcoming moral renaissance, carried on the back of a global pandemic.

It is easy to lapse into self-indulgent reveries in which there is collective change for the better—about the pandemic as a human catastrophe that led to moral transfiguration. Such reveries can be emotionally and psychologically sustaining amid a period of horrible anxiety and a shared mood of gloom. A corrective misanthropy should remind us to wake and turn back to the realities of our typical collective moral performance. All those moral lessons about the value of caregivers are as easily learned as they are forgotten. Many of the Britons who public applaud the NHS today will vote Conservative tomorrow. Our sense of community will evaporate once we feel safe once more within our own little worlds. A misanthrope need not hate or distrust people, as Judith Shklar thought, nor be disposed to do them harm.<sup>6</sup> But they certainly do not trust that spontaneous outbursts of goodness will become an enduring feature of our collective character. Nor that our "better side" will prevail without a vast amount of often painful unrewarded effort.

A bright-siding confidence that the pandemic will reveal humanity at its best seems invidious given its susceptibility

to myopia, naiveté, and other vices that manifest some of our worst tendencies—to turn away from uncomfortable truths and harsh realities and from the suffering of others. What is now needed more than ever is confronting the entrenched moral realities of the world. If the pandemic provides some perspective, so much the better.

#### NOTES

1. Rutger Bregman, *Humankind: A Hopeful History* (London: Bloomsbury, 2020).
2. Margaret Walker, *Moral Repair* (Cambridge: Cambridge University Press, 2006).
3. Barbara Ehrenreich, *Smile or Die: How Positive Thinking Fooled America and the World* (London: Granta, 2009). It was published in the US under the title *Bright-sided*.
4. Kate Manne, *Down Girl: The Logic of Misogyny* (Oxford: Oxford University Press, 2017).
5. Audre Lorde, *The Cancer Journals* (San Francisco: Aunt Lute Books, 1997), 24.
6. Judith Shklar, *Ordinary Vices* (Harvard: Harvard University Press, 1984).

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## Ordinary Women in Extraordinary Times

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I am tired. I am always tired these days; physically, mentally, and emotionally. I am at home, working, from home. Life at the university was mundane but it was not home. So what does home entail? It is great weather and good food, but can one call it a good life? The rains have just started to pour out, as I look through the window. It's hazy, the mist has swallowed the visible, vibrant valley, and now it's a white canvas of moving fog.

Life at home here, in this small state of Sikkim at the corner of the Indian subcontinent, nestled under the Himalayas, is similar to yet also quite different from the rest of the world. Women like me, educated and working, are equally adept at household chores. However, maybe it is too ordinary to be talked or written about, that my stories, and stories like mine, are rarely a part of mainstream feminist literature. How does the work that we do at home fail to meet the eye? How did our everyday become so ordinary?

I love making things. I love organizing. After all, both are area skills passed on through generations of Subba women. When we were children, our mothers taught us how to knit, sew, and make cross-stitch patterns. While knitting, if we would intertwine our knitting yarn, we were taught how to unravel it with utmost patience and skill. It was "a skill all women should have." It signified that if at all there was a family feud, the daughter-in-law would untangle the knotted relationships, just as they would untangle a knitting yarn.

Organizing a morning routine at the university was simple. Wake up, wash up, have breakfast at the dining hall, and leave for your department or the library, whatever was convenient. University life at the country's capital, with all

the necessary facilities only forty-five minutes to an hour away by metro, is way too convenient. I often wondered if we had such facilities back home, would our lives have been any better? But home is different.

At home, the routine gets complicated. Wake up, cook, serve the meal, eat, clean up, and then head to the reading area. If I get tired and upset, my mother comforts me by reminding me how much better off I am than she ever was. While she was in her early twenties, she was working, taking care of the house, and raising a child. She often gives me tips on how to manage time. Time management and "being economic," namely, being frugal, is an extremely appreciated "quality" of a daughter at home.

My younger sibling and both of my working parents are home too. "We're finally a family now," my mother says, "and it is truly a blessing." Living alone and living with my family are different experiences. Family time is every evening's prime time news. The blaring television has just numbers on it these days. Numbers of people positive with the virus, current death toll, number of people tested until now, and also the number of recovered patients. The COVID-19 pandemic has brought the world to its knees. The sheer number of people it has killed to the workers it has unemployed, and the people it has infected is appalling.

I am a working woman, yet most of my work now is hovering around the household. Suddenly, the home is the workspace and the workspace is home. Women in the domestic domain have, since time immemorial, been subjected to unpaid household labor. I am aware of this only after taking gender courses at the university. However, my grandmother, my mother, my sister, and I all were raised keeping gender parities at bay. We were to work hard at school and at home. While at the university, I read a lot about feminism: about feminist understandings, having agency, fighting for equal pay for equal work, and so on. Yet when I'm at home in the ordinary, what I read does not seem to fit into my daily reality.

My father tries to help at times, but he possesses neither the skill nor the time to do it on a daily basis. Time management is definitely not his forte either. When asked of his inability, he recalls the time when he did try helping around the kitchen but was rebuked by my mother saying, "this is not a space for men." For the longest time, household chores were distributed unevenly between men and women, and often societies have gendered segregation of domestic and outdoor household chores. The evident reality of patriarchy is reinforced during extraordinary times, and this time it is definitely one.

I consider myself to be fortunate and privileged that I have dilemmas about working rigorously in the household as well as professionally. I am privileged to have learned about patriarchy. I am privileged to know that I am a person on my own, that I have a voice and I can raise it at will. I also realize that there are many like me today, at this moment, struggling with the same questions and dilemmas.

When will our struggle for space ever end? Will our burden ever lift or simply transfer from one woman to another? How

do I break these glass boxes that we are conveniently fit into, and as I try shattering one, how is it that I find myself confined in another? Do extraordinary times always have to relegate us back to the domestic domain?

But one hopes for better days. I can only imagine how much more difficult it would be for a woman raising a child in the midst of all this. Yet, our compensation is named “chivalry.” As though the compensation is our privilege; that which we earned rightfully is someone’s charity.

How privileged are you to not know of your own privilege? And how oppressed are you to not know of your own oppression? As I remember every woman of the Subba household, up the family tree, I am overwhelmed with the thought that no woman before me in my family had ever known that they were something more than their household duties. But, in my case, with professional duties, who, then, will look after the household? Whose responsibility is the domestic domain? It is everyone’s. It is not the responsibility of the ordinary woman alone. The household is a space of shared responsibility not segregated by differences of gender. While helping greater humanity, let us not forget the contribution of ordinary women in extraordinary times.

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