3 *Traumatic Experience Is Patterned*

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

3.1 Chapter Outline

People often speak of random acts of violence, of the unpredictable nature of traumatic experiences that befall themselves or others. While it is true that we cannot say exactly who will experience trauma or when, it is not random either. Understanding the political psychology of trauma requires consideration first and foremost of the patterned nature of traumatic experiences, which is the central aim of this chapter. Peoples' responses to the events they experience are also covered in later chapters. These two factors, the experience and the response, are obviously connected. In this chapter, the patterned nature of traumatic experiences associated with gender, age, minority ethnic or religious group, and poverty is considered. Different demographic groups tend to have different types and ranges of traumatic experiences. There are

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groups of people who may be far more vulnerable than others when they encounter a traumatic experience. On the other hand, when people encounter a traumatic experience from a position of relative strength, the outcome is likely to be very different to having the same experience at a moment of vulnerability. The role of these social risks and their consequence for people's subsequent resources is centrally relevant to how people adjust to trauma. The central aim of the chapter is to reveal the way in which social, economic and political resources pattern people's exposure and vulnerability to traumatic events.

3.2 Traumatic Experience: A Fixed Mark

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

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

In the spirit of finding a better term to refer to this effect, I suggest we refer to this type of pattern as 'a fix'. I think the term is useful for

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

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

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

As my children grew up and became acquainted with history, and knowing that they had been born in Belfast, they sometimes asked about these 'olden times', the years where the political violence was referred to locally as 'the Troubles'. It isn't until you look back on those times that you realise how peculiar life had become. Security and

policing were very different. Army personnel routinely carried large machine guns on the street. Helicopters overhead were a constant; vehicle checkpoints and bag checks at the cinema or while one was out shopping were normal. Shooting and bombings featured frequently in the news, and though sometimes far too close for comfort impacted little on people's everyday business. Bomb scares were treated as an inconvenience rather than a risk to life and limb. I noted with interest the same effect being talked about life in Ukraine. People were getting on with their lives despite the ongoing hostilities. Indeed, in recent days, there have been reports of people returning to their lives in Ukraine despite the fact that for many of us we still see it as a desperately dangerous place.

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

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

3.3 The Nature and Incidence of Traumatic Experience

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

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

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

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

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

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

On the other hand, the figures also tell us that, in these regions at least, the events are not 'unusual' or 'extreme'. Indeed, previous

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

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

Finally, as well as showing the variation in exposure to trauma, the WMH survey initiative has also been used to inform the *types* of traumatic experience people encounter. Benjet et al. (2016) explored the patterns of trauma exposure with responses from 125,718 adult participants in twenty-four countries participating in the WMH survey. Using a statistical tool known as factor analysis, which reveals patterns in data, they found five types of traumatic experience. These included two dimensions representing political violence, the first as a witness or onlooker (e.g., being a civilian in a war zone, a relief worker in a war zone, a refugee) and the second as an active party to the

conflict (e.g., purposely injuring, torturing or killing someone; combat experience). Two further dimensions related to intimate and domestic violence were uncovered. The first was related to child abuse (e.g., beaten up by a caregiver as a child, witnessed physical fights at home as a child, beaten up by someone other than a romantic partner), and the second was related to intimate partner or gender-based violence (e.g., physically assaulted by a romantic partner, raped, sexually assaulted). A final dimension of traumatic experience relating to accidents and injuries (e.g., natural disasters, life-threatening illnesses) was evident. It is for this reason, as we proceed through this chapter, we consider not only the patterns of traumatic experiences but also how these patterns might link to different dimensions of trauma.

3.4 Patterns of Traumatic Experience

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

Any social psychological analysis of trauma therefore needs to acknowledge the role of social structures, group divisions and power. Sociologists and social psychologists have grappled with this issue but to date the application of these issues to trauma has been limited (Muldoon, 2013). Scholars both within and outside psychology, addressing the legacies of colonisation, have considered how subordinate and minority group members are victimised because of their social position (Bulhan, 1985). This theme lies at the heart of Heaney's 'Act

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of Union' poem. It uses the idea of sexual violence to represent the permanent scarring 'like opened ground' that resulted from the British occupation of Ireland. In social psychology and sociology similarly, insights into victimisation by violence and oppression by dominant groups against subordinate groups has been evident in critical studies and social dominance theory (Normand & Jochnick, 1994; Sidanius & Pratto, 2001). These analyses foreground the impact of structural divisions in sociological explanations of war and political violence (Bobo, 1999; Mills, 2000).

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

3.4.1 Traumatic Experience Is Patterned by Poverty and Privilege

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

as well as civilian populations: casualties and fatalities tend to occur in the populations with the fewest resources, status and power prior to the onset of the violence itself.

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

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

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

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

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

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

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

And in case you are unconvinced that socioeconomic capital matters to people's experience of a pandemic, this is not our first rodeo. UNAIDS

estimates that there were 33.3 million people living with HIV at the end of 2009 compared with 26.2 million in 1999 – a 27% increase (2010). Although the annual number of new HIV infections has been steadily declining since the late 1990s, sub-Saharan Africa, one of the poorest regions of the developing world (Platt et al., 2020), still bears an inordinate share of the global HIV burden. In North America, the percentage of the adult (15–49) population living with HIV/AIDS in 2009 was 0.5 per cent; in Central and Northern Europe it was 0.2 per cent of the adult population. In comparison, in sub-Saharan Africa, 5 per cent of fifteen- to forty-nine-year-olds were living with HIV/AIDS. And new infections continue to occur. The majority of new HIV infections arise in this region, and an estimated 1.8 million people became infected in 2009 (UNAIDS, 2010). Of the global total, 68 per cent of all adult and child HIV and AIDS cases are in sub-Saharan Africa.

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

Taken together, then, evidence indicates that exposure to a single traumatic event increases the likelihood of additional trauma exposure. Two potentially traumatic contexts are used for illustrative purposes to highlight that both the worst effects of political violence and the worst effects of the pandemic are felt by the poor. This gradient of experience across income levels within and between nations is clear. Across a whole range of traumatic contexts, the scale and intensity of the trauma exposure is related to people's material socioeconomic conditions. The world's and the nations' poor are those most affected by earthquakes, floods, gender-based violence, suicide, state violence and

terrorist attacks (Benjet et al., 2016). And this is also projected to be the case as we face the traumatic challenges that climate change will bring. These patterns do not support the contention that an individual's experience is determined randomly; rather, it is shaped and structured by group-based divisions of power and privilege. These are systematic effects that fix people's paths through life. Fixed effects are a matter of life and death.

3.4.2 Traumatic Experience Is Patterned by Minoritised Status

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

3.4.2.1 Trauma Exposure and Ethnic Division

Trauma exposure is shaped and structured by group memberships, such as in ethnic, religious, gender or socioeconomic groups (Bryce et al.,

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

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

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

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

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

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

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

3.4.2.2 Trauma Exposure and Gender

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

Banal understandings of gender identities and gender relations similarly underpin views that sexual violence and assault is inevitable and even 'natural' (Tinkler et al., 2018). In everyday life, men's greater strength and women's perceived vulnerability often have a taken-for-granted quality in how they are spoken about. In one interview study

of almost 200 US university students, sexual violence was often seen by respondents as usual, thus making it invisible or at least unexceptional in daily life (Tinkler et al., 2018). In another study, Iyer (2019) asked school pupils to reflect on the 2012 Delhi gang rape that sparked widespread debates about violence against women in India. In this study, she found that respondents linked violence against women to gender roles, making it culturally normative. This type of assumption means that women may underreport this type of trauma because it is 'just' something that must be borne. These risks women face therefore go unnoticed and responses in their aftermath absent or minimal. Indeed, it allows this type of trauma to remain endemic, invisible or at least inconspicuous, as was my own experience when I was assaulted by a passing male stranger as a student (see Section 3.2).

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

Oddly, a similar type of effect is apparent in academic work relating to men's violence against women. Mainstream accounts of gender-based violence within the field of sociological criminology routinely omit gender-based analysis. Other times gender-based violence is presented as separate or somehow different from 'normal' forms of

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

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

As well as major traumatic events, it is also commonplace for women to face instances of violence and harassment in the domestic, occupational and public sphere, sometimes now referred to as microaggressions. Women report harassment routinely when they walk, run or cycle, for example. And while men also experience street harassment, a wide range of studies using multiple methods indicate that the

intensity and nature of the harassment differ by gender. Men have fewer harassment experiences overall and they seldom report harassment that has a sexual tone (Muldoon, 2018). The #MeToo movement can be seen as a response to women increasingly unwilling to accept abuse, harassment and rape culture as 'just the way it is'. These normative and unremarkable constructions of gendered violence make it particularly difficult for women to navigate when they experience it and so problematising the issue can be seen as an important part of the solution. In publicising her experience via the #MeToo initiative, Tarana Burke, an activist survivor of sexual assault, sought to empower others through mutual support and strength of numbers (O'Neill et al., 2018). This harnessing of those with whom we share experience in support of social change is a theme to which we return in Chapters 4 and 6.

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

In peace and war, then, women are aware of the need to keep safe during even the most mundane activities. Data from the World Mental Health surveys indicates that intimate partner violence and child sexual abuse is a form of violence that carries a significant burden (Benjet et al., 2016; McLaughlin, 2015). And the heightened arousal

and fear that women experience because of their fear of male violence also has a significant psychological burden. This burden is particularly heightened for women who have direct experience of gender-based violence (Schnittker, 2022). In line with this evidence of a burden, women report that they modify their behaviour because of their feelings of risk, taking all sorts of precautionary and protective measures as they go about their everyday lives: staying on the phone when walking alone, texting friends to let them know of their safe return home. But none of these precautions, or advice to women to take care, will solve the problem, as it fails to address the cause of the problem: men's behaviour lies at the heart of gender-based violence.

3.5 Conclusion

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