1 *The Need for a Social Psychology of Trauma*

1.1 Chapter Outline

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

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

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1.2 A Tale of Two Traumas

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

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

I have had other far less dramatic experiences in my life, however, that I would describe as more traumatic than this explosion. I found

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

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

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

what risks COVID-19 brought. Sadly, and to my immense regret, he died in pain. Rightly or wrongly, I see this as something that I should have been able to foresee and feel that I let him down in his hour of need. This feeling has not been made easier by the fact that he had always done his best to care for me and my siblings over his lifetime.

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

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

1.3 Contemporary Models of Adaptation to Trauma

A key concern of many clinicians in both psychology and psychiatry is to figure out who is most at risk of succumbing to the ill effects of trauma (Bomyea et al., 2012). We can see this concern at work across

those who practise in the field and also in dominant narratives in Western countries when we talk about mental health and trauma. It comes through in ideas associated with detection for early intervention. Early identification is believed to facilitate prevention of the later development of mental health problems, referred to sometimes as 'psychopathology'. This view is built on the idea that human psychology and causes of human psychopathology are predicted by individual characteristics – attributes that are unique to people. It encourages a search for key traits or characteristics of vulnerable people. Those who succumb to the consequences of traumatic stress are somehow different and distinguishable from those who do not. Before we move on it is worth considering the truth or otherwise of this claim.

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

There is good reason to pay attention to these types of victim-blaming processes. Traumatic experience is inherently shaped by power and politics. Patterns of traumatic experience are not randomly distributed across the population. People routinely speak of random acts of violence, but trauma and resultant effects on mental health are patterned (Cairns, 1996; Muldoon, 2013). We know that the greatest burden of trauma in terms of the scale and intensity of suffering is felt by those who experience

war and sexual violence (Kessler et al., 2005). Trauma of war is disproportionately felt by those living in the poorest regions of the world. And even within regions affected by war and political violence, those with the greatest trauma experience are those of minority ethnicities within the lowest income brackets. Equally, we know, though a global phenomenon, the magnitude and intensity of gender-based violence is amplified in societies where gender inequality is highest (Buvinic et al., 2013). Though these are themes to which we return, for now it is sufficient to say that those affected by trauma are very much a product of their circumstances. Ignoring the dysfunctional social and political circumstances that give rise to trauma may inadvertently foment political anger and violence, because we also ignore the circumstances that those who are minoritised – by their age, gender, class or ethnic group – must endure. This is a theme that lies at the heart of this volume.

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

1.3.1 Defining Psychological Trauma

For the purposes of clarity and because there is limited agreement about the definition of 'trauma' in psychology, here we spend a bit of

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

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

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

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

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

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

1.3.2 Common Responses to Traumatic Experiences

Post-traumatic stress (PTS) is probably the most commonly known response to traumatic experience. Post-traumatic stress disorder (PTSD) is a major mental health diagnosis and carries a significant

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

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

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

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

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

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

feel tired or even cry for very little reason. Nonetheless, most of us ultimately find our way through the distress of traumatic experiences.

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

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

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

PTG is a remarkably common experience. Some degree of growth is reported by 30–80 per cent of people who have experienced trauma (Linley & Joseph, 2004). In common with PTS, it is experienced along a continuum, with people differing in the amount of growth they report. When people show PTG, rather than a return to pre-trauma functioning, they report beneficial psychological and social changes, including perceptions of improved relationships with others, an enhanced sense of self and/or a renewed sense of the meaning and possibilities of life (McGrath, 2011). PTG differs from resilience and

recovery. It is not merely a *restoration* of one's pre-trauma state of functioning, but a feeling that the traumatic experience has improved people's previous ways of thinking, indicative of a re-orientation towards new values or priorities.

1.4 The Case for a Social Psychology of Trauma

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

1.4.1 The Nature of Trauma and Post-traumatic Outcomes

There is a large body of research that demonstrates that not all traumas are equivalent in terms of risk for subsequent PTS. Traumas of 'human design' (APA, 2000) are consistently demonstrated to be those that result in the highest rates of PTS symptoms and ongoing concerns about people's well-being (Charuvastra & Cloitre, 2008). The impressive National Comorbidity Survey in the United States indicates that intentional acts such as rape, childhood abuse, combat exposure and physical assault are linked to approximately double the incidence (i.e., the number of new cases) and prevalence (i.e., the number of existing cases) of PTSD cases when compared with cases arising from

unintentional and accidental traumas such as car accidents, fires and natural disasters (Kessler & Merikangas, 2004; Kessler et al., 2005). Similarly, using a strong design that allowed people to be followed over time, a group of Israeli researchers showed that PTSD was higher amongst those involved in a terrorist attack than those involved in car accidents. Avoiding recall biases associated with asking people about their experiences after diagnosis, this study demonstrated that those who survived a terror attack had twice the incidence of PTSD compared with survivors of motor vehicle accidents (Shalev et al., 1998) despite having similar injuries.

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

1.4.2 *Trauma and Trust in Others*

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

These findings lie at the heart of why all trauma, and most particularly intentional human acts of harm, may be pathological. Traumatic experience impacts on a person's ability to engage with others,

hampering both social relationships and feelings of connection with others (King et al., 1995). In this way, as well as the negative consequences of the experience itself, violent traumatic experiences alter the social resources people have available to them in a more substantive way than accidents and natural disasters. For example, in qualitative studies, those bereaved due to homicide report an altered sense of connection with others in their community (Armour, 2002).

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

Trust is particularly important in situations where there is a high degree of uncertainty and where people feel they are vulnerable (Cook, 2005), a characterisation that can be easily used to describe the COVID-19 pandemic. Trust is the basis upon which people access their social networks and shared health, community and commercial resources to deal with vulnerability in uncertain times. For example, functional families and relationships, education, health and welfare systems, governance and law all rely on public trust and trustworthiness to ensure safe delivery of services. Traumatic experiences that negatively affect people's ability to trust, as well as interfering with psychological health, also have social and political repercussions. Many people faced traumatic experiences similar to those I have described during the lockdowns associated with the pandemic. And

many feel let down by their health or social care system. Because of the impact of this experience on our ability to trust these systems, the damage of the COVID-19 crisis does not vanish when restrictions ease. Rather, it leaves a pall that will have longer-term social and political implications.

1.4.3 Social and Political Ripple Effects of Trauma

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

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

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

Many events experienced remotely, from natural disasters to accidents, homicides and terrorist attacks, do appear to have wider social and political ramifications. For instance, subjective reactions to the 9/11 attacks in the United States shaped support for subsequent national security policy in that country. Support for a strong national security policy was most pronounced among Americans who witnessed the

events of 9/11 remotely. They perceived a greater threat from terrorism and felt angry at the terrorists. Those personally affected by contrast displayed more anxiety, which translated into less support for military action (Huddy & Feldman, 2011). Similarly, in Northern Ireland, in a way that was not evidenced by those personally affected, indirect experience of political violence was related to support and sympathy for political violence across both communities (Hayes & McAllister, 2001). Traumatic experience that is witnessed remotely then can be distinguished from personal experience of trauma. It is distinguishable conceptually as well as in terms of its clinical consequences and social and political implications.

1.4.4 Collective Trauma

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

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

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

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

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

1.5 Conclusion

Feelings of isolation and distress are as much a part of life as hope and happiness. Distress and sadness ebbs and flows over the course of life. In my own story of two very different traumatic experiences, the role of others with whom I could share my experience, and in one case my

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