Orla T. Muldoon

The Social Psychology of Trauma

Connecting the Personal and the Political

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Many of us have been affected by trauma and struggle to manage our health and well-being. The social psychological approach to health highlights how social and cultural forces, as much as individual ones, are central to how we experience and cope with adversity. This book integrates psychology, politics and medicine to offer a new understanding that speaks to the causes and consequences of traumatic experiences. Connecting the personal with the political, Orla T. Muldoon details the evidence that traumatic experiences can, under certain conditions, impact people's political positions and appetite for social change. This perspective reveals trauma as a socially situated phenomenon linked to power and privilege or disempowerment and disadvantage. The discussion will interest those affected by trauma and those supporting them, as well as students, researchers, practitioners and policy makers in social psychology, health and clinical psychology and political science. This title is available as Open Access on Cambridge Core.

ORLA T. MULDOON is Professor of Psychology at the University of Limerick, Ireland, where she has lived on both sides of the border. She is currently editor-in-chief of *Political Psychology* and holds a prestigious European Research Council Advanced Grant. She has written numerous peer-reviewed publications on trauma, health, and political attitudes, and she makes regular media and policy contributions, including as a columnist with *The Irish Times*.

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This book is dedicated to the memory of my parents, Olive and Tom Muldoon; the reassuring presence of my husband, Paul Breslin; and my hopes for the future, Tara and Tom Muldoon Breslin.

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Preface

At its core, this book presents a single idea: trauma is a social phenomenon. Our risk of trauma, our responses to trauma and how life unfolds for any of us after a traumatic experience are determined by our social world. Despite this, when we think about trauma, the dominant way of thinking at least in the Western world is that traumatised people are a clinical concern and that modern medicine, psychiatry or clinical psychology might be able to provide a 'treatment' for affected people.

This way of looking at trauma minimises the influence of the social and the political. And when people do think about the social and political, typically the impact of traumatic events is thought about at the population level. This perspective de-emphasises the impact of experience for individual people within a population. Entire populations will be constructed as 'traumatised' despite clear evidence that within that population there is huge variability in the direct and indirect experience of trauma.

This book is an attempt to integrate these two positions. Trauma is a clear example of when the personal is political. It is part of the reason that I chose the title 'The Social Psychology of Trauma' for the book. So, this book highlights the central and, indeed, pivotal role of individual experience of trauma. However, there is also an appreciation that people often experience traumatic events because of their group membership. As such, experiences of trauma, even where they are experienced privately, have wider ripple effects on the social groups to which victims belong.

There is a second reason I chose that name for the book. Some concepts in social psychology are ephemeral. They can be hard to explain and hard to grasp. Take, for example, the concept of social identity: the idea that a person's sense of who they are is derived from inclusion in a social category or group. This sounds like a very abstract idea until it is translated or applied to a real-world example.

A straightforward illustration of a social identity is available through reference to occupational group membership and national group membership. So, I have a sense of being a ‘psychologist’ and ‘Irish’; indeed, they are two social identities I value, because I am included in these social categories by both myself and others. This use of myself as the example, as it were, is the second reason the book alludes to both the personal and the political.

In each of the chapters that follow I illustrate the ideas by reference to my own efforts when faced with some difficulty or stressful experience in life. And whilst some of these experiences were deeply distressing at the time, my life has not been characterised by trauma. And it is not that I have led a particularly interesting or challenging life. Rather, I am using my own experience of trauma to represent or illustrate my point. My hope is that by illustrating the ideas using my own story, readers will gain a sense of the value of the approach. I am particularly hopeful this will allow readers to apply the approach in the same way to understand their own experiences. In taking this approach, I hope it becomes clear that the causes of and solutions to traumatic experiences are rarely found at the individual level. All too often it is communities and society that need to be fixed rather than those who are traumatised.

It is unusual for an academic psychologist to write a book littered with references to their own life. Indeed, research psychologists pride themselves on their academic impartiality and scientific objectivity. This makes me vulnerable on a couple of dimensions: vulnerable to scepticism of my academic peers, but also vulnerable because of the personal information that I disclose, not least my own struggles with depression and bereavement. I am hopeful nonetheless that the approach makes the book a little more accessible, and that any odd or surprising admissions will be met with the kindness of those who read the earlier version of these chapters.

Psychology is a discipline heavily grounded in the scientific approach. Empiricism, data and evidence are highly valued. Psychology distinguishes itself from other disciplines such as philosophy and political theory by this reliance on data. Though psychologists traditionally relied on numeric data, in recent years non-numeric, or qualitative, data has been embraced. Qualitative data has been used to characterise the nature of populist rhetoric, to understand the lived experience of traumatised groups and to expose rare phenomena. At the start of each chapter in this book, I use poems as a form of qualitative data. Each poem quoted speaks to the issue that the chapter addresses. We know that the poet felt their experience merited writing about. It is also safe to say that the poet assumed or at least hoped their words would be read and their experience would resonate with readers. These authors and their readers understand how the experience of trauma is socially embedded. Excerpts from ‘North’ from *Opened Ground: Selected Poems 1966–1996* by Seamus Heaney are reproduced with permission of Farrar, Straus and Girous (US) and Faber and Faber Ltd (UK). Similarly ‘Why Brownlee Left’ from *Selected Poems 1968–2018* by Paul Muldoon is reproduced with permission of Farrar, Straus and Girous (US) and Faber and Faber Ltd (UK). These poems can be seen as evidence, at least in literature, that the social and political dimensions of trauma are uncontroversial. They offer lyrical evidence that social and political psychological foundations of trauma are major, as well as interest and inspiration.

Acknowledgements

I count myself as having a very fortunate and often charmed existence. I have spent more than thirty years studying and working in universities in Ireland, North and South. I have been able to dedicate my time to reading and thinking and writing and teaching. It has been a busy three decades but equally very privileged ones.

Over the course of the three decades studying psychology, I have written many journal articles. Often these papers outline studies and data we had collected as part of a particular project. On occasion I have also written summary and review papers attempting to condense knowledge or articulate a theoretical position. For many years I have wanted to write this book, or maybe an earlier version of it. Somehow, I never quite got around to it.

There were probably two reasons for this. The first is undoubtedly related to time. Life in the academy is privileged but it is also very busy. Prior attempts fell foul to other priorities: teaching that had to be done, students who needed support, development tasks within the university. In 2020, though, I was honoured to receive a European Research Council (ERC) advanced grant. These are hard-won and competitively awarded research grants for cutting-edge research across all areas of the academy. Ireland is still relatively new to securing these awards, and I was one of the first of two Irish women to receive an advanced award. As well as being incredibly proud and delighted with this achievement, I was given the gift of time – time to write and time to research. It also facilitated this book being open access. I am very grateful I live in an EU country and have access to this source of funds that supports progressive frontier research across the humanities and social sciences. And I would like to acknowledge the ERC and thank the Council for believing in me and investing in my work.

The second reason that I was slow to write this book was my need to think through its contribution. In earlier iterations of this volume, I had thought that it might pertain only to traumatic experiences in

Northern Ireland. As the years progressed and I began to consider the fit of some of my ideas to the experiences of other traumatised populations, this seemed less and less sensible. As my own research interests extended, it was increasingly clear that the book needed to examine the impact of trauma across different contexts and groups. Thinking this contribution through and indeed collating the evidence to illustrate these ideas slowed me down.

I have not, of course, done this alone. Indeed, the data collection, analysis and thinking that underpin the book is the product of fruitful, thought-provoking, enjoyable collaborations with colleagues near and far. I have been supported and encouraged from the outset of my education by colleagues and friends in Queens University Belfast; most notably, Dr Karen Trew, Dr Clare Cassidy and Dr Jackie Reilly were particularly influential and helpful in developing my thinking around the role of identity in Northern Ireland in my early career. Along with Dr Karen Trew, Dr John Kremer and Professor Carol McGuinness were incredibly supportive mentors and colleagues. Since I moved to the University of Limerick I have been fortunate to have supportive and engaged colleagues in the Department of Psychology who have always offered a stimulating research environment. I am not sure that I would have followed through on many initiatives were it not for the energetic encouragement and enthusiasm of colleagues such as Professor Stephen Gallagher, Dr Aisling O’Donnell, Professor Mike Quayle, Dr Siobhan Howard, Dr Elaine Kinsella, Dr Sarah Jay and Dr Jenny Roth.

I would also like to acknowledge the support and encouragement I got from others at the proposal stage of this writing project. At that stage I was not entirely sure that the book merited either consideration or writing. The encouraging words on this proposal that Dr Aoife-Marie Foran, Dr Grace McMahon, Dr Cillian McHugh, Dr Daragh Bradshaw and Dr Siobhan Griffin offered in the GROWTH lab group at the University of Limerick gave me the necessary push and confidence to move forward. Big thanks too to Margaret Grene, who helped in bringing the volume to completion with her great editorial skillset, and to Edel Collins for so much administrative and background support. I would like to particularly thank Dr Aisling O’Donnell, Dr Sarah Jay, Dr Elaine Kinsella, Professor Mike Quayle, Dr Siobhan Howard and Dr Aoife-Marie Foran for commenting on early versions of this manuscript. And again, thanks to my current PhD students and postdoctoral researchers in the GROWTH group who reviewed the final version with kindness and care: Dr Aoife-Marie Foran, Dr Siobhan Griffin, Dr Grace McMahon, Dr Magdalena Skrodzka, Anna Lashkay, Alzbetha Lebdova, Dearbla Moroney, Catriona Shelley and Lisa Skilton. As well as making me immeasurably proud, this next generation of psychologists gives me great hope for our discipline.

There are others in the wider world of psychology who have also been influential in my thinking about the intersection between trauma and social identity. I would like to particularly thank Dr Robert Lowe of Manchester Metropolitan University, who has been a great collaborator and cheerleader through many projects. His questioning and thoughtful approach to our research has driven many of the insights outlined in this book. In January 2017, I spent a period of sabbatical at the University of Queensland Australia. I very gratefully acknowledge the support of the University of Limerick, which allowed me to take this leave. This was the first time in my career I managed a six-month period of sabbatical abroad. It was a golden period for me personally and professionally. The Australian dream delivered: wallabies in the back garden, sunshine and a stimulating academic environment to write and think. During that time, I worked with colleagues in the SIGN research group at the University of Queensland. I would like to particularly thank Professor Jolanda Jetten, Professor Alex Haslam, Professor Cath Haslam, Dr Tegan Cruwys, Dr Nik Steffens, Christine McCoy and Dr Zoe Walters for the warm welcome I received on arrival. I would also like to thank Alex, Cath, Tegan and Jolanda for their engagement and encouragement as we wrote and developed the Social Identity Model of Traumatic Identity Change. Like all papers and proposals, it had a few rejections and false starts before the theoretical ideas saw the light of day. There is no doubt in my mind that the support and encouragement from these collaborators was pivotal in developing these ideas that are now so central to all of my own thinking.

Theoretical ideas are of course just that, theoretical. In psychology, as in other sciences, ideas of this nature need to be backed up. Much of the evidence in support of these ideas and indeed the development of the ideas is down to capable and energetic PhD students I have worked with over the years. It is one of the greatest privileges of academic life to supervise a PhD student and their research development. Of course, PhD students have also driven my development. I am lucky to count former students amongst valued friends and colleagues. I would like to particularly acknowledge Dr Katrina McLaughlin, Dr I-Ling Fu, Dr Nichola McCullough, Dr Ciara Downes, Dr Katharina Schmid, Dr Geoff McCombe, Dr Veronica Hakhu, Dr Stephen Walsh, Dr Sarah Jay, Dr Khagendra Acharaya, Dr Catherine Naughton, Dr Clara O'Byrne, Dr Joanne Cantwell, Dr Mary Beth Gallagher, Dr Daragh Bradshaw, Dr Alastair Nightingale, Dr Michelle Kearns, Dr Megan Ryan and Dr Aoife-Marie Foran. Their thoughtful empirical work has influenced my thinking profoundly and their company and support buoyed me up on the greyest of Irish days. I hope this book does justice to their efforts.

I also want to thank a great bevy of supporters and friends who have helped me understand the value of social groups and connections in my own life. I am a 'blow in' to Limerick – this is an Irish way of articulating the fact that you cannot trace your ancestors at this location for generations. However, I have found my tribe here, a group of friends who believe in me even when I don't. Thanks to Dr Maeve Skelly, Professor Deirdre McGrath and Therese Hennessy, who are always available for sensible professional and personal advice. Some day we will manage that lunch! Thanks too to my ever-reliable running buddies Triona Crosse, Carmela Conroy and Caoimh Ryan. The chats are integral to the joy of these runs. And of course, because it is impossible to make old friends, honourable mention to those who have stuck around for so long and still cheer me on: Mary Redmond, Marcella Ronayne, Lynn Carville and Kirsten Thompson. And, last, a big thanks to my book club buddies. The book club features as an important support group in this volume, not least because it is. There I have found friendship, kindness and encouragement, and we have in our fifteen or so years of existence weathered some difficult personal storms. So, thanks to Dr Carmen Kuhling, Annie Girardin, Professor Sue Franklin, Nuria Burrell, Professor Maura Adshead, Edel Farrell and Kathleen Eull, who inspire and encourage in equal measure. Thanks too to the aspiring, albeit gate-crashing adjunct members Professor Kieran Keohane, Dr Brendan Halpin and Dr David Atkinson.

Last, but of course not least, I want to thank my family for all the help and patience over the years. Sadly, my parents are no longer with me, and so I cannot thank them for their support and belief in me. I am not sure I thanked them enough when they were alive despite their pivotal influence on my education and career. I am comforted by the fact that they very much enjoyed and took pride in all I did, which perhaps compensates for any lack of gratitude.

To ensure I don't make the same mistake twice, I want to thank my sisters and brother for their friendship and support too. I am one of five siblings, and my childhood home was a noisy house where there was much discussion and debate on the issues of the day. As we moved into adulthood these debates remained a feature of our family life. Opinions particularly of younger siblings were often not taken terribly seriously. I am the fourth of five and so had to learn early and well how to back up claims with evidence. So, thanks to my siblings John, Deirdre, Fiona and Eavan for teaching me that skill early and well. I look forward to hearing your views on this book.

Thanks also to my two children, Tara and Tom. I am immensely proud of the young adults they have become. As well as offering hope for the future, they keep me informed of developments in their social and political worlds. Like my students, they remind me across a whole range of domains that age and generational perspective shape social and political attitudes profoundly.

This book has been an occasion for me to reflect on many of the more difficult times in my adult life. Through all these times, the one constant for me has been the presence of my long-suffering husband, Paul, whom I met at the tender age of twenty. That is now truly a lifetime ago. At that stage I had little belief in myself and certainly no sense of having academic potential. But Paul always had faith in me. His unwavering loyalty and faith have given me confidence, and I want to thank him wholeheartedly.

Míle buíochas.

Abbreviations

APA	American Psychiatric Association
BGFA	Belfast Good Friday Agreement
COVID-19	coronavirus disease 2019
CVD	cardiovascular disease
CVR	cardiovascular reactivity
DSM	*Diagnostic and Statistical Manual of the American Psychiatric Association*
GDP	gross domestic profit
GFA	Good Friday Agreement
PTG	post-traumatic growth
PTS	post-traumatic stress
PTSD	post-traumatic stress disorder
WHO	World Health Organization
WMHs	World Mental Health surveys

1 *The Need for a Social Psychology of Trauma*

1.1 Chapter Outline

Doing research on the impact of traumatic experiences can be both heartening and heart-rending. You encounter people and situations that would touch the hardest of hearts and others who inspire with their tenacity and strength to go on. The study of psychological trauma and adaptation to traumatic events is without question a truly fascinating field. Even in a privileged Western nation such as Ireland, I don't have to look hard to find stories of stress and trauma. Crisis and catastrophe happen with remarkable regularity. One thing that remains poorly understood is the attributes that help or hinder people when they meet misfortune. This book attempts to unravel the social and political processes that seem to matter in how people cope with adversity.

This is a book grounded in academic research and in particular in an area known as social psychology. I have spent thirty years working in psychology, as a social psychologist. I believe profoundly that psychology, and social science research more generally, has the power to change our world. It offers a set of tools that allows us to interrogate how the world works. Our social world is very complex, though, and so the characteristics that we are trying to outline, understand and measure in social psychology, and social sciences more generally, can feel very abstract. For this reason and with the encouragement over the years of both students and collaborators, I always try to illustrate my point using real-world examples. These examples take different forms; however, as the person I know best, I frequently in teaching use stories from my own life in the interests of making information accessible. Following on then from this example of how my own traumatic experiences are shaped by social and political factors, this chapter reviews contemporary models of trauma and offers a working definition of psychological trauma. It moves on to briefly consider why a social psychology of trauma is useful and even necessary.

1.2 A Tale of Two Traumas

My life is one of comparative privilege. Even so, like many people in Ireland, my own life, and my family's life, has been shaped by the political violence that has been a feature of life in Ireland for much of the twentieth century. In this way, I can say that some of my life experiences arise from the fact that I grew up in Ireland, and later lived and was educated in Belfast. During my undergraduate years, the political violence known as the 'Troubles' continued, and street violence, bombings and gun attacks were a feature of life (Jarman, 2004). As an undergraduate student in at Queens University Belfast, we were evacuated many times from our university residence on Brunswick Street in the City Centre. On one occasion in my final year, this evacuation was completed only minutes before a massive car bomb exploded. Glass from the adjacent building showered onto us on the path where we had been evacuated. When I look back on this event, though, I rarely see it as traumatic. After this happened, I went to a scheduled exam with other psychology students. We laughed in particular at one of our number who had left their last-minute revision so late that it was interrupted by the early morning explosion. Odder again, perhaps, when I look back on that period of my life there are other events that I recall from those days before the Belfast Good Friday Agreement that were less life-threatening than this explosion, but I recall them with far more sadness, fear and distress.

My evacuation experience shows that traumatic experience is not always a path to ill health. On the day I was caught in that bomb attack, it never occurred to me to postpone the exam, even though I had a minor injury. We were all tired because of the unexpectedly early start to our day, but there was an exam to sit. We were young and ready to move on with our lives. The bomb was more an inconvenience than a trauma, unremarkable in some ways because of the times and the fact that the student residence was in the centre of Belfast. We had been evacuated many times, and this political context meant we were nonchalant about bombs and bomb scares. At the time, the event was both newsworthy and life-threatening, but for me and my peers it wasn't very distressing. Contemporary thinking about psychological trauma reflects this. The most common response people have in the face of extreme stress is psychological resilience.

I have had other far less dramatic experiences in my life, however, that I would describe as more traumatic than this explosion. I found them more distressing and self-defining, though they were perhaps more mundane events. These include, for example, events where I felt betrayed or held to account for an action carried out in good faith. In these cases, the actions were driven by someone whom I had trusted. These traumatic events were much more unremarkable than the bomb explosion I experienced, but they left me feeling isolated, angry and stupid. Finding a way to move forward, even through difficult times, is something that most of us manage. And most of us manage it more than once in our lives. This book is an attempt to explain where and how we find resilience.

At other times, resilience is not the outcome. In reality, then, traumatic experiences can have very different outcomes. We can be damaged by traumatic experiences, but, equally, a seemingly traumatic event can be water off the proverbial duck's back, almost irrelevant. We can also be changed by traumatic events. Central to which prevails, and a central theme of this book, is the idea that social and collective forces are really important as we negotiate traumatic events. My experience of a bomb explosion was homogenised by the ubiquity of these types of events in the political landscape of Northern Ireland in the 1990s. It was also helped by the fact that I shared the experience with others; we laughed about it even at the time, and we all survived relatively unscathed.

My feelings of traumatic loss over the death of my father at the start of the first lockdown associated with the COVID-19 pandemic, on the other hand, were amplified by a terrible sense of disconnection that many of us felt at that time. As my father's health declined rapidly in March and April 2020, attempts to care for him were hindered by the public health measures that disconnected us in many ways. We were not with him when he was told that he had only weeks of life left. My mother had died only months earlier, and he had cut a lonely figure since her death. He received a terminal diagnosis without the support of any of us, his family, present and later had to relay the news to each of us by phone. In the week that followed, my younger sister, through dint of persistence and no small amount of social capital, secured his release from hospital, and we managed to bring him home in line with his wishes. He died six days later. His only medical consultation to discuss his prognosis was held virtually. His decline was quicker than we all expected. We struggled to secure palliative care. COVID-19 made it very difficult to access this practical support from health care professionals. Ireland was still at the stage of not fully understanding what risks COVID-19 brought. Sadly, and to my immense regret, he died in pain. Rightly or wrongly, I see this as something that I should have been able to foresee and feel that I let him down in his hour of need. This feeling has not been made easier by the fact that he had always done his best to care for me and my siblings over his lifetime.

As we prepared for the funeral, everything remained difficult. My siblings in the United States could not come home. My father's surviving siblings could not attend his funeral. The warm and wonderful support usually available through Irish funerals was absent because of the COVID-19 restrictions accompanying the lockdown. No sharing of happy memories either. We lost the usual support and instead we experienced his death and his funeral as isolating. We couldn't as his family honour him or celebrate his life. And again, in the broad scheme of things, I was left with the sense that all was not as it ought to be. This still upsets me, and I imagine it always will.

Traumatic experiences create a kind of liminal space: the time between the 'what was' and the 'what will be' – a place of transition. Central to the experience of transition is our own and others' perception of their desirability. Unwanted change, such as the death of a parent, is particularly challenging. But make no mistake, transitions are very uncomfortable anyway. Transitions mark the movement in the sands of time. Research evidence indicates that bereavement and thoughts of death, in particular, can make us question the very meaning of life – and this can create an additional stress often referred to as 'existential anxiety'. Our ability to connect with others and the enactment of appropriate ritualised behaviours, such as funeral rites, can help us interpret our feelings about the event and find a way forward in transitional situations. These are as important to the negotiation of trauma as the traumatic experience itself. A central premise of this book, then, is this: in order to understand the nature and impact of traumatic experience, we must contextualise it. The social (e.g., being isolated or with others) and the political (e.g., being in a new lockdown situation or a situation of habituated political threat) matter profoundly to how we manage the vagaries of life.

1.3 Contemporary Models of Adaptation to Trauma

A key concern of many clinicians in both psychology and psychiatry is to figure out who is most at risk of succumbing to the ill effects of trauma (Bomyea et al., 2012). We can see this concern at work across those who practise in the field and also in dominant narratives in Western countries when we talk about mental health and trauma. It comes through in ideas associated with detection for early intervention. Early identification is believed to facilitate prevention of the later development of mental health problems, referred to sometimes as ‘psychopathology’. This view is built on the idea that human psychology and causes of human psychopathology are predicted by individual characteristics – attributes that are unique to people. It encourages a search for key traits or characteristics of vulnerable people. Those who succumb to the consequences of traumatic stress are somehow different and distinguishable from those who do not. Before we move on it is worth considering the truth or otherwise of this claim.

In some of the early accounts of those who survived the Holocaust, the role of individuals’ behaviour was sometimes highlighted to distinguish those who perished and those who survived. These behaviours were often linked to a particular positive, or indeed negative, attribute. Psychological toughness built on an ability to create meaning from everyday activities was suggested as one dispositional characteristic typical of those who survived (Bettelheim, 1943). Others highlighted that those who survived the camps were often collaborators with prison guards and its regime, and, as such, the morality of this group was called into question. Those who perished were constructed as the moral, who were not willing to collaborate with the Nazi regime (Potter, 2017). Inherent in this type of analysis is the suggestion that people who survived the concentration camps, as opposed to those who did not, are distinguishable in some individual or personal way. Yet people, whether victims, survivors or perpetrators of trauma, are rarely clearly distinguishable on one single dimension of their character. Seeking to explain away deaths because of the Holocaust, or indeed any traumatic experience, by reference to characteristics of the victim, whether good or bad, locates the responsibility for traumatic violent and aggressive acts with traumatised people. We have now come to understand this phenomenon as victim blaming.

There is good reason to pay attention to these types of victim-blaming processes. Traumatic experience is inherently shaped by power and politics. Patterns of traumatic experience are not randomly distributed across the population. People routinely speak of random acts of violence, but trauma and resultant effects on mental health are patterned (Cairns, 1996; Muldoon, 2013). We know that the greatest burden of trauma in terms of the scale and intensity of suffering is felt by those who experience war and sexual violence (Kessler et al., 2005). Trauma of war is disproportionately felt by those living in the poorest regions of the world. And even within regions affected by war and political violence, those with the greatest trauma experience are those of minority ethnicities within the lowest income brackets. Equally, we know, though a global phenomenon, the magnitude and intensity of gender-based violence is amplified in societies where gender inequality is highest (Buvinic et al., 2013). Though these are themes to which we return, for now it is sufficient to say that those affected by trauma are very much a product of their circumstances. Ignoring the dysfunctional social and political circumstances that give rise to trauma may inadvertently foment political anger and violence, because we also ignore the circumstances that those who are minoritised – by their age, gender, class or ethnic group – must endure. This is a theme that lies at the heart of this volume.

Relying on personal characteristics or, as psychologists often call them, 'individual differences' to explain people's responses to trauma is also inconsistent with the available evidence. We are remarkably poor at predicting who will or will not succumb to the negative effects of trauma. There is little evidence that pre-trauma characteristics, such as hardiness (Bartone, 1999) or self-enhancement (e.g., Bonanno et al., 2002; Bonanno et al., 2005), predict post-traumatic resilience. Perhaps more importantly, knowing that a tendency towards hardiness promotes resilience, for example, offers limited therapeutic solutions. Rather, this delivers a therapeutic approach that requires people to personally manage symptoms derived from difficult life circumstances such as poverty, disempowerment or marginalisation. Treatments encouraging minoritised groups to change patterns of thinking are increasingly questionable in the era of #BlackLivesMatter and #MeToo where social justice concerns are writ large. Indeed, it is probably time for us to think about the ways in which this individualised approach to mental health may aggravate resentment and social justice concerns. Equally, we need to question why it has taken psychology so long to find treatment approaches that emphasise empowerment and social change as a path forward for people negotiating trauma.

1.3.1 Defining Psychological Trauma

For the purposes of clarity and because there is limited agreement about the definition of 'trauma' in psychology, here we spend a bit of time defining what is meant by psychological trauma. In recent years the term ‘trauma’ has moved into everyday parlance. It is not unusual to hear people say they are traumatised. I have said it myself. Equally, it is not unusual to hear people comment that entire populations, such as Ukrainians, or women, or people of colour, are traumatised. Traumatic events are generally agreed to be a particular kind of event associated with actual or threatened risk to life and serious injury, including sexual violence. So, they might include being directly involved in a car accident, being a victim of a violent attack or being a direct victim of war and genocide. Traumatic events can also involve indirect experience such as being a first responder at an accident where a child has died or being a friend of or related to someone who dies unexpectedly or violently.

Generally speaking, people who are traumatised report a sense that their world has been shattered (Chu, 2011). Feelings of betrayal or of being let down by others or by a system of support are not uncommon. For those experiencing or witnessing violence or cruelty at close quarters, the world can feel increasingly threatening. Most of us believe in what social psychologists call the Just World fallacy (Grove, 2019). We assume a person’s actions are inherently inclined to bring morally fair and fitting consequences. Noble actions will be rewarded, and evil actions (eventually) punished. We expect some universal force to manage moral balance. My father’s death without palliative care or the culturally appropriate occasion to mourn upended this balance for me. And this is a cardinal feature of traumatic events in the harshest and starkest of ways: traumatic experience forces people to question the moral balance and social order in our world.

For clarity in this book, we use the term ‘trauma’ to refer to people’s personal experience of trauma. There is no doubt that we can all be distressed by violent and tragic events that we view on TV or that affect people with whom we empathise. The analysis offered in this book, however, is informed by ideas from clinical psychology. The conceptualisation of traumatic experience employed builds on the idea that there is something profoundly distinctive about personal exposure to traumatic experience. In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2014), the almanac of clinical psychological disorders, traumatic experience is when people have been ‘exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence’.

This definition requires that these are either direct personal experiences or vicarious personal experiences. Direct personal experiences include experiences where people themselves are victims of trauma. Indirect or vicarious experiences occur when people are witness to the trauma or become exposed to the details of a trauma because of a near relative or close friend's experience or because it is encountered during professional duties. Broader exposure through news, wider social networks, social media or TV is not, by this clinical definition, considered sufficiently close to meet diagnostic criteria for trauma- or stress-related disorders.

Moving on from traumatic experience, then, we use the word 'trauma' to refer to a process (Krupnik, 2019). Defining trauma as a process means that trauma has several elements. It includes the traumatic experiences themselves. So, using my previous examples, the experience of being caught in a bomb explosion or directly witnessing my father's death would both qualify as potentially traumatic experiences. By this definition (Krupnik, 2019), traumatic experiences are only one element of the trauma process. Traumatic experiences and trauma outcomes are connected through people's capacity to adapt, the support available and their ability to respond and act in a way they find helpful.

Traumatic responses, then, are also part of the trauma process. These responses include the health and social outcomes that arise jointly from traumatic experiences, and people's ability to negotiate and adjust to these events. Responses are linked to people's social, psychological and material resources and are relevant to how we negotiate the transition and change that can accompany trauma. Trauma and adaptation to traumatic events, in addition to being interesting psychological phenomena, then are inherently social and political phenomena. The core aim of this book is to highlight how social and political forces shape adaptation and responses to trauma. In so doing, it becomes apparent that the social-psychological foundations of trauma are major.

1.3.2 Common Responses to Traumatic Experiences

Post-traumatic stress (PTS) is probably the most commonly known response to traumatic experience. Post-traumatic stress disorder (PTSD) is a major mental health diagnosis and carries a significant burden of human suffering and associated economic cost in terms of disability. Without support, those affected are likely to experience material alteration in their socioeconomic status, often referred to as downward social mobility. Though originally linked to the horrors of war, it is now clear that post-traumatic stress arises in people affected by a wide range of adversities. In effect, the disorder illustrates the fact that extreme traumatic events can trigger extreme psychological distress.

Post-traumatic stress is revealed in the movie *Born on the Fourth of July* and offers a good illustration of the nature of the problems people can face. In the wake of Ron Kovic's (played by Tom Cruise) difficult tour of duty in Vietnam, a constellation of symptoms emerge. These are refracted through the changing social and political dynamics in the United States. PTSD has always been a disorder framed by politics. For example, its articulation and inclusion into the contemporary almanac of mental health problems was itself highly political. It first entered public discourse in the United States in an effort by veterans to secure health resources as they struggled with the aftermath of their experiences in Vietnam (Scott, 1990). Recognition of PTSD as a psychiatric disorder in the 1980 edition of the DSM was a crucial step to securing the health care distressed veterans required (Spitzer et al., 2007).

Those affected by PTSD suffer persistent, intrusive recollections of their traumatic incident, such as reminders of the event, vivid flashbacks and nightmares. In DSM-5 (APA, 2013), PTSD is characterised by *persistent* symptoms across these four symptom clusters. These are (1) intrusion symptoms (e.g., flashbacks, nightmares), (2) persistent avoidance of stimuli associated with the trauma (e.g., avoiding 'trigger' situations), (3) negative alterations in cognition and mood associated with the traumatic event (e.g., guilt, difficulty concentrating), and (4) alterations in arousal and reactivity that are associated with the traumatic event (e.g., difficulty sleeping). Symptoms from all four clusters need to be present for a diagnosis to be given. In Western nations PTSD is estimated to affect 1–2 per cent of the population in any given year, but the incidence in specific risk groups such as first responders, soldiers and populations affected by war and political violence is estimated to be considerably higher (Berger et al., 2012; Breslau, 2009; Santiago, 2013). Symptoms in those affected must result in significant interference in both work and social lives to meet diagnostic criteria. And those affected must have directly experienced or witnessed the traumatic event.

There is a school of thought (Ruscio et al., 2002; Summerfield, 2001) that resists the idea of diagnosing a 'disorder' such as PTSD in people who have survived one or more traumatic incidents. Indeed, the labelling of any person with a diagnosis can give rise to a new identity. Both political scientists and feminists have argued that discourses and representations of people's responses in the aftermath of a traumatic experience as 'disordered' are political acts. It is something that is used to undermine those exposed to trauma as 'unwell' or even 'hysterical'. This way of viewing those who are traumatised can result in both passive and stigmatising responses to those trying to adjust to very difficult circumstances. Added to this, a diagnosis of PTSD can place the focus of our efforts on the symptoms people experience. These symptoms and any associated distress can be considered reasonably normal, or indeed an expected reaction, to extreme or traumatising events (Summerfield, 2001). By emphasising these reactions as disordered, it detracts from arguments and action in support of social change to protect vulnerable populations against further or chronic traumatisation (Pupavac, 2004). For these reasons, those concerned about labelling and discourses of disorder often prefer the term 'post-traumatic stress' (PTS), which indexes symptom severity along a continuum (Brown et al., 2001; Ruscio et al., 2002). This approach avoids labelling people who experience distress as disordered, and instead tries to problematise the social conditions that give rise to trauma experience.

Because of this debate, and in line with the idea that trauma can be a process (Krupnik, 2019), the term 'post-traumatic stress' is used in this volume to refer to symptoms experienced in the aftermath of trauma. There are also times when the term 'PTSD' is used when research by others is being outlined. In all cases this term is used only when it appears in the original work. The term 'PTSD' is also used in the discussion of its definition and diagnosis in the DSM.

This shift in emphasis away from PTSD as a disorder is also warranted by the fact that the majority of people who encounter traumatic events are resilient (Agaibi & Wilson, 2005). Whilst many of us experience traumatic events, our psychological distress and its associated interference in social and occupational functioning can be short-lived. We learn to go on with our lives. That is not to say that the experience doesn't leave a scar, or that there wasn't a time period when life was very difficult. During this period, people will often have poor mood, feel tired or even cry for very little reason. Nonetheless, most of us ultimately find our way through the distress of traumatic experiences.

Indeed, resilience is the main response observed after people experience trauma. This is true across a very wide range of traumas such as war, political violence, sexual assault, accidents and natural disaster (Kessler et al., 2005). In the literature, resilience is often referred to as the ability to 'bounce back'. But resilience and its emergence can be thought of as a process. I know in my own case that when grief for my parents broke through in the weeks and months after my father's death, I didn't always cope well. But for the most part, after the first six weeks or so, the days that I coped outnumbered the days I didn't.

It can take months and even years to transition from and negotiate traumatic experiences. However, if people feel that the repercussion of their experiences is interfering with social or occupational functioning, it is a red flag. In my own case after the death of my father, I found having to re-engage with work or family tasks offered a useful distraction. In many ways this kind of re-engagement is a basis for resilience. A return to the pre-trauma level of functioning and capacity post-trauma, the ability to maintain or regain mental health after experiencing adversity, is the mark of resilience. Given resilience is the norm, understanding its psychological basis in the face of trauma is at least as important s understanding psychological vulnerability.

Resilience is distinguished from another potentially positive outcome after traumatic experience. Helpful changes following trauma are sometimes referred to as post-traumatic growth (PTG). In philosophy, religion and psychology (Linley & Joseph, 2004; Park et al., 1996; Tedeschi & Calhoun, 1995), PTG has been documented in the wake of traumatic experiences. PTG is reflected in a view people may have after their traumatic experience that there was a 'silver lining' in their alternate or changed life trajectory.

PTG is a remarkably common experience. Some degree of growth is reported by 30–80 per cent of people who have experienced trauma (Linley & Joseph, 2004). In common with PTS, it is experienced along a continuum, with people differing in the amount of growth they report. When people show PTG, rather than a return to pre-trauma functioning, they report beneficial psychological and social changes, including perceptions of improved relationships with others, an enhanced sense of self and/or a renewed sense of the meaning and possibilities of life (McGrath, 2011). PTG differs from resilience and recovery. It is not merely a *restoration* of one's pre-trauma state of functioning, but a feeling that the traumatic experience has improved people's previous ways of thinking, indicative of a re-orientation towards new values or priorities.

1.4 The Case for a Social Psychology of Trauma

There are many ways that people have sought to understand trauma. Without question, individual person-centred models have been the most predominant, useful and influential to date. In this book, another important way to think about trauma is offered. It highlights how traumatic experience and post-traumatic outcomes are profoundly and inherently social and political. In the preceding section, the case for a social and political account of trauma is emphasised using three key findings from the literature. First, we consider the strong evidence that experiences arising as a consequence of intentional human actions have more pathological consequences than even the most devastating of traumas that are considered 'accidental'. This places social relationships at the heart of our understanding of trauma. Second, we review evidence that trauma which undermines trust in others appears to be particularly corrosive in terms of personal health and wider social cohesion. And third, we consider the body of evidence that demonstrates trauma can be experienced vicariously by those who witness it in close family or friends or in their professional duties. Indeed, any psychology of trauma must accommodate these clear social dimensions of the phenomenon.

1.4.1 The Nature of Trauma and Post-traumatic Outcomes

There is a large body of research that demonstrates that not all traumas are equivalent in terms of risk for subsequent PTS. Traumas of 'human design' (APA, 2000) are consistently demonstrated to be those that result in the highest rates of PTS symptoms and ongoing concerns about people's well-being (Charuvastra & Cloitre, 2008). The impressive National Comorbidity Survey in the United States indicates that intentional acts such as rape, childhood abuse, combat exposure and physical assault are linked to approximately double the incidence (i.e., the number of new cases) and prevalence (i.e., the number of existing cases) of PTSD cases when compared with cases arising from unintentional and accidental traumas such as car accidents, fires and natural disasters (Kessler & Merikangas, 2004; Kessler et al., 2005). Similarly, using a strong design that allowed people to be followed over time, a group of Israeli researchers showed that PTSD was higher amongst those involved in a terrorist attack than those involved in car accidents. Avoiding recall biases associated with asking people about their experiences after diagnosis, this study demonstrated that those who survived a terror attack had twice the incidence of PTSD compared with survivors of motor vehicle accidents (Shalev et al., 1998) despite having similar injuries.

Findings such as these have led to the suggestion that people perceive traumatic events as more threatening where they are a result of intentional violence (Ozer et al., 2003). Intentional acts of violence undermine our faith in the goodness of others. And so, these observations tell us that an important component of adaptation to trauma is linked to our understanding of other people's intentions when we experience the event. When adapting and processing trauma, those most adversely affected, those who suffer the most persistent, intrusive recollections of the incident (i.e., reminders, vivid flashbacks, nightmares), are those who are haunted by a loss in the belief of the good intentions of others (Andrews et al., 2000).

1.4.2 Trauma and Trust in Others

There is a particular horror associated with intentional trauma and violence because this type of experience violates shared norms of appropriate and acceptable behaviour (King et al., 1995). It is perhaps no surprise, then, that the potential for trauma to destroy people's trust has been documented. People affected by intentional trauma report feelings of being let down or betrayed by others (Freyd, 1996; Herman, 1992). Heightened perceptions of threat are also documented in those who have experienced rape, abuse and political violence. Traumatic experiences lead to a withdrawal from others not least because of increasing feelings of threat and mistrust. Those affected by traumatic experiences often actively avoid people or situations, even those that are ostensibly neutral, because they perceive them as risky or untrustworthy.

These findings lie at the heart of why all trauma, and most particularly intentional human acts of harm, may be pathological. Traumatic experience impacts on a person's ability to engage with others, hampering both social relationships and feelings of connection with others (King et al., 1995). In this way, as well as the negative consequences of the experience itself, violent traumatic experiences alter the social resources people have available to them in a more substantive way than accidents and natural disasters. For example, in qualitative studies, those bereaved due to homicide report an altered sense of connection with others in their community (Armour, 2002).

Having faith in others and a sense of security can also be difficult to achieve in those who have come through a chronically abusive situation or a catastrophe (Chavustra & Cloitre, 2008). Traumatic experiences understandably make people nervous and anxious for the future. On the other hand, it would also seem that solidarity with others in the wake of traumatic violence can counter some of these effects. The potential for the damaging and debilitating responses to traumatic events to be attenuated by a sense of connection and solidarity is an increasingly prevalent theme in the psychological literature (Jay et al., 2022). (Mis)trust and solidarity have important social and political consequences too. It is not surprising that the pandemic has brought the issue of public trust to the fore. Over the course of the COVID-19 pandemic we have seen how solidarity and public trust have literally been a matter of life and death. Vaccine uptake, adherence to public health restrictions, as well as personal health behaviours have all been reliably linked to trust in science, government and health authorities and lie at the heart of our capacity to deliver a coherent response to the threat of the pandemic (Foran et al., 2021; Muldoon, Bradshaw et al., 2021).

Trust is particularly important in situations where there is a high degree of uncertainty and where people feel they are vulnerable (Cook, 2005), a characterisation that can be easily used to describe the COVID-19 pandemic. Trust is the basis upon which people access their social networks and shared health, community and commercial resources to deal with vulnerability in uncertain times. For example, functional families and relationships, education, health and welfare systems, governance and law all rely on public trust and trustworthiness to ensure safe delivery of services. Traumatic experiences that negatively affect people's ability to trust, as well as interfering with psychological health, also have social and political repercussions. Many people faced traumatic experiences similar to those I have described during the lockdowns associated with the pandemic. And many feel let down by their health or social care system. Because of the impact of this experience on our ability to trust these systems, the damage of the COVID-19 crisis does not vanish when restrictions ease. Rather, it leaves a pall that will have longer-term social and political implications.

1.4.3 Social and Political Ripple Effects of Trauma

The ripple effects of trauma are widely accepted. Numerous studies have shown that individuals in close proximity to those directly traumatised can and do suffer from psychological symptoms (Hensel et al., 2015). This has been documented amongst families of combat veterans (Yambo & Johnson, 2014), mental health professionals (Craig & Sprang, 2010) and spouses of those caught in terror attacks (Gilbar et al., 2012). These findings clearly highlight how substantive the ripple effects of traumatic experience can be across familial, occupational and social networks. So, as in my own case, clearly it was my father who endured a death without palliative care, but I remain haunted by just witnessing his death.

Similarly, learning of the sudden violent death of a close relative or friend can be traumatising. Ripple effects of this sort are acknowledged as corrosive, and the DSM-5 (APA, 2014) stipulates that these types of indirect experiences meet the criteria for events that can trigger PTSD. It is accepted that in the course of professional duties, first responders or professionals repeatedly exposed to details of violence (APA, 2013) can experience vicarious or secondary traumatisation, a position supported by a wide range of studies (Molnar et al., 2017).

There is controversy, however, around the inclusion of secondary traumatisation as a cause of PTSD in the DSM. Exposure to traumatic events through electronic media, television or pictures also appears to have ripple effects, though these are different to personal exposure. The DSM-5 specifically precludes events that are witnessed remotely as criterion events for triggering PTSD.

Many events experienced remotely, from natural disasters to accidents, homicides and terrorist attacks, do appear to have wider social and political ramifications. For instance, subjective reactions to the 9/11 attacks in the United States shaped support for subsequent national security policy in that country. Support for a strong national security policy was most pronounced among Americans who witnessed the events of 9/11 remotely. They perceived a greater threat from terrorism and felt angry at the terrorists. Those personally affected by contrast displayed more anxiety, which translated into less support for military action (Huddy & Feldman, 2011). Similarly, in Northern Ireland, in a way that was not evidenced by those personally affected, indirect experience of political violence was related to support and sympathy for political violence across both communities (Hayes & McAllister, 2001). Traumatic experience that is witnessed remotely then can be distinguished from personal experience of trauma. It is distinguishable conceptually as well as in terms of its clinical consequences and social and political implications.

1.4.4 Collective Trauma

The term 'collective trauma' is sometimes used to refer to the psychological reactions that affect an entire society (Vollhardt, 2014.). Collective trauma does not require personally experienced criterion events. Key to understanding the wider population effects of collective trauma is the degree to which people empathise with those directly affected. Empathy facilitates the transmission of feelings of distress and is driven by a sense of connection between direct victims and those witnessing the trauma (Bar-tal & Cehajic-Clancy, 2014). These types of effects do not require that people have traumatic experiences. Clayton and Opotow, in a seminal paper (2003), highlight how race, gender, social class and religious group memberships circumscribe the scope of many of our justice concerns. We routinely empathise with others whom we see as similar to ourselves on the basis of key categories or group memberships.

There are very many examples of this phenomena in the real world. In the United Kingdom, and indeed the West more generally, the bombing at the Manchester Arena in May 2017 that tragically killed twenty-three people, including ten people under the age of twenty, was a source of considerable distress and resulted in a massive outpouring of sympathy for the victims and their families. The scale of the sympathy for the twenty-six children killed and nineteen wounded in a bus attack in Yemen was not at all comparable in the West. Indeed, the coverage of the second story was marked by a lack of compassion for victims of the second attack. A key basis of empathy and transmission of distress through social networks, then, is shared group membership.

Those in the West found it easier to empathise with families in the United Kingdom rather than in Yemen because we can identify with the cultural lives and stories of the Manchester victims and their families more readily. People in the West could see themselves and their own families in the life stories of the victims. For the victims of the bus attack in Yemen, this type of identification did not come so easily. The people and environment are less familiar: ‘we’ don’t speak the same language, ‘we’ don’t understand the cultural references. Empathy for the victims, a sense of collective trauma, was therefore absent.

And so it is that group memberships, those built on language, culture, race or religion, can facilitate a sense of social identification with those traumatised. In the Manchester Arena bombing, the motivations of the bomber were linked to his Muslim Libyan heritage. This understanding of his actions has been connected to increasing anti-Muslim sentiment in the United Kingdom (Matthes et al., 2019). In Yemen, Human Rights Watch have attributed the bus attack to a Saudi-led coalition armed with US munitions and supported by complicity of the UK and US governments (Bachman, 2019). Invariably, then, religious and racial group memberships, and our associated identification with the concerns of both the victims and the perpetrators, are very relevant to understanding the attacks and our sense of the appropriate response.

The visibility of victims and our sense of connection to them is a key theme of this book and one to which we return in more detail. It is acknowledged that social group processes, such as visibility of victims and a sense of social connection, are centrally relevant to the emergence of population-level collective trauma. However, the idea that these same processes might be relevant to people’s psychological adjustment after personal exposure to trauma has taken hold only in recent years. These issues are also central to understanding personal traumatic experiences and point to the essential importance of a social psychology of trauma.

1.5 Conclusion

Feelings of isolation and distress are as much a part of life as hope and happiness. Distress and sadness ebbs and flows over the course of life. In my own story of two very different traumatic experiences, the role of others with whom I could share my experience, and in one case my despair, was very different. My father and by proxy my family were flummoxed by COVID-19 restrictions as his health declined rapidly. Less than a year prior to his death we had managed my mother's death at home. It was stressful minding her over many months, but ultimately there was a sense that we had done the job well and she had bowed out of life as she would have wished. My inability as a daughter, and ours as a family, to manage my father's death to the same standard has left me with a sense of failure. The isolating effects of a COVID-19 lockdown made things more difficult. The role of others who can help to dampen distress is a theme to which we return again and again in this book. But equally, the role of our own identities, and our ability to play them out in stressful times, is centrally relevant to how we experience the difficulties that life invariably throws our way. It is to these issues we now turn.

2 *The Cost of Trauma*

I felt a Funeral, in my Brain,
And Mourners to and fro
Kept treading – treading – till it seemed
That Sense was breaking through –

And when they all were seated,
A Service, like a Drum –
Kept beating – beating – till I thought
My mind was going numb –

And then I heard them lift a Box
And creak across my Soul
With those same Boots of Lead, again,
Then Space – began to toll,

As all the Heavens were a Bell,
And Being, but an Ear,
And I, and Silence, some strange Race,
Wrecked, solitary, here –

And then a Plank in Reason, broke,
And I dropped down, and down –
And hit a World, at every plunge,
And Finished knowing – then –
—Emily Dickinson, ‘I felt a Funeral, in my Brain’

2.1 Chapter Outline

Traumatic experience matters. Trauma isn’t some post-millennial concern. In fact, the idea that trauma has pathological effects has been around for a long time. In this chapter, the costs of trauma in terms of death and disability are considered before turning to the mental health costs of trauma. The World Mental Health (WMH) surveys are used to consider the global cost of post-traumatic stress and the associated disorder, post-traumatic stress disorder (PTSD). Both are believed to flow directly from traumatic experience. Trauma also has a significant human cost, driving incidence of substance misuse and depression (Contractor et al., 2014), which can be thought of as relevant comorbidities. The potential for symptoms of post-traumatic stress to be misinterpreted and for affected populations to be pilloried because of their trauma is also considered. Finally, the social and economic burdens of trauma are reviewed. Trauma can contribute to poverty, disability and underemployment, migration of populations, family separation and homelessness, all of which carry significant social and economic costs.

2.2 Are We All Traumatised?

Recently, during a meeting with a student, we were reviewing a standardised psychological tool that measured adverse child experiences. I was surprised by my high score. It would appear at least in terms of childhood, mine was a life that could be characterised as having adverse childhood experience. And indeed, over the years, there has been more than one occasion where I have recounted a tale from childhood and the listener, rather than laughing as I expected, was aghast at the tale. This does not at all chime with my sense of myself. I see myself as having lived a charmed existence.

Of course, like so many others, over the years there have been various events that have caused me considerable distress, some that I even think have changed me. In my first year of college, an acquaintance died whilst we took an exam. It was the first time I had heard of sudden adult death syndrome. In my final year of college, a friend was shot dead whilst working for an aid organisation in Somalia. I was very deeply upset by this and promised myself I would be forever mindful of news reports and acknowledge every life lost through unexpected and violent death. My son was taken from me in something of a panic when he was two days old. He needed emergency treatment and admission to neonatal ICU to make it through his first week of life. Happily, it was a reasonably short-lived crisis, and I have got to value him as I promised myself I would on that awful night. A close friend died by suicide in my late thirties, and this was followed very quickly by my husband receiving a life-threatening health diagnosis. The bereavement, followed so closely by my husband's health crisis, was difficult and was followed by a period where I really struggled to cope. But I did manage and even learned from that period of stress. My parents' deaths, within nine months of each other at the start of the COVID-19 pandemic, were similarly difficult. Still, mostly I emphasise to myself how lucky I was to have them in my life for fifty years and how lucky I have been in life.

Although this is not a comprehensive list of my traumatic experiences, it is certainly enough to make my point. Like pretty much everyone you will meet, I have had my fair share of challenges in life. Life can be very cruel. Despite this, I have always considered myself to be privileged, lucky even. Though I don't see myself as someone who endured childhood adversity or had a traumatic life, and whilst I try to emphasise the positives from my experiences and the lessons learned, in reality, I didn't always manage what life threw at me very well. Sometimes my body let me down and I got sick. Other times, how I felt and how I thought was affected. I got depressed: 'a funeral in my brain' and 'my mind was going numb' so to speak. Negative feelings of this type tended to cause a spiral downwards. When I became stressed, I often overate, over-consumed alcohol and had an on-and-off relationship with cigarettes. In effect, there were very many occasions where I have been my own worst enemy, responding with unhelpful or unhealthy behaviours.

This obviously made the situation worse. As well as being upset by stress, I also became upset with myself about my perceived failure to manage my emotions and my dysfunctional and unhealthy responses. Responding in a dysfunctional way to life's difficulties is common – I don't have a monopoly on that. Substance misuse in response to feelings of distress and hopelessness are also common. In my case it is no coincidence that the drugs of choice are culturally acceptable substances to misuse in Ireland, particularly amongst my generation. And oddly, though I value my identity as a psychologist and know a lot about the nature of depression, I was slow to recognise it in myself. Instead, I berated myself for not being able to cope. I offered, and saw myself as deserving, little or no compassion.

I was eventually diagnosed, by someone else, with depression. And despite all that I knew as a psychologist, I experienced that diagnosis as a personal failure. I truly felt 'wrecked'. I had become guarded and, as

Emily Dickinson says in her poem, ‘solitary’, in part because of these feelings of inadequacy and failure, and in part because I was irritable and tired. This placed a strain on my relationships with other people, including those close to me. Eventually, after getting over the monumental hurdle, which was the admission I couldn’t manage alone, I accepted pharmaceutical and psychological treatments. Despite being a so-called expert in this area I had a problematic blind spot. I had a lot of very negative perceptions about depression and depressed people that prevented me from identifying as such and therefore got in the way of my seeking help. My mother’s support, and her account of successfully adapting to depression after becoming a mother helped me to leave some of these negative feelings behind. Looking back, I find it astonishing how long it took me to get to the point where I accepted help and accepted that I needed help: it was a long road to Dickinson’s ‘sense . . . breaking through’.

Seeing the situation for what it was allowed me to move forward. As the years have gone by, I have made a concerted effort to use running, rather than food or drink, as a means of managing my distress when life throws curve balls. It is, I think, infinitely better than artificial substances, though some argue that running also has addictive properties. In my case running has the additional benefit of offering social interaction: I run with friends and I make friends when I run. And my desire to run restricts overeating and drinking alcohol. Once I realised running was key for me in terms of managing my own mental health, I prioritised it. And I learnt some other lessons too. I am now a bit kinder to myself than I was in my younger days. Now when I fall off the wagon, I remind myself that mental health is not a fixed or static state. It has multiple dimensions. Our mental and physical health are ongoing projects affected by the vagaries of life.

2.3 The Mental Health Costs of Trauma

The experience of trauma is implicated in a range of mental health disorders as well the group of problems known as ‘trauma and stressor related disorders’. PTS has a significant human cost in terms of death and disability. Chronic trauma such as child abuse has been linked to personality disorders (Jowett et al., 2020). Trauma such as bereavement and life-threatening illness have been linked to depression (Zisook & Kendler, 2007). And substance misuse and addiction disorders have also been linked in longitudinal population studies to trauma exposure (Hedtke et al., 2008). There is also a significant overlap between these disorders. Depression, anxiety disorders and substance misuse are frequently comorbid with trauma-related disorders such as PTSD (Mason et al., 2019). Indeed, the co-occurrence of PTSD with another disorder is the rule rather than the exception. Trauma, as well as having a high human cost, has a wide-ranging impact and affects multiple mental health outcomes.

2.3.1 Stress and Trauma-Related Disorders

In terms of mental health the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) has specifically recognised trauma- and stressor-related disorders in their own specific category. The DSM-5 offers three main stress response diagnoses in adults (PTSD, acute stress disorder and adjustment disorder) and two in children (reactive attachment and disinhibited social engagement disorders) that are a reaction to specific triggering events (Wakefield, 2013). PTSD is without doubt the most widely known health condition arising from trauma. It is a diagnosable mental disorder, popularised in literature and film (e.g., to critical acclaim in *Born on the Fourth of July*). Indeed, the criteria for diagnosis are only met if the symptoms experienced as a result of trauma are severe and prolonged enough to interfere with a person's social and occupational functioning.

The 1980 edition of the DSM (3) categorised PTSD as a mental PTSD (Spitzer et al., 2007). Though first classified as an anxiety disorder, it has subsequently been reclassified as a 'trauma and stressor-related disorder' in DSM-5 (APA, 2013). It is clear that the emotions involved in PTSD are not by any means restricted to fear, helplessness and horror, or to what was actually experienced at the time of the trauma. Although anxiety- or fear-based symptoms are experienced in individuals with trauma- or stressor-related disorders, they are not the primary symptoms. Indeed, people affected by trauma- or stressor-related disorders typically report a state of unease (dysphoria), numbness or inability to feel pleasure (anhedonia) and disconnection from their own thoughts, feelings and experiences (dissociation). Externalising symptoms such as aggression and anger are also reported. The poet Emily Dickinson articulates this constellation of feelings in her poem that appears as the epigraph to this chapter. Her unease is represented by the 'treading – treading' and the 'beating – beating' – until she thought her 'mind was going numb'. There is dissociation evident in the poem's conceit of a funeral occurring in her brain, but equally dissociation is very clearly referred to where the poet's voice is separated even from humanity 'Being, but an Ear / And I, and Silence, some strange Race'. In many regards this poem, though usually interpreted as one describing a descent into insanity, speaks to the toll that trauma can take. It removes much of the joy from life.

The symptoms of PTSD that people experience are demonstrably linked to culture (Smelser, 2004). The DSM outlines symptoms of PTSD in pre-defined clusters or factors. The exact number of symptom clusters is debated, and the pattern of symptoms across anger, dissociation, anhedonia and dysphoria varies (for a review, see Armour et al., 2016). Emily Dickinson wrote her poem in the nineteenth century; it was first published in 1896 but was, as most scholars agree, likely to have been written in 1861 (Perriman, 2009). Dickinson was born into a prominent family in Amherst, Massachusetts. She lived a very isolated and solitary life. She never married, which, given the norms of the time, restricted her socially. Historical commentators on Dickinson have suggested that her early life was beset by traumatic abuse including incest and later bereavement (Perriman, 2009). Expression of anger or aggression, particularly by women of her class, would have been a culturally inappropriate response, and thus abuse of the type she suffered was rarely acknowledged or discussed. This may explain why anger symptoms don't make an explicit appearance in her poem. However, even artists, and most especially women from previous eras, worked their realities and rebelliousness into their works to avoid cultural costs of speaking out (Jaspar, 2008). And so in this way we can see the poem itself allows her to speak out. It alludes to – 'and then a plank in reason, broke' – and is symptomatic of anger, a key externalising symptom of post-traumatic stress.

In total, the DSM-5 argues that there are eight necessary criteria for a PTSD diagnosis. The first is the experience of a traumatic event (criterion A). The second set of criteria relate to the symptom expression across four clusters (Bisson et al., 2015). These include, as already mentioned, persistent negative alterations in cognitions and mood associated with the traumatic event (e.g., anger, guilt, difficulty concentrating), intrusion symptoms (e.g., flashbacks, nightmares), avoidance of trauma reminders (e.g., avoiding 'trigger' situations) and alterations in arousal (e.g., difficulty sleeping). In DSM-5 (APA, 2013) a diagnosis of PTSD is seen to be warranted where there are multiple symptoms across these clusters and they are understood as persistent by a clinician (criterion F) and causing significant functional impairment (criterion G) and which are not attributable to other causes (e.g., the physiological effects of substance use or medication: criterion H).

As alluded to already, there is another school of thought, however, that sees the labelling and classification of PTSD as a disorder as problematic. Some commentators advise that it is better to think of all responses to trauma along a continuum of post-traumatic stress (PTS). Proponents of this view would argue that stress responses can be considered reasonable, normal or, indeed, expected reactions to extreme or distressing events (Summerfield, 2001). Thinking in this way encourages us to think about symptom severity. And it avoids the labelling of symptomatic individuals as 'disordered'. This gets around some of the negative feelings associated with a mental health diagnosis. Certainly, when I was diagnosed as depressed it felt like an additional burden. And, sadly, this is the way many people, myself included, continue to experience mental health diagnoses. It is also a reason that people struggle with admitting they need help (Kearns et al., 2015), in the way I did. So, thinking about responses to traumatic experiences as PTS rather than PTSD is thought to minimise barriers to seeking help as well as preventing the pathologising of traumatised people. We move away from a dichotomy between those who do or do not warrant a clinical diagnosis. This approach, rather than labelling people who are distressed by extreme events, turns attention to the social conditions that gave rise to traumatic experiences.

The value of avoiding labelling people is amplified by the fact that trauma exposure is so common throughout the world. More than two-thirds of all respondents in the WMH surveys report experiencing a trauma at some point in their lifetime. Without question, my life experience is the rule rather than the exception. The most common response to extreme and distressing events, including war, political violence, rape and sexual assault, accidents and natural disasters, is resilience to their impact (Agaibi & Wilson, 2005). Many people show some PTS in response to extreme or distressing events, but these responses often are short-lived and/or not so severe that they interfere with social or occupational functioning. So, though there have been very many incidents in my life that could be considered traumatic, for the most part, after a period of distress I managed to move on. This is borne out in the research that we have available. For example, using representative samples it has been shown that whilst 50 per cent of people in Northern Ireland have been exposed to more than one traumatic incident as a consequence of political violence (Schmid & Muldoon, 2015), only one in ten shows symptoms severe enough to warrant a diagnosis of PTSD (Muldoon & Downes, 2007). Similarly, cross-national longitudinal representative surveys of Israelis, Palestinians and residents of Northern Ireland indicated that while PTS responses severe enough to warrant a diagnosis of PTSD were more prevalent in these samples than in populations unaffected by political violence, they were still only evident in a minority of the population. So, even amongst those who reported direct and repeated exposure to trauma, 75–80 per cent did not warrant a diagnosis of PTSD (Hirsch-Hoefler et al., 2021). Accordingly, understanding the basis of psychological *resilience* to trauma is just as important as understanding vulnerability.

That said, we also know that the number of years lost to trauma-related disability is considerable. And though trauma is common, the experience of trauma is not evenly or equally distributed (Muldoon, 2013; World Health Organization, 2011). Take gender, for example. Tjaden and Thoennes (1998) estimate that each year 4.8 million acts of violence are committed against women and 2.9 million acts of violence are committed against men in the United States alone. Not only do these experiences have a profound effect on these individuals; they also affect others, including children exposed to this violence. Estimates are that each year in the United States 17.8 million children are exposed to domestic violence, either as witnesses or as targets (Evans et al., 2008). And we know trauma *type* matters – both to the risk and to the persistence of mental health symptoms. Exposure to intimate partner sexual violence accounts for nearly 42.7 per cent of PTSD evidenced across the twenty-seven countries that participate in the WMH surveys (Kessler et al., 2017). Being both an intentional act of harm and one that undermines our sense of trust even of those with whom we are closest (see Section 1.4), this type of trauma is particularly pathological.

Though statistics reported from various countries are not directly comparable, the WHO (World Health Organization) offers important insights into PTSD prevalence and patterning. The estimates for lifetime PTSD prevalence range considerably between countries, from a low of 0.3 per cent in China to 6.1 per cent in New Zealand (Kessler et al., 2009). There appears to be very different consequences of trauma, likely related to people's capacity and capital to manage traumatic stress across countries. For example, most war survivors live in low- to middle-income countries, and estimates of the impact of war suggest that, globally, the number of adult war survivors living with PTSD is huge (Hoppen & Morina, 2019). There were an estimated 1 billion adult survivors of wars fought between 1989 and 2015 alive in 2015, and based on geo-referenced data on armed conflicts a further 450 million children (data from the Uppsala Conflict Data Program, Petterson & Eck, 2018; Pettersson & Wallensteen, 2015). Using a meta-analytic approach to synthesise available data, Hoppen and Morina (2019) estimated that in 2015 there were approximately 242 million adult war survivors living with PTSD. Of these, about 117 million live with comorbid PTSD and major depression. While approximately one-third of cases recover from PTSD within a year, rapid recovery appears to be least likely amongst people with war-related symptoms (Kessler et al., 2017). Indeed, PTSD symptoms following war-related traumas have the longest median duration, at five years, followed by traumas involving physical or intimate partner sexual violence (with a median of three years).

In summary, psychological responses to trauma vary in degree and can change over time. Even in response to the same event, some people will show resilience and others severe symptoms of PTS. And though there will be other times when people struggle, our responses to traumatic events are often marked by resilience. In some cases, symptoms experienced as a result of trauma are severe enough to interfere with a person's social and occupational functioning and well-being. A diagnosis of PTSD can then ensue. Consequently, recent research efforts have largely focused on identifying those who are at increased risk of poor mental health outcomes if they are exposed to traumatic experiences (Bomyea et al., 2012). As we will see in the next chapters, a significant proportion of this variability is linked to social connections, social status, power and politics. This does not diminish the contribution of work that has explored other dimensions of traumatic responses, but rather highlights how group and social identity processes are integral to both experiences and responses to trauma – and hence that those same processes need to inform the way trauma is understood and managed.

2.3.2 Dual and Diverse Consequences of Trauma Exposure

Though trauma and PTSD have their own category of disorder in the DSM-5, in the real world, the psychological problems that people experience because of traumatic experiences are rarely clear-cut. It is apparent that many people living with PTSD have comorbid problems or dual diagnoses. For example, approximately half of the 250 million people living with war-related PTSD live with comorbid major depression (Kessler et al., 2017). Stewart's (1996) important early review of the literature concluded that trauma-exposed individuals with PTSD have a higher risk of alcohol abuse than those without PTSD. Later epidemiological studies showed the same pattern with regard to drug abuse (Reed et al., 2007) and tobacco use (Breslau et al., 2003). It is now estimated that individuals with PTSD are four to five times more likely to have a substance misuse disorder, at some point in their lives, compared with individuals who do not have PTSD (Brady et al., 2021).

In this way we can see that traumatic experience is linked to both PTS and other related psychological problems. Importantly, people who have comorbid diagnoses tend to have higher health costs. The Australian National Survey of Mental Health included 10,641 people and showed that individuals with substance use disorder and comorbid PTSD have significantly poorer physical and mental health and greater disability than those with substance use disorder alone (Mills et al., 2006). Using data from the US National Health and Resilience in Veterans Study (N = 2,732), Nichter et al. (2019a) similarly showed that the health burden of PTSD and comorbid depression was far greater than one of these diagnoses alone. Further, comorbid depression and PTSD were associated with a three times greater likelihood of disability than depression alone and was also associated with a diagnosis of heart disease and cardiovascular risk. Indeed, the evidence is that dual diagnoses are linked to disability (Campbell et al., 2007), health care utilisation (Chan et al., 2009), suicidality (Cougle et al., 2009) and poorer quality of life (Nichter et al., 2019b). The coincidence of PTSD and depression, and PTSD and substance misuse in this way imposes a greater cost on people's mental health and well-being than either condition alone (Flory & Yehuda, 2022).

There is a second way in which the divergent consequences of traumatic experience need to be considered. PTSD is unique in terms of mental health diagnoses as it stipulates its own causation. However, there are other disorders where traumatic experiences and adversity are seen and theorised to be relevant (Broeman, 2020). Childhood trauma, for example, is an important risk factor for the development of borderline personality disorder (BPD; Ball & Links, 2009). BPD was postulated originally to be a disorder inherent in people's character; now it is increasingly seen to arise from the problematic impact of childhood trauma on interpersonal relations. Typically, someone with BPD has problems in interpersonal relations. This has all sorts of costs for those affected in terms of their ability to engage and integrate in social, health, educational and occupational settings. And it can give rise to further health and well-being costs. BPD, then, though not often thought of as a trauma- or stressor-related disorder, arises from traumatic experiences and can have very high personal and socioeconomic costs (Luyten et al., 2020).

Taken together, this work tells us that the mental health implications of traumatic experiences are not clear-cut. People can have more than one set of symptoms and even more than one diagnosis. These can include depression and substance misuse (e.g., alcohol and drugs). People who experience trauma early in life may develop a pattern of behaving that means that they are characterised as having a personality disorder. Reliance on substances such as drugs, alcohol and cigarettes can become problematic and affect physical health outcomes. Reliance on these substances is sometimes a habit that traumatised people have developed to manage their own distress – often referred to as self-medication. Looking back, I can see these patterns in my own mis(use) of alcohol and cigarettes over the years. Relapse is common during times of distress or when further trauma is encountered. And it can be very difficult for people to kick these habits whilst they remain distressed. Understanding the varied and sometimes self-defeating ways in which people respond to trauma has given rise to calls for trauma-informed care (Racine et al., 2020). This approach shifts the focus in health, education and social care settings. Rather than seeing traumatised people as problematic, it acknowledges the wide-ranging impact of trauma in the hope of identifying potentially adaptative practices and pathways (Muskett, 2014).

2.4 The Physical Health Costs of Trauma

Since an acute physiological response to stress, commonly known as the flight or fight response, was first documented, a growing appreciation of the impact of stress on physical health has developed. This acute stress response has three phases, during which hormones are released to prepare the body to face imminent stress.. This is the first of two pathways through which trauma can affect physical health. The first pathway, a physiological pathway, is linked to these hormonal responses and their effect on biological markers of health, sometimes with long-term implications. A second pathway, a behavioural pathway, suggests that behaviours that support health (for example, adequate exercise and sleep) as well as those that undermine health (over-consumption of alcohol, poor diet, substance misuse) are more likely to emerge and be maintained during times of stress and trauma.

2.4.1 Physiological Pathway

We turn first to the physiological responses to stress and trauma. Physiological arousal in response to short-term (acute) stress is generally indicated by increased blood pressure, cardiac output and alterations in cortisol levels (Heinrichs et al., 2003). In laboratory settings, it is reasonably easy to stress people with simple cognitive or social stressors and observe their blood pressure and heart rate increase in response to these stressors. These can be considered short-term responses to stress and are most often driven by adrenaline. Adrenaline also gives rise to increased cortisol production. Cortisol functions to convert energy stored in the body into glucose so that it is ready for use by the body. This facilitates access to energy resources to sustain the increased requirements of our increased heart rate and blood pressure during times of stress. Indeed, these physiological responses to stress are necessary for our bodies to cope with stress. This pattern of arousal can be considered preparation for 'fight or flight' as it were. When these responses to stress are large or long-lasting, we see negative effects on our health (Lovallo, 2015).

Indeed, physiological responses to stress have been an area of serious research effort over the last forty years. It has given rise to a very influential idea in health psychology: the cardiovascular reactivity hypothesis (Obrist, 2012). Cardiovascular reactivity (CVR) measures the physiological changes, from baseline, in response to a stressor. Research shows that exaggerated or prolonged cardiovascular (i.e., blood pressure and heart rate) responses to stress are associated with increased risk of cardiovascular disease (CVD) development (Chida &

Steptoe, 2009). Generally, the more prominent and intense a stimulus or stressor is, the greater the disease risk. Cardiovascular reactivity offers a way of understanding how acute stress might affect our physical health.

The cumulative burden of repeated or chronic stress and the associated cost of cardiovascular reactivity in response to chronic stress is an important consideration. People and groups exposed to repeated trauma experience longer-term or sustained physiological responses (Gallagher et al., 2021). Allostatic load is a useful concept representing the cumulative burden of chronic stress on the body's multiple physiological systems (e.g., metabolic, immune and endocrine) as people attempt to adapt to life's many demands (McEwen and Stellar, 1993). Allostatic load has been shown to be associated with CVD morbidity and mortality (Rumsfeld et al., 1999; Zhang et al., 2010). This cumulative burden of stress and trauma is profoundly linked to later health outcomes.

Whilst much research has found that individuals who display exaggerated responses to acute psychological stress are at a greater risk of future hypertension, atherosclerosis and cardiovascular mortality (Carroll et al., 2012; Gerin et al., 2000), a failure to mount a sufficient response is also related to poorer health (Keogh et al., 2022; Phillips et al., 2013). These types of responses are sometimes called 'blunted'. The idea of a blunted response is in line with allostatic load theory, which highlights that ongoing stress and trauma leads to 'wear and tear' on the body (Glei et al., 2007; Guidi et al., 2021). Effectively, chronic stress and trauma reduce our ability to mount an adequate response in the face of ongoing stress. In our own research we have found that childhood trauma is linked to blunted reactivity, and this was most apparent in people with less social integration (McMahon et al., 2022). Blunted cardiac reactivity is also related to increased depressive symptoms, addiction, obesity and poorer self-reported health and well-being (Keogh et al., 2023; Phillips, 2011).

The physiological responses to stress and trauma do not just alter cardiac responses, however. Neuroendocrine reactivity, and in particular cortisol in response to stress, is a second key mechanism. Exaggerated neuroendocrine responses occur in situations of chronic or extreme stress, which can increase disease risk and also impact cognitive functioning. Cortisol acts as a biological intermediary between trauma and health (Cohen et al., 1997). Increased cortisol activity is displayed in response to laboratory stress and daily life stress (Gallagher et al., 2016; Keitel et al., 2011) and in response to trauma such as child abuse (Chavustra & Cloitre, 2008). Cortisol, as well as making energy available during times of stress, has an immune-suppressing effect. So, though cortisol can be important in facilitating increased energy demands, over time increased cortisol interferes with the body's immune function and our ability to fight disease (Irwin, 2008; Segerstrom and Miller, 2004).

This alteration of immune function has serious implications for people's health over the short and long term. Originally, Janice Kiecolt-Glaser and Ronald Glaser (1992) set out to consider the impact of spousal bereavement on immune function. They had noted the tendency, as was the case for my own parents, for cohabiting spouses to die within a year of each other. Their work led to the development of a field known as psychoneuroimmunology. Amongst other developments, this field has now identified links between the psychological and physiological features of cancer risk. The persistent activation of the hypothalamic-pituitary-adrenal axis during chronic stress is believed to impair immune response and contribute to the development and progression of cancer. Molecular immunological factors during the consecutive stages of the multistep immune reactions have been shown to depend on the type, chronicity and intensity of the stressor (Reiche et al., 2004). Altered immune function is similarly linked to the maintenance and progression of other diseases. For example, in the short term, antibody responses to vaccination are poorer in those with greater experience of stress and trauma (Burns et al., 2003; Burns and Gallagher, 2010; Pedersen et al., 2009; Phillips, 2011; Whittaker, 2018). Again, this evidence is consistent with the idea that stress and trauma are a type of wear and tear on the body, and over time this (allostatic) load alters people's functional adaption to stress.

2.4.2 *The Behavioural Pathway*

Any physiological effects of traumatic experience on health are likely amplified by the behavioural pathway that links stress, trauma and health. Behaviours that are linked to health are known as health behaviours. For the most part, this crucial role of behaviour in shaping morbidity and mortality has become widely accepted across medicine and epidemiology over the last three decades. Behavioural immunogens are behaviours that support health such as having a balanced diet, exercising regularly and practicing safe sex. Behavioural pathogens are behaviours that damage health such as smoking, substance misuse or poor sleep patterns. Stress and trauma appear to alter both habitual (i.e., regular, day-to-day) and non-habitual health behaviours (Sergestron & O'Connor, 2012).

The idea that stress is linked to health behaviours is a popular one. A quick click on the internet displays plenty of information on the adverse effects of stress for overeating, smoking, and alcohol consumption. And science generally backs up the popular notion that stress can change health behaviours. Stress is associated with higher fat diets (Laitinen et al., 2002; Ng & Jeffery, 2003) and greater fast food consumption (Steptoe et al., 1998), higher levels of smoking and reduced probability of smoking cessation (Steptoe et al., 1996), increased alcohol consumption (Steptoe et al., 1998) and lower levels of physical activity (Kivelä et al., 1991; Ng & Jeffery, 2003; Steptoe et al., 1998).

Health behaviours are also strongly intertwined with mental health (Parletta et al., 2016). Existing research testifies to the reciprocal nature of interactions between physical well-being, chronic disease and mortality. However, it is also becoming clear that health behaviours have an impact on mental health. For example, in one important study, the people adopting no healthy behaviours had 2.7 times more depressive symptoms compared with those adopting four healthy behaviours (Harrington et al., 2010). In another large-scale study, physical activity, alcohol consumption, smoking, body mass index and regularity of social interaction were all associated with specific mental health outcomes (i.e., depression, anxiety and stress) (Velten et al., 2014). Physical activity has been identified as an important protective factor in reducing the risk of developing depression (Mammen & Faulkner, 2013). So, my engagement with running as an important way to manage my mental health is nicely backed up by science.

While numerous studies consider the relationship between stress and specific health behaviours, much of this research is based on clinical samples or conducted in laboratory settings that rely on simulated stressors (Umberson et al., 2008). Community samples can link naturally occurring stressors and health behaviours in the general population. For the most part, these are cross-sectional studies rather than longitudinal ones. They offer a snapshot of the relationship between stress and health at one point in time. Studies of this nature present the perennial 'chicken and egg' question: Which came first? Does stress cause poor health behaviour, or poor health behaviour cause stress? Longitudinal research is needed to establish the direction of the relationship between severe trauma and stress and health behaviour over a person's lifetime. For now, available evidence seems to suggest that chronic stress and the disadvantages that co-exist with traumatic experiences tend to make the establishment of predictable and healthy lifestyle practices difficult. Indeed, disadvantaged circumstances would appear to be a type of stress in and of itself (Ryan et al., 2021; Ryan et al., 2022).

2.4.3 *Personal Pathways to Health?*

So, if I return to the idea that my own life has been charmed, certainly it would seem that although I have a relatively sedentary job, the predictability of the hours that I work has allowed me to develop healthy habits. Cortisol tends to peak in the morning, so running before a day's work puts this waking cortisol to good use. It also leaves me with a small sense of accomplishment as I face the day. Of course, running five kilometres before a day's work might be a very different proposition were I about to face a day's work on my feet, a prospect often associated with low-paid work. Nor would it be possible to leave my children home alone early in the morning to run were I a single mother. Engagement in regular exercise also requires time, something that is often in short supply for those caring for children, elders or disabled relatives. Unsurprisingly, there have been times in my life when I have struggled to find that time – when my parents were ill, when my husband was ill, when my children were ill. So, though exercise is often presented as an activity we 'choose', in reality, regular running or a pastime of any sort is much more of a luxury than a 'choice'. And it is when we need to be maintaining our destressing habits most that we tend to have the least capacity to engage. In this way we can see that whilst individual action is relevant to health behaviour, it is simplistic to think that people's health behaviour is all about healthy choices. Social, cultural and political factors shape both stress and health behaviours.

Strong assumptions about the role of individual factors in shaping health behaviour are evident across the literature in health psychology and epidemiology (Muldoon, Liu & McHugh, 2021). This can lead to scenarios where those affected by both health issues are seen as 'deserving' of their ill-health, or culpable as it were. By doing this, we erase the barriers that prevent people from engaging in healthy behaviours. To enact any health behaviour you must be both willing and able. You have to want to run and be able to run. You have to want to get vaccinated and also have access to a vaccine. But I might not feel safe enough to run if I am routinely harassed on the street. I might not be willing to get vaccinated if I have reason to mistrust the government or big pharma. Capacity to act is profoundly related to opportunity, (dis) ability and available resources. Maybe I have no time to run, or have a disability, or simply no shoes to run in. Maybe I can't get vaccinated due to work rules that do not permit time off for health care, or I have an underlying health condition, or there are no vaccines available where I live. Because we assume people's health is driven by choice, we are willing to judge and even vilify those who don't exercise, drink too much or don't get vaccinated. Sometimes we even damn ourselves for not doing these things. In so doing we obscure the role of social and political forces that drive trauma, health behaviour and disease risk.

This has two important implications for longer-term health. First, traumatic experience and chronic adversity affect people's lives in ways that affect their ability to access health and social care as well as changing their social and health care usage. Trauma-informed care aims to support engagement with public health and treatment to maximise health outcomes for vulnerable populations and, in particular, those who have lived with chronic stress. This includes offering advice about adherence or health practices that is viable for people. Advice needs to be tailored for each person's situation. Post-traumatic stress in marginalised and stigmatised groups can be misinterpreted as aggression and hostility, limiting access to services further. So, the potential for misunderstanding is high. However, there remains a duty of care to those with ostensibly self-destructive behaviours in universal health and social care systems. And it is always worth remembering that people sometimes have a good reason for limited trust in statutory services.

The second implication of this approach is the realisation that destructive lifestyles, rather than being a product of poor choices, can be habitual practices borne of chronic stress and trauma. In many regards, debates about the root cause of ill-health, and whether it is as a result of poor lifestyle choices or adverse life circumstances, go to the heart of an important methodological issue. This methodological concern – whether trauma and adversity cause poor mental health and lifestyle practices or whether poor mental health and lifestyle practices cause adversity – is often seen as a highly politicised question. In reality, this is fundamentally a political psychological question: at its heart it asks who is, and isn't, deserving of care and concern.

2.5 Trauma Has Social Costs

As well as the personal health costs of traumatic experience, we think of trauma as having wider social costs. Traumatic experience can have impact on people's social behaviour rather than just their health behaviour or their physiology. A distinct focus of much of this research has been on children and adolescents, and there remains a view that traumatic experience in early life can have a particularly powerful influence on social and political attitudes. So, for example, the experience of political violence has been related to aggressive and delinquent behaviour. An increase in juvenile crime during wartime was first documented in World War I (Leeson, 1917), and a similar increase was seen again in World War II (Titmus, 1950). This has been variously attributed to excitement attached to the notion of conflict, decreased parental supervision during times of violence and extreme stress, and normalisation of violence and social modelling as a result of the conflict (Muldoon & Cairns, 1999).

Research evidence has followed the early war observations of children using standardised indices of juvenile crime (Pfeiffer, 1998) as well as psychometric measures such as indices of externalising behaviour problems (Fee, 1980). Children who grow up in families affected by domestic violence also face challenges as a consequence of this highly traumatic early experience in their later lives (Naughton et al 2020). Those who grow up in homes affected by abuse tend to be at higher risk of becoming both victims and perpetrators of domestic violence themselves. And children and young people whose parents die by suicide are similarly at greater risk of suicide themselves (Soole et al., 2015). There is a tendency for young people to view the behaviours as acceptable and typical where others, including parents or peers, have behaved in the same way. This is sometimes referred to as social contagion of risk: risk behaviours spread through social networks as they become normalised (Christaki & Fowler, 2013).

These types of effects can also be attributed to the difficulty young people have in interpreting complex behaviour in traumatic situations. Clear conflict between what is said and what is done at times of trauma creates issues for exposed children. Take, for example, a child who is abused in their own home. Though they are blameless, it is often the case that they are removed from their home. Children can experience this as a form of punishment and can misunderstand their role in the abuse. Ambivalence around political violence is also common. In my own research we have seen how parents are often keen to keep their child removed from the risks of street violence or conflict in Northern Ireland and Nepal (Acharya & Muldoon, 2017; Muldoon, 2004). And though parents may work hard to protect their own children from the risk of violence, the conversations at home may routinely highlight the inequities and injustice of the political situation. On the one hand, then, parents are schooling their children to avoid danger, but, on the other hand, they may support and even celebrate the hostile actions of an aggressor on their own side. This type of position encourages a moral relativism that can leave young people with questions about the acceptability of violence as a solution for problems in public and private spheres (Muldoon, 2013).

In our own research we have shown how this type of gap can open up in responses to domestic violence. Domestic violence can be very difficult for young people to make sense of, and young people who grew up in homes affected by domestic violence show clear ambivalence about labelling their family situation (Naughton et al., 2019). Even young people who self identify as having grown up in homes affected by domestic violence and abuse struggle with labelling their experience as domestic violence. Similarly, we found ambivalence in the narratives of family court judges managing domestic violence cases. Even experienced judges seemed to want to maintain a narrative and an appearance of a normal family life for affected families, rather than acknowledging the very real trauma exposure that children had suffered (Naughton et al., 2015).

For those who experience stigmatising trauma, the world is equally as harsh. Stigmatising traumas such as domestic violence, bereavement by suicide, and rape and sexual assault place those affected on the margins of society. People's ability to engage with others in their existing social networks is diminished (Muldoon, Haslam et al., 2019; Naughton et al., 2015). And the legitimacy of victims' complaints about their situation is undermined (Bradshaw & Muldoon, 2020). As a result, those affected by stigmatised traumatic experiences either can find themselves removed from sources of social support or, worse, feel that their 'transgression' justifies their suffering (Bradshaw & Muldoon, 2020). Where this is the case, it is likely to impact profoundly and negatively on health (Stevenson et al., 2014).

Those affected by stigmatised trauma are constructed by others, then, as something other than innocent victims. Victim blaming can quickly ensue. This undermines the degree of social connectedness and solidarity among different community groups within a society, something that is often referred to as social cohesion. Social cohesion affects levels of trust and connectedness between individuals and across community groups (Fonseca et al., 2019; Ludin et al., 2019). Higher social cohesion and trust in others has been associated with better health outcomes for all (Chuang et al., 2013; Feng et al., 2016; Miller et al., 2004). Stigmatising a traumatic experience, then, has a social cost. It maintains and enhances social divisions within society.

In essence, for children and young people who encounter grievous and daily human rights violations, insisting on 'moral behaviour' can be interpreted as meaningless rhetoric. A study exploring how living in war-affected Colombia had impacted the views of the children and adolescents (Posada & Wainryb, 2008) speaks clearly to this issue. Young people were asked questions about justice and welfare. They clearly judged it wrong to steal or hurt others. On the other hand, judgments with regard to revenge were more mixed. Their more ambivalent attitude to revenge was underpinned by a majority belief about the nature of the world. They thought that others would steal and hurt them in most situations. In effect, the difficult contexts within which children grow up, as well as their actual exposure to violence, had profound consequences on children's developing understanding of how the world works. Where those tasked with upholding the rights of children and their families fail, trust in others is lost. The world of children who have been traumatised, disempowered and poor is a harsh world.

Insisting on a need for young people's behaviour to be moral in these contexts is likely to add insult to injury. There is no doubt that this can be a cause of anger. In situations where young people witness human rights violations and a failure by a 'moral majority' to intervene or protect vulnerable family and community members, young people can feel both compelled and justified to respond (Bar-Tal et al., 2017). These responses may seem questionable to others. In more peaceful countries, it can result in active engagement in protests. In situations where there is long-standing division and hostility, it can easily overflow into street violence and riots (Barber, 2013; Muldoon & Wilson, 2001). These hostile engagements, as well as delivering further traumatic experiences, reduce social cohesion. Those who participate in protests can come into contact with state actors. Where hostile interactions ensue, protesters lose trust in the institutions such as the police. This state system then comes to be seen as one that serves and protects the more privileged and powerful in society. As well as corroding trust of those angry and protesting, this can leave the majority, the mainstream, feeling attacked and undermined (Bar-Tal & Cehajic-Clancy, 2014).

This lack of trust in one state service, the police or army, often translates into lack of trust in other institutions such as welfare and health systems (Khatib et al., 2022; McWilliams, 1997). This can translate into other socially corrosive practices. This is in part due to the fact that those who display anger or hostility in response to trauma are not seen as deserving of our care. Traumatised children if presented as passive victims are seen as deserving of our concern (Muldoon & Cairns, 1999). This is increasingly unlikely to be our view as these children become adolescents and adults. They morph all too quickly in the public imagination into undeserving, and even dangerous adolescents or youths (Muldoon, Trew & Kilpatrick, 2000). Being proactive, and no longer conforming to our stereotype of victimhood, older children and adolescents are less likely to be seen as deserving of care or concern. Often, we emphasise particular characteristics of those who become violent. Even though perpetrators are typically young and male, their violent actions are interpreted and reported in the media with regard to race and/or ethnicity. This type of practice is destructive. It stereotypes the protagonists as ‘mad’ or ‘bad’ (Muldoon, McLaughlin et al., 2008). It stereotypes the ethnic group to which they belong as aggressive and dangerous. It erases the societal practices and structural forces that fomented a sense of anger and injustice. This results in further divergence of those who do or do not trust the state, news media and public institutions. Trauma is both self-perpetuating and fundamentally corrosive.

Awareness of this phenomenon has given rise to an area of research known as collective trauma. Collective trauma research highlights the changes in the social fabric of society associated with trauma. This work is less concerned with the personal, medical or clinical consequences of trauma felt by those directly exposed. Rather, this research highlights the ripple effects of trauma across a society. Though collective trauma can bring distress and negative consequences to individuals, the key focus is on the change it brings to the entire fabric of a community (Erikson, 1976). For example, the scale and global nature of the COVID-19 emergency means that the crisis is a collective trauma. And as such, many people will have a sense that they share the experience of this major upheaval with others. However, as the pandemic unfolded and affected many people around the world, it has become clear that the scale and intensity of this upheaval differed widely between countries and even within the same country. For the most part, the threat of the pandemic was dealt with collectively at a national level, and to some degree the WHO has attempted to co-ordinate a global response. As would be expected when a collective trauma is experienced, this has impacted relationships, changed social norms and altered policies and governmental processes, and the way society functions (Chang, 2007; Hirschberger, 2018; Muldoon, Lowe et al., 2021; Saul, 2013). And it is likely that more social and political ramifications of the COVID-19 pandemic are yet to come.

2.6 Economic Costs of Trauma

Trauma also has an economic price. This price can be felt at an individual level and a country level as well as impacting affected social groups. We can see that very clearly with regard to the COVID-19 pandemic and the rising inequality that has been associated with the crisis. Estimates are that the global response so far has costed $11 trillion, with a future loss of $10 trillion in earnings (World Economic Forum, 2020). War and gender-based violence are also extremely costly. Research indicates that the cost of violence against women amounts to around 2 per cent of global gross domestic product (GDP) (Garcia-Moreno et al., 2015). This is equivalent to $1.5 trillion, which approximates to the size of the Canadian economy (United Nations, 2013). In some countries, violence against women is costing up to 3.7 per cent of their GDP – more than double what most governments spend on education. Failure to address political and gender-based violence also entails a significant cost for the future.

And in the same vein we now know that those countries that failed to address the COVID-19 pandemic adequately are those that paid the highest price as the crisis continued (Muldoon, Liu & McHugh, 2021).

A diagnosis of PTSD is also associated with a significant economic burden. The nature and extent of post-traumatic stress have been examined in the WMH surveys. These surveys estimate the lifetime prevalence of PTSD using representative samples in twenty-seven countries. They use a metric known as 'the burden of a disease'. The burden of a disease can be thought of as the years of life lost due to death and disability from any given disorder (Murray & Lopez, 2013). Because we have data on PTSD from around the world from these WMH surveys, we can measure the burden of PTSD worldwide. This burden measure represents both the prevalence of trauma and the persistence of symptoms people experience. It is estimated that, globally, PTSD is the cause of 0.4 per cent of disability from all physical and mental health causes. This is equivalent to the disability cost of schizophrenia, the mental health condition often considered to have the most severe health toll (Ayuso-Mateos, 2002; Kessler et al., 2009).

As such, trauma and PTS are major mental health concerns that come with not only a psychological cost but a significant social and economic cost at the individual and the population level. And this cost is growing. The estimated cost of PTS in the United States for 2018, the latest year for which data were available at the time of the study, was $232.2 billion (Davis et al., 2022). The economic burden of PTS goes well beyond the individual economic burden of health felt by individuals or the associated direct health care expenses. It also exceeds the costs of other common mental health conditions, such as anxiety and depression. Increasingly, the economic burden of PTS costs is experienced by civilians. In the United States, 82 per cent of the economic burden associated with PTSD was seen in civilians compared with 18 per cent in the military population in 2018 (Davies et al., 2022). This increased civilian burden of PTS is reflective of the increasing exposure of civilian populations to traumatic events, including COVID-19, civil unrest and climate change.

Findings also highlight that trauma can amplify pre-existing inequality. Recall that the experience of trauma is more likely to be felt by those in socioeconomically disadvantaged circumstances. Traumatic experiences exacerbate the economic challenges experienced by those already disadvantaged. For example, intimate partner violence has a lifetime economic cost, and that economic burden is higher for women who experience domestic violence than men who have domestic violence experience (von der Warth et al., 2020). In the United States, current estimates are that the economic cost of experiencing intimate partner violence for women across their life span was $103,767. While there is a cost for men who are victims of domestic violence, this is much lower, at a $23,414 lifetime cost. In this way we can see how this type of trauma amplifies income inequality experienced by men and women.

War and political violence can also be seen to amplify global inequality. One way in which this can be illustrated is by comparing the average economic cost of violence in the ten most conflict-affected countries in the world with the cost of violence in the ten most peaceful countries in the world. The countries most affected by violence spend on average 41 per cent of their GDP managing the economic costs of this violence. In stark comparison, the average economic cost of violence in the ten most peaceful countries amounts to just 3.9 per cent of their GDP. In this way we can see that the burden of violence diverts a country's economic resources into managing the fallout of violence. In contrast, more peaceful countries have more resources available for development of national infrastructure (Dunne, 2017). In this way, we can see how the economic burden of conflict also feeds inequality between nations. These effects mean that people most affected by trauma, whether gender-based violence, war and political conflict or COVID-19, are those least likely to have economic resources available to deal with the fallout of traumatic experiences.

Globally, trauma is the sixth leading cause of death. In both men and women, one in every ten deaths is a result of trauma such as violence or car accidents. In those under thirty-five years of age, trauma is the single largest cause of death and disability. Globally across all ages, trauma is the fifth-ranking cause of moderate and severe disability (Murray et al., 2012). Some of the economic cost of trauma arises from its impact on death and disability. Those affected by trauma often live with long-term disabilities. For instance, one study of US Vietnam veterans estimated that almost 70 per cent had war-related disabilities more than forty years after their war experiences. These included eye and ear disorders (47% of cases), musculoskeletal disorder (18% of cases) as well as mental health conditions (47% of cases) such as PTSD (Clarke et al., 2015). And again, reflecting pre-existing disadvantage, people with disabilities are at heightened risk of further trauma during conflicts and humanitarian crises.

2.7 Conclusion

Peace is a complex and, at times, elusive construct (Davenport et al., 2018). Its most prominent definitions are the absence of direct violence and the presence of social justice and equality (Galtung, 1996). This absence is often referred to as negative peace, referring to the lack of conflict despite the ongoing presence of strained relations. Positive peace, in contrast, is derived from social cohesion and sustainability and positive social attitudes, as well as institutions and structures that create and sustain peace (Fry et al., 2021). Positive peace is sustained by high levels of human capital, acceptance of the rights of others, good relations within and between countries and free flow of information and equality (Fry et al., 2021). The UN included in its 2015 sustainable development agenda goal 16: promoting justice, peace and inclusive society (Envision 2030).

Peace, by definition, is essential to public health and prevention of death, disease and disability. At the individual level, being able to access care and enact behaviours in support of health when you are negotiating traumatic experiences is crucial. These resources are both tangible and intangible. In my case my negotiation of difficult experiences was facilitated by the fact that I live in a country where I could access tangible supports such as a family doctor, a counsellor and prescription medication. A second factor is that I have always lived, by virtue of my educational privilege, in university areas during my adult life. These areas tend to be relatively safe for women to exercise outdoors. Running has been a viable way to manage my distress because of the relative safety and acceptability of this exercise practice for women in Ireland. Positive peace in the form of a healthy and safe physical and sociocultural environment can be seen to be relevant to my charmed existence. My individual success at negotiating the curve balls life has thrown is due to a large degree to the fact that my basic needs were met because of the availability of social and public resources such as health care. On the other hand, nations without positive peace are disproportionately affected by trauma. And traumatic experiences contribute to further poverty, disability, underemployment, forced migration of populations, family separation and homelessness, all of which carry significant social and economic costs. And these traumatic experiences are directly relevant to the ability of individuals and communities to build their future.

3 Traumatic Experience Is Patterned

And I am still imperially
Male, leaving you with pain,
The rending process in the colony,
The battering ram, the boom burst from within.
The act sprouted an obstinate fifth column
Whose stance is growing unilateral.
His heart beneath your heart is a wardrum
Mustering force. His parasitical
And ignorant little fists already
Beat at your borders and I know they're cocked
At me across the water. No treaty
I foresee will salve completely your tracked
And stretchmarked body, the big pain
That leaves you raw, like opened ground, again
—Seamus Heaney, 'Act of Union'

3.1 Chapter Outline

People often speak of random acts of violence, of the unpredictable nature of traumatic experiences that befall themselves or others. While it is true that we cannot say exactly who will experience trauma or when, it is not random either. Understanding the political psychology of trauma requires consideration first and foremost of the patterned nature of traumatic experiences, which is the central aim of this chapter. Peoples' responses to the events they experience are also covered in later chapters. These two factors, the experience and the response, are obviously connected. In this chapter, the patterned nature of traumatic experiences associated with gender, age, minority ethnic or religious group, and poverty is considered. Different demographic groups tend to have different types and ranges of traumatic experiences. There are groups of people who may be far more vulnerable than others when they encounter a traumatic experience. On the other hand, when people encounter a traumatic experience from a position of relative strength, the outcome is likely to be very different to having the same experience at a moment of vulnerability. The role of these social risks and their consequence for people's subsequent resources is centrally relevant to how people adjust to trauma. The central aim of the chapter is to reveal the way in which social, economic and political resources pattern people's exposure and vulnerability to traumatic events.

3.2 Traumatic Experience: A Fixed Mark

About a year ago, I inadvertently became involved in someone else's marital spat. I had written an article for the *Irish Times* (Muldoon, 2022) to highlight the non-random nature of violence against women. There had been yet another fatal attack on a young woman in Ireland. It followed on from a similarly widely publicised case in the United Kingdom. In the first days after the terrible case in Ireland I had participated in a podcast and used the term 'asymmetrical violence' to refer to the non-random nature of violence. One of the journalists participating rightly pointed out this wasn't the most accessible term. So, when I was contacted via Twitter by a man who described, much to the chagrin of his wife, these attacks on women as 'random attacks', I tried out a new analogy.

We all understand the idea of randomness. In science, though, it has a particular meaning. It is probably best represented in everyday life by a lottery such as the Euromillions, or any other number of national lotteries. When a lottery of this nature is run, balls are drawn from the drum randomly. Every ball has an equal chance of being drawn. So, in a lottery where there are 200 balls, numbered 1–100 coloured blue, and 1–100 coloured pink, over a year of lotteries roughly an equal number of blue and pink balls across all decades should appear. Looking at who is exposed to gender-based violence, it is clear this isn't the pattern. Young women – we might think of them as the pink balls numbered 15–25 – keep appearing. Internationally, they are at disproportionate risk of this type of trauma. For the most part, men perpetrate this violence against them. So, this 'lottery' is fixed, set up for women to lose.

In the spirit of finding a better term to refer to this effect, I suggest we refer to this type of pattern as 'a fix'. I think the term is useful for several reasons. People's chances and privileges in life are rigged or 'fixed' in much the same way that football matches can be. We think there is fairness when the game of life begins, but it isn't the case. Life is a fix. I also like the term 'fixed' because in statistics and psychological research we talk about 'fixed effects' (Fidell & Tabachnick, 2003). The term is used to refer to a grouping factor in a study, such as gender or race, that has a systematic influence across all of the outcomes we are interested in understanding.

So, because of the way life is currently fixed, women and men experience different levels of sexual violence. In one of my first weeks as a student, whilst walking to lectures, a young boy I didn't know grabbed my breast as we passed each other. I was with two fellow students, both male, at the time. I was horrified, shook even. The young fellow moved on, and though they had witnessed the assault, neither of my fellow students made any comment. Of course, this type of event is one familiar to many young women and men, literally unremarkable. In that first year of college, we often spent our Thursday nights in the students' union. The night invariably ended with the claxon call of 'The women's night time mini bus is now leaving from the front door' – a bus provided by the students' union to offer safe passage home to young women. The trauma risk to young woman was clearly apparent even then.

Belfast wasn't a particularly safe city in the early 1990s. The women's night-time minibus sometimes was a bone of contention between myself and my then boyfriend, now husband. It wasn't particularly safe for young men to walk alone in the city, either. And young men, especially those like my husband from Catholic/nationalist backgrounds, often felt at risk. Again, there was good reason for these feelings of risk. There is another way in which trauma risk is fixed to place a particular group at risk. Young men are particularly likely to be victims of street violence, and in situations of political conflict, people from the minority community – in the Northern Irish case, the Catholic/nationalist group – were at higher risk again (Cairns, 1996). This isn't a random effect; it is a fixed one.

As my children grew up and became acquainted with history, and knowing that they had been born in Belfast, they sometimes asked about these 'olden times', the years where the political violence was referred to locally as 'the Troubles'. It isn't until you look back on those times that you realise how peculiar life had become. Security and policing were very different. Army personnel routinely carried large machine guns on the street. Helicopters overhead were a constant; vehicle checkpoints and bag checks at the cinema or while one was out shopping were normal. Shooting and bombings featured frequently in the news, and though sometimes far too close for comfort impacted little on people's everyday business. Bomb scares were treated as an inconvenience rather than a risk to life and limb. I noted with interest the same effect being talked about life in Ukraine. People were getting on with their lives despite the ongoing hostilities. Indeed, in recent days, there have been reports of people returning to their lives in Ukraine despite the fact that for many of us we still see it as a desperately dangerous place.

Many young people crossed the border, as I did, and attended university in Northern Ireland, in the late 1980s and early '90s. EU membership meant that tuition was free in the North for all EU citizens, whilst it remained expensive in the Republic. This willingness to cross the border into Northern Ireland, beset as it still was with conflict, reflects an insider understanding of the nature of the conflict. Those directly affected by the trauma of war and political violence in any society are always the poorest. These same patterns of violence can be seen across the world where political violence and war emerges. In hindsight, I think we were aware of this fixed effect too. Students in higher education then and now are not usually the most deprived in society. So even during the conflict, we inhabited and were protected by the safer spaces afforded to those living in and around university campus.

School leavers making their way across the border from the Republic in pursuit of higher education in Northern Ireland were perhaps not that surprising. And indeed, they did go and in serious numbers. And though as suggested by Heaney's (2009) poem 'Act of Union', Belfast through politics and the legacy of colonisation had been 'left raw', yet life went on. People had been made vulnerable by the imperial power of 'the tall kingdom' when the 'boom burst' in 'the heaving province'. It is instructive that in the poem Heaney draws a parallel between this violence and the experience of women subjected to sexual violence. In much the same way as women accommodate the risk of gender-based violence in their lives, people living in Northern Ireland, and latterly Ukraine, accommodate political violence as the backdrop to their lives. Heaney's poem speaks to the parallels between gender-based violence and war. There are fixed group effects at play. The risk is never random.

3.3 The Nature and Incidence of Traumatic Experience

Despite an enormous increase in knowledge about psychological trauma, stress- and trauma-related disorders remain controversial (Brewin et al., 2009). Some of this controversy arises from the diagnosis hinging on the experience of extreme traumatic incident, referred to as criterion A in the DSM. These are also sometimes referred to as criterion events (APA, 2000). Briefly, criterion A is an 'inclusion' criterion. This means that in order to be diagnosed as having a clinically substantive stressor- or trauma-related disorder, people must have experienced particular types of stress and trauma. It is necessary, though not sufficient, for diagnosis that the event involves actual or threatened death, or serious injury or threat to one's own or another's physical integrity. This inclusion criterion requires that these are sudden, shocking or unpredictable events that are either direct personal experiences or vicarious personal experiences. And by way of a reminder, direct personal experiences include experiences where people are themselves the victims or where they are present and witness the trauma. Indirect or vicarious experiences occur where people become exposed to the trauma because of a relative's or close friend's experience or because of the nature of their occupation, as can occur in the case of first responders (APA, 2013).

In part the reason that this criterion remains is that there does appear to be something particularly pathological about personal experience of trauma. A careful inspection of the literature shows very few examples of individuals meeting the full diagnostic criteria in response to events that are not criterion A– type (Brewin et al., 2009). Mental health consequences of trauma are almost always tied to these types of 'up close and personal' experiences. Though the dire experiences of those affected by pandemics, climate emergency or war that we learn about via the media can be very distressing, these types of experiences typically do not compromise people's mental health or trigger trauma-related disorders. Importantly, over thirty years of research tell us that exposure to traumatic events in our wider social networks is not the driver of clinically significant psychopathology.

Equally, it cannot be said that everyone who experiences traumatic events has difficulty adapting. It is well established that this is not the case. Estimates of the total population life experiences of potentially triggering traumatic events are high. Traumatic experiences are the rule rather than the exception for many of us (Breslau & Kessler, 2001).

The strongest evidence on this point is gained from the WHO World Mental Health Survey Initiative. This initiative aims to obtain accurate cross-national information about the prevalence and correlates of mental, substance and behavioural disorders. The initiative runs reliable epidemiologic surveys of mental, substance use and behavioural disorders in countries in all WHO regions (Benjet et al., 2016).

In terms of understanding mental health, the WMH survey is a hugely significant initiative as surveys are carried out rigorously and are representative of the general population. This allows estimates of the prevalence of mental disorders, associated risk factors and barriers to service use. Equally as important in this case, because of the centrality of traumatic experience to the diagnosis of trauma-related disorders and PTS, exposure to traumatic events is also measured in these representative samples across participating countries. Thus, the surveys estimate lifetime exposure to traumatic experiences. These data indicate that approximately 67.1 per cent of people sampled report one or more traumatic experiences over their lifetime. A quarter of people across the surveys (24.6%) report experiencing one experience only, whilst the remaining sample reported a mean of six experiences (interquartile range, 3–6) (McLaughlin et al., 2015). Traumatic experience is reasonably common, and so too is repeated traumatic experience.

Other evidence bears this position out too. If we take political violence as one example, there is lots of available research regarding the regularity of trauma exposure that ensues in particular regions. De Jong et al. (2001) report extensive experience of extreme traumatic events in their sample in Algeria: 84 per cent of their sample had been exposed to gun attacks through crossfire, 83 per cent to bombings and 41 per cent witnessed the death of loved ones. The amount of conflict-related trauma reported through the war in Croatia by a sample of school-going children was also considerable (Kuterovac et al., 1994), and in Northern Ireland a substantial minority of children reported having been caught in a riot (23%), witnessed guns being fired (24%) (Muldoon & Trew, 2000) or experienced a bomb scare (60%). Summerfield (2001) points to evidence indicating 99 per cent of a sample in Sierra Leone meeting experiential criteria for PTSD. These authors suggest that these findings reflect the scale and intensity of the experiences people in these regions routinely encounter.

On the other hand, the figures also tell us that, in these regions at least, the events are not ‘unusual’ or ‘extreme’. Indeed, previous descriptions of traumatic experiences that relied on the idea that they were beyond the range of normal human experience (APA, 2000) are problematic in light of this evidence. As well as communicating, however implicitly, to people that their experience of life was ‘unusual’ or ‘abnormal’, the position runs completely counter to the evidence. Thinking of these events in this way does not capture the reality of life in regions of the world where political violence is the backdrop of everyday life.

Life-threatening experiences fluctuate between populations across time and space. Ukrainians have endured very high levels of trauma exposure in 2022, for example. That said, much of the territory of Ukraine is a site of repeated trauma. People’s experiences even within this same region, however, differ not only across time but within subpopulations of the region. So whilst overall those living in Europe have far less lifetime exposure to the trauma of war and political violence, this is not the case for those living in Ukraine, the Balkans or indeed Northern Ireland. And these problems tend to be ongoing, or even chronic. Throughout the last two centuries the area that is modern-day Ukraine has been under the control of the Austro-Hungarian Empire, Poland, Nazi Germany, the USSR, the Russian Federation and Ukraine. It is a site of repeated invasion, of ethnic tension and oppression, of pogroms and genocide. Ukraine is a reminder of just how unstable European recent history has been; this instability frequently impacts other areas. European immigration is shaped by European disorder. Importantly, within such trauma-affected regions like Ukraine it tends to be the poor and minority groups who encounter the worst of the violence (Cairns, 1996; Muldoon, 2013). It is this variation in trauma exposure that is crucial to understanding the social and political psychology of trauma.

Finally, as well as showing the variation in exposure to trauma, the WMH survey initiative has also been used to inform the *types* of traumatic experience people encounter. Benjet et al. (2016) explored the patterns of trauma exposure with responses from 125,718 adult participants in twenty-four countries participating in the WMH survey. Using a statistical tool known as factor analysis, which reveals patterns in data, they found five types of traumatic experience. These included two dimensions representing political violence, the first as a witness or onlooker (e.g., being a civilian in a war zone, a relief worker in a war zone, a refugee) and the second as an active party to the conflict (e.g., purposely injuring, torturing or killing someone; combat experience). Two further dimensions related to intimate and domestic violence were uncovered. The first was related to child abuse (e.g., beaten up by a caregiver as a child, witnessed physical fights at home as a child, beaten up by someone other than a romantic partner), and the second was related to intimate partner or gender-based violence (e.g., physically assaulted by a romantic partner, raped, sexually assaulted). A final dimension of traumatic experience relating to accidents and injuries (e.g., natural disasters, life-threatening illnesses) was evident. It is for this reason, as we proceed through this chapter, we consider not only the patterns of traumatic experiences but also how these patterns might link to different dimensions of trauma.

3.4 Patterns of Traumatic Experience

In this section we consider the idea that traumatic experiences, though often experienced by individuals as random and unpredictable, are in fact experiences that are patterned. Though we may have a sense that adversity and adverse experiences occur haphazardly, there is clear evidence that life-threatening (criterion A) experiences affect populations differently. The risks are fixed; systematic effects are in play. Over the course of the COVID-19 pandemic we have seen these fixed effects play out in different ways with various occupational, ethnic, income and national groups, for example. Over the course of the COVID-19 pandemic lower-income groups who live in more overcrowded accommodations had fewer opportunities to work from home (Patel et al., 2020; Wright et al., 2021) and these structural inequalities made compliance with restrictions more difficult (Templeton et al., 2020). Similarly, the effects of climate crisis and associated emergencies have already affected those who live in the Global South, far more than people in more affluent Global North locations.

Any social psychological analysis of trauma therefore needs to acknowledge the role of social structures, group divisions and power. Sociologists and social psychologists have grappled with this issue but to date the application of these issues to trauma has been limited (Muldoon, 2013). Scholars both within and outside psychology, addressing the legacies of colonisation, have considered how subordinate and minority group members are victimised because of their social position (Bulhan, 1985). This theme lies at the heart of Heaney's 'Act of Union' poem. It uses the idea of sexual violence to represent the permanent scarring 'like opened ground' that resulted from the British occupation of Ireland. In social psychology and sociology similarly, insights into victimisation by violence and oppression by dominant groups against subordinate groups has been evident in critical studies and social dominance theory (Normand & Jochnick, 1994; Sidanius & Pratto, 2001). These analyses foreground the impact of structural divisions in sociological explanations of war and political violence (Bobo, 1999; Mills, 2000).

To date, psychologists have been slower to use these group-level factors to enhance understanding of how people negotiate and adapt to challenging circumstances such as acute and chronic exposure to trauma. We do know from the literature on stress that experience of one trauma can deplete social and psychological resources and place people at risk of further trauma (Charuvastra & Cloitre, 2008). As a general rule, cohorts with less power and privilege experience more frequent and intense traumatic experiences and have qualitatively different experiences of even the same trauma (Muldoon et al., 2017). These types of trauma trajectories are often outside the range of many people's experience, and possibly even the understanding of those with more privileged lives, even in the same country. To illustrate these effects here we consider three different types of traumatic experience: war and political violence, gender-based violence and morbidity and mortality as a consequence of the COVID-19 pandemic.

3.4.1 Traumatic Experience Is Patterned by Poverty and Privilege

It is estimated that over the past decade at least forty countries worldwide have been affected by ongoing armed civil conflict. In the history of warfare, civilian fatalities are disproportionately higher than ever before. In World War I, 10 per cent of all fatalities were civilian casualties; in World War II civilians represented 50 per cent of all casualties. However, during all subsequent conflicts, civilian casualties have represented upwards of 80 per cent of conflict-related fatalities (Cairns, 1996). The changed nature of political violence means that the traumatic experiences associated with war-related violence is more difficult to measure (Pearn, 2003). However, available evidence is remarkably consistent, amongst both security and military personnel as well as civilian populations: casualties and fatalities tend to occur in the populations with the fewest resources, status and power prior to the onset of the violence itself.

We can see this fixed effect borne out and reflected in population-level statistics. Poverty is particularly related to who is most severely affected by war and political violence. In the year 2000, 300,000 people died as a direct result of conflicts (WHO, 2002). Worldwide, the rate of mortality associated with political violence varied from 1 per 100,000 population in high-income countries to 6.2 per 100,000 population in low- and middle-income countries (WHO, 2002). Further, the highest rates of fatalities due to war were in African countries, with approximately 32 fatalities per 100,000 of the population (WHO, 2002). Besides the many thousands who are killed each year, huge numbers are injured, including some who are permanently disabled. Others are raped or tortured or suffer disease and famine. Again, available evidence suggests that those at highest risk of these experiences and carrying the costs of these experiences are those living in the least affluent nations of the world (Cairns, 1996; WHO, 2002).

We can also see this type of fixed effect at play within countries too. Take, for example, Northern Ireland, which is a relatively affluent area globally (though one of the most disadvantaged in the United Kingdom and EU) but where there is considerable evidence that violent experiences have been, and continue to be, distributed unevenly across the population. Fay et al. (1999) collated Troubles-related deaths in Northern Ireland from 1969 to 1998. Their work showed that the eighty-five electoral wards with the highest 15 per cent of deaths were also those that experienced the highest levels of deprivation in Northern Ireland (Robson et al., 1994). On the other hand, the affluent electoral ward that housed the School of Psychology that I attended during those years of the troubles was one of 122 wards that was classified as having a zero deaths per 1,000 population. The privilege that took people to higher education was a privilege that extended to students' likelihood of being exposed to the worst of the Northern Irish conflict by occupying relatively safer spaces in south Belfast.

This is not to say that all students or young people attending university were unscathed by growing up in Northern Ireland. Nonetheless, direct surveying of children and adults indicates that the pattern of experience held. In several studies with young people in Northern

Ireland over the 1990s, we showed that young people from deprived backgrounds in Northern Ireland generally report greater experience of political violence than their middle class counterparts (Muldoon, Trew & McWhrter, 1998; Muldoon & Trew, 2000). Similar differences associated with the direct personal experience of trauma reported by children and young people affected by political violence is evident in other regions of the world (Bryce et al., 1989; Slone et al., 2000; Slone & Shechner, 2009). People from less affluent backgrounds report more severe and more frequent experiences of political violence in Lebanon, South Africa, Israel and Palestine, amongst other locations. This phenomenon continues to be reflected in contemporary crises. Syria has been experiencing a war that has left half a million people dead and approximately 6 million people displaced since 2011. Though socioeconomic status is difficult to measure in war-affected populations where material circumstances are often dramatically altered, Syrians exposed to high levels of war-related violence also reported lower prior socioeconomic status as indicated by educational level and monthly income before the war (Dietrich et al., 2019). This finding can also be seen as reflective of the trauma risk associated with poverty.

Poverty doesn't just make people more likely to encounter trauma due to war and political violence. Over the course of the COVID-19 pandemic, we have also seen how poverty really matters to pandemic experiences. The virus and the associated lockdown have been difficult for all of us, but poverty, or affluence, really mattered to the experiences we all have had. The preventative actions advised by the WHO are luxuries those living in more privileged circumstances and the wealthier economies of the Global North can undertake. Those who must work to live, who cannot afford the luxury of physical distancing or self-isolation due to poor housing, or even running water and soap, are infinitely more vulnerable to COVID-19 (Chung, Donhg & Li, 2020). There are also serious inequalities in access to vaccines across countries. Access and supply of vaccines are clearly linked already to nationalism and inequality. And so, availability has brought new inequity. The WHO has repeatedly expressed its concerns about the 'my country first' approach adopted by many high-income countries. Corruption in the allocation of vaccines is also an issue. In countries with a weak health care infrastructure, this corruption has denied those most at risk of COVID-19, including front-line health care workers, from securing a vaccine, despite their obvious need.

So, as well as being at higher risk of infection, low-income nations generally have less access to health care. At the country level, the advantage low-income countries might have due to their age profile is lost due to the higher fatalities associated with under-resourced health systems (Ghisolfi et al., 2020). COVID-19 outcomes are profoundly shaped by the ability of the available health infrastructure to cope with those who are in need of treatment. Across the world, doctors, nurses and community health workers are crucial assets to battling the pandemic. In low-income countries, workers are in short supply: the average low-income country has 0.2 physicians and 1 nurse per 1,000 people, compared with 3 and 8.8, respectively, in high-income countries (Ghisolfi et al., 2020). In Europe, infections among medical staff have generated worker shortages, though vaccines are available. Given the slow roll-out of vaccines to the Global South and the high rates of infection in health care workers, it is apparent that socioeconomic conditions are relevant. In this way, economic disadvantage has become a central determinant of mortality and morbidity from COVID-19 (Elgar, Stefaniak & Wohl, 2020).

And as is the case with political violence, socioeconomic disadvantage within nations and regions also matters. Within countries there is evidence of COVID-19 risk mirroring other inequalities. In the United States it has become apparent that low-income groups face greater barriers to minimising their social contacts because of their need to be physically present at work locations, rather than work from home. Based on mobile phone data, we know those living in high-income neighbourhoods have been able to increase their days at home substantially more than individuals in low-income neighbourhoods (Jay et al., 2020). Residents of high- and low-income neighbourhoods visited supermarkets, parks and hospitals in approximately equal proportions, but those resident in low-income neighbourhoods are more likely to work outside the home. As a consequence, the stay-at-home orders were associated with only small decreases in risk of exposure in low-income neighbourhoods. In a country such as Chile, with high levels of inequality, access to health care and the possibility of staying at home during lockdown is completely stratified by income (Gerber et al., 2021). In effect there is a systematic impact. This is another ‘fix’: measures designed to prevent infection systematically disadvantage the poor.

And in case you are unconvinced that socioeconomic capital matters to people’s experience of a pandemic, this is not our first rodeo. UNAIDS estimates that there were 33.3 million people living with HIV at the end of 2009 compared with 26.2 million in 1999 – a 27% increase (2010). Although the annual number of new HIV infections has been steadily declining since the late 1990s, sub-Saharan Africa, one of the poorest regions of the developing world (Platt et al., 2020), still bears an inordinate share of the global HIV burden. In North America, the percentage of the adult (15–49) population living with HIV/AIDS in 2009 was 0.5 per cent; in Central and Northern Europe it was 0.2 per cent of the adult population. In comparison, in sub-Saharan Africa, 5 per cent of fifteen- to forty-nine-year-olds were living with HIV/AIDS. And new infections continue to occur. The majority of new HIV infections arise in this region, and an estimated 1.8 million people became infected in 2009 (UNAIDS, 2010). Of the global total, 68 per cent of all adult and child HIV and AIDS cases are in sub-Saharan Africa.

This pattern of HIV and AIDS infections, disease and death in poor regions led some to coin the term ‘viral underclass’. This is a term that has now re-emerged with regard to COVID-19 (Nuriddin, 2022). The concept of a viral underclass refers to the idea that infection and outbreaks are not randomly distributed. Here we see another ‘fix’ and clear systematic effects. Across and within countries, it would appear that both COVID-19 and HIV/AIDS continue to disproportionately affect the poorest and most disempowered members of society. Contrary to the popular conceptualisations (Lavietes, 2021), it would appear many diseases very much respect ‘class, creed and colour’. Indeed, bringing together available research it is impossible not to be impressed by the extent to which structural inequalities intersect and combine to shape the character of the pandemic and the experiences people have of pandemics in countries of the Northern and Southern Hemisphere (see Parker, 2002).

Taken together, then, evidence indicates that exposure to a single traumatic event increases the likelihood of additional trauma exposure. Two potentially traumatic contexts are used for illustrative purposes to highlight that both the worst effects of political violence and the worst effects of the pandemic are felt by the poor. This gradient of experience across income levels within and between nations is clear. Across a whole range of traumatic contexts, the scale and intensity of the trauma exposure is related to people’s material socioeconomic conditions. The world’s and the nations’ poor are those most affected by earthquakes, floods, gender-based violence, suicide, state violence and terrorist attacks (Benjet et al., 2016). And this is also projected to be the case as we face the traumatic challenges that climate change will bring. These patterns do not support the contention that an individual's experience is determined randomly; rather, it is shaped and structured by group-based divisions of power and privilege. These are systematic effects that fix people's paths through life. Fixed effects are a matter of life and death.

3.4.2 Traumatic Experience Is Patterned by Minoritised Status

In classic Marxist thinking, the great divisions in society are ‘gender, race and class’. These major structural divisions, sometimes even referred to as a trilogy, are seen as important demarcations between groups. Given the popular association of the word ‘trilogy’ with movies, there is a tendency to think of these risks as sequential. In reality, they are intersecting risks, and the social divisions that underpin risk of traumatic events go well beyond this trilogy. They include other important social boundaries such as religion, ethnicity, sexuality, (dis)ability and age. Some authors have begun to refer to groups with less power and privilege in society as minoritised populations (O'Connor et al., 2020). This word is used even where a particular demographic group is not in a minority to indicate the subordinate position occupied. For example, women in many countries are numerically a majority but because of their subordinate position in terms of political power and economic resources, they can be considered minoritised. In the same way, whilst there are many religions (for example, Islam) and ethnicities (for example, people of colour) that are in the majority regionally and even globally, these groups can remain minoritised because of their position globally in terms of power and privilege. On other occasions, people may be minoritised within particular regions because of demographics. There are very many ways in which subordinate, marginal or minoritised populations are at risk of increased experience of trauma. In the following two sections, key examples that link trauma, ethnic group and gender are offered to illustrate these systematic effects that fix people's trauma risk as they progress through life.

3.4.2.1 Trauma Exposure and Ethnic Division

Trauma exposure is shaped and structured by group memberships, such as in ethnic, religious, gender or socioeconomic groups (Bryce et al., 1989; Cairns, 1996; Muldoon & Trew, 2000; Simpson, 1993; Smyth, 1998). As I have already mentioned in my own experience and research in Northern Ireland, evidence that violent experiences have not and are not evenly distributed across the population is clear. So, whilst those from deprived backgrounds generally report far greater experience of political violence than their middle-class counterparts, there are also differences relative to ethnoreligious group. Catholics until very recently were traditionally thought of as the minority within Northern Ireland. On the whole, Catholics in Northern Ireland report more trauma exposure than the Protestant majority population (Muldoon & Downes, 2007; Muldoon & Trew, 2000). We and others found this in both adults and children across many studies in Northern Ireland (Hayes & McAllister, 2001; Muldoon 2004). In effect, there is a kind of double jeopardy at play. The experience of trauma is linked not only to socioeconomic status, then (see Section 3.4.1): The number of traumatic experiences people report is also driven upwards by their membership in minoritised ethnoreligious groups. Of course, in Northern Ireland as elsewhere, socioeconomic conditions and ethnic group status are conflated risks. They interact as they pattern traumatic experiences.

It is also important to remember that the number of experiences people have is only one dimension of this difference. A second is the nature of the experiences. In our research in Northern Ireland, in a large-scale representative sample we found experience of political violence was patterned in these two ways. After a generation of political violence, we found that only about 50 per cent of a representative sample of the population had a personal history of trauma exposure (Schmid & Muldoon, 2015). Sub-populations with very different experiences of the same conflict were also evident. Ethnoreligious group membership was relevant to the type of experience that people reported. Catholics reported more direct experience of political violence–related trauma, Protestants more indirect experience. In our studies with children, Catholic children, as well as having more experience of violence, were also more likely to have had negative interactions with the security services (Muldoon, 2003). So even within this one small geographical area affected by political violence, the nature and the extent of trauma experience was related to minoritised group position.

This same pattern of differential risk is also evident in the experiences reported by those living in other situations of political violence such as Israel and Palestine (Hirsch-Hoefler et al., 2021), Lebanon

(Bryce et al., 1989) and South Africa (Slone et al., 2000). Relations between societal groups are shaped by power differences, and nowhere is this truer than in the case of relations that are framed by an ongoing tensions and violence. The trauma exposure that arises in these circumstances reflects the first dimensions of trauma exposure evident in the analysis of World Mental Health surveys relating to political violence and causing or witnessing serious bodily harm to others (referred to in Section 3.3; Benjet et al., 2016). These differential experiences linked to ethnoreligious groupings evident in a host of regions across the world can be seen to reflect status asymmetry in the divergent military, economic and diplomatic capabilities of the parties to a conflict. This is a feature that is increasingly evident in localised violence (Friedman, 2005). Again, these effects reflect the 'fixing' of the conflict, and the likelihood of being a victim of war, by virtue of the power relationship between the dominant and subordinate groups.

Similar issues of power play out in relation to skin colour. Across a range of metrics, people of colour are more likely to be affected by political violence, war and forced migration (Asnaani & Hall-Clark, 2017). These effects are clear from global statistics. There are also clear differences in exposure to trauma associated with ethnicity in 'peacetime' (Douglas et al., 2021). For example, in the United States, people of colour are more likely to be bereaved by suicide, homicide and be victims of gun violence (Kalesan et al., 2016; Karaye, 2022). The disproportionate human costs of these violent experiences on men have associated implications for their partners and children, who are adversely affected by their sudden death and associated reduced financial security. And though this labours the point perhaps, this then places these women and children, most often also people of colour, at risk of further and ongoing trauma. People of colour have also been those most adversely affected by the climate crisis (Williams, 2021). All of these experiences and associated injuries are compounded by poor health and inadequate health care available to people of colour within and across regions, giving rise to higher levels of chronic disability. Together these effects magnify the trauma experienced by people of colour.

In the United States, it is also apparent that the experience of police violence is something that is inextricably linked to ethnicity and race. As we have moved through the twenty-first century, this non-random, fixed effect has become increasingly apparent to us all. This concern is now perhaps best represented using the iconic mantra

#BlackLivesMatter. In a discursive psychology, an opinion that represents a shared understanding does not need to be stated. On the other hand, if it must be said, we cannot assume that everyone shares the view actively (Stevenson & Muldoon, 2010). So, the fact so many people still need to assert that 'Black lives matter' is a terrible indictment and reflection of white-Black relations. Not only did the original social media poster's assertion resonate with countless others online, and on the streets of the United States; it spread widely to become a global chorus demanding equitable and civil treatment of all people of colour. Where a claim needs to be made by so many, it tells us that many people believe this is not a shared position but rather is a position that still needs to be emphasised. The continued use and value of the mantra indicates that there are many people worldwide who presume that there are 'others', presumably more privileged people, who don't understand how precious and precarious life is for people of colour.

3.4.2.2 Trauma Exposure and Gender

In political psychology, Billig (1995) uses the concept of 'banality' (with regard to nationalism) to refer to the way in which majority group social and cultural beliefs and assumptions guide daily life. A banal identity is one rooted in an ideology that is implicit in ordinary ways and that advantages and reproduces a privileged and dominant perspective. By way of example, many aspects of life are gendered and advantage men. Perez (2019) documented a wide array of large and small risks that women are exposed to in their everyday lives because of a world designed around the perspectives and needs of men. So, for example, a gender data gap in health research contributes to misdiagnosis of life-threatening diseases and psychopathologising and mistreatment of reproductive health problems. This data gap has also given rise to serious design flaws, which mean that everyday safety products (e.g., seat belts and stab vests) protect men more effectively than women. These health and design issues intersect to place women at a higher risk of experiencing adverse consequences of trauma such as road accidents and medical accidents.

Banal understandings of gender identities and gender relations similarly underpin views that sexual violence and assault is inevitable and even 'natural' (Tinkler et al., 2018). In everyday life, men's greater strength and women's perceived vulnerability often have a taken-for-granted quality in how they are spoken about. In one interview study of almost 200 US university students, sexual violence was often seen by respondents as usual, thus making it invisible or at least unexceptional in daily life (Tinkler et al., 2018). In another study, Iyer (2019) asked school pupils to reflect on the 2012 Delhi gang rape that sparked widespread debates about violence against women in India. In this study, she found that respondents linked violence against women to gender roles, making it culturally normative. This type of assumption means that women may underreport this type of trauma because it is 'just' something that must be borne. These risks women face therefore go unnoticed and responses in their aftermath absent or minimal. Indeed, it allows this type of trauma to remain endemic, invisible or at least inconspicuous, as was my own experience when I was assaulted by a passing male stranger as a student (see Section 3.2).

In the last two years we have seen this process writ large. Around the world, including in Ireland where I know the situation best, the management of the COVID-19 pandemic has worked to men's tacit understanding of how the world works. From the first days of the pandemic, the assumptions underlying the approach to keeping 'people' safe have prioritised men and men's interests and placed many women at risk. The measures to restrict social contacts with others and the spread of COVID-19 offered many women very unsafe prospects. It meant more time at home with abusive partners. Cutting contacts and fewer social interactions led to less accountability for male perpetrators of domestic violence and fewer opportunities for intervention to support women in need. Evidence based on twenty-nine studies from different cities, states and several countries around the world is strong (Piquero et al., 2021). Incidents of domestic violence increased in response to stay-at-home and lockdown orders. In the early days of the pandemic many of us were encouraged to 'stay home to stay safe'. Only those banally privileged, and blind to the trauma risk that many women and children face in their own homes would offer this as a public health mantra. Indeed, the mantra itself had the clear potential to increase traumatic experience for vulnerable women and children as well as their feelings of being isolated and forgotten.

Oddly, a similar type of effect is apparent in academic work relating to men's violence against women. Mainstream accounts of gender-based violence within the field of sociological criminology routinely omit gender-based analysis. Other times gender-based violence is presented as separate or somehow different from 'normal' forms of violence – as witnessed by the emergence of a specialised field of gender-based violence (Walby et al., 2014). Given the unusually high prevalence of violence against women, largely at the hands of men, constructing this pervasive social phenomenon as 'niche' is very strange. And it has become apparent that this narrative does not fit with real-world evidence. Zeoli and Paruk (2020) completed an analysis of mass shootings in the United States between 2014 and 2017. All of the eighty-nine shooters were male. Almost a third of the total (twenty-eight of the mass shooters) were suspected of domestic violence, and 61 per cent of this group had been involved with the justice system for domestic violence. We can see in this case how this 'normal' violence, almost always perpetrated by men, is linked to a history of violence against women and intimate partner violence.

Indeed, gender-based violence is a major social issue. The UNHCR (2021) defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. It is estimated that 35 per cent of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner (not including sexual harassment) at some point in their lives. However, some national studies show that up to 70 per cent of women have experienced physical and/or sexual violence from an intimate partner in their lifetime (Heise & Kotsadam, 2015; Shepherd, 2019). Experience of violence and victimisation is also amplified amongst transgender people. In a review of global evidence, Reisner et al. (2016) estimate that 44 per cent of transgender people have experienced discriminatory violence, of which sexual and physical violence are the most prominent. Reisner and colleagues also note that there has been little research into the concomitant trauma responses. In this way it is fair to say that gender is tied up with the experience, expectation and understanding of this type of trauma risk (Iyer, 2019; Tinkler et al., 2018).

As well as major traumatic events, it is also commonplace for women to face instances of violence and harassment in the domestic, occupational and public sphere, sometimes now referred to as micro-aggressions. Women report harassment routinely when they walk, run or cycle, for example. And while men also experience street harassment, a wide range of studies using multiple methods indicate that the intensity and nature of the harassment differ by gender. Men have fewer harassment experiences overall and they seldom report harassment that has a sexual tone (Muldoon, 2018). The #MeToo movement can be seen as a response to women increasingly unwilling to accept abuse, harassment and rape culture as 'just the way it is'. These normative and unremarkable constructions of gendered violence make it particularly difficult for women to navigate when they experience it and so problematising the issue can be seen as an important part of the solution. In publicising her experience via the #MeToo initiative, Tarana Burke, an activist survivor of sexual assault, sought to empower others through mutual support and strength of numbers (O'Neill et al., 2018). This harnessing of those with whom we share experience in support of social change is a theme to which we return in Chapters 4 and 6.

Gender is profoundly related to the different types of traumatic events men and women experience. There are important qualitative distinctions in these types of experience. A large-scale South African study demonstrated the role of gender in structuring experience of traumatic events (Kaminer et al., 2008) during times of political upheaval. Women's risk of intimate partner violence and rape and sexual assault is increased, whereas men are more likely to have been assaulted, tortured or detained. During peacetime, men are also more likely to experience trauma such as homicide, assault and suicide in public spaces, whereas women are more likely to be victims of gender-based violence in private spaces, often at the hands of people they know (Seifert, 1996; Swiss & Giller, 1993). In short, the experiences of men and women are markedly different. The risks myself and my husband felt as young people in Northern Ireland reflected a social reality. He was more at risk of becoming a victim of street violence, conflict-related violence and assault. I was more at risk of street harassment and sexual violence. And now we find, like so many parents, that the concerns we have for our daughter and our son as they embark on their own independent lives differ because experiences of violence are shaped, very profoundly, by a person's gender.

In peace and war, then, women are aware of the need to keep safe during even the most mundane activities. Data from the World Mental Health surveys indicates that intimate partner violence and child sexual abuse is a form of violence that carries a significant burden (Benjet et al., 2016; McLaughlin, 2015). And the heightened arousal and fear that women experience because of their fear of male violence also has a significant psychological burden. This burden is particularly heightened for women who have direct experience of gender-based violence (Schnittker, 2022). In line with this evidence of a burden, women report that they modify their behaviour because of their feelings of risk, taking all sorts of precautionary and protective measures as they go about their everyday lives: staying on the phone when walking alone, texting friends to let them know of their safe return home. But none of these precautions, or advice to women to take care, will solve the problem, as it fails to address the cause of the problem: men's behaviour lies at the heart of gender-based violence.

3.5 Conclusion

In this chapter, I have offered evidence that the traumatic experiences that we encounter over the course of our lives are not random events. Rather, our chances of encountering particular traumas during life are fixed. Those interested in taking a punt on a horse or a raffle might say that our odds of experiencing trauma are fixed. This fix, if we are born into a group that has power or privilege, can be protective. However, if we are born poor, female or a member of a minority ethnoreligious group, our trauma risks are fixed against us. They are fixed not only in terms of the scale of traumas we are likely to encounter but also in terms of their nature. We started with a poem by Seamus Heaney. In it he draws a parallel between gender-based oppression and the colonial oppression and violence in Northern Ireland. Ever insightful, his poem flags the importance of power and privilege in understanding the fixed effects of traumatic experience. As a general rule, those who are minoritised, marginalised or dispossessed have the greatest experience of trauma. The mental health and physical health costs of these experiences are high.

4 *Theorising the Nature of Trauma*

Integrating the Personal and Political

> You remember that village where the border ran
> Down the middle of the street,
> With the butcher and baker in different states?
> Today he remarked how a shower of rain
> Had stopped so cleanly across Golightly's lane
> It might have been a wall of glass
> That had toppled over. He stood there, for ages,
> To wonder which side,
> if any, he should be on.
> —Paul Muldoon, 'The Boundary Commission'

4.1 Chapter Outline

Building on the previous chapter, this chapter draws out the implications of the patterned nature of traumatic experiences. In doing so, a reconceptualisation of trauma that highlights the importance of group membership is offered. Trauma and adverse experience can result in the categorisation and recategorisation of people into groups. For example, people can be labelled as 'refugees' or 'widows' as a result of war or bereavement. Trauma can also reinforce existing group memberships and boundaries. Because of its relevance to understanding trauma, the social identity approach to health is introduced. This social identity approach is particularly relevant for studying trauma because the risk of trauma or experience of trauma can be identity-defining. And though shared group memberships and identities can be crucial social and psychological resources for coping with trauma, where blame is laid for the experience of a trauma, this can polarise groups or even disconnect those who experience trauma from their own group. A key aim of this chapter, then, is to highlight the value of a social psychological analysis generally, and a social identity analysis particularly, to understanding how trauma and our sense of ourselves and others as group members are inextricably linked. This hinges on the core idea that group memberships are important to how we experience and manage trauma.

4.2 What's in a Name?

I love the poem 'Boundary Commission' by Paul Muldoon (no known relation). This isn't the first time I have quoted it and I am sure it won't be the last. As someone who border-crossed regularly between the Republic of Ireland, where I was born, and Northern Ireland, where I spent nearly twenty years as a young adult, this poem really does resonate. The boundary between Northern Ireland and the Republic decided by a commission in 1922 is now called 'the border'. It divides the island of Ireland into two states. Invisible lines such as the Irish border were and remain very important. The consequence of this partition in 1922 continues to the present day with its relevance evident during Brexit (Shelly & Muldoon, 2022).

On one of the many border-crossing journeys we made from North to South when my children were young, we hit on a source of entertainment for the car journeys between Belfast in Northern Ireland and, depending on which grandparents we were visiting, Wicklow or Donegal in the Republic. The game involved watching for the border and identifying as many differences as possible between North and South. By the time my children were born, the big, securitised monoliths that marked major border crossings during the Troubles were gone. The border between North and South had become more invisible, more like the rural border crossing Paul Muldoon invokes in his poem. A border that requires us to decide 'which side if any' we should be on. My father, and his family of origin, was from this type of border location, near where Paul Muldoon grew up, in fact. In Ireland as in many other locations, last names are often geolocated. My father and his family were from just the other side of the border to the place where Paul Muldoon originated, so it tickles me to think of him as a distant relation.

Since the partition of the state, the difference between the two jurisdictions, North and South, has amplified. So, my children could point out many differences: the money spent, units of measurement used, road markings, the (non)use of Irish-language sign postings, the colour and shape of road signs, and so on. These banal markers signal much deeper and more enduring divisions. The border also divided people into two different populations or groups, Northerners and Southerners. These two groups have had very different trajectories since partition.

The conflict in Northern Ireland, often referred to using the colloquial term 'the Troubles', is central to these different trajectories. Though often talked about as religious group differences between Catholics and Protestants, the conflict is centred on two opposing political visions for the region. On one side are British Unionists, who are often though not always Protestant and wish to remain part of the United Kingdom; on the other are Irish Nationalists, who are often though not always Catholic, and who wish to be reunited with the Irish Republic. There were, and still are to varying degrees, large and deep sociocultural divisions along religious lines in Northern Ireland. These were not helped by the 3,720 fatalities and approximately 47,540 casualties caused by the conflict from 1969 to 2003. In a small region, with a small population of 1.7 million, this meant that there were very few families in Northern Ireland whose lives hadn't been impacted by the conflict, my own included.

In Northern Ireland, as elsewhere, the first piece of information that a stranger usually learns is the moniker our parents picked for us when we were born. We think of names as something that marks us out as individuals. We can each think of ourselves as distinctive because of our name. Names signal uniqueness and are the very basis of our self-conception, especially in relation to others. My move to Northern Ireland was the first time I recall being dissatisfied with my first name. I had two older sisters, and I felt that though they also had Irish first names, theirs were names that were also in common use in Scotland and England. In Northern Ireland people talk about being able to 'pass', of having names that are sufficiently ambiguous that people's ethnoreligious background isn't immediately obvious to others. At the time my given name was still reasonably uncommon in Northern Ireland. It marked me out as culturally Catholic, and that was something that I was not particularly happy about. My surname and my accent, where I attended school and where I grew up all meant that others would quickly be able to place me into an ethnoreligious group in Northern Ireland. Back then I can recall thinking my name was far too obvious. I felt branded when someone called my name in a public space, an unenviable position in a society affected by conflict and political tension.

Names offer social and cultural signals. Many years ago, at a conference in Belfast, I introduced my husband to a colleague. My husband's name is Paul. They immediately asked if he was 'the' Paul Muldoon. Aside from the amusement, this brief exchange signals the prevailing norm at the time that women take their husbands' names on marriage. In fact, my husband's surname is not Muldoon. I tell this story to illustrate how much names mark each of us. My first name indicates that I am female, but also together with my surname it identifies me as culturally Irish and Catholic. My surname also connects me to my family of origin and geolocates my origins to a particular area or nation depending on your level of knowledge. For some, particularly women, a married surname connects them to their family of generation and their spouse. For others, retaining their natal surname when they marry is an active choice. Psychologically speaking, names are important because they have consequences in terms of how we feel about ourselves, but also in terms of how others treat us. They offer others a sense of the blend of our collective social and political attributes, combined to make us individuals for sure. I can think of no sense of myself or imagine any other version of myself in which I am not female, Irish and embedded in my various familial connections and identities. All of these elements of my identity are reflected in my name, are assumed at birth and can be very difficult to change.

4.3 The Social Identity Approach

In much the same way as names represent facets of our individual and collective selves, the social identity approach weaves key characteristics of our group memberships into people's individual sense of self. The theory is just a framework that highlights the inseparability of group memberships and individual psychology (Tajfel & Turner, 2004). The approach can be thought of as a tool that aids the interpretation of what is going on in the world. It is a theory grounded in the history of social and political psychology. Incorporating social identity theory and self-categorisation theory (Reicher et al., 2010), it argues for a distinct meta-theoretical approach to (social) psychology in which analysis is not confined to the psychology of individuals *as individuals*, but recognises the capacity for attitudes, emotions and behaviour to be structured by people's psychology *as group members*. In this way, it is well placed to enhance our understanding of all aspects of well-being, trauma and health.

In Tajfel's (1974) early formulation of the theory, derived from his experience and the example of Nazi Germany, he highlighted that an individual's social identities were not necessarily a personal preference. For example, the category 'Jew' was externally imposed and tragically meaningful for many, irrespective of the individual's own preference for their identity. This is equally relevant in contemporary circumstances. The building of the barrier to separate the West Bank from Israel imposes an identity of Palestinian upon those trapped behind the wall. Their experiences are shaped by the externally imposed limitations of this categorisation. Similarly, along Belfast's 'peace line', a barrier separates traditionally Loyalist (Protestant) and Republican (Catholic) areas of the city and circumscribes both the experiences and the perceived group membership of the residents according to the side of the line on which they live. This idea speaks to the point Muldoon is making in his poem. The imposition of the border, even if people wonder 'which side, if any, they should be on', positions people on one side or the other regardless.

Group factors, then, influence our lives profoundly and implicitly in big and small ways like this every day. Traditionally, psychological models have treated groups and related social identities either as demographic factors in epidemiological models or as our own subjective inputs into cognitive processes. The social identity perspective facilitates a positive shift away from illusory vacuums, emphasising the richness of social group memberships and identities (Tajfel, 1974). A group-level analysis then moves our attention to macro and meso social factors and their impact in determining our own and others' behaviours and experiences at the micro level. In this way, it isn't just about where we position ourselves. It is also about how others position us. So as much as anyone, including myself, might try not to take a political position, in a conversation in Belfast in the 1990s, my name and my accent meant that others were quick to position me as Irish and Catholic.

Though group memberships can be imposed by socially divisive systems and structures in this way, social identities are reified psychologically in everyday practices. Identities, in the social identity framework, then, are far more than demographic factors in models. Laying claim to a social identity means that people act in ways consistent with the norms and symbolic definitions of that identity (Haslam et al., 2009). So, the way I dress, occupy public space, speak, engage with my family, exercise and undertake many other social practices are all guided by my sense of myself as a woman. I have never worn a suit and tie and don't anticipate that I ever will. I manage all manner of family and birthday celebrations. I never recall agreeing that this task would fall to me within my family of generation; it just did and does. Similarly, I speak English with an Irish accent, I use Irish words in everyday speech, I routinely eat potatoes and brown bread, I regularly drink alcohol and think everyone singing or dancing at a party is usual. In this way identities – Irish and being female – as well as being imposed, are produced using behavioural enactments of all kinds. They guide amongst other practices how I talk, what I eat, what I wear, how I celebrate and my purchase and use of material goods (Klein et al., 2007).

Billig (1995) identified a banality to a range of identities such as gender, race and religion. These types of identities are often assumed at birth and have an unexpressed and unrecognised quality. Because they are background identities, they can offer an intangible sense of belonging and are essential to making us who we are. These banal identities can give rise to affiliative identities: connections made up of groups using similar cultural references as the backdrop to life. Typically, these groups are populated by family and friend networks, which offer associated meaningful connections. The extent to which these identities imbue our sense of how we define ourselves is revealed by the difficulty many of us have imagining a version of our life that isn't bound by our gender, family or national affiliation. Affiliative groups of this nature can be so strong that the group connections may not even register in our conscious awareness. We don't get up in the morning and decide our nationality or religion anew. But yet these shared attributes influence not only all of our activities and practices but also who we see and align ourselves with politically.

Other identities, however, are actively constructed and claimed. These types of identities are ongoing identity projects and well within the sphere of conscious awareness and day-to-day discourse. These identities generally require 'performance'. To be sustainable, identities must be capable of expression (Klein et al., 2007). These identities also generally require recognition by others to be viable. So, my occupational identity as a psychologist is a central part of who I am. So too is my identity as a runner. Both identities require that I perform: so, in the first example I need to have a sense that I am working and behaving as a psychologist, and in the second I need to run regularly to have a strong sense of myself as a runner. Active identities of this sort, then, offer us meaningful sense of ourselves and can open up a range of new identities. Though I was a runner for many years, when parkrun arrived in Limerick, I developed a new identity as a 'parkrunner'. And though I primarily see myself as a psychologist, this identity has opened up the identity possibilities such as 'writer' and 'professor'. Active identities often shape and mandate how we behave and spend our time.

Group factors also drive our attitudes to others. So though as a woman, my feelings about myself might be linked to how I look, I can also decry the objectification of women and despair of others (of all genders) who routinely comment on the appearance of women in the public eye. Equally, my membership of a national group such as the Irish can mean that I have a sense of being allied with some other nations with whom there is a sense of shared history or experience. As an Irish person, then, I am likely to be positively disposed to Scottish people (fellow Celts), Danish people (members of a similar small EU country) or even New Zealanders (fellow small nation islanders) from where comparisons are often drawn. On the other hand, I may have less positive attitudes to national groups with whom, because of their size and history, there is less of a sense of shared experience and where comparisons are less usual, such as Germany or France. Group factors and the associated sense of identities that arise, then, can have a major influence. A large body of research highlights that these comparisons and allegiances are relevant to our sympathies and prejudices, cooperation and conflict (e.g., McKeown et al., 2016).

Group factors and identities, then, can also be seen to drive our attitudes to ourselves. If we value and think positively about groups we belong to, this can make us feel better about ourselves. This is amenable and sensitive to change too. We know that there is mental health benefit for members of a national group when their football team does well in international matches (VonScheve et al., 2014). Equally, if we are a member of a group that is shamed, negative feelings can ensue (Jay et al., 2022). Building on this existing literature in social psychology and sociology, a growing body of research has highlighted identity concerns as primary drivers of beliefs and behaviours related to both mental and physical health (Haslam et al., 2009). It is to this issue that we now turn.

4.4 A Social Cure: The Social Identity Approach to Health

In recent years the social identity approach has been applied well beyond its initial focus on prejudice, conflict and relationships between groups. Social psychologists have begun to use the social identity framework to understand the role of group processes and identities in determining health. Across several disciplines – not only psychology but also sociology, economics, medicine and neuroscience – ideas that highlight the relevance of groups and social connections to health have been taking hold. Large reviews and meta-analyses, which integrate the results of many studies, now indicate that social isolation and disconnection are often a more powerful a determinant of health than smoking, obesity, elevated blood pressure and high cholesterol (Holt-Lunstad et al., 2010; Pantell et al., 2013; Putnam, 2000). As a rough rule of thumb, social scientists now estimate that if you belong to no social groups at all but decide to join one over the subsequent year, your risk of dying is halved (Putnam, 2000).

Often referred to as the 'social cure' (Jetten et al., 2017) the social identity approach to health highlights how group-based relationships are especially influential drivers of health (Jetten et al., 2012). The first reason groups are important is that groups and their associated social identities drive health by stealth in meaningful and everyday ways. Social identities such as income group and nationality determine big-ticket items like the health infrastructure that we have access to, as well as health literacy and education and access to housing. Macro-level groups and their associated social identities are also central to health behaviours. For example, nationality and culture impact important health behaviours through their influence on diet, alcohol consumption or sexual practices. More proximal groups such as family and friendship, and even treatment groups, enable access to practical and emotional social support. They also offer resources such as feelings of belonging and fulfilment, all of which are relevant to our health and our ability to manage stress in particular (Gallagher et al., 2014; Steffens et al., 2021).

Haslam at al. (2009) set out a research agenda that focuses on five different ways that social identity is central to health. Taking each in turn allows an illustration of how groups are relevant to health. Strand 1 focuses on how group memberships and social identities structure how people think about health and health-related behaviour because of the system parameters within which they live. When I first moved to Belfast as a student, the sport that I had engaged with most was hockey. When I rocked up to the hockey club in the university in my first week I was totally discombobulated. No one was rude or hostile, but as someone marked as I was, by my name and my accent, as culturally Catholic, I just didn't feel like I belonged. I felt I didn't fit. Unlike in the Republic, in Northern Ireland hockey is a sport that is disproportionately played at Protestant state schools. So whilst hockey was a definite pull factor towards exercise, it was not strong enough to counter the cultural or systemic forces to get me to stay playing. Subsequently, I started to play squash and run but my engagement with exercise was much more patchy than it would have been had I remained part of a team sport. These activities I could straightforwardly manage within my own friendship network, in which though it included people from both sides of the community, I didn't feel 'othered'. This allowed me to manage my own discomfort and feel safe. In short, my own group membership structured my appraisal and engagement with a key health behaviour, namely, taking exercise.

We can see this type of appraisal is influential in research studies. One of the first studies I undertook as part of my PhD was an analysis of children's perceptions of stressful life events, including conflict-related events. Using data from 456 children in 1983 and 182 children in 1994, it was apparent that Catholic and Protestant children differed in their appraisals of such events (Muldoon, Trew & McWhirter, 1998). Catholic children rated three of the six events ('soldiers being on the street'", 'getting stopped at checkpoints' and 'getting caught in a riot') as more stressful than Protestant children. As we did with all of the items related to potential encounters with the security forces, we interpreted this as a reflection of Catholic children's assimilation of their own group's distrust of the security forces, which had become more negative and fearful as the conflict evolved (O'Connor, 1993).

A second study of children's perceptions of traumatic events in Northern Ireland tracked a sample of 113 children aged seven and eight across a three-year period, using the same measure of perceived stressfulness (Muldoon, 2003). Again, group membership was central to the appraisal of these events. Specifically, it was found that girls tended to perceive three events ('bomb scares', 'being picked up by the police' and 'people shooting guns') as more stressful than boys did. Furthermore, there was evidence that gender and ethnoreligious group predicted changes in the perceived stressfulness of events over time. Compared with Protestant children, Catholic children saw conflict-related events as being more stressful, particularly as they got older. Presumably, these effects could be again attributed to the minority group position occupied by Catholic children in this social context and, in particular, to the divergent experiences of the two ethnoreligious groups at the hands of state security forces over the course of the conflict. Taken together, these findings point to the important role that group memberships play in shaping interpretation of, stressful life events (see Haslam et al., 2018, for other examples). In this case, children living in the same conflict zone had vastly different views of the conflict-related stressful events depending on their gender and ethnoreligious group membership. These variations in children's perceptions of these events were systematically related to group membership.

Strand 2 of the social cure model extends the role of groups and social identities beyond their role shaping appraisal of stressful life events (see Haslam et al., 2018, for other examples). Specifically, this strand highlights the important role of social identities in guiding health norms and behaviours. Recently, a friend of mine had a sprained ankle after a spill whilst out hiking. She hikes occasionally. She was annoyed at the inconvenience but bore her recuperation well. I watched on with admiration. For someone like me who has run regularly for very many years and sees myself as a 'runner', I tend to appraise injuries as a catastrophe. The norm I share with other runners is that we will be out running come rain or shine. This can be seen as a healthy norm that keeps us all exercising as a matter of routine. However, we also have other less healthy norms that I know my non-running friends consider unhealthy and even problematic. We have run in storms, in snow and even during a flood warning. We seek out health professionals who rarely if ever advise against running. A couple of years ago after having an appendectomy, I was advised not to run for six weeks. I had little trouble finding medical advice to the contrary amongst my running network and so was back running distances and participated in the Great Limerick Run within that six-week window. Identity-based norms, then, influence our appraisals of events and operate in ways that are both positive and negative.

Strands 3 and 4 consider how a person's membership in groups can potentially provide access to wider support networks and also emphasise the value of the practical support of an immediate group to coping efforts (Haslam et al., 2018). Research has evidenced these effects. Where people share group memberships, help received from members of that group is more welcome and perceived as less threatening to one's self-esteem than help offered by outgroup members (Reicher et al., 2006). We also tend to be far less sensitive and defensive when ingroup members offer critique or feedback. Comments, however well-intentioned, seem more reasonable when offered by those we see as insiders rather than outsiders (Hornsey & Esposo, 2009). For many of us who run with others, then, the exercise is only one part of the enjoyment. Running also provides access to others with similar outdoor interests, as well as social interaction and conversation with running buddies. This can be an important form of emotional and informational social support well beyond advice on running injuries. Social identification with similar others facilitates social support, and together they mitigate the impact of stress on health.

We can all, myself included, belong to many groups simultaneously, all of which are represented in an array of different social identities (Ashforth et al., 2001). Group memberships provide meaning and guidance in our lives. My own journey into running and exercise was strongly linked to my sense that it was incumbent upon me as a psychologist to manage my own mental health. In this way, it is apparent that my occupational identity was the basis for the development of a second functional identity, namely, 'runner'. People with multiple identities seem to be better able to manage new group memberships when change comes, as it inevitably does in life. In studies of people affected by stroke, for example (Haslam et al., 2008), having prior multiple group memberships is associated with better health after the stroke. And so, though my hockey career came to an abrupt halt when I moved to Belfast, my prior positive experience of group exercise, together with my occupational identity, can be seen to have enabled my subsequent engagement with running and the running groups that have sustained me through my adult life.

People's membership of groups also provides access to wider communities. People gain both knowledge (cultural capital) and opportunities (social capital) from social groups (Bourdieu, 2018). One group membership can increase awareness of our connection to others. In a study we conducted in two towns in Ireland, we found evidence that identifying with the community in which you lived facilitated people's engagement with a second social identity. Further to this, the amplification of the second community-based identity improved, in particular, the perceived support for those in need of mental health supports (Kearns et al., 2018).

The benefit of multiple identities was also evidenced in a second study we conducted with people who survived acquired brain injury (ABI). In this case, assumed social identities – those strongly embedded in sociocultural group memberships – often facilitated social support seamlessly (Walsh et al., 2015). Those affected by ABI who belonged to groups where their membership was assumed, such as a family group or a church group, tended to have access to more social support. So, assumed group membership meant that people had access to practical supports, which allowed the development of new identities after their brain injury. The development of these new identities, which can be thought of as acquired identities, offered further benefits to health and well-being, which enriched the lives of those living with an ABI (Walsh et al., 2015). In this way assumed identities, or that taken-for-granted sense of belonging, was an important platform for identity-based support as well as the development of new identities in this group recovering from a life-altering injury.

Strand 5 stresses that social identity does not operate merely as an interpretative lens but is also a tangible resource that can be harnessed to affect clinical outcomes. From this initial research agenda, the 'social cure' literature has rapidly expanded. It has been successfully applied to the field of stroke and brain injury (e.g., Muldoon, Walsh et al., 2019; Walsh et al., 2017), addiction (Buckingham & Best, 2016), care provision and community work (Kellezi et al., 2019; Stevenson et al., 2014) and indeed maintenance of health behaviours such as exercise and running (Stevens et al., 2020).

More recently, I and others have been working to show how social identities and group memberships are relevant to biomarkers of health. In two different experiments we have shown that group memberships impact not only people's perceptions of stress but also their cardiovascular reactivity in responses to stress (Gallagher, Meany & Muldoon, 2014; Ryan et al., 2021). Exaggerated or prolonged cardiovascular responses to stress (i.e., blood pressure and heart rate) are associated with increased risk of cardiovascular disease (CVD) development (Chida & Steptoe, 2009). We also recently showed, using a large US data source, that social group membership is positively associated with better cardiovascular habituation to stress, a pattern of physiological responding associated with better management of stress (McMahon et al., 2022). And using the same data, we demonstrated that social integration mitigated the impact of biological outcomes (McMahon et al., 2022). We used another dataset from the UK Understanding Society longitudinal study to show that multiple group memberships drive wear and tear on the cardiac system – or allostatic load – over time. Those who reported being in more groups had a larger social network, and this larger network had better physical health seven years later (Gallagher et al., 2022). In sum, group memberships, social identities and the social identity–based connections shape responses to stress and subsequent health.

4.5 A Social Identity Approach to Trauma and Adversity

Given the strong and consistent relationships between social identity, health and stress, that there is a case for social identity dimensions of trauma is not that surprising. In this section we look at five distinct reasons that group memberships and social identities are centrally relevant to the study of trauma (see Box 4.1). First, the social identity approach offers a distinctive perspective that connects individual and collective components of traumatic experience. Second, we consider how trauma can embed social divisions by validating differences between groups. The reification of group differences is believed to be the basis of social identities (Haslam, 2014). Third, trauma can also create new social groups and identities. People become victims, survivors and sometimes even activists. The evidence that context,

Box 4.1 The relevance of social identities to trauma

1. Traumatic events can embed existing social divisions and group identities.
2. Traumatic events can create new identity groups.
3. Traumatic events can make relevant social identities salient.
4. Traumatic distress can motivate people to connect with others.
5. Traumatic events integrate the political and the personal in a changed sense of social self.

including group members' prior experiences, drives behaviour is the fourth reason that the social identity approach is particularly relevant to the study of trauma. Finally, distress can drive a need for connection and psychological alignment with others, and most often it is those who have had similar experiences that we seek out.

4.5.1 Traumatic Events Can Embed Existing Social Divisions and Group Identities

At the most basic level, groups matter to the risk of trauma exposure. Groups also matter to those directly and indirectly personally affected by traumatic experiences. Group members share similar experiences of stress and trauma in terms of their nature and intensity (see Section 3.4). Indeed, the patterned experiences of group members are a key means by which people come to understand their position and place in the world. These differences reify social divisions and make group memberships meaningful through social identities. A stronger sense of connections to others facing similar challenges, and antipathy towards those who don't understand, is an inevitability. A wide range of traumatic experiences embed pre-existing social groups in this way (see Section 3.4).

In the United States, for example, it is apparent that the experience of police violence is something that is inextricably linked to race – a point central to the Black Lives Matter movement. In Northern Ireland during what were commonly referred to as 'the Troubles', internment without trial was experienced almost exclusively by the Catholic Irish population, the subordinate group in that conflict. In the Middle East, the threat of air missile attacks is an experience shared by all Palestinians. Clearly, white people are affected by police violence, Protestants by internment and non-Palestinians by Israeli air strikes. However, for affected groups living in these contexts, for those who identify as Black, Catholic or Palestinian, particular types of traumatic experience are inherently and profoundly related to these social identities.

Whilst on average, minorities and minoritised people are disproportionately affected by trauma, it cannot be assumed that all of those who identify as minority group members have equivalent experiences. Not all minority group members have the same range and intensity of traumatic experiences. For the purposes of illustration, we can think about the example of violence against women. Some national studies show that up to 70 per cent of women have experienced physical and/or sexual violence from an intimate partner in their lifetime (Heise & Kotsadam, 2015; Shepherd, 2019). So, while being female becomes tied up with the risk of gender-based violence and the need to manage this risk (Iyer, 2019; Tinkler et al., 2018), it is still not true to say that all women have experienced gender-based violence. And some women's experiences are far more severe and life-altering and limiting than others'. This speaks to an important distinction in the literature on trauma, namely, the distinction between individual or personal trauma and collective trauma. It is an issue that is picked up in Chapter 7, as we highlight how social identity–based changes in women who have experienced rape drive their activism in support of social change.

Gender-based violence reifies the distinction between men and women. However, far from being accepted as a collective trauma, individualising explanations have been used to explain it away. It isn't all men, just some bad apples. She was out alone. Individualising narratives deny that gender-based violence is a collective phenomena, as victims are usually targeted because of their female gender. These individualising narratives can make it difficult for women trying to understand their traumatic experiences. This can give rise to feelings of injustice and anger, the latter being a core symptom of PTS. In the twenty-first century, movements like #MeToo have emerged that seek to highlight how the experience of women is defined by a continuum of adverse experiences, from verbal harassment to violent death (Jee-Lyn Garcia & Sharif, 2015; Strauss Swanson & Szymanski, 2020). Movements such as #MeToo serve to make these patterns of traumatic experience visible but also highlight how these experiences and these risks reinforce women's position in public, social and occupational spaces. In this way trauma and the risk of trauma create divisions in social spaces women can occupy safely. This lived experience, beyond the experience of many men, creates further division between gender groups. So, though the risk of gender-based violence has always marked the social identity practices of women and girls and reified the group boundaries between men and women, it is only recently that we have seen the issue brought into full public view.

4.5.2 Traumatic Experience Can Create New Identity Groups

Traumatic experiences are often defined as extreme events. These types of substantive and deeply felt distinctive experiences are used as evidence that the divisions between people are meaningful. Central to the social identity approach is the most fundamental idea: the reification of groups arises from meaningful social or political divisions between groups. Differences in the severity of people's traumatic experiences are a material reality. Whilst this can reflect and embed existing schisms, like those between women and men or Arabs and Jews, it can also create new groups. We often talk about 'refugees', 'orphans' or 'victims' based on their shared experience of war, bereavement or violence, respectively. We are comfortable defining groups of people with these labels. For the most part, these labels have connotations of sorrow and passivity: people are constructed by both themselves and others as being victims of circumstance (Bradshaw & Muldoon, 2020). These labels can also be seen as social identities people obtain through experience. People are literally defined by their trauma.

Here, using the example of forced migration, a key trauma in the World Mental Health surveys that often ensues from political violence, how those displaced by conflict fare when they take on the identity mantle of 'refugee' is considered. Refugees often survive traumatic and dangerous experiences associated with forced displacement, including loss of family members, torture and rape (Jeppsson & Hjern 2005; Schweitzer et al., 2006). At a time when people may be at their most traumatised, and feeling very threatened, a sense of shared experience with similar others can be a salve. So, a category label like 'refugee' can offer people a sense of shared experience with others who have survived similar difficulties. This point emerges from work by Hermann (2016), who studied Songhay and Bellah men during a period of extreme stress and displacement – when nearly 300,000 northerners had been displaced to southern Mali in April 2012 and another 161,000 had become refugees in Niger, Burkina Faso and Algeria (UNOCHA, 2012). This anthropological work suggested that joking about shared misfortune was a form of cultural communication that fostered solidarity among refugees and promoted cohesion. In particular, joking allowed the refugees to manage hardship and disconnection by strengthening new relationships through a process referred to by the author as *communitas*.

A related point emerges from Dudley's research (2011) on the shared cultural practices among Karenni refugees on the Thai-Burma border. She argued that cultural activities such as cooking, weaving and woodwork offered both purpose and agency to refugees in the camps as well a sense of connection to home. The activities can also be seen as a way of enacting valued identities. These activities rebalanced some of the sense of displacement and disconnection that the refugees were experiencing. Mirroring these qualitative findings, in a survey of 361 Syrian refuges in Turkey, Smeekes et al. (2017) found that refugees who had maintained group memberships and had an associated sense of connection to home after their migration had better health than those who reported loss of connection. Echoing this, stories of forced migration point to the importance that even very young refugees ascribe to remembering and living by their family's values as they struggle to survive and maintain hope (Marlowe, 2010).

Herein, though, lies a testing paradox. On the one hand, having status as refugee affords a number of rights from signatory countries to the 1951 UN convention. Being in this new group and assuming this category label potentially offers traumatised refugees a new and protected position within the wider world that acknowledges the plight of people as oppressed and pushed to the periphery of society. In the process, it can also offer a network of others with similarly difficult experiences with whom they can develop common cause and access support. In this way becoming a refugee can be considered, a 'social cure' for dispossession. On the other hand, 'refugee' can become a master identity that defines a person above and beyond any other group membership. It is a label that in many countries is associated with systematic marginalisation, physical confinement and stigmatisation (Bradimore & Bauder, 2012; Jackson & Bauder, 2014). For this reason, the new identity can also be considered a 'social curse'. It places those who share the identity at risk of further trauma associated with their already depleted social, economic and cultural resources (Muldoon et al., 2020). And so this new group membership, derived from the traumatic displacement, is a double-edged sword, linked to both protection and peripherality, passivity and agency, empowerment and disempowerment.

4.5.3 Traumatic Events Can Make Relevant Social Identities Salient

In the previous two sections, we have considered how differences in risk and experience of traumatic events make distinctions between existing groups meaningful or even can create new groups. A third reason that the social identity approach is helpful to understanding the impact of trauma is the importance this social psychological approach places on social and political contexts. Paul Muldoon's 'Boundary Commission' aligns the end of a rain shower with a geopolitical boundary. On another day and in another place or context, where the rain ended would be unremarkable. Indeed, it is the context that made the invisible 'wall of glass' visible and that requires people to position themselves on one side of the divide or the other. The social identity approach acknowledges that people belong to multiple groups and have multiple identities. Because of this, the idea of relevance, sometimes referred to as social identity salience, is crucial to deciding whether and when a group membership is used to guide thinking and behaviour. So, for example, a person is far more likely to define themselves with regard to their nationality if 'the border ran / Down the middle of the street, / With the butcher and baker in different states'. For others living in contexts where nationality is not relevant or contested, self-definition in terms of nationality is less likely and often restricted to particular days such as independence days (Joyce et al., 2013). Thinking of oneself as a group member, known as self-categorisation, then, varies as a function of the relevance of a given group membership to the situation at hand (the principle of *fit*).

There is often a readiness and willingness in situations of political conflict to self-categorise in terms of social identities (Habashi, 2008; Muldoon et al., 2007). This type of salience drives the relative accessibility of a social category, which generally is seen to reflect people's past experiences, expectations and current motives and needs (Turner et al., 1994). For most people, national self-categorisation is assumed unproblematically by birth, blood or citizenship. Markers of national identity are contested and problematised at the boundaries of nations where the geographical and political elements make categorisation less certain. Border regions are atypical of their wider societies. They manifest an ambivalence through subversion in informal economic activities such as smuggling, a sense of borders not as lines but as lands, as well as a self-reclassification process when the border is crossed (Donnan & Wilson, 2021). Paul Muldoon's 'Boundary Commission' breathes poetic life into this issue and highlights the accessibility of the national category for people living in the border regions of Ireland.

In circumstances such as these, national identity, rather than being prosaic (Billig, 1995), is in fact very salient (Stevenson & Muldoon, 2010). This can affect how other people perceive our behaviour and equally how they behave towards us. Because identity in Northern Ireland is contested (Muldoon et al., 2007), people living in border areas that actively lay claim to a nationality can quickly be perceived as fanatical, overzealous, even radical (Stevenson & Muldoon, 2010). The same behaviour in a politically uncontested location would be unremarkable. So, for example, we found in our research that those living in the border region of Northern Ireland who spoke Irish and actively declared their Irishness were perceived as highly politicised. This same construction of those who used the Irish language was not in evidence in judgments of those living in the Irish Republic where national identity is not contested.

Sometimes, then, our behaviors and judgments of others are guided by our understanding of the context and their group memberships. People resident in Northern Ireland speaking Irish were viewed, at least in this study, as being Irish Republicans. And so the Irish speaker in Northern Ireland may interpret their experiences with other communities in Northern Ireland or the British state in terms of their national or political identity. Traumatic events, particularly related to contestation and political violence in Northern Ireland, then, are likely to make group membership salient. This is because where people are treated by others as members of a particular group, group membership can become salient. When we are the recipient of these behaviors and if the treatment received fits with our stereotypical expectations of intergroup relations, self-categorisation in terms of group membership is more likely (Klandermans, 2002). Making a social identity salient in this way can therefore be an important interpretative lens on related traumatic experiences (Muldoon et al., 2009).

On the other hand, there are traumatic experiences that are interpreted in a very personalised way. Domestic violence is often constructed as a product of personal characteristics (for example, the perpetrator was a monster) and individual conditions (for example, the perpetrator 'snapped') (Humphreys & Joseph, 2004). These types of individualising narratives don't make social identities relevant or salient. Because of this, people negotiating this trauma don't spontaneously harness social identity resources to understand and manage the situation. This can give rise to even greater feelings of isolation

(Naughton et al., 2015). A perception that a traumatic experience does not arise from intergroup dynamics makes social identities inaccessible. This adversely affects people's ability to make sense of the experience and isolates people from the support of those who have previously endured and negotiated the experience.

In summary, an identity can be more or less salient or relevant to the context within which we find ourselves. When a particular identity is salient, individuals take on the status and reputation of their groups, whether positive or negative. Importantly, such connotations are conferred based on categorisation into that group by either themselves or others. Where disempowerment or disadvantage makes group membership salient, people are more likely to embrace their social identities to make sense of difficult experiences (Schmitt & Branscombe, 2002). The degree to which people identify with their group is also important. Though a strong sense of identification is important (Muldoon et al., 2009), the salience of group membership appears to be increased by adverse experiences. The idea that trauma makes identities salient, facilitating greater commitment to the group, is an important theme to which we return in Chapter 6.

4.5.4 'Misery Loves Company': Traumatic Distress Can Motivate People to Connect with Others

To begin it is important to understand that a sense of shared experience can be the basis of connection and identification with others. Tajfel famously described the process of identification as being so ubiquitous that it could arise from what he called 'minimal groups'. Minimal groups are groups that were created for the purposes of an experiment. They have no meaning in reality. In his first experiments Tajfel divided people based on whether they preferred one of two painters, Klee or Kandinsky. These two painters shared artistic influences, having embarked on their artistic education in Munich during a similar period of the twentieth century. They are seen as similar painters, then, and so the preference of one over the other was intended to have no meaning. His original experiments showed, however, that people who shared painter preferences were also inclined to prefer each other. Tajfel (1974), and a subsequent generation of researchers, have used this as evidence that even meaningless social groups can be the basis of group connections.

In the same way, a sense of shared experience appears to produce psychological alignment with others because we see them as similar. This psychological alignment can offer a sense of shared identification, which can be a particularly important basis for giving and receiving social support. It follows then that a traumatic experience, with its associated intensity of emotions and distress, is likely to increase people's need for connection, particularly with other who have had similar experiences. Banding together with affected others can also increase our sense of our ability to cope in the face of adversity. These types of effects make social identities centrally relevant to the study of trauma.

That isn't to say that the groups to which we belong or align are always protective following traumatic experiences. We are not always kind to victims even within our own group. Sometimes traumatic experiences can be profoundly norm-violating. Many traumatic experiences are linked to taboos – such as suicide, sexual abuse and accidents arising from substance misuse. Because social norms guide behaviour of group members, such violations and failures to enact group norms can result in rejection even by a group that we value highly. Children and adults can be excluded and marginalised within their own families when they report their abuse, for example (Muldoon, Nightingale et al., in revision). This type of norm-violating trauma results in exclusion from the group itself. As such, some norm violations may seriously undermine a person's ability to lay claim practically or psychologically to a valued identity. In cultures where victims are blamed for their rape or sexual assault, for example, women may have difficulties being accepted by their families and communities (Kellezi et al., 2009). This has important implication for people's ability to access important social and psychological resources within their own networks as well as their ability to assume valued identity roles such as wife and mother.

These barriers to accessing new identities, and the social identity resources that arise from them, occur because norm violations and taboos are often tied up with questions of morality. People often assume that judgements about morality are objective, but they too are in fact a product of group life (Clayton & Opotow, 2003). For example, violence is perceived as more acceptable and justifiable among highly identified ingroup members, who often believe perpetrators are acting in defence of an honour or cause (Muldoon & Wilson, 2001; Uskul & Cross, 2019). Any tolerance for perpetrators' actions, be they small or large aggressions, can amplify the distress of those victimised. This tolerance of perpetrators' actions and associated neglect of victim sentiment is maintained by shared group norms. Classically, the victim is seen as a master of their own misfortune and the preparator is acting to protect the group, be it a family, political or national cause.

This narrative that orients to victims' behaviour is seen very clearly in how we advise women to take care to avoid being attacked when they are out walking and running. As a woman who runs and has spoken publicly after one nasty incident (Muldoon, 2018), I have been subjected to more than my fair share of advice on how to stay safe. I must run with others, run before dark, run with the dog, run in floodlit areas, run with a GPS safety tracker, run in a 'safe' area and stay alert. I must not run alone, separate from the group, run after dark, or run with earphones. Implicit in all of this advice is the assumption that if I behave as advised, I won't be victimised. But none of these precautions and all the care in the world will not solve the problem. And that is because however hard it may be to hear, it is men's behaviour that is the issue. And whilst only some men are perpetrating this behaviour, many others engage in threatening micro-aggressions, and many others, men and women included, tolerate and even justify it: 'boys will be boys'. This ubiquitous view, a gender-based norm, is central to our tolerance of all forms of male aggression and violence in public and private spheres. It also serves to highlight how central groups and group-based norms are to the experience of trauma for women and men.

4.5.5 Integration of the Personal and the Political Dimensions of Traumatic Experience

The social identity approach to trauma proposed here offers a lens to connect individual and collective components of trauma process. Clinical understandings of trauma highlight that there is something meaningful and distinctive about personal exposure to traumatic experiences. In the same vein, classic psychological theorising around trauma is concerned with the operation and implications of the self in personal terms (Antonoysky, 1996; Hobfoll, 2011; Linville, 1987). Within social psychology, the social identity approach is largely concerned with the operation and implications of the self, defined in terms of group memberships (Haslam et al., 2010; Reicher et al., 2010). By this token, the impact of traumatic experiences can only be understood by thinking about people as group members. The impact of my experiences whilst out running, then, can only be understood with reference to my gender, the gender of those harassing me and the associated gender-based power dynamics. This integrative perspective highlights how the collective and the political affect individual psychology in terms of health and well-being, as well as social and political attitudes.

Personal exposure, though clearly linked to group membership, is not the same as collective traumatisation. Collective trauma constitutes an earth-shattering, threatening episode in a group's history, then, that affects not only direct victims but the entire community (Canetti et al., 2018). American sociologist Kai Erikson (1976) was probably the first person to document the concept of collective trauma in the aftermath of a catastrophic flooding in the United States. A collective trauma can transform the way a population perceives the world and their understanding of the relationship between their group and other groups (Vollhardt, 2014). The group can develop a collective sense of endangerment, community disorder can ensue, and even profound fracturing of networks and societal institutions (Keynan, 2018). Collective trauma confers effects on individuals directly affected as well as those in the wider community.

Using the social identity approach allows us to conceptualise and distinguish between the effects of personal exposure and collective trauma. Self-categorisation theory holds that social identification produces psychological alignment with members of the groups to which we see ourselves as belonging. Both self-categorisation theory and social identity theory, interested as they are in the role of sociopolitical context and political power, highlight that adverse experience in low-status groups delivers a particularly strong sense of belonging and identification through this alignment with others; an individual's personal fate can become psychologically tied to the fate of others (Drury, 2012). As such, the experiences of threatened or disadvantaged fellow ingroup members are taken much more seriously because they are relevant to oneself (Haslam et al., 2018). Though this is different to the burdens faced by those who directly experience trauma, this means that the trauma experienced by ingroup members can have a significant ripple effect on the wider group (Muldoon & Lowe, 2012; Huddy & Feldman 2011).

On the other hand, the traumatic experiences of outgroups can be ignored. When we do not identify with victims, we may be blissfully unaware of the risks our outgroups face. Privileged group membership, in particular, can offer protection and obscure understanding of outgroup or subordinate group risk. This is because where we lack familiarity with the experience of other groups, or we perceive others as dissimilar to ourselves, our ability to take a perspective can be particularly weak. In these cases, social identities, people's attributes as group members rather than individuals, are very relevant or salient (Ackerman et al., 2006). In divisive situations, making group memberships salient can result in the situation becoming nasty and contentious. In situations of political violence, people who attribute their own group's victimisation to a particular outgroup are more likely to endorse hostility and aggression towards that outgroup (Halperin et al., 2009). Equally, perpetrator groups can respond aggressively in these contexts, seeing this as a need to defend their own position.

Power and privilege are centrally important to these dynamics. The experiences of minoritised populations, who are more at risk of trauma because of the fixed effects discussed in Chapter 3, are not understood or appreciated by those who occupy more privileged positions. In other contexts, however, particularly where majority group members feel threatened, rather than being unaware of the experiences of the outgroup, those with the direct experience of trauma are actively belittled or demeaned (Clayton & Opotow, 2003; Koch et al., 2016; Levine & Thompson, 2004). For example, while New Yorkers were distressed by the attacks on the Twin Towers, they may have been unconcerned about killings in Afghanistan. Supporters of al-Qaeda would be more likely to show precisely the opposite pattern. This gives rise to circumstances where similar traumatic events can cause distress and moral outrage, on the one hand, or celebration and triumphalism, on the other, depending on whether the observer and the victim share an identity. And so, Paul Muldoon's reference to the invisibility of these boundaries that 'might have been a wall of glass' resonates. Group boundaries are too often not even visible to our sense of our own, and more particularly others', trauma.

4.6 Conclusion

The social identity perspective represents two related theories known as social identity theory and self-categorisation theory. Both approaches highlight the importance and power of categorisation processes for how we see ourselves and others and indeed how others see us. We can see this type of categorisation at work in how we view people who have experienced trauma. We know that how we feel about our own group, our ingroup, is important to our health. And here we theorise why it is also centrally important to how we negotiate personal exposure to traumatic events, our recovery from these experiences as well as our resilience to them. Intragroup processes are distinct from intergroup processes. Intergroup processes drive how we feel about other groups of which we are not members: outgroups. Because of this, traumatic experiences are relevant to people's feelings about outgroups especially where a situation is polarised, or the traumatic experience is attributed to a particular outgroup. Taken together, this way of thinking about trauma offers a way to integrate current individual and collective understandings of trauma and its impact on (1) risk and resilience and (2) social and political attitudes, as we do in the next chapters.

5 Comfort in Dark Times

If we winter this one out,
We can summer anywhere.
—Seamus Heaney

5.1 Chapter Outline

Heaney alludes to dark times through reference to winter in the opening quote of this chapter. He sees this as an experience shared: it is ‘we’ rather than he that has ‘to winter this one out’. In life, whatever ‘this one’ at hand may be, traumatic events that consolidate social identities can act to protect health and resilience and even give hope for the future, Heaney’s metaphorical summer. We have already seen in Chapter 4 that trauma can change our social identities through the consolidation or acquisition of new identities. The aftereffects of trauma are driven, then, by both the traumatic experience and our sense of ourselves as group members and associated social identities. In the proceeding sections, we consider some of the implications of this for people negotiating trauma. We begin by considering the role of existing and multiple group memberships as a platform for resilience. We move on to consider evidence that psychological outcomes after trauma exposure are structured by changes in the number of group memberships and the change in our degree of connection to these groups. Last, we consider the impact of change in the value placed on our group memberships on trauma outcomes. In reviewing this evidence, it becomes clear that change in group memberships and social identities is a powerful determinant of psychological adjustment in response to trauma.

5.2 A Sad and Salutary Tale

In my late thirties a close friend died by suicide. I experienced her death as very traumatic. Looking back, it was probably the most affecting experience of my life to date. Clare died aged forty. A fellow academic, we had completed our undergraduate degrees together. We shared the identity of ‘Southerners’ in a Northern Irish university. We were reasonably unusual in that environment. We both went on to study for PhDs, I immediately after completing my degree, she two years later. We shared the same generous and encouraging supervisor and indeed the same social network in those early days of our PhDs and later too as our careers developed. We both proceeded into careers in social psychology. Ours was a friendship built on twenty years of trials and tribulations, forged as women pursuing careers in an occupation and a field still dominated by men. But we also had lots of other things in common. We both came from a houseful of female siblings and had a single brother. We had both attended a convent school run by the same order: ‘Loreto Girls’ if you will. We both were from the Republic with partners from Northern Ireland. Our upbringing had been similar, and much to our amusement after many years of friendship we realised we were related. We implicitly understood each other. At times, we both struggled with depression.

In short, this friend and I shared multiple experiences and identities. And we were often positioned similarly by others in terms of gender and nationality. Her death left me with a sense that I had lost a key support. She was hugely supportive as a colleague and a friend. At the time of her death, I was negotiating a new academic landscape. I had recently moved to the University of Limerick to set up a new department. Prior to this point I had spent many years in Belfast. I didn’t know Limerick. My first visit to the city was to interview for the job I subsequently took. The many promises made to me as an incoming head of department, tasked with setting up a shiny new department of psychology, were not honoured as the great recession hit Ireland and funding in the education sector dried up. The move took its toll. I was socially disconnected, had young children and a new challenging job in an unfamiliar organisation. I felt my dear friend’s death keenly. I missed her wise counsel, her belief in me and, of course, having someone who got it and with whom I could laugh about it all.

Her death changed me too. I had tried to be an ally and support to her. Her death by suicide left me with a sense that I had failed her. This was someone who, whenever we met, had always seemed as though she was delighted to see me, as though she had been hoping that I would come along or ring to chat or share the latest issue or gripe. Of course, there must have been times she didn't need interruption, but it never came across. She was so very careful of others' feelings. In the first weeks and months after her death this added to my sense of guilt. I worried I hadn't been the friend to her that she had been to me. Typical of her thoughtfulness, she had been very clear to counter this narrative in my head prior to her death. As I struggled to make sense of her death in the weeks and months that followed, I realised that there was a psychological cost to this level of thoughtfulness and being available to others.

In time – and it was quite some time before this became apparent to me – I was left with a strong sense of the inadvertent damage we can do to ourselves by having an over-developed sense of responsibility to others. The challenges 'women like us' faced on the professional front, and on the home front, were different to those experienced by many of our male colleagues. In many regards this is counter-normative for women in many work and family contexts to limit their availability or care for others. As I struggled through this difficult time, I avoided those who seemed judgmental. At the same time, I began to look for the characteristics that defined her in others: compassion towards others, quiet determination and unequivocal warmth. These people and relationships got me through. So though I think back to her death with tremendous sadness, it was also an experience that revealed the kindness in many others around me.

5.3 Trauma and Social Identity Change

Social identities define us. The social identity approach tells us that group memberships and connections to others are central to our sense of self. We are all individual and idiosyncratic. Equally, we are all defined by distal group memberships such as gender, race and nationality and more proximal ones such as family groups, place-based groups and interest and hobby groups. Our sense of who we are is bound up in our relationships with others: we are husbands, wives, sons, daughters, runners and book clubbers. So much of how we define ourselves is shaped by relevant groups and people in our lives. Trauma can change these defining social identities. It can reduce the number of group memberships, and also associated identity connections. Trauma can alter our sense of belonging to one or more valued identity groups. On the other hand, trauma that adds new group memberships may offer meaning and purpose to life, however unwelcome the trauma was to begin with.

Trauma can change self-definitions. First, trauma in and of itself may change how people are identified: trauma can make widowers out of husbands, and refugees out of residents. In this way we can see that trauma can result in a change in how people are categorised, and the access people have to different groups. Trauma can also therefore define wider social networks. These networks or groups can offer us great solace, even during life's darkest times. This is because groups are the basis of social identity resources, such as feelings of belonging, solidarity and support as well as social bonds and community spirit. In my own case, as I negotiated the unexpected death of my friend, others in my social network, most particularly my colleagues and friends who also felt Clare's loss keenly, were crucial supports. The sense of connection that we felt because of our shared distress at that time is something that connects us all to this day. So, as a group, we developed a strong internalised sense of being a group of colleagues and friends connected by this loss, which offered us resources or assets as we negotiated her loss.

Life changes that result in a loss of valued social identities will tend to have negative consequences (Jetten et al., 2009). Early conceptualisations of stress linked 'life change' to the severity of stressful events. This gave rise to the popularisation of 'life change scores' and the often used truism that moving house is more stressful than getting a divorce. In narrative accounts, too (Armour, 2002), trauma is often seen as 'life changing' (Holmes & Rahe, 1967), and certainly this is how I experienced my friend's death. I knew her as reliable, thoughtful and even-tempered. After she died, I felt less confident in my judgments of others and myself, and it shook my sense of the certainties of life.

Individuals' own perspectives on their identities are central to understanding the impact of any identity change. To illustrate the importance of people's perceptions of identity change with students in class, I often use an example from my childhood. I recall vividly the death of a neighbour. We were friendly with the man's children and as teenagers involved in the same school and peer group. There was much sympathy for these children and much expectation that this his wife would be bereft and daunted by her new life as a widow. As a teenager, I recall the mismatch between the concern of the adults around me and the behaviour of her children and their ability and their mother's ability to move forward. They all seemed well. They were engaged and cheerful towards us, and it became apparent as time went on that they were expanding their social worlds. The children took up swimming and dancing. Their mother took up bridge. They even seemed to be better dressed.

There is no doubt there are circumstances where parental or spousal loss is devastating. But equally there are circumstances where it is not. These effects are totally dependent on people's view of the event. There are no universal reactions. Observing her behaviour, we speculated naively that she may not have been the happiest of wives. I now know that marital disharmony and domestic abuse are likely to be centrally relevant to people's experience of spousal and parental bereavement. Regardless, having financial security after the death of a spouse mattered. So, in the example of my neighbour, her change of status from wife to widow seemed to allow her to expand her and her children's social world. In this way she would appear to have had autonomy, a new respectable identity of 'widow' and, flowing from that, the compassion of others.

Widowhood was a respectable status, though one in which there was still navigation required. Women could be judged harshly for being a 'merry widow' or indeed find themselves unable to participate in former groups due to changed financial or childcare responsibilities. My neighbour didn't appear to be facing these issues. At the same time in Ireland, divorce was not legally available. Single separated women were treated with far less compassion. Being 'separated' or 'divorced', also identity labels, was incompatible with an important social identity – namely, Catholic group membership – which was the order of the day. A life-changing experience that results in a new identity, like widow or divorcee, that is compatible with existing and valued identities can ensure continued access to support and a sense of belonging in work or school life. Incompatibilities are likely to result in less positive health outcomes in response to life change, creating psychological tensions for individuals as well as tensions in social relationships (Muldoon et al., 2020).

We can think of traumatic experiences as pivot points. They can cause shifts in how we think about ourselves as individuals, as well as how we think about ourselves in relation to others and to groups to which we belong. In the proceeding section, we think about how our social groups, both new ones and those that we were already a member of, shape thinking in the aftermath of great trauma. In a similar vein to social cure research (see Chapter 4), this social identity approach to trauma is centrally concerned with the role of groups in shaping health, positively and negatively, where life changes occur (Haslam, Haslam et al., 2021).

5.4 The Social Identity Model of Traumatic Identity Change

The social identity model of traumatic identity change (SIMTIC; Muldoon, Haslam et al., 2019) provides a framework for understanding the impact of traumatic life changes. SIMTIC predicts likely outcomes for people as they negotiate the changing circumstances that inevitably flow from trauma (see Figure 5.1). SIMTIC highlights processes and pathways that are relevant to understanding health and well-being in response to life change brought about by trauma. To date, SIMTIC has offered three working hypotheses. They are that maintaining social identities contributes to resilience, whereas trauma that weakens identities results in PTS. We term this the social identity continuity hypothesis. The second hypothesis proposed by SIMTIC is the social identity gain hypothesis. This represents the idea that acquisition of valued new identities can contribute to resilience, whereas the loss of valued identities can contribute to PTS. A final hypothesis suggesting that post-traumatic growth can arise from revitalised and reenergised identities is discussed at length in Chapter 7.

Trauma, then, can cause the value and strength of our identities to change. There can be change for the better and SIMTIC tells us this will foster resilience. As we see in Section 5.4.1, trauma can help us to band together with others and even enhance the strength of connections to others. In SIMTIC terms, social identities are maintained or even gained. But trauma may also devalue and undermine our identities. This happens in one of two ways. First, how we see ourselves – our subjective sense the value of our identities – may change (see Section 5.4.2). Second, others might see and categorise us into new groups that we are ambivalent about. In Section 5.4.3, the impact of events that devalue an identity or invite social stigma is considered. In SIMTIC terms, this represents social identity loss and failure to maintain strong identities, and this is associated with poorer outcomes.

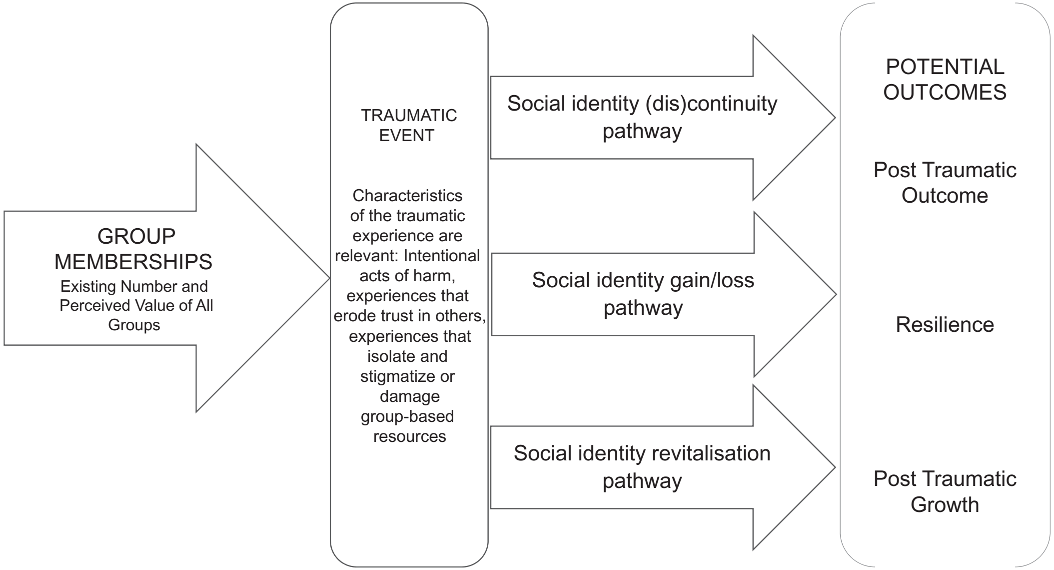

Figure 5.1 The social identity model of traumatic identity change

5.4.1 Trauma and Change in Identity Strength

In some of the earliest research I completed after my PhD, I was interested in how experience of the political violence in Northern Ireland affected people. By that stage, it was clear to me that many people in my life had been affected by their experiences over the course of the conflict. My father was from the border region and he and his family had been devastated by the imprisonment and subsequent death of his brother as a young man. This brother, my uncle, had become involved in the Irish Republican Army's 1960s 'border campaign', a period of warfare that predated the later and better-known 'Troubles'. Similarly, my husband and his siblings had lived through the violence in the Bogside of Derry as children in the early 1970s. These were dark days and his childhood had little of the hope that characterised and popularised the recent Derry Girls TV show, set as it was more than twenty years later in the 1990s.

My father was, psychologically speaking, a strong man. He was resilient and purposeful. His brother's death was not something he spoke of often, and indeed I was in my twenties before I heard the full story from a cousin. The past was not something that my father ever wanted to dwell on. He (and my mother) were of the school of thought that you could 'make too much of things'. My father did have very different views politically to many people I knew, and to those who lived and worked around him in the Dublin area, where he lived most of his adult life. He was one of the few people I knew who voted against the Belfast Good Friday Agreement, the accord that brought a resolution to the conflict in Northern Ireland. Indeed, 99 per cent of the population in the Irish Republic voted in support of it. My father's position was ideological and unmovable. We shouldn't give up *the claim* on Northern Ireland, or the North of Ireland, as he preferred. Reunification wasn't an aspiration as laid down in the Belfast Good Friday Agreement; in his view, it was an ideological imperative.

Drawing on these observations, in some of the early research I completed, I was interested in how potentially traumatic experiences might affect people's commitment to their political positions. My working hypothesis was that if traumatic experience strengthens a person's sense of identification with a group, this will tend to reduce its psychological toll. However, if the trauma compromises belonging or identification with a meaningful group, then this will tend to amplify mental health costs. In the social identity literature, a wealth of research has demonstrated that adverse experiences, such as discrimination, increase identification with the group. Schmitt et al. (2014) have demonstrated convincingly that adversity and discrimination as a consequence of social identities (such as race or gender) can lead to increased social identification with a person's group. My sense then, and now, was that these findings also had important implications in terms of the impact of trauma. Social identities can be powerful resources in the face of adversity and trauma. Traumatic experience can consolidate an identity, thus generating the resource people need to adapt to the event.

There was a cost for my father in losing his older brother. They had had a good relationship growing up. His death and the loss of his life was perhaps easier to bear if it was linked to the pursuit of a higher-order political goal. And though my father himself never supported any campaign of violence in Ireland, he had a strong view that Ireland had a legitimate claim to the north-eastern six counties of Ireland and that it ought to be honoured. Psychologically speaking, absorbing the cost of his brother's death may have been easier for him to rationalise if he could see it as part of a wider collective effort, a loss endured in the hope of better days ahead – if he could 'winter it out'.

This type of identity process is evident in a large-scale representative study of the population in Northern Ireland and the Border Regions that we have completed (Muldoon et al., 2009; Schmid and Muldoon, 2015). Personal experience of the conflict mattered to the strength of people's identification with their preferred national group. This effect was apparent for people who had the highest direct experience of conflict and trauma as well as those, like my father, who could be thought of as having an indirect experience of conflict-related events. The effect was there for those who saw themselves as Catholic/Irish as well as British/Protestant. There was no difference between the two ethnoreligious groups. Importantly, at least for our present purposes, the extent to which the conflict was associated with psychological well-being was driven by people's strength of national identity. Whilst the perceived threat associated with the conflict had a direct negative effect on well-being, there was also an indirect *positive* effect of social identification on well-being. So, we find that those with the most experience of political violence were those with the strongest identification with their national group and that this strong pattern of identification protected psychological health.

As well as well-being, we measured post-traumatic stress (PTS) in those who reported a particularly traumatic event. Exposure to conflict-related violence was a significant predictor of PTS. However, strong national identification was associated with fewer symptoms of PTS (Muldoon & Downes, 2007). Respondents with a strong sense of national identity, who saw their preferred nationality as an important part of who they were, were those who were least likely to be PTS 'cases'. Central to understanding expression and maintenance of PTS symptoms are people's subjective appraisals of events. Perhaps not surprisingly, then, subjective perceptions of threat are more powerful predictors of symptoms and responses to treatment than 'objective' indicators (Alvarez-Conrad, Zoellner, & Foa, 2001). Identification can thus be seen as an important factor that alters perceptions of threats, including those emanating from other groups as a result of intergroup tensions and violence (Schmid & Muldoon, 2015).

In other parts of the world, we find similar patterns of resilience and risk linked to identity strength. In Lebanon, mothers with the strongest commitment to their group position during the conflict show the lowest level of PTS symptoms. This benefit was also evidenced in higher levels of well-being of their children (Qouta et al., 2008). And in Palestine, those who see the political violence as essential to improving the rights of Palestinians experience less psychological distress despite greater exposure to conflict-related violence (Hammack, 2010). Effectively, a person's subjective social identification with their political group affects interpretation of both threat and violence. This allows the traumatic experiences associated with the conflict to be interpreted as meaningful, and even expected, towards achieving valued group outcomes. This minimises the health costs of the trauma and in particular is associated with less PTS.

Interview research also indicates that political and religious activists understand trauma as something that can be endured. It is taken as reflecting and embodying a higher commitment to a cause and one's part in it (Silove, 1999). Indeed, because of this, activists demonstrate reduced risk of PTS (Basoglu et al., 1996). In their studies, Basoglu and colleagues observe that among those who experience torture within their own countries, political activists tend to be less traumatised than non-activists – even though activists often endure more severe torture (Basoglu et al., 1994; Basoglu et al., 1997). Moreover, non-activists – who have little or no commitment to the cause, and also had no pre-trauma expectations of arrest or torture – are more likely to experience psychological distress. They also experience higher levels of PTS than members of activist groups. Thus, despite their prolonged exposure to severe traumatic experiences, Basoglu and colleagues observed that levels of PTS among activists were moderate rather than severe, and that those with strong commitment to their cause were least likely to be symptomatic.

This brings us to the fit between an identity and the trauma experienced. We conducted another analysis of the same large dataset (N = 3000; Muldoon et al., 2009) where we considered *which* group memberships were useful for negotiating trauma. In Northern Ireland, there were by this time three widely used national categorisations: British, Irish and Northern Irish. Self-categorising as British or Irish is generally associated with the long-standing oppositional political attitudes associated with the conflict. These are the two sides from which the violence is seen to arise. Seeing oneself as Northern Irish is a relatively more recent national identity associated with more inclusive and socially progressive attitudes (Lowe & Muldoon, 2015) that emerged after the Belfast Good Friday Agreement. In this second analysis, we looked at not only the strength of identification but also people's preferred national self-categorisation. National identification protected well-being for respondents who described their identity as British or Irish. However, this mechanism did not mitigate the impact of conflict experiences for those who saw themselves as Northern Irish. This is consistent with the historical context, where British and Irish identities (rather than the Northern Irish identity) are used to frame, and help to make sense of, the animosities of the conflict.

In essence, then, we see that it is only when a group offers an interpretative frame to assist understanding of the traumatic events endured that strong social identities are helpful. Taken together, this evidence suggests that identities associated with the trauma of political conflict can provide an interpretative lens through which any traumatic experiences are given meaning. In this way, conflict-related events can appear less traumatising and are endured because they are seen as part of a wider collective cause. On the other hand, events that undermine identity positions can lead to increased post-traumatic symptoms. Put differently, these findings suggest that people are less likely to be traumatised by violence that flows from conflict if they define themselves in terms of a social identity that allows them to make sense of that conflict in a meaningful way. So, a strong sense of the importance of 'us' and 'our cause' can make conflict worth enduring. Without this, the conflict and its traumatic consequences are much harder to negotiate.

5.4.2 Trauma and the Subjective Devaluation of Identities

Where traumatic events arise from experiences that undermine people's faith in themselves, or others they value, social identities may not be able to offer an appropriate interpretative frame. This may be particularly likely when the trauma emanates from trusted others with whom we share a strong social identity. For example, being a victim of torture is consonant with the expectations of highly identified political activists who oppose a political regime. It is not, however, consonant with the expectations we have of our parents, siblings and spouses or even state services such as the police or health and social care services. In these latter examples, the traumatic experiences can be a violation of our beliefs about people and things we previously held dear. If traumatic experiences undermine highly valued identities and identity-based connections, they can also undermine our sense of ourselves as a cherished member of that group. It is to this issue we now turn.

Returning to my own story of depression, and in particular the weeks and months after my friend's death by suicide, there were many dark days. I really valued my friendship with Clare and thought of her as a close and dear friend. I have always valued friendship and have tried to be a good friend to others. I was saddened by her death but also felt that I failed her. I didn't see her death coming, and that left me with a sense that I was not a good or useful friend. I ruminated on whether I could have done more. I felt guilty. These types of feelings, of guilt, shame, sadness, humiliation, frequently accompany and exacerbate poor psychological health in the aftermath of traumatic experience (Freyd, 1996; Resick & Schnicke, 1992; Reynolds & Brewin, 1999). In a series of studies with passengers who survived the sinking of the cruise ship *Jupiter*, those who attributed negative experiences during the unfolding disaster to their own actions had much poorer mental health outcomes and more severe symptoms of PTS (Joseph et al., 1991; Joseph et al., 1993).

The two years that immediately followed Clare's death I probably found the most difficult. I was trapped in a cycle of going over old messages, replaying events endlessly, wondering if I could have done more, or less, or better. I recall a colleague commenting that there were many who would claim friendship in the wake of her death. This I could not understand, as all I had was a profound sense of having failed as a friend. It is true that there can be a kind of beatification of those who die young. Indeed, 'Only the good die young' is immortalised in Billy Joel's lyrics. There can be an additional unhealthy aggrandizement of those who die by suicide (Carmichael & Whitely, 2018). As I ruminated endlessly over my failings as her friend, I was very clear she was the best friend I had so wanted as a child. Finding that connection in young adulthood was wonderful. Feeling that you hadn't lived up to her friendship was devastating.

Shifting contexts can impact on the value, or devaluation, of identities. So even though people may be able to harness social identities in support of their health at one point in time, a change in the context or, for that matter, political culture can mean an important aspect of our sense of social self is devalued. An illustration of this is seen in a study of the Royal Ulster Constabulary (RUC) in Northern Ireland. At the front line of the conflict for many years, this police force was comprised almost entirely of one section of the divided community in Northern Ireland (the Protestant British Unionist population). At best seen as partisan, and at worst likened to a military wing of the British state, in the period after the Belfast Agreement, the force was reformed and renamed, effectively winding down the RUC. This reform process opened up a discourse in which the RUC was no longer presented as protectors of the people or peace in Northern Ireland. Members of the police who had previously negotiated difficult security contexts with limited mental health consequences (Wilson et al., 1997) began to evidence much higher incidences of PTS (Mulcahy, 2013). The post-Agreement context, where the RUC was seen as part of the problem in Northern Ireland, effectively undermined the occupational identity previously so central and valued by officers (Mulcahy, 2013). Similar findings are evident amongst former members of the South African security forces, forced to relinquish military roles and identities in the post-apartheid era (Langa & Eagle, 2008).

These changes in the content and meaning of a valued identity can therefore be seen as part of the driver of risk and resilience. Militarised identities in Northern Ireland and South Africa protected personnel during the many years of prior political violence in both jurisdiction.

Betrayed and bewildered by new political dispensations similarly, security forces in both places found their old identities no longer protected their mental health. They, as I did in the wake of Clare's death, presumed others would see us differently. Misattributed shame I felt altered my belief in myself, as it is likely to do (Joseph et al., 1993), and so I no longer saw myself as a useful or valued friend or colleague. The extent to which an event is seen as central to our own self-definition is closely related to the damage that a traumatic event inflicts (Robinaugh & McNally, 2011). In essence, then, the inability to no longer see myself as a 'good friend and colleague', or the officers' inability to see themselves as 'protectors and peace keepers', can drive post-traumatic responses.

5.4.3 Stigmatising Trauma, Social Identity Change

At the time of Clare's death her family made the brave decision to be open about the cause of her death. Suicide then, and even now, was stigmatised (Pitman et al., 2018). The decision by Clare's family to be open about the cause of her death allowed those of us who knew her well to speak openly to each other. We could talk freely about the guilt and distress and find company for our misery. It allowed us to resist the stigma of suicide and depression. On the other hand, traumas that are stigmatising reduce our ability to engage with others in our existing social networks. People are removed from sources of social support. In extreme cases people who have endured trauma are identified as 'deviant' and are excluded and silenced (Kleinman & Hall-Clifford, 2009).

In adjusting to stigmatised traumatic experiences, then, there are additional identity dynamics at work. Stigma affects the social identity resources or the social and psychological resources that flow from being a member of a group. The relationship between rape and unusually high incidence of PTS speaks to this issue. Rothbaum et al. (1992) found that 94 per cent of victims had PTSD shortly after their rape, and 47 per cent continued to have PTSD three months after. The continued stigmatisation of the victim and the crime (Anderson, 2007; Walker et al., 2005) is an important element of these high rates of PTSD. In research studies, attribution of blame and responses to disclosure are seen to exacerbate victims' distress (Gueta et al., 2020).

Stigma is really relevant to accessing social support in those who have been traumatised. And stigma can also change people's subjective sense of themselves as group members. Sometimes people who are stigmatised no longer feel able to participate or engage with groups and communities they belong to in the ways they had previously (Bradshaw & Muldoon, 2020). Male survivors of rape, a highly stigmatised trauma, describe difficulties fitting into traditional male roles and groups and a need to manage and often conceal their trauma from others (Javaid 2016). Other research suggests that the counter-normative nature of male-on-male rape is identity-threatening: it undermines men's entitlement to and feelings of masculinity (Creamer et al., 2001). These processes amplify victims' exclusion and stigma and are reflected in the very high rates of PTS symptomatology in survivors of this trauma (Walker et al., 2005).

The damage of stigma for victims of rape is also exemplified in the work of Kellezi et al. (2009). This team demonstrated that social norms acted as a barrier to accessing support among women who were traumatised by the campaigns of mass rape during the Balkan Wars. PTS was experienced more severely where women remained silent. This silence was built on a fear of being shunned for transgressing culturally acceptable norms of gender-appropriate behaviour (Kellezi et al., 2009; Skjelsbaek, 2006). Powerful social prohibitions also drive the health impacts of non-violent traumatic events. Adewuya and colleagues (2009) investigated the psychological impact of a diagnosis of HIV in Nigeria. This study evidenced the damaging impact of stigma and reduced access to social support networks on health and well-being.

Social stigma, then, has two components. Survivors can often experience self-stigmatising feelings as well as endure the discomfort other people feel when hearing about their traumatic experiences. The severity of PTS has been shown to be strongly amplified by reactions of others, reactions that can be thought of as stigmatising responses. Schneider and colleagues (2018) found that elevated prevalence of current and lifetime PTSD was strongly predicted by stigmatisation, concluding that heightened traumatic responses are because of the stigmatising responses of others. Equally, the perceived severity of stigmatised trauma can be reduced where social support and feelings of inclusion and belonging can be maintained to some degree (Muldoon, Haslam et al., 2019).

Clare's life and death is without question something that is now part of my own autobiographical memory, the story of my life. Traumatic experience can profoundly change a person's sense of 'who I am'. Clare's death did alter me in many ways. It changed how I viewed my occupational identity irrevocably. Clare's death made me much more aware of the stress inherent in the academy. It also altered my connections to others, helped me think about those I should value and prioritise. Charuvastra and Cloitre (2008) articulate a key role for social bonds in determining risk and recovery from traumatic experiences, which highlights their importance in shaping our internal working model of relationships and social expectations during times of subsequent distress or difficulty. And available research would say that a trauma that brings negative and permanent changes in these working models is linked to poorer outcomes (Dunmore et al., 1999; Ehlers & Clark, 2000). Clare's death made it clear to me that I needed to learn to lean more on those in my network. Before her death I was slow to ask for help. I was always willing to help but was slow to take help. Her death made me see how problematic this pattern was. It changed my tendency and ability to ask for and avail myself of social support from friends and family. I was lucky to have that network. This care and love allowed me to see the value of these existing connections.

5.5 Multiple Group Memberships as Platforms for Resilience

The one period of serious depression that I have suffered in my lifetime coincided with a move to Limerick, from my job and life in Belfast. I had been an undergraduate and post-graduate student in Queens University and spent nine years as an academic member of staff. I knew my way around; I was well integrated and had wonderful colleagues and friends in the School of Psychology. By contrast, when I moved to Limerick, it was to set up a department of psychology at the university. I knew no one. I didn't know how the University of Limerick worked. Obviously, I sought information and support from others in my new role. That said, it wasn't always forthcoming. There was a widely held view that a person appointed at professorial level shouldn't need support. Universities, despite their claims of collegiality, can be isolating and adversarial places.

It was stressful moving from Northern Ireland to the Republic with my husband and two small children. As well as not knowing the university, we didn't know the city. We had to find housing and schools, and my husband was searching for a job. This was the point at which I developed depression. In my corner, as I negotiated this period, were strong relationships with family members and friends who had negotiated similar transitions. They offered both understanding and support and perhaps most importantly a sense of shared experience, that I wasn't alone in having these difficult feelings. I also had a long-standing relationship with running. I didn't have a strong sense of myself as a runner back then, as I wasn't fast and didn't win races. But I was a regular runner. Before leaving Belfast, I said my goodbyes to the city by completing the marathon there.

When I had first moved to Limerick, feeling friendless as I was in my new location, I set about finding a book club. I used my new connections at work to try establish one. Effectively, my occupational group membership delivered a new group: the book club. It is not uncommon for one group to scaffold the development of new group memberships and connections in a person's social network (Kearns et al., 2018). In general terms, although life change is considered stressful and unsettling, and thus a potential threat to health, life change will tend to have minimal or even positive effects on health when it leads to positive social identity gains. My sense of shared experience with others in the book club, many of whom were also working mothers, offered me access and support of a new group, as I settled into my new life in Limerick. Access to multiple group membership is a particularly positive and valued resource for health. Not only can existing identities contribute to acquisition of new identities, but they are important sources of support in and of themselves (Foran et al., 2021; Walsh et al., 2015).

The social identity approach to health (SIAH) offers a theoretical perspective on why group memberships and social identity–based connections affect health and well-being. Social identification can provide a means for people to access tangible psychological resources. In particular, this is because a sense of shared social identity is a basis for the provision and receipt of various forms of *social support* (Haslam et al., 2005; Haslam et al., 2012). Flowing from this, social support from groups (e.g., those entailing family, community, work or book club connections) have been shown to have a range of positive health consequences (e.g., in reducing chronic illness and pain, while also increasing well-being; Sani, 2012). At the same time, though, if social identities and the psychological resources they provide are compromised, then psychological well-being is undermined. In many regards, then, the disruption to life caused by the move from Belfast to Limerick can be seen to have undermined my social support network, affecting my well-being. Disclosing my difficulties to family and close friends, though hard at the time, allowed me to avail myself of important resources to cope with this episode of depression. I recall a family member saying she wished she had been so forthcoming when she was unwell. She wondered if sharing her diagnosis would have made it easier. My sense is that it would have, and to a point the research agrees with me. Regardless, her comment validated my disclosure and the tale effectively illustrates the importance of a sense of shared experience and existing group memberships as a basis for psychological resilience.

We know from social identity research that having access to many different group memberships, sometimes referred to as multiple group memberships, prior to life change is protective. The more group memberships a person has to draw on, the more psychological resources they can recruit when attempting to deal with a particular life change (Jetten et al., 2015; Postmes et al., 2019; Praharso et al., 2017). My relationship with running, though often a solitary activity, was also the basis for tackling my depression. As well as the dampening effects of running on rumination and feelings of stress, it has demonstrable antidepressant effects (Salmon, 2001). And this activity also offered a basis for new connections in Limerick. I found others I could run with and attended a running group. In the short term this offered company and meaningful activity, and in time it became the basis for long-lasting friendships, connections and engagement with voluntary community-based activity: namely, (Limerick) parkrun. In this way my existing activity-based identity, as well as my occupational identity, allowed me to build further connections through running and the book club, and, through this, resilience for the years ahead.

A study of young adults making the transition from school to university (involving a loss of secondary school/hometown identity, and the formation of a new identity as a student of a particular university) reflects my experience. Iyer et al. (2009) found that if students had multiple social identities before going to university, this predicted greater adjustment and well-being once they were at university. This was particularly the case where students saw their old and new social identities as compatible. Similarly, in a study of stroke patients, those who belonged to more social groups before their stroke experienced better adjustment afterwards (Haslam et al., 2008). This was due to the increased likelihood that those who had suffered a stroke were able to maintain at least some of their pre-stroke group memberships. Similarly, Dingle et al. (2015) measured the social identities of people entering a drug and alcohol programme and found that where people gained a social identity such as ‘recovery identity’, this played an important role in supporting their well-being and sustained abstinence from substance use.

Existing group-based experiences affect people’s resilience in another important way. A person’s existing social group memberships create opportunities to join new groups. So though I found the move to Limerick challenging, I was a member of the new group of the staff community at the University of Limerick. This gave me the opportunity to create and join other new groups. And, of course, people who have had positive experiences of groups – and I had many happy and positive experiences prior to this point – are more likely to be willing to engage in new group-based activities. So, whilst I tried to settle into life in Limerick, I harnessed my connections to others in the university community to form a book club. Like so many book clubs, this was a group of women, many of us with school-aged children, interested in female company and a nice chat. And ‘the book club’, though it has had several different names since, became a collective that is the basis of shared self-categorisation. During times of trauma and distress, existing identities can be an important source of support. This consolidates existing identities in an upward positive cycle of reinforcement. So, as I negotiated my friend’s death, I found support in my new book club buddies. There were some in the group who had had similar bereavement experiences, and I was left with a sense that this group understood how difficult the experience was. Not only did this consolidate my sense of connection to my fellow book club members, but it was also an important additional support as I negotiated the aftermath of this traumatic news.

Beyond these examples, multiple group membership is demonstrably a platform for health and resilience in large population studies. The UK Understanding Society dataset measures multiple group membership, social integration and physical health. Because the study and data series is longitudinal, this allows examination of the connection between these factors across time. An important indicator of health available via this dataset is allostatic load. This is an indicator of physical health built on measures of cardiovascular, immune and metabolic function (Gallagher et al., 2021). Allostatic load reflects the health costs of dealing with the prolonged stress (McEwen, 2000). It is an important predictor of morbidity and mortality and can be thought of as a measure of wear and tear on the body (Juster et al., 2010). Using this data, we have shown that multiple group membership facilitates the extension of people's social networks (Gallagher et al., 2021). Multiple group membership drives up the number of friends people have in their networks over time, which increases social embeddedness. This, in turn, reduces the physiological cost of dealing with prolonged stress as indicated by allostatic load.

Overall, then, it can be said that though trauma can change existing social identities, multiple group memberships are an important platform for mental and physical resilience. Where groups are compatible with each other – as Catholic and widowed are, more so than Catholic and divorced – the outcome is likely to be particularly positive, as the multiple identities will be easier to manage. Existing identities can also scaffold development of new group memberships. This can facilitate the development of multiple group memberships that extend a person's social group network in a way that is both welcome and easy for people to manage. However, this is also a harbinger for the potential impact of trauma. Trauma can disrupt identities or create new social identities that are incompatible with existing group memberships. In these cases, trauma is likely to have a negative impact if group memberships are lost and associated social and psychological resources are undermined. It is to this issue we now turn.

5.5.1 More Is More: Social Identity Gain and Resilience

There is considerable research evidence that potentially stressful life transitions, such as retirement (Haslam et al., 2018; Haslam, Haslam et al., 2021), childbirth (Seymour-Smith et al., 2017) and migration (Jetten et al., 2018), are negotiated more successfully where people have many group memberships. A key strand of research that has been done in this area particularly relates to people affected by acquired brain injury (ABI). ABI is one of the most common neurological conditions worldwide, and an estimated 69 million people are affected globally each year. An acquired brain injury can lead to long-term physical, behavioural and cognitive impairments, and many people report a profound change, and even a loss of their pre-injury sense of self, in the wake of their injury (Bryson-Campbell et al., 2013; Gracey et al., 2008; Walsh et al., 2015). Our qualitative research highlights how many of those affected by ABI lose occupational identities and, with that, also lose access to employment-based social connections (Muldoon, Walsh et al., 2019). Often occupational identities are central to who we are and are very highly valued. For instance, one police officer we spoke to talked poignantly about the sense of identity loss that arose when it became clear her future career and ambitions for her occupational life had imploded.

In those affected by acquired brain injury, Jones and colleagues (2012) demonstrated that the acquisition of new group memberships was important to reducing PTS symptoms. Measuring group membership and PTS symptoms across time, this study demonstrated that forming new group memberships was linked to lower levels of PTS symptoms following brain injury. Development of new group memberships after a brain injury has been explored in other studies too (Walsh et al., 2015). This research found that social identities have an important effect on adjustment after brain injury. These studies asked people living with acquired brain injuries to complete measures of identity and health over time (Walsh et al., 2015, 2017). We found a positive and reinforcing relationship between social identities and social support. Those with higher numbers of identities prior to their injury enjoyed greater social support, which facilitated the acquisition of new active identities after their injury. Importantly, these newly acquired identities were linked to post-injury emotional status and psychological health in this very vulnerable population (Walsh et al., 2017). This idea is encapsulated in the social identity ‘gain’ hypothesis, which states that the addition of new group memberships promotes resilience in the face of trauma (Muldoon et al., 2020)

The number of identities people have also acts to promote health in those affected by brain injury by supporting self-regulation. One of the key issues for people living with an ABI is associated with their (in) ability to self-regulate their emotions and their behaviour (Barkley, 1994). The ability to effectively self-regulate enables individuals to organise their actions towards goals, manage emotional distress, obey laws and internalise societal standards of moral and competent behaviour (Vohs & Baumesiter, 2016). Self-regulation enhancement is a central component of ABI rehabilitation as it facilitates improved personal care, participation in meaningful occupation, and managing one's emotions and psychological well-being (Brinkmann & Franzen, 2015). In our research we have shown that ABI survivors tended to lose group membership after their injury. In our quantitative work, loss of group memberships after being injured predicted depression symptoms. However, where survivors acquired new group memberships, often through occupational rehabilitation and employment initiatives, self-regulation was enhanced and symptoms of depression were reduced. In this way our research has shown that the number of group memberships predicts social support and self-regulation, both of which are important bases for resilience in the face of life-changing injury.

Along the same lines, a group of researchers in Australia have looked specifically at the value of therapeutic groups. In a series of papers, they explore the value of these support groups for people with addiction and substance misuse issues, a population that often has a history of traumatic experience. These longitudinal studies have shown that participants who lose their 'user' identity and instead gain a 'recovery' identity are those who have the most successful rehabilitation outcomes (Dingle et al., 2015). Identity change was measured as the difference between user identity and recovery identity over the period of time participants were engaged in their group rehab. This identity change explained more than a third of subsequent substance misuse. As well as reducing misuse over time, comorbid PTS symptoms were often reduced in this cohort (Perryman et al., 2016). These studies also demonstrate that this group approach offered additional identity resources in terms of social connections and support for those recovering from substance misuse. This was particularly potent for those who could harness these group resources in support of their recovery (Best et al., 2016).

It is not surprising, then, that recent contributors in social and political psychology have moved the focus from the isolating consequences of trauma to highlight the way in which traumatic events can be instrumental in developing new community and political identities (Drury et al., 2009; Hutchinson, 2010). Drury and colleagues' study (2009) of survivors of the London bombings presented evidence that survivors reported that their collective experience of this event led to the emergence of a new shared identity. This, in turn, led to more effective coordination of responses in the immediate aftermath of the event. In effect, the development of social identification had a positive role in ameliorating both the threat to life during the traumatic event and the longer-term psychological consequences. In a similar vein, Hutchinson's (2010) analysis of media reactions to the Bali bombing suggests that consolidated community solidarity lessened the impact of the event. These situations, then, where a new identity is shared with others affected by the same trauma, can be seen as fundamental to resilience.

5.5.2 Social Identity Loss, Identity Ambivalence and Risk

To now, our discussion has focused on the value of social identity gain to resilience. On the other hand, social identity loss has the potential to damage health. Indeed, in the literature on trauma, social identity loss is also a common theme. In longitudinal studies, the impact of losing a child on the health of their mothers is evident across the lifespan and even into later adulthood (Cohen-Mansfield et al., 2013). An important protective factor for mothers recovering from such a loss appears to be having additional children (Rogers et al., 2008). Using the Wisconsin longitudinal study, Rogers and colleagues (2008) demonstrated that parents' adjustment to losing a child an average of eighteen years following the death was positively associated with having additional children. The authors linked this finding to the associated sense of purpose parenting gives in such cases. Additional children also allow parents to retain, unambiguously, their identity as a parent. On the other hand, parents who lose an only child are likely to also feel the loss of their identity as mother or father alongside the loss of their child. This can aggravate their situation.

The loss of a child is widely viewed as an extremely traumatic event. It is interesting to note that although in the English language we have words like widow/widower and orphan, we have no such identity signifier for those who lose a child. Those affected report that losing a child is an unspeakable loss (Rycroft & Perlesz, 2001). And certainly, the absence of an appropriate language to talk of the loss means that people may find it difficult both to disclose and to discuss this loss. It also has implications for finding and accessing others who have been similarly bereaved for social identity–based support. Parents also report loss of identity-based social connections and difficulty interacting with parents in their social networks prior to their bereavement. These identity factors appear to be predictive of PTS in later life and are more important to parents' health than the child's cause of death or the amount of time since the child's death (Cohen-Mansfield et al., 2013; Rogers et al., 2008).

Even in such tragic circumstances, however, gaining new identity-based connections can help people negotiate traumatic experiences. Gaining social identities can buffer the expression of PTS symptoms even when the trauma itself facilitates the development of the new, and unwanted, social identity. Starting in the United States, the Mothers against Drunk Driving organisation is an example of one such identity (Brewer, 2001). This group, founded by a mother whose daughter was killed by someone driving under the influence of alcohol, uses their valued parental identity and shared traumatic experience to band together. Women who engage in advocacy using their mother identity and shared traumatic experience in this way (Brewer, 2001) often report feelings of empowerment and connection to others. Though rooted in grief and trauma, this can offer some catharsis and assist with healing from grief. Importantly, though, mothers also feel that there is a cost to advocacy and going public (Morris et al., 2021). There is a double-edged sword, with both benefits and costs associated with identities arising from trauma.

There is a similar double-edged sword for those who adopt a 'refugee' identity. On the plus side, category labels can offer members of traumatised groups a sense of connection with others who have survived similar difficulties (see Section 4.5.2). Refugees often have similar traumatic and dangerous experiences associated with forced migration, including loss of family members, torture and rape (Jeppsson & Hjern 2005; Schweitzer et al., 2006). At a time when people may be at their most traumatised and threatened, it is clear, even from my salutary tale (see Section 5.2), that feeling as though others understand the predicament we find ourselves in can be helpful (Hermann, 2016). Equally, retaining a sense of connection to home and prior group memberships is important. In a survey of 361 Syrian refuges in Turkey, Smeekes et al. (2017) found that refugees who maintained group memberships and had a sense of identity continuity to their homeland had higher well-being after their migration than those who reported losing group memberships. Echoing this, stories of forced migration point to the importance young refugees ascribe to remembering and living by their family's values in an effort to survive and maintain hope (Marlowe, 2010). Thus, as we would expect based on the social identity model of traumatic identity change (Muldoon et al., 2020), whilst a new group identity, refugee, signals a sense of disconnection from one's nation or family, those who are able to hold onto some of their pre-existing identity resources are more resilient.

'Refugee', like so many traumatic labels, is one bound up in ambivalence. It is an unwanted moniker, in much the same way as 'victim of clerical abuse' or 'survivor of genocide'. Having the traumatic label can often afford a number of important material rights and maybe even greater social understanding of the trauma experienced. But being in this new group and assuming this category label also has costs. It can become an everyday signifier of a traumatic past. These identities, because they signal profound trauma, can become a master identity, more important than any other group membership (Brown, 2018). And so, this unwanted identity, something that at its heart is derived from a traumatic experience, becomes self-defining. As such, these social identities are identities that people are highly conflicted about. Their traumatic experience has not only resulted in identity recategorisation but delivered a new identity with very equivocal meaning. For this reason, these types of traumatic labels can be associated with both anger and distress (see Chapter 6) and growth (see Chapter 7).

5.6 Conclusion

Trauma can irrevocably change how we see ourselves. Where valued identities are lost, or a devalued group membership acquired, people's ability to adjust to trauma can be undermined. Identities that people are ambivalent about tend to be challenging and can make it difficult for people to move forward with their lives. A socially stigmatised identity can also be very challenging. As well as being undermining, it can interfere with people's access to social support, which is essential to resilience. People are most likely to be resilient where they can maintain memberships and connections to groups of which they are already a part. The number of group memberships together with the strength of identification with these groups in the wake of traumatic experiences are likely to support adjustment and promote resilience. New group memberships, particularly where they can be integrated with pre-existing identities and highly valued ones, can also be a lifeline.

6 *Trauma, Groups and Political Action*

. . . why I can't go out without changing my clothes my shoes
my body posture my gender identity my age
my status as a woman alone in the evening
. . . I am the wrong
sex the wrong age the wrong skin
. . .
I am not wrong: Wrong is not my name
. . .
and I can't tell you who the hell set things up like this
but I can tell you that from now on my resistance
my simple and daily and nightly self-determination
may very well cost you your life.
—June Jordan, 'Poem about My Rights'

6.1 Chapter Outline

Because people have many identities, or multiple identities as we have called them previously, social context and cues are important in determining when a social identity or group membership drives behaviour. Traumatic reminders, or triggers, can make group memberships salient. These reminders can take the form of discrete events or even wider events where political or historical context is seen to be relevant. Trauma has the capacity to reveal differences between us, or between us and 'them'. A long tradition of research in social psychology documents the role of a sense of ingroup and outgroup, 'us' and 'them', to understanding tensions and hostilities between groups. In contexts where the situation is already oppositional or polarised, these tensions can quickly give rise to anger and even open hostilities. This can lead to a downward spiral of events where the anger and distress associated with traumatic circumstances give rise to social and political action.

6.2 A Personal and Political COVID-19 Experience

In March 2020, Ireland, like most of Europe, faced into the first harsh reality of the coronavirus pandemic. The early days of the pandemic brought strict lockdowns across Europe, and this was very much the case in Ireland too. Our lockdown announcement coincided with St Patrick's Day, and certainly once the usual annual festivities were cancelled people understood how serious the emerging pandemic was. My father, who was an avid listener of the radio news and recently widowed, began to take it seriously when the religious obligation to attend mass was suspended. He had never seen this in his eighty years of life. At that stage, as a family we all had started to pay attention. These early days of COVID-19 were, for me and many others, fraught with worry for those in our families who were more vulnerable. I worried about my father. My mother had died the previous summer. I was keen to help my father get over her death and to find a way to enjoy some more years with him. My father's health had been checkered during my mother's illness and not good since her death. As a psychologist, I was very aware of the risk of widowhood to his health. The effect of spousal bereavement on all causes of mortality is well documented (Elwert & Christakis, 2008). Excess mortality among bereaved men is about 21 per cent (Martikainen & Valkonen, 1996), another example of the health costs associated with stress and identity loss (see Section 5.4.2).

In the days before the lockdown, we did as much as we could. We filled his prescriptions for months to come. We filled the house with supplies of all sorts. We got him access to newspapers online in preparation for the time when trips to the newsagents were no longer advisable. Despite our preparations we were not prepared for what actually ensued. He got sick. Then he got sicker. Then he needed to go to hospital. My father hated hospital. He had spent Christmas of the previous year, his first as a widower, in hospital. He told me after that stay that he would sooner die than return to hospital again. But there was no reprieve for him. Shortly after Ireland declared its first lockdown, my father was admitted to hospital. But this was an admission like none he had experienced previously. He had a temperature, so he was put in isolation. He was initially suspected as having COVID-19. He was admitted alone. He could not be accompanied. He was cared for by front-line workers he could barely see, hidden as they were in full protective gear. Lockdown and COVID-19 restrictions made it a profoundly isolating and upsetting hospital experience for him and also for us his family.

He didn't have COVID-19. It took a while to figure out what his health problem was, but after about ten days or so in hospital it became apparent his problems were much bigger than a temperature. He had terminal cancer. He heard this news alone, from a doctor he hardly knew, without any of his family present to offer comfort or support. Later that day he rang, to break the news to me. It must have been a difficult call for him to make. He tried to break the news of his own death gently to me. That he felt the need to do that in this most vulnerable time for him still upsets me deeply. As soon as he knew his fate, he wanted to go home. He wanted to sort out his affairs, as they say, and die in the comfort of his own home. He had been told he had about four to six weeks of life left. As we had already missed precious time with him whilst he was in hospital and out of our reach, as a family we were in complete agreement.

We set about getting him home. It took considerable effort. He was by now increasingly unwell. Between me and my siblings who were living in Ireland, we thought we could manage his care. We had been through a similar situation recently enough with our mother, so we thought we had a sense of the process. We didn't. There were two key differences. First, my father had been a late diagnosis. His illness was very different. His time was short. As his health declined rapidly, we could not access the palliative care he so desperately needed. This was the second clear difference. COVID-19 had seriously impacted palliative care services. It was so early in the pandemic that people were trepidatious about home visits. Unlike our experience of looking after our mother, we had no professional support caring for my father.

There is no doubt that COVID-19 has been hard on many people. And there has been fallout from restrictions. In April 2020, the month my father died, there were 3,750 deaths in Ireland. Many families lost the chance to comfort their loved ones in the last days of their lives. Many lost the last of their precious time together. Others didn't get the care or treatment they needed. My siblings living abroad didn't get to come home to say their goodbyes. We never got to have his funeral as we would have wanted, a rite that would have allowed us to honour him and also gain comfort from the presence of wider family and friends. Now almost three years since his death, I remain unhappy about how these issues were managed in Ireland. It is very difficult to watch someone you love die in pain, and indeed it is not something that should happen in a modern society. But the public health response repeatedly failed to take account of the terrible costs imposed by lockdowns on the most vulnerable people: the old, the dying, carers, babies, those affected by domestic violence. On more than one occasion, using what influence I had, I raised concerns (e.g. Muldoon, 2021a; 2021b; 2021c) regarding the effects of Irish lockdowns on more marginal and vulnerable groups. I never was confident that my concerns were heard, much less acted upon. And that has left me feeling annoyed and even betrayed by policy makers, tasked with taking care of 'us all' during the worst of times.

Self-categorisation theory (Turner et al., 1987) helps to explain *when* group memberships are likely to be the basis for people's interpretation of events and *which* social identities shape trauma responses. When people are *treated* as members of a particular group and this treatment is in line with their stereotypical expectations of intergroup relations, self-categorisation is particularly likely to ensue (Klandermans, 2002). So, for example, my experience at the time of my father's death fit with a stereotypical expectation that 'women' and 'carers' often have their concerns ignored. As a consequence, I interpreted this experience in group terms. I saw a distinction between those who decided policy and those who had to live with these decisions, as well as a distinction between those who typically assume caring responsibilities and those who don't. I didn't have to see the treatment of my father as acceptable or know for sure the motivations of those who made the decisions that affected him. My sense that his treatment was in accordance with stereotypical patterns is enough for an interpretation that those who had power were not thinking about 'people like us' – carers, the old, women and children – when they made their decisions.

This perception has given rise to my strong sense that political change is needed in Ireland. There was a thoughtlessness to much of the Irish COVID-19 response. Vulnerable groups were forgotten. I am haunted by the fact that my father's end was so difficult for him. I am upset he never had a proper funeral. But most of all I am indignant with leaders who continued to respond to the crisis with performative politics rather than care and concern at the time when so many people like me struggled with grief. It suggested to me that some political leaders had lost a grip on the real-life horrors of the pandemic and associated restrictions. My sense now is that there is a need for the voices of women, ethnic minorities, the young and the old to be part of the decision-making processes. Political change is needed. The COVID-19 context amplified divisions globally, nationally and locally. And these divisions and associated indignation are likely to have political and social implications for some time to come. Achieving unity and solidarity in highly diverse or fractured societies during times of stress or trauma is of course challenging. Context matters.

6.3 In It Together? Different Boats in the Same Storm

Belonging to social groups provides individuals with a definition of their group (i.e., a social identity) and also what is involved in being a group member. Norms are a broad concept with diverse meanings; however, we know that they are important for understanding behaviours. Descriptive norms are based on what 'we' usually do. Injunctive norms examine the perception of what 'we' think is as appropriate and emerge through everyday connections. So, a strong sense of 'daughter' meant that I regularly visited my parents and spent time in their company, and caring for them as they aged was appropriate. This norm is gender-based; it is daughters more so than sons, mothers more so than fathers who take on caring responsibilities. It is also based on collective understandings of the role of family. So, norms are very much tied to social identities. Who 'we' are, what 'we' do and approve of is central to all sorts of social and political behaviour.

Colleagues here in the University of Limerick published a paper that is very instructive in this regard (Quinn and Vaughan, 2019). In this paper they analysed the newspaper coverage of two tragedies that resulted in terrible loss of young life in Ireland in 2015. The first was an incident known as the Berkeley balcony collapse. Six young people lost their lives in the incident. Five Irish University students on J-1 summer visas to the United States together with one Irish American student died and seven others were injured. They were attending a birthday party in a friend's apartment when the balcony collapsed. The second incident was equally tragic. A fire at a halting site in Carrickmines, in Dublin, claimed the lives of four adults and six children. This time the casualties were members of an ethnic minority known as the Irish Travelling community.

The Travelling community are an ethnocultural group of Irish origin with protected legal status because of a long history of systematic marginalisation in health, social care and education. Travellers continue to experience the type of structural inequalities and stigmatisation associated with membership of less powerful groups within a broader society to this day (McKey et al., 2022). Using a linguistic analysis, Quinn and Vaughan (2019) analysed newspaper coverage to probe similarities and differences in public discourse about these tragedies. The language used to report on the Traveller tragedy reflected this subtle othering and tended to distance and depersonalise the Traveller tragedy. The discourse of the Berkeley balcony collapse was different. Coverage communicated the casualties belonged to ‘us’. In this way the reporting of the newspapers not only legitimised the power relations in society but also communicated the norms about who ‘we’ are and who ‘we’ ought to care about. Even in times of tremendous trauma and grief, social norms can implicitly dictate who is deserving of our support and solidarity.

We can see similar processes at work in many countries across the world during the COVID-19 pandemic. During this time, the people managing national responses were disproportionately white, middle-aged, middle-class, educated men living in large urban centres: senior politicians, medics and policy makers. Within the EU, for example, this group represents between 2 and 5 per cent of the population; they are an even smaller proportion of the global population. During the initial stages of the pandemic, these decision makers enacted many far-reaching public health guidelines. Many of these public health guidelines were quickly seen to contribute to poor health, for example, weight gain, alcohol consumption, unemployment and mental health problems. However, they also contributed to people’s risk and experience of trauma, separating families and increasing child abuse and domestic violence. In the example offered from my own experience, it led to a very distressing and traumatic death for my father. Those most adversely affected by blanket restrictions were the old and the very young, women, minorities, the poor. They were not represented at the table when these decisions were made.

Tasked with managing large and diverse national communities’ responses, decision makers were informed by a restricted set of norms tied to their own largely privileged male, middle-class and middle-aged identities. In a systematic review of eighteen studies (Piquero et al.,

2021) yielding a total of thirty-seven estimates, an overwhelming increase in reports of domestic violence was evident over the first year of the pandemic. Specifically, twenty-nine of these thirty-seven studies showed a significant increase in domestic violence. In short, the evidence based on several studies from different cities, states, and several countries around the world is that incidents of domestic violence increased in response to stay-at-home and lockdown orders. Yet concerns about domestic violence were so overlooked during the pandemic that the WHO and UNICEF had to repeatedly highlight the issue to policy makers (Muldoon, 2021a; Muldoon, Liu & McHugh, 2021). Lockdown orders, devised and implemented by men, failed to see the normative reality for many women and children. In abusive contexts, staying home does not mean staying safe. Indeed, fewer social interactions and minimising social contact leads to less accountability for perpetrators and few opportunities for intervention to protect vulnerable women and children.

In those early days and weeks of the pandemic, there was a heightened sense of threat. The scenes of overwhelmed health care systems, health professionals in hazmat suits, rising case numbers, and the unprecedented situation all worked to amplify people's fears. As I struggled, in vain, to secure palliative intervention for my father during his last days of his life, I interacted with health professionals whose reluctance to help was driven by this fear. These feelings of fear and threat, which we and others have referred to as 'pandemic threat' (Maher et al., 2022), inadvertently gave rise to support for more restrictions and regulations. In two studies in Ireland and the United Kingdom, we have shown how pandemic threat increased national identification, which in turn drove more authoritarian attitudes. These types of attitudes were evident across many countries, where pandemic threat was seen to increase desire for heavy-handed policing, particularly when the pandemic first emerged, and people were at their most frightened.

National identity was something frequently thought of as a vehicle for coordinating responses to the pandemic. However, the reliance on national identification to support the public health response comes at a cost. Over the course of the pandemic, Chan et al. (2021) found national identification was generally associated with an increase in disease-preventive behaviours in two countries. However, in the United States, those with the highest national identification tended to have the greater trust in Trump's administration and therefore were slower to adopt preventive behaviours. Worldwide, it has also been clear that the least effective responses to COVID-19 were found where national sentiment was stoked in support of populism (Montiel et al., 2021), not least because this divisive rhetoric is often targeted against 'others'. This populist orientation presents a problem for improving co-ordinated compliance because actions in support of 'others' become problematised (Mudde & Kaltwasser, 2018).

Identities, then, not only are important to our support for political decisions, but also play a role in determining the likelihood of whom we help (Levine et al., 2002). Levine et al. (2002) assessed people's willingness to help a stranger after they witnessed them sprain their ankle. Participants, who were all students, had already indicated their football team allegiance and were ostensibly showing up to a research study in a psychology department when the accident happened. Levine et al. (2002) demonstrated that when the accident-prone stranger in need was perceived, by virtue of the football shirt, as sharing the same identity as the prospective helper, help was more likely to be offered. On the other hand, people were not as quick to help those with whom they did not share a football identity.

Social identities can be thought of as an important basis for social support (Haslam et al., 2005). Giving and receiving social support between group members can be useful, energising and seamless. However, if we see those who need help as 'different', 'not like us', there are two barriers. First, we may not be able to see their needs. Over the course of the pandemic there have been very many times when decisions have been made that do not appear to recognise the challenges faced by the young, the old, the sick and the elderly – sins of omission, as it were. This type of omission resulted in increased trauma experienced by women and children in the domestic arena. In other cases, vulnerable groups appeared to have been wilfully ignored. Decisions were made with the full knowledge that more marginal or vulnerable groups could be devastated. These are more like sins of commission. These purposeful acts, for example banning family members from being with their dying relatives, have also resulted in traumatic experiences.

At the collective levels these types of experiences can leave those people with a sense that when they were at their most vulnerable, they were forgotten. These experiences change us. It has changed me and made me more sensitive to the relevance of representation in politics and decision making. Decision making always needs a diverse set of voices, including people who understand social and relational concerns. So, because I see groups and in particular the failure of middle-class men to attend to the needs of people like me – women, mothers, daughters and carers – this will affect how I vote in the future. And so it is this type of distressing experience, when it is interpreted in terms of group memberships, that is likely to impact on wider political views and political actions.

6.4 When Do We Care? Identity Salience, Stress and Trauma

We have already considered how social identities may act as a comfort in times of stress and adversity and the ways in which social identities can connect (Chapter 5). This is because social identities can be the basis for solidarity and support for those affected by traumas. But groups can also be the basis of divisions and drive prejudice and intergroup hostilities. As people have many and various group memberships and identities (see Section 5.4), a social identity has to become relevant for it to affect our behaviour and feelings. This relevance is generally referred to as social identity salience.

Identity salience is crucial to the enactment of identity-based thinking or behaviour. Identity-based actions towards others play out when a context or environmental cues makes an identity salient. The higher the identity salience (Stryker & Burke, 2000), the greater the probability that the choices and actions that a person makes will be identity-driven. This is because when an identity is salient, the group provides people with not only a definition of their group (a social identity) but also the relevant group norms for enactment. This has implications for how we think and feel about ourselves as well as other relevant outgroups.

The activation of identity in this way can be seen to arise from threat, like a pandemic threat, or indeed as a result of stress and trauma. Though the conceptualisation of salience in the social identity tradition is often thought of as something that is invoked experimentally, traumatic experiences can make social identities salient. Indeed, some of the symptoms we associate with psychological trauma share much with the concept of social identity salience. For example, triggers can include sounds, sights, smells or thoughts that act as a reminder of a traumatic event. Some triggers are obvious, such as seeing a news report of an assault or a war-time attack. Others are less so and might include the smell of a particular dish that was being cooked when an attack took place. Triggers cause intrusive and uncontrollable reminders of the traumatic event. Even for people who have experienced a single acute stress or trauma, this is an important pathway to making an associated identity salient.

Experimental work offers evidence in support of this idea. Salient social identities are relevant to how people manage stress. For example, Levine and Reicher (1996) showed that risk of facial scarring was seen as more problematic amongst physical education students when their gender identity rather than their student identity was made salient. When thinking of themselves in terms of their gender, women students had greater concerns about appearance, and so the perceived stress of scarring was heightened. However, when thinking of themselves as physical education students, the participants in the experiment were less stressed by the possibility of a scar. Similarly, Skilton et al. (in press) found that when they made running identity salient rather than their gender identity, women's safety concerns about exercising outdoors were reduced. Haslam et al. (2005) provide another illustration of how identity salience effects stress responses. They asked two groups of participants, bar workers and bomb disposal officers, to rate the levels of stress in their own and the other occupational group. Both groups rated their own occupations as less stressful than the other group's occupation. Despite the likelihood of the bomb disposal officers experiencing an objectively more extreme or traumatic event, the officers' discussion of their own and others' stress illustrates the way that occupational identity was relevant to their appraisals: 'You expect what you see, so it's not so stressful. Disposing with bombs is something you do, not something out of the ordinary' (Haslam et al., 2005, p. 365).

Experiments like this show that the salience of social identities is important to how people process stress and trauma. Group memberships and salient social identities alter the interpretation of the stress and may also impact people's ability to deal with the situation. In this way the same event experienced can be seen very differently depending on whether or not people feel it has identity-relevant implications. If we consider the COVID-19 context, we can see clear identity and group dimensions. However, the COVID-19 context is one in which tensions arose quickly between groups. Initially, we could see tensions between nations, with China blamed for the onset of pandemic. We have also seen real tensions emerge between leaders and followers and the old and the young in many countries, including Ireland.

In the United States and the United Kingdom, the COVID-19 response quickly became a partisan issue with new identity labels such as maskers and anti-maskers and vaxxers and anti-vaxxers emerging. COVID-19 effectively exposed the fault lines that already existed in our societies. It made social and political group divisions salient and revealed inequitable relations. Evidencing this, Syropoulos et al.'s (2021) study using publicly available data in 155 countries showed how equitable distribution of resources, acceptance of human rights, better government functioning and low levels of corruption, together referred to as 'positive peace', reduced the severity of the impact of COVID-19. Syropoulos et al. also note a similar effect in a within-country analysis of more than 4,000 counties in the United States. Social identities and group memberships matter to the sense of distress people associate with their pandemic experiences. In the same way as pre-existing illnesses are a risk on contracting COVID-19, pre-existing social and political fault lines have been disrupted by this pandemic.

6.4.1 Identity Salience and Social and Political Attitudes

There is wide-ranging evidence, then, from surveys and in real-world settings that highlight division making identity salient can influence people's support for political positions. In the United States, an important literature has developed showing that messages used to win the support of white voters, by casting non-whites as others (Brown, 2016), can prime support for particular political candidates. These divisive appeals do not mention race explicitly. Explicit reference to race can undermine beliefs in equality, which is integral to American national identity, and so the relevance of race must be made more covertly. An early prototype of such an appeal was used in the 1988 presidential campaign by George W. Bush, which became known as the Willie Horton ad. The ad oriented to the problem of violent crime in the United States. Though race was never mentioned, a picture of William Horton, an African American guilty of murder and imprisoned for life, was presented during the ad, which emphasised Republicans' strong approach to crime, and Democrats' overly liberal one. Similarly, divisive messaging was used during the Brexit campaign in the United Kingdom. Advertisements depicting lax immigration control, overseen by the EU, depicted vast queues of non-whites at UK borders. In this way, those campaigning for Britain's departure from the EU made racial identities salient in the minds of voters even though EU membership allowed its disproportionately white population free movement between member states.

Evidence shows that divisive appeals of this sort influence political behaviour (Mendelberg, 2008; Tesler, 2012). The effect of the Bush's Horton ad is well documented. It increased support for Bush amongst white conservatives (Mendelberg, 2008). In later research, commercials framing a Black person counting money, while a narrator stated that "Democrats want to spend your tax dollars on wasteful government programs" (p. 79), were also found to increase support for Bush (Valentino et al., 2002). Equally, making race relevant by using incidental pictures of non-whites in stories that emphasised the costs rather than the benefits of immigration was associated with increased opposition to migration. This effect was stronger amongst respondents of European rather than Latinx descent, further emphasising the role of identity salience. This framing mattered for political reasons too. Forty-five per cent of the respondents who viewed the anti-immigrant story were willing to send a message to Congress asking for reductions in immigration. Similarly, a recently published analysis predicting support for presidential candidates using the American National Election studies explored the effect of white identity salience on 859 white Americans during the 2016 presidential election. This analysis indicated that white identity salience was associated with greater support for Donald Trump (Levchak & Levchak, 2020).

These effects have also been observed outside the United States. In an experimental study, Fischer et al. (2010) experimentally manipulated the identity salience. In one condition, participants' gender identity was made salient, and in the other British identity was. Participants were then presented with photographs and statements relating to the 7 July 2005 London bombings (a threat to national identity) or with photographs and statements about the Taliban's treatment of women in Afghanistan (a threat to gender identity). For some participants, then, there was a fit between identity salience and identity threat (Britishness and the London bombing, for example) and for others there was not (Britishness and treatment of women in Afghanistan). Fischer et al. (2010) found that the impact of threat depends on the interplay between social identity salience and the social identity–related significance of the threat. Concretely, they found that where identity was salient and higher levels of threat were experienced, support for military retaliation and aggression was highest.

Another study in a North American sample considered the effects of making religious identities salient. In this study that comprised Muslim, Christian and Jewish respondents, tolerance of other religious groups was examined. Comparison was made between those whose religious identity was salient versus those in a control condition where their religious identity was not made salient during the study protocol. All participants were presented with a threat to their respective religious identity through a newspaper clipping that described an ideologically motivated and physical attack on members of their respective religions. In the high salience condition, a more aggressive response was apparent. This hostile response to other religious groups was evident across all three groups (Wright & Young, 2017). Even though all of the religious identities are routinely aligned with positive and caring characteristics by believers, these findings support the notion that when confronting a threat, religious identity salience drives both anger and hostility to other religious groups.

In another study, Ginges et al. (2009) assessed the effect of religious identity salience on Israeli Jews' support for suicide attacks against Palestinian Muslims. In one group, participants were primed by asking them about their prayer frequency. A second group was primed by asking them about their synagogue attendance. These results were compared against a no-prime group. Those in the synagogue-prime group reported greater support for suicide attacks. These researchers interpreted their findings as a social identity salience effect (Ginges et al., 2010). In Northern Ireland, we conducted a similar study and presented images of the British and Irish flags (Muldoon et al., 2020). Flags remain actively contested in Northern Ireland and are symbolic of the issue at the heart of the political violence. They make the political differences between Irish nationalist and British unionist identities salient. In this study, we found that when people's ingroup flags were presented, there was a clear pattern of positive emotions apparent. However, when outgroup flags were presented, people showed high levels of uneasiness and annoyance. And it was those who were most highly identified who showed the most negative emotions when their nationality was made salient in this way.

Taken together, these studies highlight how cues and contexts are centrally relevant to how we feel about outgroups because of their role in making social identities salient. Making an identity salient is a relatively simple task. Social identities can be very easily primed implicitly and unknowingly with visual cues such as pictures, symbols, and flags. They can also be made relevant intentionally and explicitly. So, it can be inadvertent, but it can also be purposeful. Because of this, situational and environmental, and social and political cues frame people's responses to trauma and, in particular, can drive hostile and angry reactions to others perceived as responsible or even complicit. In the next section we consider social and political contexts where identities can become chronically salient, and therefore are often if not always relevant to understanding how traumatic experience plays out.

6.5 Social Identities Writ Large

Some years ago, at a conference I presented a paper about the changing nature of identities in Northern Ireland. At the time the emergence of Northern Irish as a 'new' national identity in the wake of the Good Friday Agreement was apparent (Lowe & Muldoon, 2014). A Dutch colleague commented on how unique it was to have such a rich identity context to study. And it is true. There are some circumstances in which social identities are writ large. In such circumstances, social identities may be chronically salient. As we have seen in previous chapters, this can be a blessing and can offer solidarity with similar others during times of trauma (see Section 5.4.1). However, it is not always the case. And there can be other responses too. June Jordan refers in her poem quoted at the start of this chapter to a response that 'may very well cost you your life'. In the poem, Jordan makes it clear that her anger is a response to larger trauma and small stresses she feels she lives with daily. Indeed, the expression of negative attitudes and hostilities towards others is likely to be apparent where the situation is actively stressful and there are negative and oppositional interdependencies. This section reviews the risks of oppositional groups and identities and how they are likely to ferment anger and feelings of injustice amongst minorities and young people, with consequent impacts on social and political attitudes.

6.5.1 Polar Opposites? Oppositional and Interdependent Identity Contexts

The quotation at the start of this chapter is only a short excerpt from June Jordan's poem 'About My Rights'. The poem speaks to the anger she feels because of the constraints she regularly places on her own behaviour to minimise her risk of rape and assault as a Black woman: she wants a simple pleasure: to go out 'alone in the evening'. In the full poem she represents this as not being able to do what she wants with her own body, which she links directly to her risk of rape as a young Black woman. It is the experience of having to manage this risk and being labelled as 'the wrong sex the wrong age the wrong skin' that brings her to the realisation and indeed a position where she rejects that idea that she is 'wrong'. In rejecting the idea that her experience of violence and risk of future violence can be attributed to being alone, 'alone not being the point', her anger becomes apparent. The last line of the poem reads as though she is calling herself to arms. Those who impede her right to self-determination will pay a price that 'may very well cost you your life'. Her intention is resistance.

Implicit in Jordan's analysis is that there are architects of this system who confine and restrict her. These people are not named; indeed, she cannot 'tell you who the hell set things up like this'. If she is the 'wrong' sex, skin and age, it is safe to assume there are others for whom it is safe to be out alone. So, though she is not explicit in naming any specific demographic as the architects of the system that constrains young Black women, as readers we are prompted to think about 'who the hell' these people might be. Because linguistically, we can make this assumption that if she is the 'wrong' sex, others are the 'right' sex. Indeed, there is an implicit suggestion that these architects of the system must be the right sex, the right age, the right skin. Jordan then offers us a bifurcation: she creates binary groups, polar opposites, right and wrong.

We know from available research on oppositional and negatively interdependent thinking that when someone is right and another is wrong, when their win is our loss, that anger and political action as is evident in Jordan's poem often ensues. Binary assumptions about group memberships are often made even if they are equally as often false. Race and ethnicity, for example, are such crude categorisations that researchers are not entirely clear what they refer to (Harawa & Ford, 2009; Helms et al., 2005). Race has little basis in biology, is not fixed, and in reality people frequently self-identify with multiple racial or ethnic categories (Schwartz, 2001). The vast majority of studies that use race do so in simplistic ways (e.g., as white versus Black or ethnic minorities). Indeed, the simplistic ways that race and ethnicity are inserted into analyses and designs can reify racial categories and reproduce difference and prejudice (Proctor et al., 2011). You can see similar factors at play when you look at how ethnoreligious categories are dealt with in Northern Ireland. Identities that underlie conflict are perceived as polarised and oppositional (e.g., Catholic and Protestant; Muldoon et al., 2007), though they are only one dimension of any conflict. Other identities and categories co-exist even where there are highly pervasive social divisions. Practically, academics and commentators alike have been criticised for their emphasis on singular category differences, particularly where such emphases serve to reify and embed these group distinctions.

In recent years we can see the same debate has emerged in public consciousness around sex and gender. Indeed, non-binary gender identification can be seen as a reaction to this ever-increasing polarisation of sex and gender categorisations. And many of the major political cleavages and debates of our time are marked by these types of binaries. The construction of gender, political, racial or any group difference as binary amplifies already tense situations. This type of identity construction gives rise to divisions that are consistent, substantive and increasing. Although systematic cross-country evidence is rare, one analysis has classified 233 politicised groups in 93 countries according to political, economic, and ecological differences (Gurr, 1993). This analysis found that group-based inequalities often lead those who are adversely affected by the situation to direct political action.

Traumatic experience is also relevant. Sharp inequalities in economic, social and political dimensions or status between culturally defined groups are always relevant to the development of conflict (Stewart, 2008). Clear binary status differentials, as well as offering a relevant context to understand people's risk of traumatic experience, further divide people into meaningful and distinct cultural groups on the basis of distinctive experiences. When these distinctions are linked to binary categories such as gender, inequalities in access to sociopolitical and economic resources not only make it difficult for minorities to deal with their trauma but also mean that the majority group can be insensitive to the challenges the minority face (Cederman et al., 2013). So, for instance, men may be oblivious to the challenges women face within the justice system as they negotiate gender-based violence (Naughton et al., 2015), compounding distress. These polarising differences or inequalities do not have to be large. They just have to be clear (Kelman, 1999). Over time, this social division, together with people's direct experiences and response to trauma, exacerbates group-based division and amplifies social polarisation further.

Social identity theory can help us understand why this is the case. When we categorise ourselves on one side of a boundary, this influences how we see ourselves as well as how we see 'others' on the far side of that line. Those we share an identity with, our ingroup, are thought about differently to those we see as being in a different category: the outgroup. There is wide-ranging evidence that even in the most banal of circumstances we tend to be kinder, more accepting and generous towards similar others because of our sense of identification with our ingroup. This bias can give rise to the type of solidarity that helps people to cope with trauma (see Chapter 5) and is referred to in social identity parlance as ingroup favouritism. So, people for the most part tend not to be wilfully hostile towards others; it is just that they are kinder to those they see as similar to themselves (see Section 6.3). However, polarised contexts with their associated strong patterns of division offer an exception. In these contexts, zero-sum thinking can arise. In these situations, ingroup members can come to view their relationship with the outgroup as oppositional and negatively interdependent (Muldoon et al., 2008). This zero-sum mentality is reflected in beliefs that if 'they' are winning, 'we' must be losing. Not only that, but in these contexts, because the rising fortunes of the outgroup are tied to the falling stocks of the ingroup, looking after 'them' is presumed to damage 'us'.

This thinking can arise in both majority/dominant group members as well as minoritised/subordinate group members. For majority group members, when a traumatic experience is attributed to minority action, zero-sum thinking can result in group protectionism and suspicion of minorities. Because the majority have both power and privilege, this can reinforce the protections afforded within the system to those who are already advantaged. For minoritised group members, traumatic experiences that are attributed to actions of the dominant or majority group action are likely to result in calls for social change. June Jordan articulates this response to her minoritisation arising from this perceived negative interdependence: her 'resistance / [her] simple and daily and nightly self-determination / may very well cost you your life'. Her resistance, then, her right to act against the system, will undermine your privileged way of life.

Hostile intergroup dynamics arise, then, when the fortunes of one group are tied to the sorrows of another. So, if my right to 'to take a walk and clear my head' is perceived to interfere with men's rights, this is likely to make progress on women's nighttime safety problematic. Recently, in Ireland and the United Kingdom, in the wake of the murder of two white women, the ensuing outcry led to calls for a curfew on men at night. It is hard to know whether the calls were meant as meaningful; however, they are a useful illustration of how an action to protect women can quickly be seen as both hostile and antagonistic by men. This call for curfews clearly threatens some, though not all, men's gender-based identity as protective and respectful men, husbands or fathers. This framing of violence against women as a product of men's behaviour, along with the feelings of identity threat, results in negatively interdependent interpretations of gender relations.

There are many examples here where sociopolitical contexts have given rise to growing intergroup divisions. It is apparent with regard to Brexit where political differences in the United Kingdom have amplified considerably since the 2016 referendum. What was previously a voting choice is now clearly transformed into polarised social identities of 'Leavers' and 'Remainers'. In the United States we can also see increasing polarisation between Democrats and Republicans. Again, forced political choices and the ongoing tensions between these two polarised opinion groups have led to increasingly harsh partisan politics and positions in that country (Mason, 2018). Whilst these tensions are often linked to battles over power and resources, in tandem there tends to be symbolic identity struggles that are just as important to understanding the hostilities (Kelman, 1999). Identification gives rise to in group favouritism first and foremost, because we are more likely to look after 'our own' than 'others' (see Section 6.2 above). Additionally, where identity groups are constructed as oppositional – for example, a win for Republicans is a loss for Democrats – the preference for our own can quickly become a basis for antagonistic relations. Overall, then, where people identify strongly, and groups are locked in oppositional relations, hostility and aggression towards the other group is more easily endorsed (Halperin et al., 2009). Protecting 'us' becomes the basis for justifying aggressive action towards 'them'. And when this happens it really matters who wields power. It is to this issue we now turn.

6.5.2 Social Identity Salience, Minoritised Identities and Political Action

June Jordan's (2005) poem reflects the intersection of her multiply minoritised position. She isn't just the wrong sex, she is also 'the wrong skin'. This intersection, or multiple minoritisation, is central to her story and indeed likely to be linked to her declared anger. As well as the two highly publicised deaths of white women in Britain and Ireland, there were two other, less publicised murders in both countries at the same time. These two murders of women of colour garnered far less attention in the news media. Like the deaths of the Irish Traveller families mentioned earlier (see Section 6.3), they got far fewer column inches. This reflects the relative privilege and protection white women have that is often not available to women of colour, which Jordan alludes to in her poem. Not only are the deaths of women of colour less remarkable (MacDorman et al., 2021), but women and girls of colour are more likely to be trafficked for sex work, raped and sexually assaulted than their white counterparts (Keys, 2021). Constructions of women of colour as sexually compliant are frequently used to dismiss women of colour when they come forward. And the likelihood that their complaints of assault are taken seriously, or acted upon by the police and judicial system, are greatly reduced.

Identity salience is increased when a group is repeatedly affected by major and minor aggressions (see Section 3.4). Because of this even in multicultural and relatively equal societies, a minority or subordinate identity can be chronically salient (Palomares, 2004; Schaffner, 2011; Wang & Dovidio, 2017). A wealth of research demonstrates that adversity as a consequence of minority and subordinate group membership, including race, ethnicity and sexual orientation, is common (Branscombe et al., 1999). Certainly, being 'the wrong skin' is central to how June Jordan defines herself in this poem and her experience of life. In this vein, Branscombe and colleagues' wide-ranging programme of research has articulated a path through which social identities are made salient and are consolidated because of the poor treatment people receive on the basis of their group characteristics. They have labelled this process the rejection identification hypothesis (Branscombe et al., 1999; Jetten et al., 2001). The core argument of the rejection identification model is that being treated differently by others based on a group characteristic heightens feelings of identification with the group. Extending this idea further, we found that in those who have lived through the political violence in Northern Ireland, feelings of threat amplified participants' identification with their national group. We labelled this process the threat identification hypothesis (Schimd & Muldoon, 2015). Amongst minority group members, in particular, both feelings of threat and direct experience of violence, then, can result in chronically relevant identities.

Experimental studies have mimicked these findings. In an experimental study, Jetten et al. (2001) presented some evidence of discrimination against those with body piercings to those who had piercings. Participants identified more strongly with those who had piercings where evidence of discrimination was available (Jetten et al., 2001). When the researchers made clear that this discrimination was meted out by the (unpierced) majority population, these feelings of identification were even more pronounced. So, this experiment shows that it is being treated differently because of a group attribute as well as group status that increases people's sense of belonging and identification.

As a result of this increased identification, an individual's personal fate becomes psychologically tied to that of other ingroup members (Drury, 2012). Majority and minority group members are more likely to encode their own group information more fully. So, highly identified minority group members are more aware of their own increased risk of adversity and trauma and are more sensitive to news of traumas visited upon fellow ingroup members. These events are experienced as identity-relevant; they may make the identity salient; they may also be perceived as triggering.

For minority groups, then, new events can give rise to feelings of political déjà vu. This is a phenomenon that appears to be memory-based. It is derived from the detection of the familiar. A new traumatic event can feel familiar, the latest in a long sequence of similar events. As such, Chayinska and McGarty (2021) argue that political déjà vu, where an analogy between past and present traumatic events is perceived, is an identity-based phenomenon. In a field study in Argentina, they show that connecting two events from different time periods had important implications for people's identification, including support for political leaders. Not only that, but making the connection between the disappearance of an activist in the present to the mass disappearance in Argentina's history had important implications for people's political attitudes and political engagement.

Similarly, in a study of Aboriginal people in Canada whose parents had survived institutional abuse, Bombay et al. (2014) found that social identities were an important driver of intergroup attitudes across time. More specifically, adult children of survivors of the Indian Residential Schools system who saw their ethnocidal identity as central to who they were were more likely to interpret subsequent negative intergroup scenarios as arising from discrimination. The authors interpreted their findings as evidence for mutually reinforcing relationships between identity and adversity and discrimination. Appraisals of discrimination that were linked to distress of intergenerational trauma can in this way be seen to damage interactions between victims of race-based trauma and wider mainstream society.

Group members use strong and salient minority identities to make sense of adversity and trauma they experience. We have seen how this helps minority group members adjust to traumatic experience and allows trauma to be viewed as something to be endured (see Chapter 5) because it reflects and embodies a higher commitment to a political cause (Acharya et al., 2020). A strong identity impacts on the stereotypical expectations of intergroup dynamics (Başoğlu et al., 1997), and so minority group members are alive to the idea that majority group members and culture are oppressive. This not only reduces trust in majority group members (Acharya & Muldoon, 2017), but also can give rise to a sense of injustice. This combination of perceived injustice, social identification and the sense that the group has the power to act (known as collective efficacy) has been shown to drive political protest and collective action. So identities, as well as offering a sense of meaning to interpret traumatic experiences, also drive minority group members and supporters to action (Acharya et al., 2020). In this way, trauma experiences of some with whom we share a sense of identity can have a ripple effect on the wider group (Muldoon & Lowe, 2012).

6.5.3 'A Bad Age': Trauma and the Salience of Trauma and Divisions for Young People

In Ireland, there is an expression, mostly used by adults, where a young person is referred to as being at 'a bad age'. It is used to cover both challenging behaviour and challenging circumstances. It is interesting, too, amongst her other 'wrongs', that June Jordan says she is the 'wrong age'. There is no question that age or, as psychologists prefer, developmental stage is centrally important to both experience of trauma and the development of social identities. It is to this issue we now turn.

During childhood and adolescence, traumatic experiences, adversity and disadvantages offer a set of circumstances that can give rise to strong patterns of identity and also particular identity meanings. Betancourt and Khan (2008), in their wide-ranging review of the studies of children affected by war and political violence, point to the importance of meaning making for children and young people growing up in chronically traumatic contexts. Available empirical studies speak to this issue. We know from a large meta-analytic review (Schmitt et al., 2014) that a key factor that amplifies the impact of negative discriminatory experiences at the hands of others is the age at which they occur. Daniel Bar-Tal, in a range of studies, has examined the emergence of identity-based ideology in young people (Bar-Tal, 2002, 2007; Oren & Bar-Tal, 2007). This research in Israel suggests that identity-based views are often passed through the education system, facilitating the interpretation of conflict-related experiences and embedding identity positions (Bar-Tal, 2002). Subsequent narrative and ethnographic work with youth in Israel, Palestine, Bosnia and Croatia also points to appraisal and interpretation of traumatic experience as a basis for development of strong patterns of identification relevant to the ongoing conflict (Barber, 2009; Daiute & Turniski, 2005; Hammack, 2010). Youth turn to their relevant identities to make meaning of the adversity and trauma that they encounter as a consequence of the unforgiving context of their lives.

The invocation of identity in this way is not without its problems (Kelman, 1999), though the consequences are inherently related to the sociopolitical context (Urdal, 2005). In a survey of adolescents in Northern Ireland, violence against outgroups was perceived as more acceptable and justifiable by those who identified highly with their own group and its cause (Muldoon & Wilson, 2001). Muldoon and Wilson (2001) demonstrated that youth in Northern Ireland with the strongest ideological commitment who were thought to be the most psychologically resilient were also the group that viewed violence as most acceptable. Similarly, in a later study, Muldoon et al. (2008) found that young people in Northern Ireland presented social identification with one's own group as an explanation for paramilitary violence. Young people made sense of their own side's aggressive action in identity terms. This is no doubt embedded in the oppositional and negatively interdependent nature of the context in which they lived. Ultimately, however, the use of identities in this way as meaning-making vehicles can contribute to the cycles of violence.

This use of identities to make sense of traumatic experiences and in particular violence also has implications for young people's understanding of justice and morality. In developmental terms, it is clear that concerns about morality and justice are key concerns for young people. Both concepts, however, are highly malleable, and our definitions of both are linked to social identities and group life (Clayton & Opotow, 2003). Social identities and, more specifically, who we perceive as being deserving of our care, or indeed our hostility, limits the scope of our morality. In June Jordan's poem quoted at the start of this chapter, her anger is clear. She is angry enough to threaten violence: 'it may very well cost you your life'. It is unclear if she sees a threat to others' mortality or cultural life; however, she invokes an identity-based logic about who is deserving and entitled to her concern. It is certainly not 'who the hell set things up like this'. The boundaries of her concern and entitlement to rights does not include this group who created the system (Opotow, 1996). Indeed, the perceived injustice of her own experience is used to justify her lack of concern and potentially immoral treatment towards the group who set up the system. This poem, then, can be seen to reflect exposure to trauma and violence, particularly in those who are 'the wrong age'. This seems to alter the normative acceptability of violence, contributing to identity-based validation of aggression we see in empirical studies in violent contexts (Muldoon & Wilson, 2001; Punamäki, 2009).

It is important too to remember that young people are often not in the mind's eye of those who 'set things up'. Returning to where we started this chapter, this was patently self-evident during the pandemic. In many societies the front-line work that kept societies going was undertaken by young people who staffed medical, educational, retail and service industries. In addition, young people often have more precarious housing, are more likely to share housing and be reliant on public transport than adults aged over twenty-five. All of these factors, together with the fact that COVID-19 was perceived and in reality was often less threatening for young people, meant that the rates in this age group were higher. In Ireland, this often gave rise to a perception of young people as a problem in the spread of the virus (Breslin et al., 2023). In my own university, senior management took to patrolling areas where university accommodation predominated to minimise the lockdown breaches, which were seen as having a negative effect on both the university and young people's reputations. In India, Arabaghatta et al. (2021) found that the attribution of responsibility for the spread of the virus was more strongly polarising than the government response to outbreaks. Highlighting and apportioning blame for the spread of the virus inadvertently amplified existing political divisions. This treatment of young people has had its own social and political cost across Europe, reducing political trust in institutions in societies where treatment was less equitable (Bottasso et al., 2022).

Ignoring the diversity of who we are, and how we ought to keep us all safe, resulted in more difficult experiences during COVID-19 for some. At one end of life, there was the pain caused by the inability to secure care for my family in their last days. Added to this, families like mine could not mourn our loss in the usual and culturally appropriate way, amplifying the pain of loss and the stress of the pandemic. People like my father-in-law admitted to hospital were not allowed companionship to support them when confused, ill and dying. Even those receiving end-of-life hospice care, like my much-loved aunt, endured heavily restricted visiting in her final days. All of this prevents those around the sick from enacting important familial, national and religious identities.

At the other end of life, the young also faced serious and often unnecessary challenging pandemic experiences. In Ireland, parents could not buy shoes for young children for almost nine months. Children, my lovely nephew included, who needed first shoes were literally barefoot. Amongst young people the spread of COVID-19 was often attributed to their failure to adhere to public health guidelines in their social and sporting lives. It routinely ignored the fact that many young people were working in front-line roles (Breslin et al., 2023; Kinsella et al., 2022). The mental health costs of lockdowns for young people for whom the establishment of peer networks is a central developmental task was not considered (Crawford, 2021). Nor was the social cost of the disproportionate fining of young people for lockdown breaches (Moloney 2021). And whilst the policing and the disproportionately negative experiences of young people in comparison to older adults (Muldoon, 2013) during times of crisis and adversity is not something that is restricted to COVID-19 times, the unfairness of a system, set up by older adults, can be seen as part of the process that foments feelings of injustice, anger and intergenerational tensions.

6.6 Conclusion

Social identities and group memberships have always been seen as relevant to tensions between groups. For group memberships to drive hostilities, however, a number of factors matter. First, social identities need to be seen as relevant to the situation. In social identity parlance this is referred to as identity salience. As well as the context being relevant, some groups are particularly likely because of their minority or subordinate status to have their concerns ignored or misunderstood by mainstream groups. Here we have looked at the role of age, gender and race, though these effects also apply to those minoritised by a disability or their sexual orientation or religion, for example. Minoritised groups are more likely to see their identity as relevant to both their own trauma experience and the experience of other minoritised group members in both the past and the present. In situations where identities are relevant, and the social context is divisive or oppositional, identities, rather than resulting in bias towards the ingroup, can result in political action and even hostility against the outgroup. In minoritised groups, where identities and justice concerns collide, traumatic experiences that give rise to anger are likely to fuel political action.

7 Trauma, Personal and Political Growth and Change

> It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair.
>
> —Charles Dickens, *A Tale of Two Cities*

7.1 Chapter Outline

Previous chapters have looked at how social identities can be both a benefit and burden in terms of health and social and political attitudes. Here the idea that social and psychological growth flows from trauma because of social identity change is considered. Social identities and the resources they offer play a significant role in processing, responding to and recovering from traumatic experiences. Two possible mechanisms are outlined. The first is that trauma reveals the value of existing social identities, which drives post-traumatic growth (PTG). The second relates to the sense of connection that can emerge amongst victims of trauma that allows new social identities to develop. In these cases, people can develop insight, or collective consciousness, into how their traumatic experiences are tied to their group membership. This understanding of the systematic and patterned nature of trauma not only enables connections between those affected but also facilitates push back against problematic or even oppressive systems and structures. This change in collective consciousness can be thought of as a form of collective PTG. This chapter concludes by outlining the potential for trauma, because of the identity-based consequence, to be a force for positive social change. Trauma can drive a sense of collective empowerment. This empowerment alongside an alternative, more hopeful sense of the possibilities for structuring our social worlds offers us all brighter personal and political futures.

7.2 A Tale of Two Traumas: It Was the Best of Times, It Was the Worst of Times

I started out this book with a story from my own days at university. I called it a tale of two traumas, a play on the Dickensian title *A Tale of Two Cities*. The book has a well-known opening paragraph, in which Dickens speaks to the controversies and contradictions associated with the tumultuous times that are the backdrop to his novel. This opening passage is an apt description of how it is possible to experience the same trauma as both positive and negative. For sure, traumatic events cause extreme distress. They bring sorrow, and mostly we never want to revisit or re-experience such trying times again. Oddly, though, because of such experiences, we may begin to see the world differently or even envision change that we would like to see: 'a season of Light' after the dark days. It is from this change, this wisdom as Dickens calls it, that 'a spring of hope' emerges. The idea that dark times can also give rise to new, more hopeful beginnings has gained credence in literature and poetry. And it merits serious scientific study as a social phenomenon.

I can remember very vividly the weeks and months in the run-up to the day my doctor diagnosed me with depression. I had in those weeks read Sylvia Plath's *The Bell Jar* (1963) for the first time. I remember discussing the book with a colleague, who looked at me askance when I said the internal emotional world Plath described in her book resonated very much with me. I didn't feel particularly sad; I didn't feel very much at all, in fact. During the months before I found the courage to see a doctor, I frequently found myself crying, sometimes almost to my own surprise, for no particular reason. Despite this, I spectacularly failed to recognise my own problem and was shocked when I was diagnosed with depression.

I was deeply nervous of disclosing this diagnosis back then. I did, however, disclose how unwell I felt to my immediate family, some close friends and a small number of people with whom I worked directly. There were one or two people at work who clearly changed how they behaved towards me, but for the most part I was met with care and kindness. Although I was stuck in a 'season of Darkness' at the time, this kindness steered me towards 'the Light'. In very many ordinary ways, though those days were the worst of times for me, that care and concern was a beacon. Some part of me thought that my family and friends would be disappointed or impatient with me. But I felt the warmth of their embrace.

In the early days and weeks following diagnosis I identified as depressed, not that I had depression. I felt labelled. In one of the conversations with my mother after my diagnosis, she advised me ‘not to make too much of it’. By this she meant that I shouldn’t let this diagnosis define me. And she was right. I was busy pathologising and stigmatising myself, thinking depression was an indelible mark. She and my sister were busy advising that ‘this too will pass’ and life will move on. She also told me about her own struggles with depression. It allowed us to connect based on our shared experience as mothers and reconnect as mother and daughter. And now my mother has died, I cherish these memories. My very nervous disclosure about myself at ‘my worst’ I now remember as ‘the best of times’ too. This idea that this type of changed outlook, from negative to positive, can be driven by identities and shared social relationships lies at the core of this chapter.

As life continued and time moved on, I like to think the ‘foolishness’ of my catastrophising perspective is behind me. I have moved towards a new ‘wisdom’: an appreciation that life tends to throw curve balls that can unseat you. In the years that have followed this period of depression, I have had my resilience and ‘wisdom’ tested more than once. Patience is crucial during these personally difficult times. I try to wait for the storm to pass. I am more patient and compassionate towards myself and others during these tough days. Everyone deserves a break. And I try too to appreciate the good times when they come, as we all need to when we can. In psychological parlance this might be referred to as post-traumatic growth.

7.3 Post-traumatic Growth

Post-traumatic growth (PTG) is evidenced across many cultures and appears in literature across the ages (Tedeschi & Calhoun, 1995). PTG has been evident in response to traumatic experiences endured because of earthquakes (Muldoon et al., 2017), bereavement (Davis et al., 1998), rape (Burt & Katz, 1987; Thompson, 2000) and war and conflict (Elder & Clipp, 1989), as well as life-changing health diagnoses such as cancer (Collins et al., 1990; Stanton et al., 2006), HIV diagnosis (Bower et al., 1998), acquired brain injury (Grace et al., 2015) and even childbirth (Verreault, 2012).

Personal PTG has also been reported after the type of diagnosis I had, namely, depression (Bianchini et al., 2017). My distress at my diagnosis was linked to a sense that my depression was evidence that I was faulty. I was a problem. I was broken. This type of black-and-white thinking is often associated with depression, but at the time I did not recognise this despite my own expertise and strong sense of being a psychologist. I was floored by my diagnosis. It is not unusual for people to show PTS symptoms in response to health events. Up to then, my sense of myself was built on my psychological stability, and this evenness and strength meant that I could help others and be effective in difficult situations. Being useful and feeling needed was an important part of who I was. My diagnosis with depression upended this view of myself. I found this very upsetting and indeed for a time felt lost.

It is this type of extreme distress that results in PTG (Joseph & Linley, 2006; Tedeschi & Calhoun, 1995). Current thinking and research suggest that PTG does not directly result from trauma. Rather, it appears to be linked to the psychological struggles people encounter as they deal with altered contexts in the aftermath of their trauma (Tedeschi & Calhoun, 2004). PTS and PTG are not opposites, then, but rather may co-exist. In this way distress is a necessary prerequisite for PTG (Dekel, Ein-Dor, & Solomon, 2012). Longitudinal studies indicate that PTG occurs over and above any experience of PTS. PTG occurs, then, because of efforts to adapt to the kind of upset and disruption my diagnosis of depression caused me. The phenomenon is perhaps best epitomised in the phrase 'if it does not kill you it'll make you stronger' (Jones et al., 2012).

PTG normally arises from a major discontinuity in personal identity and a period of re-evaluation and reflection. A substantial proportion of people report they no longer see themselves as the same person after their traumatic experiences. In this way, personal PTG is distinct from resilience. It isn't about bouncing back or and returning to the same life. PTG involves a step change in how people see themselves. My own depression stopped me in my tracks in this way. Reflective of the three key processes associated with PTG, it made me revaluate myself and my priorities and appreciate far more the social support and connections I had around me.

My sense of myself before I was depressed was that I was useful, good in a crisis. I like to be needed. I defined myself by my actions and valued myself for what I could do. I value many people in my life for who they are. Indeed, most of us value those we love most for just being themselves. So not valuing yourself in this way is odd. Learning to value myself in this way also changed my priorities. It meant that my own needs had a legitimate position in the hierarchy of needs. Obliging others didn't have to be my priority. Sometimes it is important to look after yourself first. This reluctance I felt was not an innate quality or a genetic blind spot. It can be seen as a product of group life. As a society, we teach girls that it's not nice or appropriate to focus on their own needs or interests. There is also now evidence that when women and girls tend to face backlash when they prioritise themselves. Indeed, there is overwhelming evidence that women are much less likely than men to ask others for assistance at home, at work and in the wider social world (Babcock et al., 2003; Babcock & Laschever, 2003). However, as I reflected on my own distress, I began to see the value and fulfilment that I garnered from helping others. This allowed me to see that others wanted to help, too, and our relationships were enriched by their help. This in turn allowed me to see the value of the support I had around me. The best and the worst of times.

I will always look back with sadness on those years where I had slipped into depression and regret how little joy life brought me at that time. But this time delivered a positive sea change in my sense of myself too. Personally, this positive change was linked to improved relationships with family and close friends and a new ability to lean on others. Professionally, establishing the basis for this positive shift became an important goal. It opened up the possibility that groups and social connections were core to the causes, consequences and even the treatment of trauma. And so, in many regards, this period reinvigorated me as a psychologist and a researcher. I cannot but be grateful for that.

Personal PTG signals personal growth such as enhanced wisdom, insight or empathy; collective PTG signals social identity–based growth. This can be a different way of thinking about an identity. In my case, being diagnosed or labelled 'depressed' prompted me to revisit and reinterrogate valued identities. And whilst my family and friend network helped me to improve my personal psychological well-being, my identity as a psychologist offered a vehicle for growth too. Though I had always seen the value of the discipline, I came to see it as imperative to supporting those made vulnerable by trauma. My strong belief and identification as a social psychologist alongside the support of collaborators have given me the capacity to speak out. Social psychological insights must inform patient services, student experiences, research efforts, workplaces and public policy. In this way my engagement with the discipline as well as my sense of responsibility to speak out on national and international debates on trauma and health care has been amplified by my own experience. This can be seen as a form of collective, rather than personal, PTG. In the proceeding sections how personal and collective PTG are driven by social identity dynamics is more fully outlined.

7.4 Social Identities and Personal Post-traumatic Growth

In recent years, with colleagues I have been trying to understand what drives these kinds of positive changes. Guided by a theory we call the social identity model of traumatic identity change (SIMTIC; see Figure 5.1), we have been exploring the idea that traumatic experience may sometimes revitalise social identities, and it is through this revitalisation that the potential for positive and hopeful trajectories opens up. We currently have evidence in support of two working hypotheses. The first is that traumatic experience can offer a renewed appreciation of the value and importance of social identities. So, we think it is this renewed appreciation that fosters personal PTG. The second hypothesis is that traumatic experience can offer a sense of connection to others, which can be experienced as energising or empowering. Traumatic experience then can present opportunities for new group memberships and identities or indeed may enhance allegiance to pre-existing identities. Both may offer the basis for post-traumatic growth. In this section we consider each of these ideas in turn.

7.4.1 Social Identity Revitalisation and Post-traumatic Growth

Support for the idea that trauma can lead to a renewed appreciation of the value of social identities is evident from research. In a study of children who lived through earthquakes in Italy (Vezzali et al., 2016), the presence of post-traumatic stress symptoms predicted a sense of shared identity over time. Experiences that people find traumatic can facilitate both the emergence of a strong sense of a new social identity (Drury, 2018; Vezzali et al., 2016) as well as the consolidation of existing relevant identities (Muldoon & Downes, 2007). In another study, Drury and colleagues found that an emergent sense of common fate among a study of 1,240 survivors of the 2010 earthquake in Chile led to the development of a strong sense of shared identity and that this fed into the provision and receipt of support (Drury et al., 2016). Mirroring findings from areas affected by political violence (Muldoon, 2013), rather than PTS creating a desire to disconnect (which might be expected, based on the pattern of symptoms often described), post-traumatic stress symptoms appeared to do the opposite. It creates a desire for connection and a sense of collective community (Vezzali et al., 2016).

A premise of the social identity approach to health is also that subjective perceptions of belonging to a group are what drives positive adjustment, such that individuals who identify as a member of a particular group and report stronger ties with other group members will reap benefits: 'the social cure' (Haslam et al., 2018; Jetten et al., 2012). The importance of identifying and engaging with a group, as well as the quantity of group memberships (e.g., Postmes et al., 2019; Sani et al., 2012), is central to their beneficial impact on health. PTG too can be thought to be derived from the number of group memberships people have as well as the quality of these social connections. In a study of thirty-six people living with acquired brain injury (ABI), Griffin et al. (2022) demonstrated the number of groups and strength of connections combined to predict PTG. Tracking group membership and engagement across two time points, the study showed that the benefit of additional new groups was predictive of PTG because these new group memberships acquired after brain injury were associated with a stronger sense of connectedness.

Multiple group membership is known to be an important basis for health, because those with more group memberships tend to have a greater number and diversity of resources to draw upon during times of change and transition. This research suggests the number of groups a person belongs to (Kinsella et al., 2020), as well as the quality of the connections offered through these group memberships, is central to PTG. A related qualitative study illuminates this finding further. In this in-depth interview study with people living with disability in the aftermath of an ABI, respondents spoke of a heightened awareness of group-based resources (e.g., in the form of kindness and generosity from family and community). Participants stated their perspectives changed in the wake of their injuries: they reported a fuller appreciation of their identity-based social resources, including the new identities they forged after their injury, which helped to reduce the isolating effects of their injuries. These new group memberships were also able to offer meaningful activity and a positive sense of self (Muldoon, Walsh et al., 2019). Respondents indicated that making sense of their injury and the associated disability was something they achieved through interaction with others and participation in group activities. Moreover, their acceptance and adaptation to life post-injury was implicitly linked to changes in the social identity resources that flowed from their group memberships. Indeed, in this context, social contact, and renewed connections with valued groups, whether peers, family or friends, was taken as a marker of recovery. Remarkably, then, these participants, who were often very disabled, focused on their *good fortune*.

Another study in a different traumatic context provides further evidence of the value of multiple and new group memberships as a platform for PTG (Haslam, Latilla et al., 2021). Drawing on a sample over 100 largely female (86%) and white participants (88%) recruited through an organisation that supports victims of gender-based violence and abuse in South Africa, this study offered consideration of the impact of physical, emotional and financial abuse and domestic violence or sexual assault. Findings of the study showed that those participants with multiple group membership were those who showed the highest levels of post-traumatic growth. Building on previous research, these findings also suggested that multiple group membership worked in tandem with feelings of personal control and new activist identities to foster growth. So, multiple group membership can facilitate the development of new group memberships in times of disruption and stress (Cruwys et al., 2014). These new groups can be pertinent to the specific life-changing contexts. Specifically, this study appears to offer evidence that multiple group membership offers a pathway to identification with activists, a factor that we have seen previously can reduce traumatic stress (Basoglu et al., 1997; Muldoon et al., 2009) but here also seems to foster the development of PTG (Haslam, Latilla et al., 2021).

More recently, Craig et al. (2022) directly tested the idea that social identity gain, or acquiring new identities, could promote PTG. In a study of 140 adult survivors of the Australian Black Summer bushfires, this study showed that group membership gain predicted PTG over and above demographic factors and the scale of the damage people endured. Further, this study highlighted that new group memberships were associated with a distinct path to PTG, through a process of social identity revitalisation. Social identity revitalisation is a process, not unlike my own experience with close family and friends when depressed, whereby connections are reinvigorated and appreciated more than they had been previously. Whilst existing group memberships in this Australian study then were associated with fewer PTS symptoms, new meaningful group memberships provided bushfire survivors with opportunities to create new identities that became the basis for growth and thriving.

This idea is consistent with another group of studies that suggest that changes in the number or the value ascribed to identities can also be a catalyst for PTG through enhanced sense- or meaning-making. As we have already discussed in Chapter 5, traumatic experience can disrupt identities, and so it can also disrupt associated motivations and meaning in life. One of the reasons that the South African survivors of abuse evidence PTG was perhaps because the newly developed activist identity offered more than new social connections. The link between PTG and social identity–based meaning-making is apparent in a study of sixty female survivors of childhood sexual abuse. Specific benefits accrued to those who could make sense of their experience. Those who believed they had improved relationships or were better parents or had stronger religious identities because of their early childhood adversity were those most likely to show PTG (Wright et al., 2007). Relatedly, in studies of military personnel who have experienced combat trauma, growth is most likely to emerge where a focus on the value of the collective effort survived. Cacioppo et al. (2011) showed that a focus on the collective goals can buffer the effects of traumatic stressors and help groups of military personnel grow from traumatic experiences. An interpretation that makes sense of personal traumatic experience with reference to a wider cause or collective effort is more likely to deliver PTG.

In summary, following exposure to traumatic events, people often find themselves in a fundamentally different psychological world – one that necessitates an evaluation and overhaul of how we see ourselves. Identities hitherto central to our sense of self can be lost or gained, some are maintained and consolidated, still others undermined (Hefferon et al., 2010; Muldoon, Haslam et al., 2019). New group memberships seem to have a particular value in promoting positive post-traumatic change. So too does the revitalisation of social identities, enhancing the perceived value of groups that were previously perhaps a little neglected. This new sense of social self, enabled by social identity changes, can bring with it a new sense of meaning, purpose and connection to others, often thought of as PTG.

7.4.2 Social Identity Empowerment and Post-traumatic Growth

We know from Chapter 3 there is evidence that those most affected by trauma are those who are most disempowered and that traumatic experience itself can be disempowering. Those most affected by trauma are often on the margins, or made marginal, by their experience. They are most often groups without social, economic or psychological status or resources. Their distress is driven in part by their hopeless and helpless circumstances. However, there is also now emerging evidence that social identities and connections to others similarly affected are the basis of empowering connections and collectives. Here I present evidence that this may also be the basis for growth in response to trauma. This is thought of as a social identity empowerment hypothesis: social identity–based empowerment can be the basis for personal post-traumatic growth.

We turn first to evidence that trauma may be the basis of empowering and agentic social identities. Drury and colleagues highlight how an emergent, shared social identity was evident in a series of research studies with British residents who had been involved in a range of different traumatic events – including the bombing of Harrods in 1983, the fire at Bradford City's football stadium in 1985, the sinking of the cruise ship *Jupiter* in 1988, the deaths of ninety-six Liverpool supporters at Hillsborough in 1989 and the crush that occurred at a Fatboy Slim beach party in 2002. One of the most striking findings was the extent to which participants developed a sense of social identification with others as the disasters unfolded. Far from being 'madding crowds' or 'panicked' response, those caught in these catastrophic circumstances felt a sense of solidarity and connection with others in the same situation. This sense of identification dampened feelings of threat, and identification with others allowed people to feel safer and more secure. This programme of research also indicated that a calm and orderly response, alongside feelings of being capable of responding to the unfolding demands of the situation, was associated with a stronger sense of connection and identification with other victims (Drury et al., 2009).

This sense of having 'got this', known as personal efficacy, is important to people's responses to traumatic events. In a longitudinal study by Kinsella and colleagues (2020), the impact of group membership on ABI survivors' ability to manage their own emotions, thinking and behaviour was examined. For those with acquired brain injury, reduced regulation and self-efficacy creates difficulties for survivors in family, work and wider social settings. This study found that survivors with more group memberships had better self-regulation capacities, which were linked to better psychological health. This was also found in the previously mentioned study of survivors of gender-based abuse in South Africa (Haslam, Latilla et al., 2021). An enhanced sense of personal control appeared to be derived from multiple group membership, which in turn was associated with higher levels of personal post-traumatic growth.

Muldoon et al. (2017) explored this idea further by looking at whether a sense of shared or collective efficacy in the aftermath of trauma can be important to the development of post-traumatic growth. Collective efficacy is epitomised by the phrase 'we shall overcome'. In a study of nearly 400 survivors of the 2015 Nepal earthquake, six months after this event had devastated large areas of the country – killing 9,000 people, injuring over 20,000, and leaving more than 3 million people homeless (Muldoon et al., 2017) – the role of community identity and collective efficacy on PTG (using measures that had been translated and adapted for use with populations with limited literacy) was examined. Reflecting the fact that power and position affect people's experience of trauma, respondent's socioeconomic position and, in particular, their position in the caste hierarchy that persists in Nepal affected the extent and nature of trauma experienced was linked to earthquake experience. Equally as hypothesised, community identification and the sense that the community had the ability to overcome trauma, known as collective efficacy, facilitated personal PTG.

The knowledge that groups can empower people adversely affected by traumatic experience gives rise to the tantalising possibility that group-based empowerment is a potential pathway through trauma for the most marginal and disempowered groups. Small groups have been shown to have the capacity to engender identity based on membership in an existing social category (Postmes et al., 2005). And when there are no pre-existing connections (for instance, amongst victims or survivors), groups often actively engage in negotiations and discussions over who they are, the realities they are collectively facing, and the norms and content that define their group (Reicher et al., 2006). Communication and debate then help small groups to integrate an understanding of the norms that define their group, including their efficacy beliefs and their opinions about appropriate actions given their circumstances (Thomas et al., 2009).

Building on this knowledge, with colleagues in Nepal we have been evaluating the value of a community-based approach to supporting those affected by leprosy. Leprosy remains a highly stigmatising illness in Nepal, most often affecting the poorest and lowest-status members of society. The diagnosis can be very traumatic as those affected realise that their lives may be very altered. As well as the potential for illness and disability, those affected are often rejected by their communities, even their own families, losing important social identity–based connections and supports. Using a small group approach centred on the importance of empowerment for these marginalised and low-status people living in rural villages, we have shown how feelings of belonging and identification with self-help groups formed to support those affected by leprosy have a range of positive consequences. These include practical gains the groups are designed to address such as improved health literacy and social participation (Muldoon et al., 2020). Over and above this, these group-based connections mitigate stigma and enhance solidarity and empowerment amongst those affected by leprosy (Jay et al., 2021; Muldoon et al., 2020). Taken together, our evidence suggests that these small group contexts offer identity resources to reduce stigma-related harm and promoted resilience over at least a six-month time span (Jay et al., 2022),

Disempowerment and stigma are also associated with being a victim of sexual violence. Stigmatised trauma can damage interpersonal relations and community connections and fundamentally challenge people's sense of their own autonomy. On the other hand, some survivors report identifying with the stigmatised identity, and this can improve interpersonal relationships, offer a greater sense of community connection. It can also be associated with a growing sense of activism that is reflective of personal PTG. Certainly, although I felt stigmatised when diagnosed with depression, disclosing this to understanding family and friends brought me closer to those who had shared this same experience.

People's responses to any potential stigmatising disclosure, of course, is pivotal. There is evidence that positive responses from others when speaking about sexual assault can aid people's recovery (Gueta et al., 2020; Strauss Swanson & Szymanski, 2020). And again, on the other hand, those who experience sexual assault can find that others are unwilling to listen (Gueta et al., 2020; Mendes et al., 2018) or to acknowledge their experiences; they may even be blamed for their own victimisation (Lynch et al., 2017). Trauma in the form of sexual assault constitutes a serious challenge to people's sense of personal safety and autonomy as well as their social relationships (Roberts et al., 2005). Stigmatised trauma, then, because of its relationship with empowerment and autonomy, is likely to present a particular barrier to post-traumatic adaptation and growth.

Overall, then, the research literature offers a small but promising body of work showing that social identities acquired because of trauma have the potential to drive personal PTG (Muldoon, Haslam et al., 2019; Vezzali et al., 2016). For some, the low status or a marginal position in society that placed them at risk of trauma will also be associated with stigma and disempowerment. This can be a barrier to positive or growth outcomes. It is likely to interfere with group cohesion and social connections, block personal and collective agency and reduce coordinated action over time. On the other hand, collective and personal efficacy and agency can mitigate feelings of helplessness and the stigma-related harm often experienced by those affected by trauma. Social identity–based empowerment can be derived from multiple group memberships, social connections and participation and engagement with 'active' identities. All these social identity–based assets contribute to empowerment and personal growth.

7.5 Collective Post-traumatic Growth

In the early days of my research career, I recall reading many research articles where a key critique was that the population studied was involved in litigation. Litigant studies were seen as offering questionable evidence relating to the impact of trauma. Since then, it has been apparent to me that scepticism about the authenticity of claims people make about their trauma is a persistent feature in this field. This scepticism speaks to the concern then, and now, that people who claim to be traumatised are in fact faking their distress. Claims are taken as indicative of another agenda – for example, monetary compensation, citizenship rights or even a political plan.

Trauma has always been a highly political and politicised concept. In Northern Ireland over the years of the conflict, both people and politicians were known to use the phrase 'innocent victims'. This well-worn phrase is suggestive of another group of victims who are less innocent or maybe even deserving of their own misfortune. In the literature related to gender-based violence, there is a clear and disturbing narrative relating to the types of girls who are victims of gender-based violence. Victims are too often constructed as 'silly girls' who were 'asking for it', somehow responsible for the violence perpetrated against them (McMillan & White, 2015) and simultaneously unworthy of care or concern (Muldoon et al., 2020).

Despite these clear social psychological dimensions, the personal cost of traumatic experiences has been primarily informed by clinical psychology, psychiatry and medicine. These clinical perspectives rely on an individualised model of human behaviour. They see social factors as having an influence on people's personal resources to manage the experiences they encounter. On the other hand, the literature related to collective action highlights how group memberships – particularly where there is injustice – are likely to give rise to an appetite for social change. Studies in the field rarely consider the impact of people's own experience of trauma. The idea that personal experience of trauma impacts social identities not only allows a social psychology of trauma but also reveals the possibility that traumatic experience and social identities can combine to drive social and political change.

7.5.1 *What Is Collective Post-traumatic Growth?*

Solnit (2010) observes in her comprehensive volume *A Paradise Built in Hell* that it is far more common than one would imagine for communities that experience catastrophic disasters to both recover and thrive (Evans-Campbell, 2008; Sundet & Mermelstein, 1988). This idea of community growth in response to trauma has been evident in the literature for some time. For the most part, though, those writing about growth in sociology and politics are thinking about changes in social practices or systemic change arising from post-trauma commitment to structural reform of a city or a country. As a social psychologist, I see this response as the product of people's redefinition of their social selves post-trauma: a changed sense of 'who we are' and 'how we imagine our future'. These changes in the social self include changed sense responsibility and loyalty to valued groups. This shift in thinking about trauma is important to move the field forward.

If we think of the last two years since the onset of the COVID-19 pandemic, the swiftness with which new group memberships have emerged and been integrated into common parlance is instructive in this regard. We have 'anti-vaxxers', 'COVID deniers', 'maskers' and 'anti-maskers', 'the COVID anxious' and 'COVID vigilantes', amongst many other new groups that have appeared. In many cases, people are happy to identify in these ways and have integrated these labels into their sense of self. I have been involved in many conversations where people have declared that they are 'pro-mask' or 'pro-science'. But, of course, people are not in and of themselves pro-science; it is their values or beliefs that are this way. In this way we can say group memberships define our sense of self and our values. And this has profound cognitive and motivational consequences (Turner, 1982).

Collective post-traumatic growth can be thought of as a form of psychological growth that includes a greater awareness of possibilities and purposes of the groups of which we are members, an enriched sense of oneself as a group member and a stronger sense of connection to other group members. This collective growth, or positive change as a group member, is plausibly an important driver of social and political actions. And it articulates a link between direct personal experience of trauma and changed collective social or political priorities. It forges a path between the personal and the political.

In a recent study, we used public accounts of women who waived their right to anonymity after a conviction of sexual assault or rape was secured in the Irish courts. In such cases of rape and sexual assault in Ireland, victims are guaranteed anonymity. This is a provision in law designed to protect people from the stigma associated with experiencing sexual violence. It highlights that there remains a cost for people who are identified as the victim in rape cases. When we completed our analysis of public statements and media interviews with women (all the victims were women), we examined the reasons these women spoke out. Our analysis of their public discourse highlighted the victims' descriptions of how a personal trauma, even one as intimate as rape, has psychological consequences that went well beyond individuals' own health and sense of personal identity. A key feature of the conversations we analysed was that the identity changes highlighted were not always negative. The women talked about an altered and enhanced sense of responsibility to other women and particularly to others who had experienced similar trauma. They felt it imperative to redefine those affected by gender-based violence, of both themselves and others, in the eyes of wider society. They spoke about garnering support, strength and agency from the reaction of others who shared their experience and those who witnessed someone they loved negotiating similar trauma. They indicated that they felt empowered by these social identity–based connections to see social cultural and legal change (Muldoon et al., 2023)

All these women had this in common. They used their highly publicised court cases and the circumstances in which they found themselves by dint of their trauma to press for social and political change. They identified variously at least in the public sphere as women, as victims, as Irish people and even by occupation. They used these identities to push for redefinition of Irish practices and norms around disclosure, blame, support, sentencing and judicial management of rape and sexual violence. In their public discourse, the women sought to offer a shared alternative vision for supporting and responding to incidents of sexual assault and rape in Ireland. In so doing, they trusted that like-minded others, be they women, victims, families, friends of victims or those working in the health or judicial system, would also be keen to offer appropriate support to protect victims of sexual violence. This identity-based shared vision for Ireland's future could be thought of as an attempt to 'grow who we are' in order to look after 'all of us'.

These are also issues that have come to the fore in the face of the COVID-19 pandemic. Though we can see that the adverse impacts of COVID-19 are linked to status, power and positionality in society, the requirement for action by all is central to the success of public health measures. Living and working conditions are profoundly related to risk and vulnerability (Chung et al., 2020). As such, the crisis is drawing wider health inequalities within and across nations into sharp relief (Atchinson et al., 2020) in terms of both preventative medicine and health care. The amplification of the inequality between the rich and the poor that has occurred over the course of the COVID-19 crisis has enhanced the appetite for change in those most directly affected by disability, death and inadequate access to vaccines and health care. In short, the trauma associated with the pandemic has already had political consequences.

Whilst contemporaneous events such as the pandemic, or indeed the climate crisis, may be seen as a tipping point resulting in a sea change in thinking, historical events can also be influential. Linking historical wrongdoing and contemporaneous events is often contentious. Take, for instance, the rise of recent social movements like the #BlackLivesMatter (e.g., Leach & Allen, 2017) or the #MeToo movement. Their momentum was often linked to unresolved experiences of trauma and historical disadvantage of people of colour and women. When people fail to connect present-day events with past traumatic experiences, this can support the status quo. On the other hand, when historical disadvantage is connected to current political events, this can lead to an appetite for profound institutional change (Foran et al., under review; Ghilani et al., 2017).

Chayinska and McGarty (2021) argue that 'political déjà vu' – perceiving a connection between past events and those that are unfolding – can become an instrument for social change. They studied the responses of 272 Argentinian activists following the disappearance of activist Santiago Maldonado and the perceived silencing of opposition during the 2017 election. This silencing was paralleled by some with the silencing and disappearances during the Argentinian dictatorship of 1976–1983. Those who connected past and present events, feeling political déjà vu, identified more strongly with the political opposition group. In effect, recollection of traumatic memories reconstructed a victim-perpetrator frame through which identities and group memberships were used to view current and past events (Augoustinos & Every, 2007). This aligns with the idea that people seek comfort from their identities when confronted with the distressing traumatic memories (see Chapter 4). The pattern also revealed that political déjà vu alongside this pattern of social identification produced the system challenge necessary for collective action to occur (Chayinska et al., 2019). Importantly, the analogous perception of past and present traumatic events was related to people's sense of agency (Drury & Reicher, 2005; Muldoon et al., 2017; Rimé et al., 2010). This shared belief in 'our capacity' to effect social and political change is crucial to the mobilisation of collective action.

7.6 Conclusion

Traumatic distress is linked to personal post-traumatic growth: a season of light and a season of darkness. Personal PTG, *the spring of hope*, arises from the social connections and sense of meaning or agency developed to manage post-traumatic distress, *the winter of despair*. In this way social identities and group-based resources can be seen as an important driver of personal PTG. Traumatic experience also appears to be linked to positive changes in people's group memberships and social identities. Traumatic experiences can result in the acquisition of new identities or result in reimagining of old identities. This idea, which can be thought of as collective PTG, is captured clearly by Charles Dickens in his book *A Tale of Two Cities*. And though articulated in literature previously, this idea of collective PTG has not been widely researched or articulated in psychology.

It is sometimes difficult to express the idea that traumatic experiences can have positive consequences without sounding trite or indeed heartless. There is no sense in which the analysis offered here seeks to deny the pain or distress people endure because of trauma. Traumatic experiences, and people's responses to those who have been traumatised, can be both overwhelming and alienating. For some, particularly the most vulnerable and marginal in society, it can be impossible to move forward, and the health consequences include a lifelong physical and psychological price. We can use the knowledge of how systems failures, social betrayal and shame and injustice compound the experience of those who have experienced trauma. This offers the potential for new interventions oriented to destigmatising, empowering and connecting vulnerable populations in support of healthy and positive social change (Jay et al., 2022). Though in its infancy, we are trialling this idea and collecting evidence of the value of this approach to people's mental and physical health in the wake of trauma in our new research (see https://growth-ul.wixsite.com/psychology).

Connecting people through shared experience, even if it is in the past (Ghilani et al., 2017), galvanises people's identities and appetite for change. Calls for collective political action are routinely reinforced by unresolved experiences of trauma and historical disadvantage of minority groups. In this way, because of the social identity consequences, trauma can be politically mobilising. And whilst this can lead to violent protest, it can also lead to collective PTG. It can offer an opportunity to imagine a shared future with new collective possibilities. Traumatic experiences, then, have the potential to deliver major social and political dividends, to make the world a place where the concerns of women, children, people of colour and the diversity of our societies are understood and acknowledged equally. When it comes to trauma, the personal is political.

7.7 A Last Word

For the avoidance of doubt, I am a psychologist. I have a first-class single honours degree, which means I studied psychology exclusively for my undergraduate degree. I have a PhD in psychology. At the time in my life that I acknowledged my depression I had been actively researching mental health for almost fifteen years and was a full professor of psychology. Yet if my sister had not encouraged me to go to my doctor, I may have waited many months more. Looking back, it is hard not to be struck by my own lack of insight. I had lots of knowledge. I failed, spectacularly, to recognise my own problem. This is in part due to my orientation to knowledge rather than sentiment, in part a symptom of the depression, and wholly reflective of the society in which we live.

As I hope I have made clear in the pages of this volume, my area of expertise is social psychology. Though my identity as a 'psychologist' is important to me and very strong, I am at heart a 'social psychologist'. I am expert in the role of environmental or contextual factors in driving health and social behaviour. I am keenly aware that these social processes are routinely camouflaged in everyday life. However, it is only through looking back and reflecting on my own emotional response to my own diagnosis of depression that I realised that I *felt* people like me, affected by mental health problems, were broken, problematic. Despite all my knowledge, how I felt about the diagnosis was telling.

I was truly devastated by the diagnosis I received. Our understanding and approach to mental health problems, such as depression and PTS, remains highly stigmatised. Though I knew this prior to my own diagnosis of depression, I really didn't think that I was someone who was inclined to think in this way. Indeed, I had met many people affected by mental health concerns before I was diagnosed myself and sought always to treat them with empathy and compassion.

My devastation was linked to a sense that this diagnosis was evidence that I was faulty. I was the problem. I berated myself for being weak. I had swallowed a deficit model of mental health hook, line and sinker. Despite all my knowledge, my reaction told me that I implicitly accepted that people with mental health problems were broken and needed to be fixed.

This book is an attempt to work against this narrative. Many of the solutions we offer to people with symptoms of trauma or stress presume that action at the level of the individual will deliver respite. These actions can be things like taking medication or engaging in talking therapy, things I did myself when I was depressed. Actions of this nature assume it is the person who needs to be fixed. This doesn't address the underlying cause of the problem. It is like treating the symptoms of cancer without removing the tumour. Before we ask people to fix themselves, we need to make sure that it isn't their world that is broken. A career studying trauma tells me hope for us all is found in a more just and equitable world, where our efforts work towards minimising the risk of adversity arising from war, violence and catastrophe.

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