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Personal and Political: Post-Traumatic Stress Through the Lens of Social Identity, Power, and Politics

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Post-traumatic stress disorder (PTSD) has always been controversial and highly politicized. Here, using a social identity approach, we review evidence that trauma and its aftermath are fundamentally linked to social position, sociopolitical capital, and power. We begin this contribution by demonstrating how a person's group memberships (and the social identities they derive from these memberships) are inherently linked to the experience of adversity. We then go on to consider how it is through group memberships that individuals are defined by their trauma risk and trauma histories—that is, a person's group memberships and their trauma are often inherently linked. Considering the importance of group memberships for understanding trauma, we argue that it is important to see these, and group processes more generally, as more than just “demographic” risk factors. Instead, we argue that when groups are defined by their trauma history or risk, their members will often derive some sense of self from this trauma. For this reason, attributes of group memberships are important in developing an understanding of adjustment and adaptation to trauma. In particular, groups' status, their recourse to justice, and the level of trust and solidarity within the group are all central to the impact of traumatic events on individual-level psychological resilience. We review evidence that supports this analysis by focusing on the exacerbating effects of stigma and social mistrust on post-traumatic stress, and the value of solidarity and strong identities for resilience. We conclude that because of these group-related processes, trauma interweaves the personal with the political and that post-traumatic stress is fundamentally about power, positionality, and politics.

KEY WORDS: psychological trauma, social identity, groups, PTSD, traumatic events

In a seminal article, Haslam, Jetten, Postmes, and Haslam (2009) set out a research agenda that focuses on how social identity, the sense of self derived from perceived membership of social groups (Tajfel, 1972), is central to health. From this initial research agenda, work informed by the social identity approach to health (SIAH), has rapidly expanded to consider a range of health issues (e.g., brain injury Muldoon, Walsh, Curtain, Crawley, & Kinsella, 2019; Walsh, Muldoon, Fortune, & Gallagher, 2017; addiction Buckingham & Best, 2016, and care provision and community work Kellezi, Bowe, Wakefield, McNamara, & Bosworth, 2019; Stevenson, McNamara, & Muldoon, 2014). In our review, we highlight how a social identity-informed focus transforms our understanding of trauma.

Here, our critical review allows us to move away from conceptualizing responses to trauma as the reactions of individuals *as individuals* to instead appreciate how trauma is structured by group life and the attendant political dynamics that shape traumatic experiences. Our focus is on the impact of trauma and adversity. Despite its regular usage, there is limited clarity about the definition of “trauma.” Krupnik (2019) delineates two definitions, one that tends to a very narrow definition and is located within the DSM-5 PTSD diagnosis (see Criterion A below). The second broader definition proposed by Krupnik (2019) herself grounds trauma within general theories of stress. So while the current review frequently focuses upon PTSD, and resilience to PTSD, because of its central relevance to understanding the psychological impact of trauma (PTSD; DSM-5, APA, 2013), we also consider trauma as part of a wider stress response. This also moves us away from a view of trauma as pathological and towards seeing trauma responses as normal responses to extreme circumstances.

We build on a central strand of the SIAH or “social cure” literature, namely stress and adversity (e.g., Gallagher, Meaney, & Muldoon, 2014; Haslam, Jetten, & Waghorn, 2009; Haslam, O’Brien, Jetten, Vormedal, & Penna, 2005; Häusser, Kattenstroth, van Dick, & Mojzisch, 2012; Muldoon, 2013). Within social and political psychology, the social identity approach has been repeatedly applied to understand behavior in difficult situations. This work has had a major influence in political psychology—particularly in the study of prejudice, intergroup competition, and conflict (e.g., McKeown, Haji, & Ferguson, 2016). However, the social identity paradigm has more recently been used to understand the role of group processes in determining health. The approach therefore allows us to move the conceptualization of health and well-being as an individual concern (as suggested by the biomedical model; see Engel, 1977; Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018) to a perspective that focuses on the way that group memberships and the social identities structure adaptation and, in this particular case, responses to stress and trauma.

Trauma, PTS, PTSD, and Resilience

Trauma has a high human cost. Commonly documented responses to traumatic events include symptoms of post-traumatic stress (PTS), a diagnosis of post-traumatic stress disorder (PTSD), and resilience. So a key focus of research to date has been on predicting different trajectories through trauma (Breslau, 2009; Elwood, Hahn, Olatunji, & Williams, 2009). PTSD is perhaps the most widely known consequence and is a diagnosable mental disorder, popularized in literature and film (e.g., to critical acclaim in *Born on the 4th of July*). A diagnosis of PTSD is associated with significant health burden for those affected. Indeed, the criteria for diagnosis is 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 WHO World Mental Health (WMH) surveys are used to calculate the adverse societal costs of mental health problems. The WMH surveys are representative community surveys in 28 countries aimed at providing information about the prevalence, distribution, and social burden of common mental disorders. PTSD was first officially categorized as a mental disorder in DSM-3, the 1980 edition of the *Diagnostic and Statistical Manual of Mental Disorders* (Spitzer, First, & Wakefield,

2007). Though classified as an anxiety disorder in earlier versions of the DSM, it has subsequently been reclassified as a “trauma and stressor-related disorder” in DSM-5 (APA, 2013). The nature and extent of post-traumatic stress has been examined in a series of WHO World Mental Health (WMH) Surveys allowing for PTSD lifetime prevalence arising from these representative samples in 27 countries. The surveys estimate a metric known as the burden of a disease which represents the years of life lost to a given disorder due to death and disability (Murray & Lopez, 2013). The global *burden of PTSD*, the prevalence of trauma by trauma-specific PTSD risk and persistence of symptoms, is estimated as .4% of the total of disability from all causes of ill health globally. This is equivalent to the percentage of years lost to schizophrenia, a mental health problem often considered to have the most severe health toll (Ayuso-Mateos, 2002; Kessler et al., 2009). As such, trauma and PTSD are major mental health issues.

Although statistics reported from various countries are not directly comparable due to methodological differences, the WHO synthesis nevertheless offers important insights into issues of PTSD prevalence and patterning. First, trauma exposure is common throughout the world, with more than two-thirds of all respondents reporting experience of traumas at some point in their lifetime. Second, the experience of trauma is unequally distributed (Muldoon, 2013; WHO, 2011). Third, trauma *type* matters—both to the risk and the persistence of PTSD symptoms. In general, the estimates for lifetime PTSD prevalence range from a low of 0.3% in China to 6.1% in New Zealand (Kessler et al., 2009). We also know incidence is particularly high in specific risk groups such as first responders, soldiers, and populations affected by rape, war, and political violence (Berger et al., 2012; Breslau, 2009; Santiago et al., 2013).

In total, there are eight necessary criteria for a PTSD diagnosis. Symptoms occur in four associated clusters (Bisson, Cosgrove, Lewis, & Roberts, 2015): (1) Criterion B: Intrusion symptoms (e.g., flashbacks, nightmares); (2) Criterion C: Persistent avoidance of stimuli associated with a given trauma (e.g., avoiding “trigger” situations); (3) Criterion D: Negative alterations in cognitions and mood associated with the traumatic event (e.g., guilt, difficulty concentrating); and (4) Criterion E: Alterations in arousal and reactivity that are associated with the traumatic event (e.g., difficulty sleeping) (APA, 2013). In DSM-5 (APA, 2013), a diagnosis of PTSD is seen to be warranted where there are multiple symptoms and a clinician has established evidence of a range of persistent symptoms across all four symptom clusters. Further criteria stress the duration of the disturbance (Criterion F), that the disturbance causes significant functional impairment (Criterion G), and finally that it is not attributable to other causes (e.g., the physiological effects of substance use or medication: Criterion H).

PTSD is unusual among other DSM disorders in that Criterion A states diagnosis requires exposure to a particular type of social experience: namely, experiencing or witnessing someone else experience an actual or threatened risk to life, serious injury, or sexual violence. The fact that these social experiences often arise in group contexts (e.g., war, natural disaster), and because of a person’s membership of groups (e.g., as a soldier, or as a resident in a given community) is a key reason why memberships of particular social groups are so relevant to the distribution and experience of traumatic events. However, while exposure is often social in nature or context, this is not explicitly identified or acknowledged in the criteria.

Despite this, the burden metric demonstrates that the number of years lost to disability because of PTSD is linked to the social nature of the trauma people endure. So, for example, the subcategory of intimate-partner sexual violence accounts for nearly 42.7% of the burden of PTSD across the 27 countries taking part in the WMHS (Kessler et al., 2017). 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 (based on the Uppsala Conflict Data Program (UCDP: Pettersson & Wallensteen, 2015; UCDP, 2018)). When

a war was regional rather than national, regional population estimates were taken. Most war survivors live in low-to-middle income countries, and so high-quality data is not available from many of these countries. Nevertheless, using meta-analyses and 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 recovery from PTSD within a year occurs in approximately one-third of cases, rapid recovery from PTSD appears to be least likely among people with war-related PTSD (Kessler et al., 2017). Indeed, PTSD following war-related traumas has the longest median duration, at five years, followed by traumas involving physical or intimate-partner sexual violence with a median of three years. In sum, the burden of this disorder, like trauma itself, is not equally distributed.

That said, labeling and classification of PTSD as a disorder has always been controversial. Some commentators advise that it is better to think of all responses to trauma along a continuum of post-traumatic stress (PTS). In this way, stress responses can be considered reasonable, normal, or indeed, expected, reactions to extreme or distressing events (Summerfield, 2001). By orienting towards symptom severity and thinking about PTS responses as a continuum, the labeling of symptomatic individuals as “disordered” is avoided. As well as avoiding labeling, this approach turns attention to the social conditions that give rise to traumatic experience rather than the people who are distressed by extreme events. In short, then, PTS allows us to move away from a dichotomy between those who do or do not warrant a clinical diagnosis. This is not a trivial issue. On the one hand, a diagnosis can validate those who feel overwhelmed by their experiences and help people to receive support (Wright, Jorm, Harris, & McGorry, 2007). On the other hand, diagnostic labels, and particularly mental health diagnoses, can be used to undermine people’s sense of autonomy and increase their marginalization and stigmatization (Muldoon & Lowe, 2012; Pupavac, 2004). This can occur at both the individual and collective level. At the individual level, a diagnosis can result in a people ceding the management of their mental health to health professionals (Byrne, Schoeppe, & Bradshaw, 2018). And at the collective level, labeled populations or groups can be seen as incapable of managing their own affairs giving rise to interventions that create dependence and undermine autonomy further (Jay & Muldoon, 2018; Muldoon et al., 2019; O’Byrne & Muldoon, 2019). Paradoxically where national populations are labeled as a consequence of war trauma, this is often used as a justification for military intervention to support external governance creating conditions for further traumatization of affected populations (Pupavac, 2004).

At a population level, resilience is the *most common response* to the range of adverse events that people experience as a consequence of war, political violence, rape and sexual assault, accidents, and natural disasters. Without question, the majority of people that encounter extreme and distressing events actually prove to be resilient to their impact (Agaibi & Wilson, 2005). Many people manage extreme and distressing events in ways that show some PTS, but these are short-lived and/or not so severe that they interfere with social or occupational functioning. For example, using representative samples, it has been shown that while 50% of people in Northern Ireland have been exposed to more than one traumatic incident as a consequence of political violence (Schmid & Muldoon, 2015), only 1 in 10 show symptoms severe enough to warrant a diagnosis of PTSD (Muldoon & Downes, 2007). Similarly, cross-national longitudinal representative surveys including Israelis, Palestinians, and residents of Northern Ireland observed 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 among those who reported direct and repeated exposure to trauma, 75% to 80% did not have PTSD (Hirsch-Hoefler et al., 2019). Accordingly, understanding the basis of psychological *resilience* to trauma is just as important as understanding vulnerability.

In summary, psychological responses to trauma vary along a continuum of PTS, with resilience on one end of the continuum and PTSD on the other. For the most part, people’s responses

to traumatic events are marked by resilience. However, in a proportion of cases, symptoms experienced as a result of trauma are severe enough to interfere with a person's social and occupational functioning in ways that meet criteria for PTSD. A diagnosis of PTSD is associated with significant health burden for those affected. Consequently, recent research efforts have largely focused on identifying those who are at increased risk of PTSD if they are exposed to traumatic experiences (Bomyea, Risbrough, & Lang, 2012). In what follows, we seek to show how this variability in PTSD risk and resilience might be explained with reference to the group-based dimensions of trauma—including those relating to both power and politics. This does not diminish the contribution of work that has explored other dimensions of traumatic responses, but nevertheless it seeks to show that social identity processes are integral both to experiences of trauma and to responses to it—and hence that those same processes need to inform the way those experiences and responses are understood and managed.

The Social Dimensions of Post-Traumatic Stress and PTSD

The political and social psychological foundations of trauma are embedded in the original conceptualization of PTSD. This viewed the disorder as a direct consequence of exposure to a traumatic event in otherwise “normal” individuals. As originally described, the emphasis for diagnosing clinicians was on establishing the trauma as the primary aetiologic agent, rather than particular individual vulnerability factors. Therefore, in addition to attention to trauma experience (which as outlined above is socially patterned), there are three additional risks for PTS/D that have been identified in the literature that are germane to our present argument.

First, there is widespread acceptance that it is not only direct experience of an event that can be traumatic and lead to PTSD, but also *witnessing* an event can have the same consequences. Second, there is a body of evidence that life-threatening trauma as a consequence of *human design* is more pathological than trauma that can be considered accidental (Charuvastra & Cloitre, 2008). And third, beliefs about (1) the world and (2) our relationships to others also appear central to the development of PTS (Elwood et al., 2009). We review each of these issues here in turn. Our aim is to illustrate the logic of widening understandings of trauma and to emphasize the value and rationale for our approach that accounts for these social and political dimensions of trauma.

First, it is widely accepted that trauma can be experienced indirectly, by virtue of one's social connection to others. Indeed, of the four types of trauma that the DSM-5 identifies as having the capacity to trigger PTSD, three involve trauma experienced by *others*, rather than direct personal exposure. These include indirect exposure through the traumatic experience of a family member or another close affiliate, witnessing trauma to others, and occupational exposure to a traumatic event (e.g., as a military mortuary worker or a forensic child-abuse investigator; Pai, Suris, & North, 2017). In this way, we can see that the very definition of traumatic experience is not only personal, but also familial, social, and occupational. This implies that the experience of trauma is structured by people's understanding of kinship and social connections, as well as the collective circumstances in which they live and bear witness and the social roles and functions they take on in life.

Turning next to the type of trauma: there is a large body of research which demonstrates that not all traumas are equivalent in terms of risk for PTS/D. As noted above, traumas caused by “human design” (APA, 2000) are consistently demonstrated to be those that result in the highest rates of PTSD (Charuvastra & Cloitre, 2008). For example, the impressive National Comorbidity Survey in the United States has found that the incidence and prevalence of PTSD resulting from trauma as a consequence of intentional acts such as rape, childhood abuse, combat exposure, and physical assault is approximately twice that associated with unintentional and accidental traumas such as car accidents, fires, and natural disasters (Kessler et al., 2005; Kessler & Merikangas, 2004). Similarly, Shalev and Freedman (2005) provide strong evidence to support the claim that the increased risk

of PTSD associated with these traumas is due to the fact that they are caused by intentional human action. Using a prospective design, they assessed rates of PTSD arising from exposure to a terrorist attack or being involved in a car accident in a community sample in Israel. They demonstrated that the incidence of PTSD among people who survived a terror attack was twice that of survivors of motor vehicle accidents. We can conclude then that there are important social dimensions of trauma that signpost the social psychological foundations of response trajectories.

King and colleagues (1995), in a study of combat veterans that highlighted a specific risk associated with exposure to violent atrocities, attributed these differences to the particular horror associated with intentional trauma and violence. Such trauma violates shared norms of appropriate and acceptable behavior. It undermines our faith in human nature, violating our trust in those we encounter in our social worlds (Charuvastra & Cloitre, 2008; King, King, Gudanowski, & Vreven, 1995). Along these lines, a meta-analytic review by Ozer, Best, Lipsey, and Weiss (2003) demonstrated that perceived *threat* is higher where traumatic events are experienced as a result of intentional violence. Similarly, in a comprehensive review, Charuvastra and Cloitre (2008) present evidence that intentional human acts of harm may be particularly pathological because they are associated with reduced trust, altered beliefs, and perceptions of threat.

Findings such as these have led to a number of authors to emphasize the third social dimension of trauma: its impact on the social attitudes and world views of those affected. Those most adversely affected by trauma, perhaps unsurprisingly, tend to believe that they have been let down or betrayed by others (Freyd, 1996; Herman, 1992). For example, in qualitative studies people who are bereaved by homicide commonly refer to an impoverished sense of connection with others in their community (Armour, 2002). Similarly, the loss of a belief in the good intentions of other people is reported (Andrews, Brewin, Rose, & Kirk, 2000). When adapting to and processing trauma, those affected suffer persistent intrusive recollections of the incident (i.e., reminders, vivid flashbacks, and nightmares). Because of this, members of affected groups may actively avoid ostensibly “neutral” circumstances that they feel may trigger recollection of their trauma. This avoidance can amount to social withdrawal, which alongside the loss of feelings of connection with others can substantively alter people’s sense of connections to others and the fabric of their social worlds.

In short, the experience of trauma that is due to intentional human acts, such as rape, abuse, killing, or terrorism, leads to heightened perceptions of threat that may impact on a person’s capacity for and interest in engaging with others, across family, community, and even ethno-religious and national boundaries. This in turn emphasizes the need for an approach to trauma risk and resilience that fully engages with its sociopolitical dimensions.

Who Is Most Likely to Experience Trauma?

Researchers from a range of disciplines including psychology, epidemiology, and political science have observed that health risks are not equally distributed. Members of some groups are more likely to be at risk for trauma and poor health outcomes than others (Marmot, 2015; Wilkinson & Pickett, 2009). However, these unequal health risks have typically been studied by focusing on the demographics of a population, rather than on psychological group memberships (of a form studied by social identity theorists; e.g., Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018). In the next section, we first review evidence that demographics matter profoundly to trauma risk. However, we then move on to explore why the social psychological concept of “a group” is also crucial to understanding demographic risk.

Demographics, Minority Group Membership, and Trauma Risk

The sustainable development goals (SDG) set out by the UN highlight the inextricable link between demography and trauma risk. The Peace and Justice goal (SDG 16) emphasizes the role

of societal structures, beliefs, and value systems in establishing safety, security, and protection of human rights. The World Health Organization has been at the forefront of work highlighting differences in morbidity and mortality rates across the globe. National group membership is an important dimension to health risk. Differences between nations are often linked to global inequality, and particularly poverty, with startling differences between life expectancy between rich and poor nations. These differences have multiple causes, including compromised infrastructure and limited public health resources such as access to clean water, vaccination programs, and health literacy.

These differences between national groups also extend to their exposure to traumatic events. Econometric studies show that the incidence of conflict is higher among countries with low per capita incomes (Stewart, Holdstock, & Jarquin, 2002). To illustrate this point, an analysis of the children who are most likely to experience war is instructive (Muldoon, 2013). Many of those most severely affected by war and political violence reside in the poorest regions of the world. By way of example 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). The highest rates of fatalities attributable to war was 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 many who are permanently disabled. Others are raped or tortured or suffer disease and famine. Available evidence suggests that those at highest risk of these experiences are those living in the least affluent nations of the world (Cairns, 1996; WHO, 2002).

The United Nations has emphasized the link between economic disadvantage and traumatic experience such as persecution. At the end of 2017, the UN estimated that a total of 68.5 million people had been forcibly displaced because of persecution, conflict, violence, or human rights violations (16.2 million in 2017 alone: UNHCR, 2017). At the same time, those at greatest risk of these adversities reside in the world's poorest nations, many of which are one of the 49 countries that have no laws against violence towards women and children. And approximately 10 million people are stateless, having been denied nationality and associated rights. Indeed, an unfathomable 1.1 billion people globally are estimated to be legally invisible (World Bank, 2019), being unable to prove who they are and therefore having no rights to welfare, health, or educational provision. Included in this number are an estimated 625 million children under 14 whose births have never been registered. Multiple forms of violence are the hallmark of life for this group.

However, national group membership is only one dimension of difference. For example, gender matters to health and trauma in a wide variety of ways (Connell, 2012). Results of research on the discrepancy between women and men in self-rated health have highlighted the complexity of gender differences in health (Bambra et al., 2009). In particular, while women's life expectancy is higher than men's, differences in morbidity are less clear cut than differences in mortality. Generally, men have more life-threatening diseases at younger ages (e.g., coronary heart disease), as well as more externalizing mental health problems (e.g., conduct disorder) and substance use disorders. Women present with higher rates of chronic debilitating conditions (e.g., arthritis and gastrointestinal conditions), and more internalizing mental problems (e.g., affective and anxiety disorders) (Needham & Hill, 2010). Critically, these differences vary in terms of the type of health indicator used, the life-cycle period analyzed, and intersect with nationality, race, and class (Connell, 2012).

Experiences of violence are also shaped, sometimes profoundly, by a person's gender. For instance, the experience of homicide and political violence are more common among men, increasing their risk of early mortality. The business of war and violence has been constructed as a masculine pursuit (McWilliams, 1997), placing young men at particular risk of being homicide fatality and casualties of war (Cairns, 1996). On the other hand, sex crimes during times of peace and war disproportionately victimize women (Seifert, 1996; Swiss & Giller, 1993). The use of rape as a weapon during war often has long-term consequences for girls and women, with the stigma associated with

being a victim of a sex crime grounded in strong ethno-religious beliefs (Kellezi, Reicher, & Cassidy, 2009). High experience of violence and victimization is also associated with transgender people. In a review of global evidence, Reisner et al. (2016) estimate that 44% 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 concomitant trauma.

Sociologists and social psychologists have also documented the incidence of violent experience and trauma in “peacetime.” For example, there were an estimated 475,000 deaths globally in 2012 as a result of homicide. Sixty percent of these were males aged 15–44 years. Overall, 82% of deaths due to homicide were male. Globally, homicide is the third leading cause of death for males in this age group (Butchart & Mikton, 2015). Within low- and middle-income countries, the highest estimated rates of homicide occur in the region of the Americas, with 28.5 homicides per 100,000 population, followed by the region of Africa with a rate of 10.9 homicides per 100,000 population (Mikton, Butchart, Dahlberg, & Krug, 2016).

As well as being directly damaging, there is follow-on costs to those bereaved by premature deaths (Simpson, 1997). For example, using nationally representative samples, death of a child prior to age 5 has been shown to heighten women’s risk of intimate partner violence across 13 African countries (Weitzman & Smith-Greenaway, 2020). So these early deaths often driven by unclean water, or inadequate vaccine programs, can be seen to result in additional stress for parents and particularly mothers. Equally, premature death of men due to accidents, suicide, or coronary heart disease can leave spouses negotiating new trauma and adverse circumstances (Simpson, 1997). This is not to belittle the fate of men, but rather to highlight that there is a link between the elevated risk of early mortality for men and the elevated risk of distress for women. Furthermore, in many countries, this will be compounded by circumstances that disadvantage women financially (Bindley, Lewis, Travaglia, & DiGiacomo, 2019). As well as being driven by poverty, negative health experiences such as bereavement and disability can have serious financial consequences, exacerbating the situation of the already disadvantaged (Bindley et al., 2019).

On the basis of this brief review, we can surmise that demographic factors are centrally relevant to health. Race, gender, nationality, and class all matter to morbidity and mortality risk (Assari, 2018; Cummings & Braboy Jackson, 2008) as has been clearly demonstrated during the current COVID19 pandemic (Bowleg, 2020). While the exact nature of these relationships is sometimes contested and often intersectional, the fact that groups are linked to health is widely accepted and acknowledged. However, it is important to be mindful of a caveat to such analyses—namely that it is not only objective financial position that is associated with health risk. There is a growing concern among researchers that traditional objective measures do not capture the meanings of class in people’s lives (see Adler, Epel, Castellazzo, & Ickovics, 2000; Savage, 2003; Singh-Manoux, Marmot, & Adler, 2005). Accordingly, *subjective* socioeconomic status has been linked to a plethora of health outcomes including depression, infant mortality, and morbidity, cardiovascular disease, and access to health care (Lorant et al., 2003; Pollitt, Rose, & Kaufman, 2005; Weightman et al., 2012). Even among children, measures of class that have subjective meaning are likely to be linked to demonstrable physical and psychological health effects (Huston & Bentley, 2010; McCullough, Muldoon, & Dempster, 2009). This necessitates a model of disadvantage and its link to health that not only explores the implications of the denial of material resources but is also sensitive to the (social) psychology of disadvantage.

An analysis that provides this social psychological analysis focuses on the role of nation, class, and gender not just as demographic factors (e.g., being from the United States, high SES, and female), but instead as psychologically meaningful social-group memberships (e.g., so that being American, affluent, and a woman is acknowledged as definitional to a person’s sense of self). In this regard, we argue that one reason why gender, class, and national group memberships have important consequences for health is that they position people as group members in relation to others (Bonanno,

Galea, Bucciarelli, & Vlahov, 2007; Cornish, Campbell, Shukla, & Banerji, 2012). Of relevance here is the extent to which demographics (and associated group memberships) interact with structural factors in society to determine the social status of an individual. Broadly speaking, demographics can relate to lower power and status position (e.g., being from a developing country, being working class) or higher social status (e.g., being male, being of higher social class). As we will clarify in the next section, it is the underlying social standing associated with a demographic characteristic, and not this characteristic in and of itself, that matters for health outcomes and trauma risk.

Group Memberships as Specific Risks for Trauma

The evidence reviewed above highlights the fact that risk of trauma and adversity is systematically associated with both demographic characteristics *and* group membership. Group differences in status impact the experience of trauma. Building on this evidence, we argue that this type of substantial and consistently distinctive experience of trauma divides people into meaningful cultural groups. And these are circumstances that are most likely to maintain conflict, thereby increasing further the differences in trauma experiences between groups.

Incidence and prevalence statistics bear out the idea. For example, war experiences themselves are not evenly distributed within a nation or population affected by the same conflict (Barber, 2009; Cairns, 1996) and a focus on group memberships might help to better understand trauma risk. By way of example, in previous work, we found that among children in Northern Ireland, those from low-income groups are more likely to be exposed to conflict than those in high-income groups. In a survey of 689 children, Catholic children aged 8–11 reported more experience of conflict and violence than their Protestant counterparts (Muldoon & Trew, 2000; Muldoon, Trew, & McWhirter, 1998). Subsequent work in Northern Ireland supported the link between religious group membership and experience of the conflict in a representative survey sample of adults (Schmid & Muldoon, 2015). Specifically, in a latent class analysis of this representative population, there was a clear category of people who had unusually high direct experience of the conflict. These people were largely members of the Catholic minority community. A second class of people—mostly Protestant majority group members—reported moderate direct and indirect experience of political violence. A third and fourth profile of experiences was characterized by limited indirect experience and no experience of the conflict respectively. These latter two groups were more privileged in terms of socioeconomic background. In comparative work, this majority-minority effect was also evident in Israel, where Jews were less likely to report direct personal exposure to the conflict than Arabs living in Israel (Hirsch-Hoefler et al., 2019). Similar intersectional differences associated with affluence, gender, and minority and majority group status have also been reported in other regions affected by conflict (Bryce, Walker, Ghorayeb, & Kan, 1989; Simpson, 1993; Slone, Kaminer, & Durrheim, 2000; Slone & Shechner, 2009). Any analysis of the impact of political violence, therefore, needs to acknowledge the likely risk people have of encountering political violence which is determined by their intersectional or multiple group memberships.

Although systematic cross-country evidence is rare, one study classified 233 politicized communal groups in 93 countries according to political, economic, and ecological differences (Gurr, 1993). This found that group-based inequalities often led groups to resort to direct action to assert their own interests, ranging from nonviolent protest to rebellion. In contexts where divisions are consistent, substantive, and increasing, this is likely to be associated with greater social polarization. Sharp inequalities in economic, social, political dimensions or status between culturally defined groups are also relevant to the development of conflict (Stewart, 2008). For example, group inequalities in political access frequently result in subordinate group members resorting to violence rather than seeking to resolve differences through political negotiation (Cederman, Gleditsch, & Buhaug, 2013). Group

inequalities in economic resources are also relevant. These differences or inequalities are not always large, and such conflict is not confined to poor countries (e.g., the Northern Ireland “Troubles”).

It is because of this that conflicts are usually understood through the lens of extant groups. Indeed, from a social-psychological perspective conflict can be understood as primarily an inter-group phenomenon (Kelman, 2010; Livingstone, Sweetman, Bracht, & Haslam, 2015). In particular, violence can be seen to arise because of conflict over power and resources; however, these occur in tandem with symbolic identity struggles that are just as important to understanding conflict dynamics (Kelman, 1999). For example, in the Northern Ireland “Troubles,” inequalities such as political representation or access to social housing ran in parallel with symbolic arguments over ethnoreligious heritage (Cairns, 1996; for similar analysis of Israeli and Palestinian conflict, see Kelman, 1999). Such dynamics also strengthen and consolidate social identities, allowing them to maintain their centrality as the social and psychological bases of political conflict (Cairns, 1996; Kelman, 1999).

In line with these observations, scholars both within and outside psychology, who have examined the legacies of colonization have considered how, as a consequence of their social position, subordinate group members can experience violence as both victims and perpetrators (Bulhan, 1985). Critical analysts and social dominance theorists have also highlighted how dominant groups oppress subordinate groups through violence (Jochnick & Normand, 1994; Sidanius & Pratto, 2001). What these contributions have in common is the foregrounding of *structural* divisions and sociological explanations of violence during war and peace time (Bobo, 1999; Mills, 2000). However, for our present purposes, the key point is that memberships of ethnic, national, gender, and class groups provide people with very different experiences of life. And these patterns of experience divide group members consistently and substantively into distinct and meaningful cultural groups. In this way, people’s sense of self and their place in the world are marked profoundly and very differently by the nature and extent of traumatic experiences.

The Social Identity Approach and Its Application to the Understanding of Trauma

Building on the recognition that people’s nationality, place of residence, gender, ethnic origin, religion, and language shape their lives in profound ways, we turn to the ways in which trauma-related challenges impact on health and well-being. Importantly for current purposes, there is now a growing body of work which shows that the groups to which we belong determine, not only our general health, but also the extent to which we are at risk of exposure to trauma (both large-scale traumas and everyday adversity). Therefore, in this section, we review the multiple ways in which group memberships (and the social identities derived from these group memberships) affect trauma risk and adversity. We also draw on the social identity approach (SIA) to understand how power and politics become embedded in different trauma trajectories.

In an era of movements such as #metoo, #blacklivesmatter, and #neveragain, there is a rising tide of awareness that the experience of identity-based trauma is social and political in origin and hence not inevitable. Yet while the social identity framework has been prominent in social psychology and sociology for over four decades, it is only in the last decade that researchers have clarified its relevance for clinical and health psychology (Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018; Haslam, Jetten, Postmes, & Haslam, 2009; Jetten & Haslam, 2012). The social identity approach focuses on understanding of the relationship between group memberships and the construction and consequences of internalized social identities. Incorporating *social identity theory* and *self-categorization theory* (Reicher, Spears, & Haslam, 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 also recognizes the capacity for attitudes, emotions, and behavior to be structured by people’s psychology *as group members*. In this, it is well placed to enhance our understanding of trauma.

Early work on social identity theory (Tajfel, 1982; Tajfel & Turner, 1979) focused on understanding prejudice and discrimination by focusing on the links between groups, identities, and intergroup relations. Subsequently, self-categorization theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) sought to also examine intragroup processes, not least by clarifying the psychological processes through which group memberships become internalized into a person's sense of self and the role of sociopolitical context and shared experience in shaping power and influence. As we will see in the following sections, the social identity approach—and the intra- and intergroup processes that it specifies—are relevant to both social and political attitudes on the one hand, and trauma risk and resilience on the other.

A Socio-Political Lens on Trauma: The Social Identity Approach

Tajfel's (1982) original formulation of social identity theory observed that the categorization of people into groups, such as Nazi or Jew, Catholic or Protestant, contributed strongly to the development of prejudice. Nazism was successful, he argued, because of the support it enlisted from "ordinary" Germans (Tajfel, 1982). Contemporary analyses continue to support this point, noting that many of the worst atrocities in history have arisen as a consequence of the complicity of a dominant national, gender, religious, or racial group (Lemarchand, 2011).

Early work informed by social identity theory (Tajfel, 1982; Tajfel & Turner, 1979) highlighted the significance of categorization on the basis of relevant social divisions for intergroup relations. Social categorization is a key process that underpins violence and conflict. A tendency to label or categorize self and others according to group characteristics facilitates self-stereotyping as well as prejudice and discrimination. Most famously, work inspired by the so-called minimal group studies (Tajfel, Flament, Billig, & Bundy, 1971) showed how mere categorization (into an otherwise meaningless group) enhanced "us-them" distinctions resulting in enhanced intergroup antagonism.

Fundamentally, though, a key meta-theoretical goal of the social identity approach is to link the sociological with the psychological (Haslam, 2004). Indeed, while categorization can and does occur in "minimal" conditions, it is easy to forget that Tajfel's (1982) fundamental proposition was that the reification of social categories occurs in ways that reflect meaningful social or political demarcation of groups. Theoretically then, the process of categorization is driven by existing social structures and social relations. This means that categorization is most likely to occur when social and political systems and structures (and the agents who represent and promote them, e.g., leaders) serve to make group differences meaningful (Haslam, Reicher, & Platow, 2011).

The central concept of the approach, of course, is "social identity": the sense of self that a person derives from their group memberships. As Tajfel noted (and showed in the minimal group studies), social identities provide an important platform for people's attitudes and behaviors towards their own and other groups. This includes evaluations of events that give rise to traumatic experiences such as prejudice, violence, and war. Although we often assume that judgments about the morality of violence and discrimination in these and other contexts are objective, they are in fact a product of group life (Clayton & Opatow, 2003). For example, in a survey of adolescents in Northern Ireland, violence against outgroups was perceived as more acceptable and justifiable by those who identified highly with a perpetrator group and its cause (Muldoon & Wilson, 2001). Equally, where people identify more strongly with a group, they are more likely to endorse hostility and aggression towards outgroups with which their group is in conflict (Halperin, Canetti-Nisim, & Hirsch-Hoefler, 2009).

Although we often think about traumatic events primarily in terms of their impact on health, traumatic events also have an impact on how we perceive and interpret the behavior of our own group and other groups. This point was highlighted by longitudinal studies in Northern Ireland and Israel/Palestine which looked at the impact of conflict-related experiences on attitudes towards conciliation. Across *both* contexts, and in both principal groups in each conflict, the distress that trauma

caused gave rise to feelings of threat from the other group that had a polarizing effect on group members' willingness to compromise (Canetti, Elad-Strenger, Lavi, Guy, & Bar-Tal, 2017). In this way, we see that social identity processes help us to understand not only the health outcomes of traumatic events, but also how such events can entrench intergroup conflict.

Similarly, in a study of Aboriginal people in Canada whose parents had survived institutional abuse, Bombay, Matheson, and Anisman (2014) found that social identities were an important driver of intergroup attitudes. More specifically, adult children of survivors of the Indian Residential Schools system with high identity centrality were more likely to see subsequent negative intergroup scenarios as the result of discrimination. The authors interpreted their findings as evidence for mutually reinforcing relationships between identity centrality and appraisals of discrimination. Appraisals of discrimination which 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.

Status is centrally important to understanding identities (Haslam, 2004). In general, minorities tend to be more "mindful" of their group membership and its position. In other words, their minority identity is more likely to be chronically salient (Palomares, 2004; Simon & Brown, 1987; Wang & Dovidio, 2017), and this brings with it an awareness on the part of group members of their positionality in society as a minority. Majority group members, on the other hand, are often less mindful of intergroup relations in ways that make them less aware of their identity position vis-à-vis others (Schmitt, Davies, Hung, & Wright, 2010; Simon & Hamilton, 1994). Indeed, majority identities can be so ubiquitous that group members have difficulty appreciating them as "social" identities (cf. Diangelo, 2018).

For this reason, majority and minority group members approach and adapt to trauma differently. Billig (1995) uses the concept of "banality" (with regard to nationalism) to refer to the greater availability of cultural, social, and psychological resources for majority group members. A *banal* identity is one rooted in an ideology that is imbued in an assumed way in everyday life and that advantages and reproduces the dominant perspective. By way of example, many aspects of life are gendered and advantage men. As a result, Perez (2019) observes that there are a range of large and small risks that women are exposed to in their everyday lives because they live in a world designed around the perspectives and needs of men. In particular, a gender data gap in health research contributes to misdiagnosis of life-threatening diseases and psychopathologization and mistreatment of women's reproductive health problems. The same 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 same health and design issues in turn place women at a higher risk of experiencing adverse consequences of trauma.

Equally, the existence of the national category and its boundaries is often banally assumed. In previous qualitative work, we have demonstrated that when atypical group members lay claim to an identity they can be met with surprise and even suspicion, particularly by prototypical majority group members (Stevenson & Muldoon, 2010). In addition, where banal membership is the default, atypical or peripheral members may be rejected by a majority group where they attempt to claim national identity (Joyce, Stevenson, & Muldoon, 2013). Following on from this, in a recently completed study, we found that minority group members in Ireland saw themselves as less prototypically Irish than majority group members and reported lower solidarity with the national community at the time of the emergence of the COVID-19 crisis (Foran, Roth, Griffin, Jay, & Muldoon, in review). This in turn led to lower adherence to the health protective behaviors being encouraged by national government. This can be seen as part of the reason that those on the periphery of the national community are more adversely affected by the pandemic. And it also suggests that the national health message may not meet the most pressing concerns and needs of peripheral group members. And as time goes on it may result in majority group members whose sense of connection to the state facilitates adherence to

health messaging are less traumatized by the current crisis. This is likely to exacerbate existing social tensions between majority and minority group members in multicultural societies.

As this example shows, distal group memberships are often connected to everyday social practices and patterned norms of behavior that accept the practices and the entitlements of majority/dominant groups while at the same time questioning the legitimacy of minority/subordinate groups. Indeed, because their identities are banally assumed, majority group members often have no understanding of the relevance of their social identity to their experience of life. Obviously, this too can give rise to divisions between groups which are fundamentally linked to group membership, group status, and social identities. In short, the evaluation of the trauma experienced by others is complicated by both shared group memberships and group status positions. So not only is the likelihood of trauma linked to the positionality of groups within and across the world's regions, the empathy and understanding offered when "others" face adversity is also affected by these factors.

A Sociopolitical Lens on Trauma: The Social Identity Approach

The social identity approach to health (SIAH) offers a theoretical perspective on the effects of internalized group membership on health and well-being. It argues that social identities can be an important source of *tangible psychological resources* that provide a platform for health and resilience and that can help people to counteract the adverse psychological impact of trauma. These may be material resources such as access to financial and medical support or intellectual resources that allow people to explain and find meaning in a traumatizing event (e.g., seeing it as having arisen in pursuit of a just cause; Kellezi & Reicher, 2012).

In this regard, self-categorization theory argues that social identification produces psychological alignment with members of the groups to which we see ourselves as belonging (e.g., other trauma victims) and distinction from relevant outgroups (e.g., groups unaffected by trauma, members of external agencies sent to help; Turner & Oakes, 1997). In this way, an individual's personal fate becomes psychologically tied to the fate of other ingroup members (Drury, 2012). And while the traumatic experiences of those with whom we do not see ourselves as sharing group membership are often ignored (or even belittled because they relate to "others"; Clayton, & Opatow, 2003; Koch, Imhoff, Dotsch, Unkelbach, & Alves, 2016; Levine & Thompson, 2004), the experiences of fellow ingroup members are generally taken much more seriously (because they are relevant to self; Haslam et al., 2018). As a result, the trauma experienced by ingroup members can have a significant ripple effect on the wider group (Huddy & Feldman, 2011; Muldoon & Lowe, 2012). Indeed, this means that the very same event could be a cause of either PTSD or a cause for celebration depending on the shared identity between the observer and those directly experiencing the event. For example, while New Yorkers may have been traumatized by the attacks on the Twin Towers but celebrated the killing of Osama Bin Laden, supporters of Al-Qaeda would be more likely to show precisely the opposite pattern.

When people self-categorize in terms of a given group membership, this is also a basis for them to feel connected to other group members. However, *which* group membership is used as a basis for self-categorization varies as a function of the meaning and relevance of a given group membership to the situation at hand (the principle of *fit*). For example, a person is more likely to define themselves as a member of a political group if they are at a protest rally than at a football match. This also means that where people are *treated* as members of a particular group (e.g., by the military) and this treatment fits with their stereotypical expectations of group relations (e.g., my ingroup is repressed by the state), then self-categorization in terms of that particular group membership is more likely (Klandermans, 2002). In this way, self-categorization in terms of a given social identity (e.g., as "us Jews" or "us political activists") provides a framework for interpreting potentially traumatic experiences, such that these are appraised not in a personalized way (as something relevant to "me")

alone) but through the lens of a given group membership (as something relevant to “us”; Muldoon, Schmid, & Downes, 2009).

In line with the foregoing arguments, a sense of shared social identity can also be seen as a basis for the provision and receipt of various forms of effective *social support* (Haslam, O’Brien, Jetten, Vormedal, & Penna, 2005; for a review, see Haslam, Reicher, & Levine, 2012). In line with this point, social support from ingroups has been shown to have a range of positive health consequences in traumatic circumstances in a way that is typically less true for support from outgroups which can be seen as unhelpful, undermining, and even disempowering (Kearns, Muldoon, Msetfi, & Surgenor, 2018; Pupavac, 2004; Walsh, Muldoon, Gallagher, & Fortune, 2015). Because we know that social support is crucial to both PTSD risk and resilience (Charuvastra & Cloitre, 2008; Hobfoll, 2011), it therefore follows that social identities are key to understanding how people deal with trauma.

Power, Politics, and Trauma Trajectories

How does a social identity framing help us to develop a better understanding of trauma? In a nutshell, we argue that because of the relevance of (1) positionality and status of group memberships and (2) the psychological resources inherent in social identities derived from these groups, post-traumatic sequelae are fundamentally borne of power and politics. To understand this dynamic, we begin by considering the protective role of group identification among those confronted with violence as a result of their beliefs and group memberships. Because social identities are dynamic, we next consider the way that the identities that emerge *in response to* traumatic events might affect the impact of the traumatic experience on post-traumatic stress. We then conclude this section by focusing on the importance of identity status dynamics for those negotiating trauma.

The Protective Role of High Social Identification in the Face of Trauma

Research on torture has shown that strong identification—often operationalized as commitment to the “cause” of one’s group membership—is protective for health. Among those who experience torture within their own countries, political activists emerge as less traumatized than nonactivists, even though activists often experience more torture (Başoğlu et al., 1997). In particular, comparing activist and nonactivist groups using a structured interview format, Başoğlu and colleagues (1997) found that the nonactivists—having no commitment to a cause or activist group or prior expectations of arrest or torture—were likely to report greater psychological distress and higher levels of PTSD symptoms. In another study, Başoğlu et al. (1994) compared activists who had and had not been tortured. Torture survivors reported having endured an average 23 forms of torture and the mean length of their imprisonment was 47 months. Most had experienced a range of indignities including threats to their life, witnessing torture of others, beatings, isolation, and hanging by the wrists. However, levels of PTSD within this group were only moderate; indeed, some tortured activists reported no symptoms at all. Moreover, those with strong commitment to their cause were least likely to be symptomatic. This is consistent with a social identity analysis, which would predict that the most committed activists had a framework through which to understand their experience and give it meaning. This meaning as well as mitigating the impact of the trauma allows activists to stay committed to their cause even in the face of adversity (Acharya, Muldoon, & Chauhan, 2020).

Some attribute this to a form of psychological preparedness or “immunization” on the part of these political activists (Başoğlu et al., 1994), who presumably saw their own national situation as so problematic that it warranted involvement in direct political action. In this way, the activist identity provides a framework for interpreting the trauma that is consistent with activists’ sense of the existing political situation (Başoğlu et al., 1997). Indeed, a large body of evidence indicates that a strong sense of identification predicts who becomes involved in political action in the first place

(van Zomeren, Postmes, & Spears, 2008). Furthermore, the salience of group membership increases when a group is oppressed, and so group members are more likely to be able to use this identity to make sense of their experience. As a result, trauma is more likely to be reported as something that can be endured because it reflects and embodies a higher commitment to a political cause (Acharya, et al., 2020).

A strong activist identity also impacts on the stereotypical expectations that activists have of the situation they find themselves in when captured. Many activists have a sense of their oppressors as people that they have never been able to trust and with whom they did not share values and norms (Acharya & Muldoon, 2017). Accordingly, experiencing torture from their oppressors does not result in a loss of faith or trust in these “others,” in a way that it may for nonactivists. Indeed, because identities are dynamic, the more activist group members are mistreated by their torturers, the better the fit between the perceptions of this treatment and stereotypical expectations of the other group. This results in higher engagement with the relevant social identity and a stronger sense of depersonalization (Klandermans, 2002). In this way, the forms of psychological immunization and preparedness identified by Başoğlu and colleagues (1994, 1997) can be seen as social-identity-based phenomena in which the relative resilience of activists arises from the ways in which activists position themselves vis-à-vis their oppressors.

Trauma and the Emergence and Availability of Social Identities

Although social identities are often grounded in ongoing group memberships, they can also be emergent outcomes of trauma. That is, trauma itself can facilitate the development of *new social identities*. In these situations, where the new identity is shared with others affected by the trauma, social identities can be seen as fundamental to resilience. Indeed, while early work focused on how traumatic events contribute to a sense of isolation, recent contributors in social psychology have moved the focus to highlight the way in which traumatic events can be instrumental in *consolidating* community and political identities in ways that sustain health (Drury, Cocking, & Reicher, 2009; Hutchison, 2010; Kearns, Muldoon, Msetfi, & Surgenor, 2017).

In a study of survivors of the London bombings, Drury, Novelli, and Stott (2015) presented evidence of shared identities emerging from the collective experience of this event (Drury et al., 2009). They observed that the sense of common fate that experiencing the event facilitated contributed to the development of shared social identity, which in turn played a positive role in ameliorating the potential negative consequences of the trauma. Similarly, Hutchison’s (2010) analysis of media reactions to the Bali bombing suggests that consolidating community solidarity lessened the impact of the event. This media coverage focused on the willingness of people to help others in times of great need and thus afforded victims, bystanders, and helpers to feel supported at a time of great sorrow and trauma. This same trajectory has also been apparent in responses to the COVID-19 crisis where a sense that “we are all in this together” provides a platform for solidarity on the part of those affected by the virus as well empathy, altruism, and great sacrifice on the part of those tasked with tending to them (Jetten, Reicher, Haslam, & Cruwys, 2020; Heffner, Vives, & Feldman-Hall, 2020; Holmes et al., 2020).

Drury and his colleagues (e.g., Drury, Cocking, & Reicher, 2009; Drury, Novelli, & Stott, 2013) have also studied British residents involved in a range of different traumatic events—including bombings, crushes at mass gatherings, and travel accidents. Although the majority of people who experienced these events tended to be unknown to each other, there was variation in the degree to which it was psychologically meaningful for participants to self-categorize in terms of shared group membership. For example, football fans at a match where a crush happened were more likely to feel a sense of connection to other fans than people caught in the bombing of a department store. In line with predictions derived from social identity theorizing, respondents who encountered traumatic

events in situations where there was a high degree of shared social identity reported feeling a strong sense of togetherness and solidarity—to the point where they were prepared to put the safety of others (including strangers) *before* themselves. On the other hand, in situations where there was a low level of shared social identity, people tended to feel that this was a situation of “everyone for themselves” and so feelings of isolation and fear were heightened.

In light of the importance of shared identification for resilience, Kearns et al. (2017) conducted a quantitative study which aimed to evaluate an initiative that sought to increase community solidarity among those bereaved by suicide. Participants were all attendees at a suicide awareness-raising event who completed measures of their own exposure to suicide, their sense of solidarity with the crowd at this community event, and their positive affect, both before the event and afterwards. Findings indicated that participation in the event had a positive impact on the well-being of participants ($N = 2050$). Moreover, this was particularly true for those who had experienced the death of an immediate family member by suicide.

A second important social identity resource associated with adaptive responses to trauma appears to be the group’s perceived ability to respond to trauma. In this vein, Drury and colleagues studied the 2002 Fatboy Slim beach party (Drury et al., 2013), in which an event designed to accommodate 65,000 revelers saw a dangerously high concentration of 250,000 people arrive on Brighton beach in the south east of England. Based on survey responses from 48 people who were caught up in the unfolding drama, Drury and colleagues suggested that the high level of shared identification among the crowd on the beach led to high levels of order and calm and, indeed, that this allowed the crowd to narrowly avoid the potential calamity. In particular, statistical analysis showed that high social identification was associated with a high level of collective self-regulation and that this was mediated by trust in the others in the crowd.

This same pattern was reproduced in a study of nearly 400 survivors of the 2015 Nepal earthquake conducted six months after this event had devastated large areas of the country—killing 9000 people, injuring over 20,000, and leaving more than 3 million people homeless (Muldoon et al., 2017). The extent and nature of traumatic experiences respondents reported was linked to respondent’s socioeconomic position and, in particular, in this study the respondent’s position in the caste hierarchy that persists in Nepal. This highlights the cumulative impact of adversity for the most disadvantaged groups. However, while exposure to traumatic experiences during the earthquake predicted higher rates of PTS symptoms, exposure was also associated with increased collective efficacy and community identification. Community identification and the sense that the community had the ability to overcome trauma (collective efficacy) also facilitated respondents’ adjustment to the adversity experienced thereby mitigating some of the impact of the trauma.

In short, recent contributors in psychology and political science have moved the focus from the isolating consequences of trauma to highlight the way in which traumatic events can be instrumental in consolidating social identity resources such as group solidarity (Drury, Cocking, & Reicher, 2009; Hutchison, 2010; Kearns et al., 2017) and collective control and efficacy (Drury et al., 2013; Muldoon et al., 2017). Importantly, then, while a wide range of commentators have emphasized the potential for trauma to destroy trust and lead to feelings of being let down or betrayed (e.g., Freyd, 1996; Herman, 1992), it is apparent that trauma can also facilitate new or strengthened identities which are a basis for solidarity and control that helps to counteract the feelings of threat and powerlessness that often accompany trauma.

The Importance of Group Status

As outlined in previous sections, the social identity approach highlights the interconnection between identities and structural and social divisions in society. As a result, identification, solidarity,

and belonging as well as feelings of empowerment and control are all inherently and inextricably linked to the relative position and status of groups in society.

This observation has important implications for trauma trajectories. For example, in a large representative study of the population in Northern Ireland ($N = 2000$), those with the most experience of political violence were those with the highest identification with their national group memberships (noting that the Northern Ireland “Troubles” can be in part simplified to a conflict between those who see themselves as “British” and believe that Northern Ireland should be part of the United Kingdom and those that see themselves as “Irish” and believe that Northern Ireland should be part of the Republic of Ireland). Moreover, this identification mediated the impact of the experience of violence on psychological well-being such that strong national identification was associated with fewer PTS symptoms (Muldoon & Downes, 2007; Muldoon et al., 2009). Importantly too, this relationship was most clearly evident among respondents who saw themselves as being part of the Irish national group—the group that was the numerical minority and the subordinate group socially, economically, and politically.

Along similar lines, research has found that women affected by conflict in Lebanon had lower level of PTS symptoms when their commitment to their ethnic group was strong. This was a benefit which was also evidenced in the comparatively better well-being of their children (Qouta, Punamki, & El Sarraj, 2008). And in Palestine, again among a minority ethnic group, those who were committed to political violence intended to improve the rights of Palestinians experienced less psychological distress despite greater exposure to conflict-related violence (Hammack, 2010). In this way, we can see that subjective social identifications have a considerable bearing on people’s interpretation of violence—particularly for minority or subordinate group members. Strong social identifications can allow violence to be interpreted as meaningful and even necessary to achieving valued group outcomes in ways that reduce people’s propensity to experience PTS/D.

However, this does not mean that having a subordinate group position is beneficial to the psychological health of those affected by trauma. In the large-scale study outlined above (Muldoon et al., 2009), those with an annual income of less than £10,000 had 2.3 times greater risk of being evaluated as a probable PTSD case than those who earned more than this, while respondents with a household income of less than £20,000 were at 1.32 times the risk. A similar effect was found in research among survivors of the 2015 earthquakes in Nepal. Although identification with the community was a protective factor, the number of PTSD cases was also strongly affected by people’s position in the hierarchical caste system which persists in Nepal.

Taken together, this evidence suggests that the social identities that emerge from trauma, or the existing identities that are associated with the trauma risk, provide an interpretative lens through which experiences are given meaning. This has important implications for majority group members who typically have higher status in society and who, as we noted above, tend to be less aware of their identity positions. For example, one study analyzed sympathetic callers to a national radio show in Ireland at the height of the refugee crisis in 2015, which troubled many Irish and European people (Nightingale, Quayle, & Muldoon, 2017). This analysis included charity workers and care professionals who had witnessed loss of life in the Mediterranean at the time. Callers described their emotional response to the plight of the asylum seekers. Interestingly, though, these same speakers struggled to articulate an inclusive sense of political solidarity—in part because the radio show’s national frame of reference and banal assumption of nationhood contributed to a form of ambivalence among respondents which increased their distress because it could not be reconciled with a meaningful political position or aligned with a preferred national response. Therefore, while members of majority groups are at less overall risk of trauma, they may struggle to harness their social identities in ways that support them to reduce their distress or help to engage prosocial action.

Quantitative survey work also suggests that group memberships affect how people respond to wartime contexts. In particular, there is evidence that majority group members are equally susceptible

to increased perceptions of intergroup threat, despite the fact that the risk of personal direct exposure to trauma is actually higher for minority group members (Mac Ginty & Du Toit, 2007; Schmid & Muldoon, 2015). In Northern Ireland, survey findings indicate that it is heightened perceptions of threat which were particularly linked to poorer psychological well-being for both religious minority and majority group members (Muldoon et al., 2009; Schmid & Muldoon, 2015). Intergroup threat was also linked to increased identification in both majority and minority group members. However, this increased identification was only protective for psychological well-being among minority group members.

Similarly, work on the unfolding dynamics in emergency crowd situations suggests that relative group-status positions affects peoples' understandings and representations of emergencies (Drury, 2018). Here too there is often a difference between emergency personnel and crowd members' identities and their subsequent interpretations of events. For example, in Drury et al.'s (2015) research in the aftermath of the Fatboy Slim concert, emergency personnel who were empowered to manage events saw them as extremely threatening while those who were caught up in them, and in particular those who were highly identified with the crowd, saw the situation as ordered and functional. Because emergency personnel did not share identity with the crowd, they were not able to make meaning out of the situation or predict crowd behavior. It therefore appeared more threatening in ways that seem likely to have been a barrier to effective management of the situation.

Trauma, Stigma, and Positionality

In the proceeding section, we suggested that minority or subordinate group status is a mixed blessing in the context of trauma. On the one hand, the denial of material and structural resources can increase the risk of PTS/D. Alternatively, minority group status can simultaneously offer some protection from trauma, because minority status is often associated with a stronger sense of shared social identity. However, it should be recognized that some traumas divorce those affected from their groups, and trauma itself can leave victims isolated or ostracized. In these cases, where the impact of experience of trauma repositions affected minority populations, adaptation to trauma will be particularly challenging.

The relationship between rape and unusually high incidence of PTSD speaks to this issue. Rothbaum, Foa, Riggs, Murdock, and Walsh (1992) found that 94% of victims reported severe PTSD symptoms one week after their rape, and 47% continued to have PTSD three months later. Similarly, Walker, Archer, and Davies (2005) reported extremely high levels of PTSD symptomatology in survivors of male rape. This may be in part because these kinds of trauma prevent social support and disclosure of trauma, due to fear of the reactions of others' (Ullman & Filipas, 2001). Here, then, the reduced identity resources available to these stigmatized victims (Walker et al., 2005) can contribute to the high rate of PTSD.

We propose that there is evidence here of these two identity processes at work. First, the availability of identity resources such as social support may be reduced. Second, people's subjective sense of themselves as group members may be undermined as a consequence of experiencing stigmatizing trauma such as sexual violence. Kellezi et al. (2009) investigated this possibility in ethnographic work among women who were traumatized by the campaigns of mass rape during the Balkans conflict. They found that normative perceptions of stigma associated with rape served to deter people from accessing support. Furthermore, PTSD was experienced more severely by women who remained silent for fear of being shunned for transgressing culturally acceptable norms of gender-appropriate behavior (Kellezi et al., 2009; Skjelsbaek, 2006).

Studies of male victims of rape also suggest that the counter-normative nature of this event exacerbates the trauma because of its identity-threatening dimensions (Creamer, Burgess, & McFarlane, 2001; Kessler, Mickelson, & Williams, 1999). Here, then, the perceived severity of the trauma is

intensified by both the stigma of the event and the consequent impact on social support (Walker et al., 2005). Powerful social prohibitions may also drive post-traumatic responses to nonviolent events. Speaking to this, Adewuya and colleagues (2009) examined PTSD in individuals diagnosed with HIV in Nigeria, a diagnosis that has been associated, like rape, with strong social stigma as well as traumatic responses. Again, the researchers documented social stigma and reduced access to social support networks—both of which would be expected to reduce access to social identity resources in ways that increase PTSD symptomology.

There is also strong evidence that emotions that are bound up with PTS symptoms and the situations that give rise to them (e.g., war, political and gender-based violence) can be group-based and experienced collectively (Halperin, 2015; Imhoff, Bilewicz, & Erb, 2012; Muldoon, Trew, & Devine, 2020; Smith & Mackie, 2015). This is true, for example, for feelings of guilt, shame, sadness, betrayal, humiliation, and anger that frequently accompany and exacerbate PTSD (Freyd, 1996; Resick & Schnicke, 1992; Reynolds & Brewin, 1999). Here too, while some collective emotions may help people deal with trauma (e.g., hope), others may undermine adaptation (e.g., guilt). In responding to the COVID-19 crisis, for example, it seems likely that people who feel their national group response offers learning and hope for the future are likely to show more resilience than those who feel ashamed of their national group response.

Sometimes traumatic events also transgress social mores. As a result, survivors of trauma may find themselves either removed from sources of social support or, worse, feel that their transgression justifies their suffering (Bradshaw & Muldoon, 2020). For this reason, traumas that are stigmatizing are likely to reduce people's ability to engage with others in their existing social networks (Muldoon et al., 2019; Naughton, O'Donnell, & Muldoon, 2019) as well as the legitimacy of complaints about the situation in which victims find themselves (Bradshaw & Muldoon, 2020). Where this is the case, this is likely to impact profoundly and negatively on the well-being on those affected by stigmatizing trauma and adversity (Stevenson et al., 2014).

Trauma Defines Groups

In this section, we consider the consequences of trauma for groups and identity. We begin by considering how the experience of trauma may create different social realities for people as a function of their group membership. Here we observe that traumatic experience can become central to social identities and also central to how group members define themselves. There are two different ways in which trauma defines group membership. First, trauma in and of itself may be defining for victims as well as their wider social network. For example, bereaved children are often defined as orphans, bereaved spouses as widows. However, sometimes there is not perfect symmetry between the experience of trauma and group membership. For example, not all group members may have experienced trauma; however, all group members are aware of their greater risk, and many have experienced less intense forms of the same adversity. In the 21st century, this type of effect has been most clearly illustrated through the emergence of the #metoo and #blacklivesmatter movements that highlight respectively how the lived experience of women across the world and ethnic minorities in the United States have been defined by a continuum of traumatic experiences from verbal harassment through to violent death (Jee-Lyn García & Sharif, 2015; Szymanski, 2020). These movements alert people to the fact that even simple activities like riding public transport, exercising or shopping are experienced very differently because of group membership. Their effect is also to make it more likely that these group-based patterns are felt and experienced as both ubiquitous and defining for some groups. A second process then is when trauma risk comes to inform the everyday life of group members at the same time that it remains beyond the experience and imagination of other groups—often those that are more dominant in a given society (e.g., men, Whites). Yet this fact in turn means

that traumatized groups can have difficulty having their trauma acknowledged, in ways that foment injustice and anger (itself a core symptom of PTSD).

Traumatic Experience Can Place People in New Groups: Refugees Are Made Not Born

Some people are defined, by others or by themselves, though their exposure to a trauma. For example, we often talk about “refugees,” “orphans,” or “victims”; labels applied to groups of people because of their prior traumatic experiences. These labels define people based on their shared experience of war, bereavement, or violence. For the most part, the category labels applied to those with experience of trauma are defined by sorrow and passivity: People are constructed by both themselves and others as being victims of circumstance (Bradshaw & Muldoon, 2020). Here, using evidence from the research literature on forced migration, we consider how those displaced by conflict fare when they take on the mantle of refugee.

In the first instance, category labels can offer members of traumatized groups a sense of shared experience with others who have survived similar difficulties. Refugees often survive traumatic and dangerous experiences associated with forced migration, including loss of family members, torture, and rape (Jeppsson & Hjern, 2005; Schweitzer, Melville, Steel, & Lacherez, 2006). At a time when people may be at their most traumatized, and feeling very threatened, a sense of shared experience with similar others can be a salve. This point emerges from work by Hernann (2016) which 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 their hardships and disconnection by strengthening new relationships through a process referred to as *communitas*.

A related point emerges from research by Dudley’s (2011) which examined 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 as a sense of connection to home. In this way, 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 refugees in Turkey, Smeekes, Verkuyten, Çelebi, Acartürk, and Onkun (2017) found that refugees who had maintained group memberships and therefore had a sense of identity continuity had higher well-being after their migration than those who reported losing group memberships. Thus, as suggested by the social identity model of identity change (SIMIC; Haslam, Haslam, Jetten, Cruwys, & Steffens, 2020), while acquiring a new group identity as a refugee may itself create a sense of disconnection from one’s nation or family, those who are able to hold preexisting identity resources are more resilient.

Echoing this finding, stories of forced migration point to the importance that even very young refugees ascribe to remembering and living by their family’s values in an effort to survive and maintain hope (Marlowe, 2010). Marlowe’s narratives of Sudanese refugees highlight how stories of trauma, hardship, and despair also reveal the oppressive and marginalized circumstances of the lives of people affected by trauma. These experiences of refugees after migration are also centrally relevant to well-being. Among Darfur refugees, Rasmussen et al. (2010) found that ongoing unmet needs mediated the effects of trauma on distress in a sample of 848 Darfuris across two refugee camps. These authors concluded that although war-related traumatic events are the initial causes of refugees’ hardship, the day-to-day challenges and concerns in camps are more central to people’s adjustment.

Herein lies a paradox. 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 therefore offers traumatized 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. As a result, the concept of “refugeehood” within resettlement contexts can become a master identity that defines a person above and beyond any other group membership. On the other hand, it is a label that has been associated with systematic marginalization, confinement, and stigmatization (Bradimore & Bauder, 2012; Jackson & Bauder, 2014). This is because of a two-way relationship, where groups most at risk of trauma are the dispossessed, but equally those traumatized can become dispossessed, and this has an impact on access to economic, cultural, and social resources. Thus, what begins as a day-to-day hassle for refugees becomes an ongoing challenge. For these two sets of reasons, becoming a refugee can be considered both a “social cure” and a “social curse” (Muldoon et al., 2020) in so far as the group membership that is derived from the traumatic flight experience is fundamentally linked to both protection and peripherality, passivity and agency, empowerment and disempowerment.

Trauma Foreshadows Group Membership: Why Do We Need to “Keep Women Safe”?

Group members share similar experiences of life. Indeed, the patterned experiences that group memberships provide are a key means by which people come to understand their position and place in the world, as well as their connections to others with whom they share social identity. This point is highlighted by the way in which a range of traumatic experiences are inherently linked to preexisting social groups. 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 are commonly referred to as “the Troubles,” the trauma of internment 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. And clearly while White people are affected by police violence and non-Palestinians are affected by Israeli air strikes, for affected groups, being Black, Catholic, or Palestinian in these contexts is inherently linked with these experiences.

Put another way, trauma risk can be an essential component of particular group memberships. For the purposes of illustration, we can look in more detail at the case of violence against women. The UNHCR (2011) 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% of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a nonpartner (not including sexual harassment) at some point in their lives. However, some national studies show that up to 70% of women have experienced physical and/or sexual violence from an intimate partner in their lifetime (Heise & Kotsadam, 2015; Shepherd, 2019). Because of this, being female becomes tied up with the experience, expectation, and understanding of this type of trauma risk (Iyer, 2019; Tinkler, Becker, & Clayton, 2018). In other words, violence, and managing the risk of violence, is central to the experience of being a woman.

Available data support this position. Indeed, gender is linked to risk and vulnerability to violence in everyday conversation (Hollander, 2018), news media (Bleiker & Hutchison, 2019), mainstream social representations (Lelaurain et al., 2018), as well as social policy and practices (Hyman et al., 2016). Despite this, the analysis of gender-based violence is skewed by assumptions about gender and risk. Mainstream accounts of violence within the field of sociological criminology routinely leave gender out of focus or present it as separate or somehow “different” from “normal” forms of violence—as witnessed by the emergence of a specialized field of gender-based violence (Walby,

Towers, & Francis, 2014). Given the unusually high prevalence of violence against women, largely at the hands of men, constructing this as “niche” is remarkable. Equally, the literature on the impact of rape implicitly associates rape and sexual assault with gender. Indeed, a review of the literature reveals how rare it is for studies of sexual assault to ask men about their experiences of this trauma. Thus, in a Web of Science search of studies published since 2000 using the key words “gender,” “violence,” and “post-traumatic stress,” the vast majority of the more than 804 studies we reviewed included only women. Moreover, the study titles often make no reference to the fact that their sample is exclusively female. In so doing, authors make an assumption that rape and sexual assault is an experience that has female victims. Equally remarkable is the relative dearth of studies that examine the psychopathology of men that perpetrate rape and sexual assault, while documenting the multiple psychopathological consequences for female victims.

Indeed, men’s perceived greater strength and women’s perceived vulnerability are often so taken for granted in everyday conversation that they are unremarkable. In one interview study of almost 200 university students in the United States, sexual violence was oftentimes seen by respondents as “natural,” thus making it invisible or at least inconspicuous in daily life (Tinkler et al., 2018). In another study, Iyer (2019) asked secondary-school pupils to reflect on the 2012 Delhi gang rape that sparked widespread debates about violence against women in India. Young people’s understandings were heavily linked to gender. In particular, girls reported day-to-day experiences of schooling that were shaped by constructions of girls’ vulnerability and lack of agency. In contrast, boys’ narratives revealed assumptions of implicit capability and even heroism. Indeed, linking violence against women to gender roles works to further obscure violence against women by making it a banal, culturally assumed, norm. Here, then, the “natural” gendered assumption provides an identity-based prescriptivism that is highly patterned and rarely questioned (Klein, Spears, & Reicher, 2007).

At a sociocultural level, although violence against women is an inevitable feature of everyday life, certain types of violence against women, especially rape and sexual abuse, are predictors of an increased risk of PTSD (Darves-Bornoz et al., 2008). A number of authors have emphasized the potential for these kinds of trauma to destroy trust and to lead to victims’ beliefs that they have been let down or betrayed (Freyd, 1996; Herman, 1992; Shay, 1995). This is likely to be particularly the case for women who experience violence at the hands of intimate partners and family members, rather than at the hands of the more distant outgroup members (of a form that men face during war). And so perhaps it should not be surprising that rape, over and above many other traumatic events, is most strongly associated with PTSD diagnosis because of it fundamentally fractures social relations within a person’s intimate and valued social groups.

Despite this, “sex” differences in the increased vulnerability to PTSD among women have been variously attributed to brain morphology, gendered interpretations of trauma, or/and the peritraumatic dissociative experience (Kalaf et al., 2017). Typically, research controls for trauma experience and other factors such as assaultive experience or prior experience of trauma to highlight women’s inherent biological vulnerability (Ramikie & Ressler, 2018). Such analyses often reveal that women have a higher probability than men of developing PTSD once they are exposed to trauma, independent of previous traumas, experiences of sexual assault, other violent experiences, or level of education. Such analyses assume these variables are discrete social factors that can be partialled out. However, this essentially denies the all-encompassing nature of the risk, the major and minor aggressions of gender-based violence women face every day, and the ways in which these influence trauma trajectories for women in a diffuse, rather than a discrete, way.

Rather than reflecting women’s biological vulnerability, these findings can be seen to reflect the sociopolitical reality of women’s lives. All women are aware of the need to keep safe during even the most mundane activities (e.g., see Figure 1). And those women who have experienced gender-based violence are more acutely aware than most other women. Nevertheless, constructions of gendered violence make it particularly difficult for women to navigate when they experience it. By way of



Join together

- Consider exercising in a group to gain confidence from others and the support of a network. Group activities are more sociable and avoids the need for headphones, which can deter threatening behaviour. They can also motivate you to stick to your fitness goals!
- A joined up approach can tackle this behaviour. Get support from your local community and share a warning to perpetrators by putting up posters in problem areas or sharing social media posts to promote a message of zero tolerance. [Download our poster and social media graphics below.](#)

Remain Observant

- Be alert but not worried. Enjoy your time exercising and remember your safety should always be your priority.
- If an incident occurs, note distinguishing features like a company name, vehicle type or personal description and remember the time and location. It is also legal to take photos if a crime has occurred.
- Stay cool and remain an 'observer'. Responding to hecklers isn't always the safe or appropriate thing to do, as it can encourage further exchanges and escalate the situation.

Give us a call

- If the incident is in progress we may be able to respond immediately so call 101. If it is an emergency or you feel in danger always call 999. You can also [report online](#) after the incident and this can be anonymous.
- Telling the police could result in a warning, a community resolution or possibly a conviction, especially for repeat offenders.
- Reports may not always result in arrest but your information ensures police are aware of local issues and can develop a strategy to tackle them. You may be able to prevent this happening to someone else.

Figure 1. 2019 police notice in use to combat harassment of exercisers in the UK. Downloaded from www.avonandsomerset.police.uk/news/2019/01/getting-fit-for-2019-you-need-to-jogon. [Colour figure can be viewed at wileyonlinelibrary.com]

illustration, one can see that the police notice in Figure 1 advises people (women) that (in order to minimize risk of violence) they should exercise with others, remain vigilant when outdoors, and seek help. In all of the notices published by this police service, the exerciser was a woman. This speaks to a number of shared assumptions about the nature of violence and those who are subjected to it. First, it tells women this is a problem for them *as women*. Second, it tells then it may not be safe for them to be outdoors alone. Third, it tells them to be vigilant against potential attacks. And fourth, it tells female targets they need help from the (largely male) police force to deal with this form of violence. So while the poster was undoubtedly intended to be helpful, it actually sends a range of messages which position women as vulnerable to trauma, needing to be wary of risk, and highlights their dependency on others for their safety.

Despite this, assumptions about the nature of the gender-based violence means that notices such as these are unremarkable, as unremarkable as the practice of controlling for gender in research on trauma. However, this example also illustrates how gender and trauma are profoundly intertwined. Gender identity is more than trauma risk, yet we can see how it imbues everyday lived experience and the perils that women may face. And though men may experience these same events, this experience for them is more remarkable and far less threatening. Men know that despite any public heckling from other people they are largely safe to exercise. Women on the other hand are aware and indeed reminded by this notice, that gender-based violence is a real and present danger. And so, in rich and textured ways women's and men's experience of the most banal activities are inherently linked with trauma risk and resilience.

Challenges and Conclusion

Taken together, the analysis developed above points to a new way of thinking about trauma that centers on appreciation of its social psychological dimensions—especially those that relate to the social identities of people who experience trauma. Among other things, this has the potential to

increase our understanding of the very differing trauma trajectories that are evident even when people experience the same trauma. For example, we know that the impact of traumatic experience can be mitigated by access to social identity resources such as the strength of a person's social identification with relevant trauma-relevant groups (Cruwys et al., 2014; Muldoon et al., 2009), their access to group-based social support (Dingle, Stark, Cruwys, & Best, 2015; Haslam et al., 2005; Kearns et al., 2017), their sense of identity-based common fate and shared experience (Bradshaw & Muldoon, 2020; Drury, Brown, González, & Miranda, 2016) and group-based trust. We know too that poorer responses to trauma are more likely when this undermines or compromises valued social identities (Bombay et al., 2014; Robinaugh & McNally, 2011).

We can see too that it is crucial that conceptualizations of PTSD do not divorce traumatized individuals from the social context in which their trauma is experienced. To emphasize the role of individual pathologies, while neglecting the role played by wider societal practices and structural factors that contribute to the generation and management of trauma compromises both our scientific understanding and good practice. Indeed, our analysis tells us that stigmatizing trauma can reduce normative expectations of social support in ways that have negative consequences for victims. It also tells us large-scale events which generate national sympathies for victims can provide support and reduce the likelihood of PTSD. Equally, comparable experiences that arouse little response, or which leave victims confused or blamed, are likely to result in heightened PTSD symptomology.

This analysis also points to the need to consider the role of the clinician in the evaluation of PTSD. Clinicians often assess their patients from the perspective of a mainstream and middle-class world. Yet as we have seen, events that may seem unusual to members of more advantaged and/or majority ethnic groups can be experienced as normal, and therefore not worthy of comment, to other cultural groups. Similarly, events that a clinician might think of as exceptional and traumatic may not be viewed in this way by a client. This appraisal is functional in terms of PTSD but relies heavily on social identity understandings of what is normal and expected (e.g., in Rwanda, the Army, or an impoverished neighbourhood). Here, a person's sense of being of my country, my gender, occupational group or neighborhood can help them to make sense of the event. Moreover, a sense of adversity as being central to "who we are" can also allow people to make sense of their experience. Accordingly, practitioners who undermine the coherence of this world view may unwittingly undermine their client's mental health. This is likely to be a difficult issue to negotiate in everyday practice.

There are also many future methodological challenges. As we have attempted to highlight, social identities are dynamic constructs that emerge and evolve in different ways. Traumatic contexts can also shape these constructions. In situations where power and conflict dynamics are at play, constructing one's group as the victim in the situation can allow disempowered groups to reclaim some power. In this way, dynamics identities are used strategically to reposition the group. However, if conditions are polarized (as they often are in conflict situations) between men and women, Catholics, and Protestants, or Blacks and Whites, a group's claim to victimhood can exacerbate intergroup tensions. This tension is facilitated by the fact that often two groups occupying polar positions will have no understanding of the lived experience of the other group. However, these positions can also be seen as a product of the false binaries that often arise in polarized situation—where we routinely construct groups as either victims or perpetrators, PTSD cases or noncases, happy or depressed. However, identities are dynamic rather than static. Context and positionality matter, and these can shift relative to the gender, race, class, or national group. As such it is better to think of groups along a continuum from powerful to powerless and to understand trauma, with reference to the costs and benefits associated with these different identity positions.

Methodologically, the dynamic nature of social identity also creates challenges. A dynamic construction of identity is difficult to measure and manage in terms of research. Added to this is the fact that some identities are largely invisible even to those that hold and honor them (Stevenson & Muldoon, 2010), and we know that multiple group memberships and multiple identities are centrally

relevant to issues of trauma and stigma (Kearns et al., 2018; Kinsella, Muldoon, Fortune, & Haslam, 2020). Multiple methods need to be brought to bear on this topic, and researchers need to be open to working at the interface of politics, sociology, and psychology.

To date, the research literature has largely highlighted the fact that trauma and identity is linked to negative social attitudes and outcomes. However, we also propose that trauma may—when it drives growth in social identities—ultimately contribute to positive outcomes and progressive forms of social change (Solnit, 2009). Indeed, a small but promising body of work shows that the social identities acquired as a result of trauma may be linked to post-traumatic *growth* (Muldoon et al., 2019; Vezzali, Drury, Versari, & Cadamuro, 2016).

These are issues that have recently come to the fore in the face of the COVID-19 pandemic. Here there is a strong sense that our current collective trauma will have political consequences. We can see too that the adverse impacts of COVID-19 are linked to status, power, and positionality in society. Those who cannot afford the luxury of physical distancing or self-isolation are made more vulnerable (Chung, Dong, & Li, 2020). Furthermore, the crisis is drawing wider health inequalities within and across nations into sharp relief (Atchison et al., 2020) and is highlighting very clearly how inequality damages both the rich and the poor. Though this has been articulated before (Wilkinson & Pickett, 2011), we hope this crisis will be a cause for a sea change in thinking. We can think of this as a form of collective post-traumatic growth in that it may occur at the level of nation, federation, and even globally. This type of collective growth might include a greater awareness of collective possibilities and purposes, an enriched sense of ourselves as group members with improved connections to other group members (Solnit, 2020). As such, social identity growth is plausibly an important driver of social and political actions. Importantly, this could also articulate a link between psychological distress associated with trauma and altered collective social or political priorities.

At the same time, moving away from an individualized model of trauma has benefits and costs. A potential cost is that we may deny the distress of those most in need. This is not at all our aim. However, our approach questions the prevailing focus on individual treatment and argues instead for a serious interrogation of the pathogenic effects of inequity and adversity. Attending to the collective determinants of these two things orients us to the role of the wider social environment and structural inequalities that create and maintain cycles of direct and indirect violence. It also highlights the importance of collective efforts to dismantle pathological environments. As we rethink our world during this COVID-19 crisis, this has never been more important.

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