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The social psychology of responses to trauma: social identity pathways associated with divergent traumatic responses

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ABSTRACT
Research in clinical psychology and social psychiatry has highlighted the importance of social factors for outcomes following trauma. In this review, we speak to this issue in two ways. First, we highlight the value of a social identity framework for understanding the experience and impact of psychological trauma. Second, we draw on the Social Identity Model of Identity Change (SIMIC) to understand reactions to trauma. Specifically, we show (a) that negative responses to trauma are more apparent where trauma serves to undermine valued social identities; (b) that people prove more resilient in the face of trauma when valued social identities can be maintained or new social identities developed; and (c) that where old or new positive identities are reinvigorated or extend the self, this can be a basis for post-traumatic growth. We conclude by discussing the implications of this model for practice, and emphasise the importance of social identity management in the aftermath of trauma.

ARTICLE HISTORY Received 4 October 2018; Accepted 3 December 2019

KEYWORDS Social identity; social identity change; trauma; post traumatic stress disorder; post traumatic growth

Although symptoms of post-traumatic stress (PTS) can differ across cultures, there is robust cross-cultural and historical evidence that exposure to extreme traumatic experiences can trigger extreme psychological distress (e.g., Brewin, Dalgleish, & Joseph, 1996). However, such responses are not inevitable, and there is a growing awareness that traumatic events do not always have adverse psychological sequelae (Halligan & Yehuda, 2000). In particular, some traumatised populations not only demonstrate resilience,
but also report post-traumatic growth (PTG) in response to the experience of extreme events (Joseph & Linley, 2006). Indeed, the vast majority of individuals exposed to violent or life-threatening events do not go on to develop post-traumatic stress disorder (PTSD). Many experience short-lived or subclinical stress reactions, but these symptoms often abate spontaneously (Bonanno, 2004).

The analysis we present in this review uses the social identity approach to understand how features of social categories and group life may determine individual responses to trauma. This approach is consistent with the broad tenets of the social identity approach to health (Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018). Different aspects of this approach lead us to conclude that internalised group memberships (i.e., social identities) can be antecedents, mediators, and outcomes of trauma experiences. And whilst we argue that group membership and social identities are at the heart of responses to extreme stress, in the analysis presented here we orient to the role of social identities and related resources derived from group memberships as mediators of the relationships between traumatic experience and post-traumatic outcomes. We use the term social identity resources to describe the social psychological capacities that flow from internalised group memberships such as support, solidarity and belonging. This allows us to integrate findings that speak to the importance of group-based resources – such as social capital, social bonds, and community spirit – for post-traumatic responses. Importantly, we do not seek to discount alternative analyses that also point to the value of these same resources, but instead argue that the social identity framework provides a useful and distinctive perspective for understanding divergent response to traumatic experience.

We begin by reviewing key concepts in the trauma literature (namely, PTS, PTSD and PTG), and locating our contribution in the wider literature on trauma. Then, in the first substantive review section, we argue that group memberships and social identities are important for understanding the risk of, and responses to, traumatic experiences. Drawing on our own research, we illustrate the centrality of groups and social identities to experiences and perceptions of traumatic events (see Table 1). Taking this further, we go on to review evidence that identification with a group can mediate the impact of traumatic experiences on relevant sequelae. We conclude this section by reviewing work that points to the importance of social identity as a basis for accessing resources such as solidarity and social support. We argue that whilst group memberships can place people at risk of trauma, they also provide a platform for the development of social identities and access to associated resources, which mediate the link between traumatic experience and well-being.

Our second substantive section systematically integrates this work to develop a social identity model of traumatic identity change (SIMTIC) see
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<th>Paper</th>
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<th>Group/identity variables</th>
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</table>
| Muldoon & Trew, 2000   | Political violence  | Membership of gender, religious and socioeconomic groups                                   | Cross sectional survey        | Reported Experience of political violence and self-perception profile for children | 689 Children aged 7-11         | Variation in reported experience of conflict related experiences was linked to group membership. And exposure to political violence was linked to behavioural adjustment.
| Muldoon et al., 1998   | Political violence  | Membership of gender, religious and socioeconomic groups                                   | Comparative analysis of two cross sectional data sets from 1983 and 1984 | Perceived stressfulness of conflict related events                       | 10 year old children in 1983 (n = 456) & 1994 (n = 182) | Group level differences in ratings of the perceived stressfulness of events. Perceptions were linked to religious group and changing perceptions of parties to the conflict.
| Muldoon, 2003          | Political violence  | Membership of gender, religious and socioeconomic groups                                   | Longitudinal survey           | Perceived stressfulness of conflict related events                       | Children at two time points age 8 and 11 (N = 113) | Developmental trajectory in perceived stressfulness of conflict events linked to religious group affiliation.
| Muldoon & Wilson, 2001 | Political violence  | Membership of religious and gender groups, ideological commitment to conflict              | Cross sectional survey        | Reported experience of political violence, self-esteem, psychological well being | Adolescents aged 16 (N = 96)    | Young people with a lot of exposure to political violence ideologically committed to the conflict, had comparatively good well-being.
| Schmid & Muldoon, 2015 | Political violence  | National identification                                                                   | Cross sectional survey        | Experience of violence, identity threat, social identification & well being | Representative sample of adults (N = 1515) | Perceived intergroup threats have the most profound effects on social identification and well-being for those subsets of the population with the most exposure to conflict.
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<td>Muldoon et al., 2009</td>
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<td>Representative sample of adults (N = 3000)</td>
<td>National identity buffered the impact of exposure to trauma for those with national group memberships relevant to the conflict</td>
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<td>Naughton et al., 2015</td>
<td>Domestic violence</td>
<td>Identification with family</td>
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<td>Having a strong sense of belonging to the extended family for young people who were exposed to parental IPV improved psychological outcomes</td>
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<td>Naughton, O'Donnell, &amp; Muldoon, 2019</td>
<td>Domestic violence</td>
<td>Shared understanding of experience</td>
<td>Qualitative discursive approach</td>
<td>Semi structured interview</td>
<td>Young adults who had indicated they grew up in a home affected by domestic violence</td>
<td>A shared understanding of the situation facilitated communication and adjustment, without this young people felt silenced.</td>
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<td>Naughton et al., in press</td>
<td>Domestic violence</td>
<td>No direct measure</td>
<td>Cross sectional survey</td>
<td>Experience of domestic violence, social support, psychological well being</td>
<td>Young adults (N = 465) (mean age 20 years)</td>
<td>Ambiguity about the nature of the domestic violence rather than the extent of the abuse impact social support and well-being.</td>
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<td>Gallagher et al., 2014</td>
<td>Experimentally induced stress</td>
<td>(un)shared group membership of stress or challenge message</td>
<td>2 x 2 experimental approach</td>
<td>Perceived stress, cognitive performance cardiovascular reactivity</td>
<td>Undergraduate students (N = 104)</td>
<td>Communication from an ingroup member that a task is challenging rather than stressful reduces perceived stress, cardiac reactivity</td>
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Table 2. This draws on the Social Identity Model of Identity Change (SIMIC; Haslam et al., 2008; Jetten, Haslam, Iyer, & Haslam, 2009) to explore how changes in social identities as a result of adverse experiences can structure responses to trauma. This analysis suggests that post-traumatic responses can be understood as manifestations of social identity change associated with the impact of traumatic events on people’s group-based sense of self. We propose three hypotheses. First, the Identity Continuity Hypothesis proposes that negative responses to trauma (i.e., PTS) will be amplified where trauma weakens or undermines valued social identities. We also consider the corollary of this hypothesis, that resilience will be more apparent in the face of trauma where social identities are maintained. Second, the Social Identity Gain Hypothesis proposes that the development of positive and meaningful new social identities can be source of resilience in the face of trauma. Finally, the Identity Revitalisation Hypothesis extends the SIMIC model to propose that PTG in response to the stress arising from traumatic experiences is most likely to occur where existing identities are reinvigorated or new identities are formed. In this context, we present preliminary evidence that social identity growth can explain the capacity for trauma to stimulate a renewed sense of self, to create a sense of stronger connection to others, and to imbue life with enhanced meaning. We conclude with a discussion of the model’s implications for practice.

Understanding trauma: concepts and theories

Trauma and its psychological sequelae

Traumatic events are universally defined as adverse. These are a particular kind of event associated with actual or threatened risk to life, serious injury, or sexual violence. Events of this nature are classified as trauma when a person experiences them either directly (e.g., by witnessing them) or indirectly (e.g., because a close relative or close friend experiences or witnesses them; Friedman, 2013). The most widely known consequence of exposure to traumatic events is post-traumatic stress disorder (PTSD). PTSD was officially categorised as a mental disorder in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM; Spitzer, First, & Wakefield, 2007). Although in earlier versions of DSM it was classified as an anxiety disorder, it was subsequently reclassified as a “trauma and stressor related disorder” in DSM-5 (American Psychiatric Association (APA), 2013). PTSD is unusual among other DSM disorders in that its diagnosis requires exposure to a particular type of event. PTSD is diagnosed where the symptoms that arise because of a trauma are severe and prolonged and interfere with social and/or occupational functioning.
Table 2. Summary of studies linking trauma trajectories to social identity change.

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<td>Muldoon &amp; Downes, 2007</td>
<td>Political violence</td>
<td>Social identity continuity</td>
<td>PTS, exposure to political violence</td>
<td>Representative sample of 3000 adults in Northern Ireland</td>
<td>National identity was related PTSD: Those who saw national identity as less important were more likely to be designated PTSD ‘cases’</td>
</tr>
<tr>
<td>Hirsch-Hoefer et al., 2019</td>
<td>Political violence</td>
<td>Social identity continuity</td>
<td>PTS, exposure to political violence, self-categorised religious group</td>
<td>Longitudinal panel Israelis/ Palestinians (n = 2572), and Northern Ireland (n = 343).</td>
<td>Context matters to PTS symptoms: positive relationship between exposure to violence and PTS not evident in post-conflict setting participation in the event had a positive impact because of increased identification with others at the event</td>
</tr>
<tr>
<td>Kearns et al., 2017</td>
<td>Bereavement by suicide</td>
<td>Social identity gain</td>
<td>Crowd Identification, bereavement by suicide, PANAS</td>
<td>Cross sectional panels (n = 2541, n = 2050) and longitudinal sample (N = 131) of adults</td>
<td>Participation in the event had a positive impact because of increased identification with others at the event</td>
</tr>
<tr>
<td>Jones et al., 2012</td>
<td>Accidents road traffic, falls &amp; sports injuries</td>
<td>Social identity continuity and social identity gain</td>
<td>General health &amp; PTS symptoms, maintained group and new group memberships</td>
<td>Longitudinal sample 2 weeks and 3 months after acquired brain (n = 62) or orthopaedic injury (n = 31)</td>
<td>New group memberships were associated with reduced PTS symptoms and greater resilience as indicated by psychological well-being.</td>
</tr>
<tr>
<td>Walsh, Muldoon, Gallagher and Fortune, 2015, Walsh et al., 2017</td>
<td>Acquired brain injury</td>
<td>Social identity continuity and social identity gain</td>
<td>Anxiety &amp; depression, affiliative &amp; acquired identities, social support</td>
<td>Cross-sectional (n = 53) and longitudinal (N = 32) sample of adults living with acquired brain injury</td>
<td>Identity continuity fostered social support and facilitated the acquisition of new identities with associated benefits for psychological health</td>
</tr>
<tr>
<td>Muldoon et al., 2017</td>
<td>Earthquake disaster</td>
<td>Social identity revitalisation</td>
<td>Post traumatic stress symptoms, post traumatic growth, community identity, collective efficacy</td>
<td>Adult of sample of Nepali adults (N = 399)</td>
<td>Survivors with a strong sense of community identity and collective efficacy in response to disaster, reported higher PTG.</td>
</tr>
<tr>
<td>Muldoon, Walsh Curtain, Crawley, Kinsella, 2019</td>
<td>Acquired brain injury</td>
<td>Social identity revitalisation</td>
<td>Qualitative semi structured interviews</td>
<td>Adults living with brain injury (n = 15)</td>
<td>Social identity change participation in new social groups linked to a changed sense of self, and connections to others.</td>
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In Western nations, PTSD is estimated to affect around 2% of the population, although estimates are considerably higher amongst specific risk groups such as first responders, soldiers, and populations affected by war and political violence (Berger et al., 2012; Breslau, 2009; Muldoon & Downes, 2007). In DSM-5 (APA, 2013), PTSD is characterised by the presence of multiple persistent symptoms across four symptom clusters. Symptoms from all four clusters must be present to warrant diagnosis. These comprise (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; APA, 2013).

The distinction between PTSD and PTS is not always stark, and some commentators have suggested that acute PTS responses are reasonably normal, or indeed expected, reactions to extreme or distressing events (Summerfield, 2001). Nevertheless, the majority of people who encounter extreme and distressing events prove to be resilient (Agaibi & Wilson, 2005). Many people who experience traumatic events show some PTS responses, but these responses usually do not severely interfere with their social or occupational functioning (or, if they do, this is short-lived). Indeed, it has been found that resilience is the main response to adversity as a consequence of war, political violence, sexual assault, accidents and natural disaster (Charuvastra & Cloitre, 2008). It would appear that understanding the basis of psychological resilience in the face of trauma is at least as important as understanding psychological vulnerability.

It has long been recognised that alongside negative responses to trauma there can also be positive changes (Linley & Joseph, 2004; Park, Cohen, & Murch, 1996; Tedeschi & Calhoun, 1995). In particular, the phenomenon of PTG is apparent in many survivors who value their changed sense of self or their changed life trajectory following trauma. PTG is experienced along a continuum, with some degree of growth reported by between 30 and 80% of people who have experienced trauma (Linley & Joseph, 2004). PTG differs from resilience and recovery. It is not merely the restoration of a person’s pre-trauma state of functioning, but a positive change in previous ways of thinking, indicative of a reorientation of values or priorities in the wake of trauma.

**Theories of PTSD risk and resilience**

Much of the existing literature is concerned with explaining different trajectories in the wake of trauma. A first point to note is that different trauma responses are not explained by variations in traits or attributes such as
hardiness (see Nemeroff et al., 2006). Rather, it would appear that the construction of the self and, in particular, a complex sense of self (i.e., one that incorporates multiple self-aspects; Linville, 1987; Rafaeli-Mor & Steinberg, 2002) is implicated in positive responses to traumatic experiences. This observation is entirely consistent with a social identity approach which emphasises the relevance of the social self, derived from group memberships, for understanding trauma trajectories. The approach we offer builds on this work which highlights the importance of personal and collective resources that contribute to risk and resilience. Reflecting the idea that there are psychological resources that can support resilience, we also move away from a medically oriented understanding of vulnerability and instead use Antonovsky’s (1993, 1996) notion of salutogenesis to emphasise the effective negotiation achieved where stress is seen as manageable and comprehensible. Our analysis also has points of contact with Hobfoll’s (2011) conservation of resources theory which argues that changes an individual’s objective, psychological and cultural resources have particular relevance to PTSD resilience and risk. So for example, an adverse reaction to a traumatic experience is more likely where people lose out economically or lose social support as a result of trauma (Hobfoll, 2011). In a similar vein, Charuvastra and Cloitre (2008) emphasise the importance of social bonds as a key resource for people who experience trauma. And Norris, Stevens, Pfefferbaum, Wyche, and Pfefferbaum (2008) argue that community resilience in the wake of trauma emerges from adaptive capacities at a communal level associated with multiple forms of community competence (e.g., economic, developmental, informational).

All of these findings are consistent with the social identity framework we present in this paper. Nevertheless, what is distinctive about our approach is its particular focus is on the role that group memberships and associated social identities play in structuring trauma responses. As we will see, as well as lending itself to distinctive theoretical propositions, this also has novel practical implications for trauma intervention and management.

**A social identity approach to trauma**

*Perceptions and experience of traumatic events are structured by group membership*

The social identity approach emphasises the importance of group memberships to everyday life (Tajfel & Turner, 1979; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). And the social identity approach to health has pointed to the ways in which group memberships structure individuals’ health and psychological resilience (Haslam & Reicher, 2006; Postmes, Wichmann, van Valkengoed, & van der Hoef, 2019). At the most basic level the fact that some groups are more (or less) at risk of exposure to trauma helps to explain some of the variation in outcomes associated with group
membership as traumatic events is not uniformly distributed (Muldoon, 2013). This point is illustrated by three studies that we conducted in Northern Ireland over a 10-year period in the 1980s and 1990s – a period prior to the Belfast Good Friday Agreement and the period of relative peace that followed. These examined the perceptions and experiences of children (aged between 7–11 years) who had experienced conflict-related events.

The first of the three studies (N = 689) asked children about their experience of 25 negative events, including six that were directly related to the conflict in Northern Ireland (Muldoon & Trew, 2000). Despite a widespread belief that children in Northern Ireland had been protected from the ravages of political violence, the results showed that their experience of conflict-related events was considerable. For example, the police had picked up 13.6% of the sample, 23.8% had seen others shooting guns and 22.5% had been caught in a riot. More common still was getting stopped at police checkpoints (54.4%), experiencing bomb scares (59.5%), and meeting soldiers on the street (70.4%). Experience of each of these events was also correlated; suggesting that exposure to each event was not independent.

Importantly, findings indicated that respondents’ group membership had a bearing on their risk of experiencing specific conflict-related events. For example, Catholic children had more experience of soldiers on the street and bomb scares than Protestant children. However, low-income Protestant children were more likely to experience these events than middle-income Protestants, or Catholics of any income group. Overall, Catholic children experienced a greater number of negative events than Protestant children (2.56 vs. 2.38). These findings suggest that even amongst children as young as eight years old, the risk of encountering a conflict-related event associated with the political violence in Northern Ireland was contingent on group memberships related to religion and social class. Moreover, as one might expect, we also found that such exposure was related to children’s ratings of their own behavioural adjustment as measured by the Harter (1985) self-perception profile for children (Muldoon & Trew, 2000). Put simply, particular group memberships put children in the way of harm, and, as a result, actually did them harm.

Extending this work, two subsequent studies delved further into the impact of group membership on perceptions of conflict-related events in ways that accord with principles of intergroup emotions theory (Smith & Mackie, 2015). These studies investigated distress arising from 25 negative conflict-related events in Northern Ireland (Muldoon, Trew, & McWhirter, 1998). Each event was described as an experience that can cause children to feel “bothered, worried or troubled”. Child respondents were asked to indicate on a scale of 1 to 4 their perceptions of each event; higher ratings indicted that the event was seen as more distressing. Two samples completed the scale, 456 children in 1983 and a second sample of 182 children in 1994. Again, results showed that
Catholic and Protestant children differed. In 1994, Catholic children rated three of the six events (“soldiers being on the street”, “getting stopped at checkpoints” and “getting caught in a riot”) as more stressful than Protestant children. As all of the items related to potential encounters with the security forces, this was interpreted to reflect Catholic children’s assimilation of their own group’s distrust of the security forces, which became more negative and fearful as the conflict evolved (O’Connor, 1993).

The final analysis of children’s perceptions of traumatic events in Northern Ireland was a longitudinal analysis of 113 children aged seven and eight across a three-year period, using the same measure of perceived stressfulness (Muldoon, 2003). Again, group membership was central to the appraisal of these events. Specifically, it was found that girls tended to perceive three events (“bomb scares”, “being picked up by the police” and “people shooting guns”) as more stressful than boys. Furthermore, there was evidence that gender and religion predicted changes in the perceived stressfulness of events over time. Compared to Protestant children, Catholic children indicated that getting caught in a riot and being picked up by the police was more stressful, particularly as they got older. Presumably, these effects could be attributed to the minority group position occupied by Catholic children in this social context and, in particular, to the divergent experiences of the two religious groups at the hands of state security forces over the course of the conflict. In short, being Catholic (the minority group), was associated with a heightened sense of threat and fear relative to being Protestant (the majority group).

Taken together, these findings point to the important role that group memberships play in shaping exposure to, and interpretation of, traumatic events (see Haslam, Jetten et al., 2018, for other examples). In this case, children living in the same conflict zone had vastly different experiences of the conflict depending on their gender, class and religious group membership. In this way, it is clear that group memberships can contribute to the risk of being exposed to trauma. These variations are both quantitative and qualitative, such that differing types of events are experienced with different frequency and intensity in a way that is systematically related to group membership. In the next section, we build on this idea that groups are central to understanding trauma by exploring how these experiences and responses to trauma are also structured by social identification with these same social groups.

**Responses to trauma are structured by social identification with trauma-relevant groups**

Self-categorisation in terms of a given social identity (e.g., as “us Jews” or “us refugees”) provides a framework for interpreting one’s experiences – including traumatic experiences. That is, traumatic events are appraised not only in
a personalised way, but also through the lens of a given group membership (Acharya & Muldoon, 2017; Basoglu et al., 1996). Self-categorisation theory (Turner et al., 1987) can help to explain when group memberships are likely to be the basis for appraisal and which social identities shape trauma responses. For example, principles of social category fit (Oakes, Haslam, & Turner, 1994) suggest that a person is likely to define themselves as a member of a particular political group if at a protest march rather than at a football match. Where people are treated as members of a particular group (e.g., by the police) and this treatment fits with their stereotypical expectations of group relations (e.g., seeing the ingroup as oppressed by a particular outgroup), then self-categorisation in terms of that particular group membership is also likely (Klandermans, 2002).

We argue that the psychological consequences of trauma can be predicted by a person’s affiliation with groups that espouse a particular social and political worldview. In line with this proposition, Muldoon and Wilson (2001) examined ideological commitment to traditional identity positions in Northern Ireland, to see whether this might attenuate the impact of exposure to political violence on adolescents’ mental health. Using survey methodology, 96 young people (on average 15 years old) were asked to complete four measures: the Rosenberg self-esteem inventory (1965), the General Health Questionnaire (Goldberg & Williams, 2000), a measure of exposure to political violence, and an ideological commitment scale (comprised of two subscales: patriotic involvement and glorification of war). Young people who scored highly on ideological commitment tended to agree with statements such as “Peace is possible only when my community is strong” and “In a situation of violent conflict, you must also obey orders that you disapprove of”. As such, this is a measure of participants’ support for their group’s socio-political ideology. Two variables predicted general health in this sample: (a) gender (with boys tending to report better mental health than girls), and (b) the interaction between ideological commitment and total experience of conflict events. Consistent with predictions, this interaction indicated that the negative relationship between experience of conflict and well-being was attenuated among young people who had a strong commitment to their ingroup’s traditional position.

Similarly, Basoglu and colleagues observe that among those who experience torture within their own countries, political activists tend to be less symptomatic than non-activists – despite the fact that activists often endure severe torture (Basoglu et al., 1997; Basoglu et al., 1994). Moreover, non-activists – who have little or no commitment to the cause, and no pre-trauma expectations of arrest or torture – are more likely to experience psychological distress and higher levels of PTS than members of activist groups. Thus, despite their prolonged exposure to severe traumatic experiences, Basoglu and colleagues (1994, 1997) observed that levels of PTSD among activists
were moderate rather than severe, and that those with strong commitment to their cause were least likely to be symptomatic.

Our prediction, then, is that if trauma strengthens a person’s sense of belonging to a valued group, this will tend to reduce PTS risk. However, if the trauma compromises belonging to a valued or meaningful group, then this will tend to increase risk. Along these lines, further evidence that group membership and social identification affect traumatic responses and perceptions of threat in conflict situations comes from research by Schmid and Muldoon (2015). In this study, a representative sample of adults in Northern Ireland ($N = 1515$) completed measures of political conflict experience, threat (designed to capture both realistic threat and symbolic threat), social identification with their national group (Luhtanen & Crocker, 1992), and psychological well-being. Structural equation modelling indicated that perceived threat had a direct negative effect on well-being. However, there was also an indirect positive effect of perceived threat on well-being via social identification. This is consistent with the argument that threat led participants to identify with their national group, and that this in turn was protective for their well-being (in ways predicted by the rejection–identification model; Branscombe, Schmitt, & Harvey, 1999). At the same time, this effect was most apparent for people who had the highest direct and/or indirect experience of political conflict-related events. Indeed, there was no difference between the two ethno-religious groups in the extent to which intergroup threat was associated with compromised psychological well-being. Identification can thus be seen as an important coping resource for dealing with intergroup threats, including those that result from exposure to conflict (see Figure 1; Schmid & Muldoon, 2015).

**Figure 1.** Estimated threat identification model for fully representative Northern Ireland sample.
Note: $N = 2000$, $^*p < .01$, $^{**}p < .001$, unstandardised betas reported; from Schmid and Muldoon (2015).
In the case of trauma, the experiences of other ingroup members can also have a ripple effect on the wider group (Muldoon & Lowe, 2012). An individual’s personal fate becomes psychologically tied to that of other ingroup members via social identification (Drury, 2012). Speaking to this point, secondary analysis of the same large dataset (N = 3000; Muldoon, Schmid, & Downes, 2009) highlighted the importance of considering which group memberships are used as a basis for self-categorisation in the context of trauma. In Northern Ireland, there are now three widely used national categorisations: British, Irish, and Northern Irish. Self-categorising as British or Irish is generally associated with the long-standing oppositional inter-group attitudes, whilst seeing oneself as Northern Irish is a relatively recent national identity associated with inclusive and socially progressive attitudes (Lowe & Muldoon, 2014). In this second analysis, participants stated their preferred national self-categorisation and indicated their strength of identification. We then investigated whether identification mediated the relationship between exposure to conflict and general health for each of the three national groups. Interestingly, national identification only acted as a mediator for respondents who described their identity as British or Irish. This is consistent with the historical context, where British and Irish identities (rather than the Northern Irish identity) are used to frame, and help to make sense of, the animosities of the conflict. In essence, then, we see that it is only when a group is relevant to trauma that social identification with that group mediates the impact of traumatic experience.

**Responses to trauma are structured by social identity resources**

Social identity resources are the psychological and social resources that emerge from membership of, and identification with, social groups (Haslam & Haslam, 2012). When people self-categorise in terms of a given group membership, this becomes a basis for them to feel connected to other ingroup members. This in turn provides access to psychological resources that protect well-being in the context of traumatising events (Haslam et al., 2018). Social identity resources include, amongst other things, a sense of belonging, a sense of perceived efficacy associated with social identification as well as experiences of support, trust, and solidarity directly linked to a sense of shared identity. A core argument of the social identity approach to health is that social identification can be an important basis for people to access these resources in ways that help them counter the effects of threat and loss (Haslam & Haslam, 2012). This, we argue, is also true for trauma.

This assertion was explored in a study that assessed the impact of exposure to intimate partner violence (IPV) on young people’s global self-esteem and anxiety (N = 355, Naughton, O’Donnell, & Muldoon, 2015). As expected, exposure to parental IPV was associated with decreased levels of self-esteem and increased levels of anxiety. However, there was also evidence
of a positive indirect effect via strength of identification with one’s wider extended family group. Specifically, in similar ways to what Schmid and Muldoon (2015) found as reviewed above, exposure to violence had a direct negative effect, and indirect positive effect on psychological health. This was because a sense of identification with family was protective, such that respondents who reported higher family identification reported higher self-esteem and lower levels of anxiety, and those with weaker identification with their families had lower self-esteem and more anxiety.

Equally, identification can be a source of vulnerability in the context of trauma – particularly when people are unable to access support from groups with which they identify. Consider, for example, those affected by stigmatising trauma such rape – where there is a particularly high incidence of PTSD. Rothbaum, Foa, Riggs, Murdock, and Walsh (1992) found that 94% of victims had PTS symptoms of clinical severity shortly after their rape, and 47% went on to be diagnosed with PTSD three months later. Similarly, Walker, Archer, and Davies (2005) reported extremely high levels of PTS symptomatology in male survivors of rape. Indeed, in the context of war, commentators have noted that rape is a particularly potent weapon because it creates a sense of shame among victims that erodes family bonds – bonds which, under other circumstances, might have been a key source of strength and resilience (Ramanathapillai, 2006).

These dynamics were explored directly by Kellezi and colleagues (2009) in ethnographic research with survivors of war crimes and rape in Albania. They found that women tended to perceive rape victims in highly stigmatised ways. As a result, women who had been sexually assaulted during campaigns of mass rape over the course of the Balkans war reported that this acted as a barrier to accessing support. However, if women remained silent for fear of being shunned for transgressing culturally acceptable norms of gender-appropriate behaviour, they reported severe PTS symptoms (Kellezi et al., 2009; Skjelsbæk, 2006). Studies of male victims of rape also suggest that the counter-normative nature of this experience exacerbates its negative psychological impact, because it is often viewed as extremely threatening to social identities linked to masculinity (Creamer, Burgess, & McFarlane, 2001; Kessler et al., 1999). Again, PTS symptoms are believed to be intensified by the extreme stigma of rape for male victims and the associated difficulties that survivors have accessing social support (Walker et al., 2005).

Relatively, it is clear that traumatic events originating from human acts such as rape, abuse, and terrorism are associated with the highest documented incidence of PTSD. It has been argued that this is because the experience of such traumatic events undermines a person’s ability to engage and bond with others (Charuvastra & Cloitre, 2008) as well as their assumptions about this ability (Janoff-Bulman, 1992). In this regard, a core element of our argument is that where trauma undermines a shared social identity or targets
a person’s group membership, this can lead to the destruction of a sense of belonging and of the social identities that provide the psychological footing for effective social support (Haslam, O’Brien, Jetten, Vormedal, & Penna, 2005; Haslam, Reicher, & Levine, 2012). For example, trauma caused by human acts (e.g., as opposed to natural disasters) can undermine a person’s sense of trust in others who might otherwise be in a position to offer support. This can lead victims to feel isolated, confused or betrayed (Freyd, 1996). Consistent with this point, a meta-analytic review of longitudinal research found that a reduced sense of trust and connection to others is common among people affected by child abuse (Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008). Moreover, where social relationships are undermined in this way, heightened risk for PTS is evident in later life (Weich, Patterson, Shaw, & Stewart-Brown, 2009). In this way, the negative effects of traumatic experiences can be compounded because survivors are pushed to the margins of group life and have reduced opportunities to develop group resources.

It follows that just as disclosure can help people deal with trauma, so too powerful social prohibitions against disclosure can equally breed a sense of isolation for those negotiating trauma (Ullman & Filipas, 2001). This point is made by Adewuya and colleagues (2009) who examined PTSD among individuals who had been diagnosed with HIV in Nigeria— a diagnosis that, like rape, has been associated with both social stigma and heightened traumatic responses. As in Kellezi and colleagues’ (2012) work, these researchers found that increased PTSD symptomology was predicted by experiences of HIV social stigma and an associated reduction in access to pre-existing social support networks.

Reflecting the stigma associated with IPV, our qualitative work also highlights difficulties that young people experience around dialogue, recognition and acknowledgement of their experience within their homes (Naughton, O’Donnell, & Muldoon, 2019). Specifically, discursive analysis found that young people often feel that they can only talk about their experience of domestic violence after a shared understanding of the problem has been reached with others in their family group. Where there is limited discussion or perceived ambiguity about the violence, young people often feel silenced. These patterns were corroborated in a larger survey study (Naughton, O’Donnell, & Muldoon, in press) which found that exposure to psychological domestic violence (vs. physical domestic violence) was associated with lower perceived availability of social support within the family group. This speaks to ways in which stigma and ambivalence around traumatic events can undermine a person’s capacity to access social support from ingroup members that might support adjustment and psychological well-being.

Experimental work confirms that appraisal and responses to a stressful situation are often driven by shared understandings of the situation. For
example, it has been found that shared group membership affects stress appraisal, as well as cardiac reactivity, when a stressor is presented to participants. Thus Gallagher, Meaney, and Muldoon (2014) found that communication from an ingroup member that the Trier Stress Test (Gronwall, 1977) was “challenging” rather than “stressful”, led to reduced perceptions of stress, cardiac reactivity, and better cognitive performance (N = 104; see also Häusser, Kattenstroth, van Dick, & Mojzisch, 2012; Platow et al., 2007). However, the “challenge” versus “stress” manipulation had no effect on stress responses when the same message was received from an outgroup member (Gallagher et al., 2014).

Taken together, the evidence points to the fact that traumatic events are not interpreted in a social vacuum. Rather, as well as providing a lens through which those events are construed, group memberships and social identities also provide access to a range of social and psychological resources that help people deal with them. These resources include a shared sense of identity and connection with others and feelings of belonging that facilitate support and disclosure of trauma experiences. So as well as structuring trauma-related appraisals, social identity resources are also implicated in post-trauma responses and recovery trajectories.

**Understanding traumatic responses as a process of social identity change**

In narrative accounts (Armour, 2002), trauma is often seen as “life changing” (Holmes & Rahe, 1967) and a particular focus of social cure research has been to consider the effects of life changes on stress and health. In general terms this approach argues that, although all life change is unsettling, and thus a potential threat to health, life change will tend to have minimal or even positive effects on health when it ultimately leads to positive social identity gains. On the other hand, life change that results in a loss of valued social identities will tend to have negative consequences (Jetten et al., 2009). These ideas are integrated within the *Social Identity Model of Identity Change* (SIMIC) which identifies a number of group processes that contribute to successful life transitions (Haslam et al., 2008; Jetten et al., 2009). In what follows, we draw on this model to develop key ideas about the way in which social identity changes that occur in the wake of trauma might influence post-traumatic trajectories.

SIMIC draws on social identity theorising to specify a set of interrelated group processes and pathways that are protective of well-being in the face of life change. First, having access to *multiple group memberships* prior to life change is considered protective because the more group memberships a person has to draw on, the more psychological resources they can recruit when attempting to deal with a particular life change (Jetten et al., 2015;
Multiple group memberships also increase the likelihood of maintaining group memberships in the course of life change to provide a sense of social identity continuity. They can also scaffold development of new group memberships that extend a person’s social group network and thereby contribute to social identity gain. This is particularly important if some meaningful and valued group memberships are lost as a result of the life change in question (as is often the case in trauma; Haslam, Jetten et al., 2018). Critically too, SIMIC recognises the importance of group compatibility. While having access to multiple, new, and maintained groups can be positive, these are far easier to manage and maintain when they are compatible.

There is considerable support for SIMIC in the context of understanding a range of life transitions such as retirement (Haslam, Lam et al., 2018; Haslam, Steffens et al., 2019), childbirth (Seymour-Smith, Cruwys, Haslam, & Brodribb, 2017) and migration (Jetten et al., 2018). For example, a study of stroke patients found that patients with a greater number of group memberships before their stroke experienced better adjustment afterwards (Haslam et al., 2008). Path analysis suggested that this was because respondents were likely to be able to maintain at least some of their pre-stroke group memberships after their stroke and thereby maintain a sense of social identity continuity. Likewise, a longitudinal study of young adults making the transition from school to university (involving a loss of secondary school/home town identity, and the formation of a new identity as a student of a particular university) found that having multiple group memberships before going to university predicted greater adjustment and well-being when at university (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009). This was particularly the case for students who saw their old and new social identities as compatible. Speaking to the importance of social identity gain, Dingle, Stark, Cruwys, and Best (2015) studied people entering a drug and alcohol programme and found that when participants gained a social identity as “a person in recovery”, this played an important role in supporting their well-being and sustained abstinence from substance use.

In what follows, we argue that SIMIC processes and pathways are also relevant to understanding adjustment trajectories in response to life change brought about by trauma. In reviewing the trauma literature, we provide evidence that trauma trajectories are structured by three key processes: (a) social identity continuity (vs. discontinuity), (b) social

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1It could be argued that these relationships can be explained by stroke severity. However, while these analyses did not control for stroke severity (as medical data were not available) we would note that cognitive failures only correlated with maintenance of old group memberships ($p < .05$) and not with other group-related variables (i.e., number of pre- and post-group memberships and sense of belonging with multiple groups and new groups). Were cognition (as a proxy of severity) a causal factor we would expect it to predict all these variables.
identity gain (vs. loss), and (c) social identity revitalisation and growth. The proposed Social Identity Model of Traumatic Identity Change (SIMTIC) extends current understanding of responses to trauma and, we argue, provides a useful framework for understanding and managing life change as a result of trauma.

**Social identity continuity: maintaining valued social identities reduces post-traumatic stress**

As noted above, SIMIC argues that social identity continuity has a key role to play in protecting well-being in the context of life change. This is because this continuity is an important basis for retaining a sense of stability, meaning in life, and connections to other group members (e.g., family, occupational, or community groups). In line with this proposition, there is evidence to the extent that where trauma undermines social group memberships and associated social identity resources it leads to greater PTS and PTSD (Cohen-Mansfield, Shmotkin, Malkinson, Bartur, & Hazan, 2013). In this context, it has been demonstrated that social identities which pre-exist and survive trauma can help to reduce symptoms. However, if valued identities are weakened in the wake of traumatic events this will amplify risk and will often be associated with increased symptoms.

By way of illustration, research in Northern Ireland explored the relation between exposure to a traumatic event associated with the conflict, severity of PTS symptoms and identification with a national group (Muldoon & Downes, 2007). Relevant data were obtained from a telephone survey of 3000 people in Northern Ireland and the border counties of the Irish Republic that examined exposure to political violence and strength of national identification (using Luhtanen & Crocker, 1992, collective self-esteem scale). Of the 3000 people sampled, 1269 (42%) reported experiencing a distressing event as a result of the “troubles” leading them to be assessed as having PTSD (on the basis of the PTSD Checklist – a screening tool based on DSM-IV criteria that has been used in telephone surveys; Schlenger et al., 2002; Schuster et al., 2001). Based on standard cut-off scores, 10% of respondents (n = 299) had symptoms severe enough to warrant a diagnosis of PTSD. Critically, though, the strength of national identity was also related to PTSD diagnostic status such that people with a stronger sense of national identity were less likely to develop PTSD (F(1, 1138) = 6.78, p < 0.01; Muldoon & Downes, 2007).

This finding is corroborated by findings from other conflict zones. For example, research by Qouta and colleagues with people affected by violence in Lebanon found that PTS symptoms were lowest amongst those who retained a strong sense of ideological commitment to their ethnic group during the conflict (Qouta, Punamki, & El Sarraj, 2008). Similarly, Hammack (2010) found that Palestinians who saw political violence as part of
a continued commitment to their group and the group’s future experienced less psychological distress. This was despite the fact that this group had greater exposure to conflict-related violence. Moreover, in both of these samples, maintaining an ideological connection to valued group goals served to protect those who were exposed to violence from subsequent PTS.

In this way, the sense of the importance of “us” and “our cause” (e.g., as might be experienced by political activists or military personnel), can make trauma bearable and worth enduring. Indeed, in this context, traumatic events may sometimes be seen to consolidate existing identities in ways that give the experience of trauma meaning (as suggested by Rovenpor et al., 2019) and increase access to social identity resources – in particular, from other “true believers” or fellow combatants (Acharya & Muldoon, 2015).

Trauma, of course, does not go on forever, and a changing social or political landscape can change the perceived value of identities in ways that has implications for post-traumatic symptoms. For example, researchers in Norway have observed that the incidence of PTSD among naval personnel after World War II was higher among members of the merchant navy than among members of the Royal Norwegian Navy. This was attributed to the merchant group not being able to link their naval identity to the war effort in an ongoing way, in contrast to military personnel who continued to have access to a valorised and valued military identity (Magerøy, 2009). This was also evident from a study on the impact of changing socio-political landscape in a comparative study of Israelis and Palestinians in Israel and Palestine (n = 2572) and Protestants and Catholics in Northern Ireland (n = 343; Hirsch-Hoefler, Canetti, Rapaport, Lowe., & Muldoon, 2019). In the Palestinian/Israeli context, group membership affected both exposure to violence and PTS in both groups (Hirsch-Hoefler et al., 2019). In the Northern Irish context, however, by the time of data collection traditional conflict-based identities and asymmetrical power relations had receded in the wake of the Belfast Good Friday Agreement (Lowe & Muldoon, 2014). Group membership no longer featured in the relationship between previous traumatic experience and PTS (Hirsch-Hoefler et al., 2019). The entrenched identities offered by ongoing conflict (as seen in Palestine/Israel) appeared to help to counteract the negative impact of political violence. When the socio-political context changes, the value and salience of identities for coping with experiences of violence is reduced.

Identities associated with one’s traumatic experiences can also themselves become stigmatised. For example, a once-valorised identity can become stigmatised following changes in socio-political context (Mulcahy, 2006) – a phenomenon documented among US soldiers returning from Vietnam. Here, then, emergent stigma associated with a “spoiled” identity (Goffman, 2009) may reduce the capacity for people to draw upon social identity resources. To test this idea, a study was conducted to examine the potential for an initiative aimed at reducing stigma and improving collective belonging...
to act as a “social cure” in a naturalistic setting in Ireland (Kearns, Muldoon, Msetfi, & Surgenor, 2017). Participants were attendees at a large suicide awareness-raising event who completed measures of their own exposure to suicide, their sense of belonging and connection to others 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 ($N = 2050$). This was particularly the case for those who had experienced the death of an immediate family member by suicide; a trauma that remains stigmatised in Ireland. Longitudinal analysis found that amongst those affected by suicide ($N = 131$), feelings of belonging and connection to others taking part in the event mediated the relationship between participation and better psychological well-being.

Overall then, PTSD is linked to changes in the number and meaning of valued social identities. Specifically, negative PTS symptomatology is more likely when positive identities are weakened and negative identities are reinforced. On the other hand, positive outcomes are likely to the extent that negative and stigmatised identities are weakened and positive identities are maintained and reinforced.

**Social identity gain: gaining a new social identity reduces post-traumatic stress**

In the context of traumatic events, continuity is not always achievable or desirable. It is not unusual for people to lose or let go of old identities because of traumatic life change (e.g., as a result of injury). To counter this loss and provide a basis for self-redefinition, SIMIC points to the importance of a second pathway that involves developing new valued group memberships following a life change – the social identity gain pathway. For these new groups to provide a positive basis for support, they must be compatible with existing group memberships (Iyer et al., 2009). Prior group memberships can help to scaffold the development of new group memberships (Cruwys et al., 2014; Kearns, Muldoon, Msetfi, & Surgenor, 2018). For example, having belonged to a range of community groups might make a person more open to joining a community suicide awareness or mental health support group if they are bereaved by suicide. And this is more likely to be the case if they are invited to join by people they see as ingroup members.

However, where new and old identities are at odds with each other, tensions between past and present identities can undermine the capacity for either to be a positive resource (Jetten, Haslam, Haslam, Dingle, & Jones, 2014). This might be the case, for example, if someone who was embedded in a group that advocated for gun ownership was traumatised as a result of a mass shooting. Here engagement with gun advocacy and gun control groups might be challenging and lead the person to have difficulty accessing
associated social identity based resources from either or both of these groups. Formally, then, we suggest that meaningful new or emergent identities reduce the impact of traumatic events and promote resilience when they can be integrated with pre-existing identities and/or provide access to identity-based resources.

Support for this claim comes from a body of research which shows that PTS is less likely where a new identity is gained as a result of the shared traumatic experience, or where the response to the trauma leads to the development of a new identity. For example, a longitudinal quantitative study of people recovering from serious injury – such as road traffic accidents, falls, and sports injuries – measured PTS symptoms and general health two and ten weeks post-injury. The study included measures of people’s group-based belonging and support before and after injury using the EXeter Identity Transitions Scales (EXITS; Haslam et al., 2008). Analysis indicated that acquiring new group memberships predicted both PTS symptomatology and resilience (Jones et al., 2012). Moreover, having more new group memberships predicted fewer PTS symptoms after injury even after controlling for general health symptoms.

Other research explored the idea that social identities may provide psychological resources, in this case social support, and thus affect health in traumatised groups. In line with the idea that having multiple group memberships increases opportunities to acquire new group memberships in the wake of trauma, a study assessed the impact of different types of social identities and associated social support on resilience among people living with acquired brain injury (N = 53; Walsh, Muldoon, Gallagher, & Fortune, 2015). Findings suggested that affiliative identities, typically family identities, were an important basis for accessing social support. Indeed, having access to this type of affiliative identity provided support and was also an important basis for accessing additional new active (or “doing”) identities. It was the combined contribution of these two types of identities that predicted lower psychological distress in both cross-sectional (Walsh et al., 2015) and longitudinal analyses (Walsh, Muldoon, Fortune, & Gallagher, 2017). Maintained identities seem to foster social support but also to facilitate the acquisition of new identities that have psychological benefits for those facing traumatic and life-changing injuries (see Figure 2).

It may also be the case that new and emergent identities need not be related to trauma in order to promote resilience. For example, in a study of clients accessing a specialist service for PTSD in the UK, Carr and colleagues (2012) found that participation in a music therapy group served to alleviate PTS symptoms – an outcome that participants themselves attributed to their engagement and identification with others in this new group setting. Relatedly, in a mixed-methods study of Somali refugee adolescents in the United States, Ellis and colleagues (2010) found in survey data that male
refugees who began to define themselves in terms of a new social identity (as Americans) had reduced PTS symptoms. Participants also described this change in focus-group discussions. This suggests that, at least for these young men, identification and acculturation was a key factor in reducing trauma responses.

Together then, findings from a wide range of research settings suggest that new social identities, and the associated social identity resources these afford, promote psychological resilience and reduce stress in the face of trauma. It is true that in most, if not all, of these instances these identities are not wanted or expected. Nevertheless, where, and to the extent that, they provide a platform for positive social identity gain – either through the development of new identities or by facilitating increased access to social identity resources – it appears that trauma has the capacity to unleash sometimes extraordinary human potential for support and resilience. This is a point we elaborate on in the next section.

**Social identity revitalisation: improvement in the quality and/or value of social identities increases post-traumatic growth**

Building on the previous point, we noted that trauma can result in psychological growth in the form of PTG. As Solnit (2009) observes in her survey of this topic, *A Paradise Built in Hell*, it is far more common than one would imagine for communities that experience catastrophic disasters to both recover, and thrive (Evans-Campbell, 2008; Sundet & Mermelsteon, 1997). PTG has also been reported at the individual level after a range of life challenges, including being affected by an earthquake (Muldoon et al.,
2017), cancer (Collins, Taylor, & Skokan, 1990; Stanton, Bower, & Low, 2006), HIV diagnosis (Bower, Kemeny, Taylor, & Fahey, 1998), bereavement (Davis, Nolen-Hoeksema, & Larson, 1998), rape (Burt & Katz, 1987; Thompson, 2000), and war and conflict (Elder & Clipp, 1989). This prompts the question: how can devastating events that lead to dramatic change and serious adversity have positive consequences?

This robust phenomenon appears to indicate that “that which does not kill you makes you stronger” (Jones et al., 2011; Joseph, 2012). Indeed, a widespread belief in this adage has also been linked to a phenomenon whereby those affected by trauma are often held to higher moral standards than other people (Warner & Branscombe, 2011). In this context, it is important to note that PTS and PTG are not opposites but rather, are complementary. In particular, PTG is believed to occur because of efforts to adapt to a traumatic event and the distress and disruption it causes. Longitudinal studies thus indicate that PTG occurs in addition to PTS – leading some researchers to argue that PTS is a necessary pre-requisite for PTG (Dekel, Ein-Dor, & Solomon, 2012). Nevertheless, current thinking and research suggests that growth does not directly result from trauma. Rather it appears to be linked to the psychological struggles people encounter as they deal with altered contexts in the aftermath of trauma (Tedeschi & Calhoun, 2004). PTG theorists (Joseph & Linley, 2006; Tedeschi & Calhoun, 1995) have argued that this is because extreme distress following trauma drives the re-evaluation of one’s sense of self, a process that represents both a major discontinuity in personal identity, but also an opportunity to integrate and re-evaluate one’s self in light of the trauma. Validation of this view is offered by studies that (Boals & Schuettler, 2011; Boals, Steward, & Schuettler, 2010) demonstrate where events are more central to personal identity both PTG and PTS are likely to ensue.

PTG is often conceptualised as having three key attributes: (a) changing self-views that include greater awareness of the possibilities and purpose in life, (b) enriched connections with others, and (c) change in life priorities. Such observations are commensurate with the claim that, as well as having the potential to promote resilience in the face of trauma, social identity change can also be a vehicle for PTG. Indeed, suggestive of this possibility, many people who are affected by trauma report that they no longer see themselves to be the same person that they were before the trauma. In particular, at times they report changes that reflect a more positive view of their social self, their relationships with others, and their role and place in the world. More formally, then, we extend SIMIC to argue that, by creating potential for positive and hopeful trajectories, the social identity change that is brought about by trauma can be reinvigorating and revitalising. In what follows, we elaborate on this idea by offering evidence of ways in which growth may be driven by the transformation of social identities and/or the
revitalisation of existing identities and identity resources. The latter process can involve either (a) a renewed appreciation of the value of pre-existing identities, (b) an enhanced sense of the ability or value of a group, or (c) a renewed sense of a group’s importance and centrality to the self.

In the first instance, trauma can result in positive changes to our views of our social identities and related resources. This point is evidenced by a study of nearly 400 survivors of the 2015 Nepal earthquake six months after this event had devastated large areas of the country – killing 9,000 people, injuring over 20,000, and leaving more than 3 million people homeless (Muldoon et al., 2017). The study examined the role of earthquake experience, community identity, and collective efficacy on PTG and PTSD (using measures that had been translated and adapted for use with populations with limited literacy). As hypothesised, it was found that exposure to the earthquake predicted higher rates of PTS symptoms. At the same time, this exposure was associated with a sense of increased collective efficacy and community identification. This in turn was associated with PTG, suggesting that social identity processes are important mediators of the relationship between traumatic experiences and PTG. That is, PTS was increased in people who had greater exposure to the earthquake, and this predicted greater community identification. Community identification and the sense that the community had the ability to overcome trauma (collective efficacy) also facilitated respondents’ PTG.

Further support for the identity revitalisation hypothesis is provided by research with children who lived through earthquakes in Italy (Vezzali, Drury, Versari, & Cadamuro, 2016). In line with the rejection–identification model (Branscombe et al., 1999), the presence of PTS symptoms predicted an emergent sense of shared identity among over time. This is consistent with Tedeschi and Calhoun (2004) conceptualisation of PTG as a phenomenon that arises from the distress associated with traumatic events, rather than the traumatic event per se (in ways also suggested by self-expansion theory; Aron & Aron, 1996). Rather than creating a desire to dissociate oneself from others, PTS appears to stimulate a renewed drive for social connection. For this reason, we suggest that trauma can facilitate positive change and the emergence of a stronger sense of collective identity (Drury, 2018; Vezzali et al., 2016) in the wake of disaster.

As well as expanding a sense of connection to others, trauma also appears to have the ability to change people’s sense of self. This suggestion is supported by a qualitative study of people recovering from Acquired Brain Injury (ABI; N = 15; Muldoon, Walsh, Curtain, Crawley, & Kinsella, 2019). In this study, respondents living with this chronic and often disabling condition spoke of their increased awareness of group-based resources following trauma (e.g., in the form of kindness and generosity from family and community). In particular, participants’ perspectives changed in the
wake of their injuries such that they reported a fuller appreciation of their identity-based social resources. Equally, the new social identities and associated resources they forged after their injury were valued, not least because of the isolating effects of their injuries. These new group memberships, which often replaced social and occupational group memberships that had been held prior to injury, were seen as central to adaptation and growth post-injury. Groups were also able to offer meaningful activity and a positive sense of self (Muldoon et al., 2019). Respondents indicated that making sense of their injury and the associated disability was something they achieved through interaction with others and participation in group activities. Moreover, their acceptance and adaptation to life post-injury was implicitly linked to changes in the social identity resources that flowed from their group memberships. Indeed, in this context, social contact and renewed connections with valued groups, whether peers, family or friends, was taken as a marker of psychological adjustment and recovery. These participants, who were often very disabled, focused on their good fortune.

This pattern of findings led to the conclusion that post-traumatic growth can be understood as a social identity-based phenomenon (see also Grace, Kinsella, Muldoon, & Fortune, 2015; Jones et al., 2011). Specifically, these findings speak to the possibility that social identity change can be a catalyst for PTG through enhanced sense- or meaning-making. Here, then, social identities entail more than simply new social connections. Instead, when group memberships are internalised within a person’s self-concept, they (re)define their sense of self and their values, and this has profound cognitive and motivational consequences (Turner, 1982). Beyond the domain of trauma, this capacity for social identities to increase motivation and commitment has been demonstrated in social and organisational contexts (Ellemers, De Gilder, & Haslam, 2004;) where group-based connection has been shown to be a source of creative energy (Steffens, Gocłowska, Cruwys, & Galinsky, 2016) and purpose (Ysseldyk, Matheson, & Anisman, 2010). In the context of trauma, though, it appears to be an important element of growth, because when trauma disrupts identities (as it routinely does) it also disrupts associated motivations and meaning in life.

Consider, for example, the sense of meaning in life that one can develop as a strong and competent woman who stands her ground with male peers. Trauma in the form of sexual assault constitutes a serious challenge to this self-concept (Roberts, Dutton, Spreitzer, Heaphy, & Quinn, 2005). An existing strong (gender) identity is also likely to be an important source of strength in dealing with the trauma (Campbell & Wasco, 2005). Consistent with this idea is evidence from case studies which finds that women affected by rape often experience increased centrality of their gender identity and increased motivation to engage in gender-based meaning making (Wasco, Campbell, & Clark, 2002). As well as being an important avenue for further
research, this proposition is Furthermore, there is preliminary evidence that making sense of a sexual assault in this way is associated with the emergence of a new feminist identity, and with personal growth centred on advocacy and activism for social change in support of women’s rights (Lewis, Marine, & Kenney, 2018). So although both gender and potentially feminist identities may exist prior to a traumatic event, these can be transformed in its aftermath in ways that contribute to PTG.

The link between PTG and social identity-based meaning-making is also apparent in other populations that are affected by trauma. For example, survivors of childhood sexual abuse who report PTG also report accrued identity benefits, such as improved relationships with others and stronger religious affiliation (Wright, Crawford, & Sebastian, 2007). Relatedly, studies of military personnel have observed that a focus on the collective (rather than the personal) experience of trauma helps both individuals and groups to learn and grow from their traumatic experiences (Cacioppo et al., 2015).

Overall, then, growing evidence of people’s capacity for PTG suggests that various components of this change are emergent aspects of social identity revitalisation following trauma. This reflects the fact that, following exposure to traumatic events, people often find themselves in a fundamentally different (psychological) world – one that necessitates an overhaul of the identities that were hitherto central to their self-concept (Hefferon, Grealy, & Mutrie, 2009; Muldoon et al., 2019). It is this revitalisation of the social self, we propose, that makes it possible to experience positive post-traumatic change. This new sense of social self, is enabled by social identity change which brings with it a new sense of meaning, purpose, and connection to others.

**Discussion**

**Implications for practice**

The analysis set out above has a range of important implications for practice. The first involves recognition that, in the wake of trauma, it is those people who lose valued social identities or access to associated social identity resources who are likely to be adversely affected and distressed. Indeed, for those directly affected by trauma, the first line of support should ensure that, so far as possible, pre-existing identity resources remain intact. This is in line with best practice models of crisis response and PTSD prevention. We would add that it is important to orient support and intervention to identities and group memberships that are important to those affected by trauma (Drury, 2012).

In this regard it is notable that current practice places emphasis on what is often termed *interpersonal* support. Amongst other things, this focuses on working to keep families and dyads together. Yet while we agree that families can offer interpersonal support, we would note too that they are also
important proximal groups (Naughton et al., 2015; Wakefield, Sani, Herrera, Khan, & Dugard, 2016). So as well as focusing on them, there is also value in considering broader social identities that can provide similar access to social identity resources in the aftermath of trauma. It will often be important, for example, to protect the integrity of more distal social identities such as those associated with work, religion, or ethnicity. For if access to these group memberships falls away, the negative effects of trauma are likely to hit harder. In reality, this means that efforts to keep those affected by trauma nested within existing supportive occupational, community, religious or ethnic groupings is imperative.

On the other hand, trauma that undermines access to available social identities or associated social identity resources demands alternative solutions. As we have seen, access to existing social identity based supports can be difficult if the trauma results in stigma or shame (Kellezi & Reicher, 2012). In these cases, it is important to recognise that the psychological “ground” from which an individual responds to the traumatic threat is likely to be compromised. As a result, individuals may not be willing to disclose their trauma. Or, if their trauma is visible or disclosed, engagement with pre-trauma groups may exacerbate feelings of isolation and exclusion. In such cases, support groups may provide a shared sense of experience, social connections and support even in stigmatised contexts (Bradshaw & Muldoon, 2019).

Where group supports are not possible – either as a result of the trauma or its sequelae – support for those who are affected is likely to be most beneficial when it is provided by those who share important and relevant social identities with the victims (Haslam et al., 2012). This is because social identity is an important and implicit basis for the provision and receipt of social support (Haslam et al., 2005). In practice, support needs to respectful and sensitive not only to individual need, but to the needs associated with salient group memberships. This means that centres to support people who are affected by trauma (e.g., as a result of natural disasters or, conflict) should be staffed with ingroup members (e.g., people from the same locality, of the same religion, or same sex) where possible. However, support of this nature must always be sensitive to the particular identities that are operative in any context, and these will vary as a function of the nature of the trauma.

In some cases it should also be possible to harness local identities to support and scaffold resilience (e.g., in ways suggested by the GROUPS 4 HEALTH intervention; Haslam, Cruwys, Haslam, Dingle, & Chang, 2016, 2019; Tassell & Lock, 2012). This approach may offer a sense that the community itself can overcome its trauma (Muldoon et al., 2017), whereas support drawn from those who are seen as being outsiders risks promoting a sense of victimhood and dependency (Pupavac, 2001). At the same time, it is worth noting that one important avenue to resilience or growth may
involve collective action and activism in response to the traumatic experiences (e.g., as seen in the “#metoo” and “#churchtoo” movements spearheaded by survivors of sexual abuse; Becker & Tausch, 2017; van Zomeren, Kutlaca, & Turner-Zwinkels, 2018). Indeed, collective action in response to trauma can not only be a driver of social change, but also provide meaning-making opportunities and social connections for people adapting to trauma. This reflects the more general point that there is a role for peer groups (therapeutic or otherwise) in helping people either revitalise old identities or to develop new ones in the process of negotiating the identity change that often accompanies trauma.

Conclusion

The capacity for trauma to restructure a person’s (social) self-concept is central to understanding its destructive power. Yet alongside this potential for destruction, it is also important to recognise that, even in the face of tremendous loss and adversity, many people report renewed meaning, connection and an enhanced sense of self following trauma. This allows them not only to continue to live functional lives but sometimes also to find renewed purpose (Solnit, 2009). Not least, this occurs where trauma (e.g., as a result of sexual assault or gun crime) provides both a stimulus and platform for people to advocate for positive forms of social change (e.g., through legislative reform). These potentialities, and our analysis of the processes that make them possible, provide important avenues for a more nuanced appreciation of the impact of psychological trauma, and also for more focused practice that recognises the capacity for positive forms of social identity change to support resilience and PTG.

In general, the analysis we have developed in this review suggests that differences in trauma outcomes can be explained by changes in the social identities and social identity resources available to those affected by trauma. We have attempted to move beyond previous models by integrating the individual and collective dimensions of trauma. A key point here is that trauma takes its toll by affecting people’s sense of who they are as group members: it changes “children” into “orphans”, “soldiers” into “veterans”, “people” into “victims”. A group-level analysis of the form that we have provided emphasises how group memberships can provide an additional and distinctive basis for understanding traumatic outcomes. Here too, it is recognised that group memberships also provide an important platform for resources such as social support, a sense of belonging, and collective empowerment. These facilitate smooth interpersonal relationships, but social identities also offer much more than interpersonal relationships. Specifically, the strong social identities that result from defining oneself in terms of
a larger collective can be an important source of strength, even in the absence of interpersonal relationships (Levi, 1996).

This analysis moves us beyond seeing gender, age, or social class as additional risk or vulnerability factors, to instead seeing the psychological groups that cohere around these demographic factors as critical to both positive and negative trauma trajectories. For this reason, group memberships and social identities may appear to have, and indeed in reality do have, a role at all stages of the trauma process. Here we have explored the role of social identities and the social identity resources derived from group memberships as mediators between traumatic experience and post-traumatic outcomes. However, social identities can have other functions when responding to trauma. For example, we hypothesise that social identity may mediate the relationship between PTS and PTG. And we have offered evidence that prior group memberships may be important antecedent resources for those affected by trauma (Haslam et al., 2008; Walsh et al., 2015) and are currently exploring the idea that new social identities may emerge from trauma (Muldoon et al., 2019).

Much of this research is in its early stages. So though our analysis is consistent with a wealth of evidence related to a range of traumatic experiences, it remains the case that support for the three SIMIC hypotheses we derived is limited. Accordingly, it is the case that further focused research is needed to move beyond observational and correlational evidence (Frazier et al., 2009). We hope that this review will stimulate such work and encourage more direct testing of these hypotheses in ways that establish the broader value of our model as a framework for treatment and intervention. Some of this work is currently underway (e.g., Cruwys et al., 2014; Haslam et al., 2016; Tarrant et al., 2016) and its initial results suggest that the social identity approach offers a powerful framework for both theory and practice. In particular, by speaking to the importance of group life for the lived experience of trauma, the approach alerts us to the capacity for trauma not only to cause intense psychological damage, but also to be a potent source of psychological regeneration.

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