Investigating sexual violence through a social identity lens

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Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university. To the best of the author's knowledge, it contains no material previously published or written by another person, except where due reference is made in the text.

Kate Western
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Abstract

It is increasingly recognised that the mental health consequences of sexual violence are in part driven by social phenomena. That is, people's responses to sexual violence are shaped by their social context, including pre-existing conceptualisations of what sexual violence is, and to whom it occurs. My PhD sought to understand this via a social identity approach (SIA). Applying SIA to understand sexual violence is a relatively novel area of application, and as such the overall aim of my PhD was broad: I sought to understand the relationship between social identities and mental health in sexual assault victim-survivors. This was addressed in the form of three sub-questions:

1. How do "victim" and "survivor" identities relate to post-trauma mental health following sexual assault?
2. How do victim-survivors make meaning of their identity in the aftermath of sexual assault?
3. How does disidentification relate to mental health outcomes in sexual assault victim-survivors?

My first study used a cross-sectional survey design to survey 290 victim-survivors of sexual violence, about their experience with a focus on mental health outcomes and social identification with "victims" and "survivors". I found that cumulative sexual trauma positively predicted identification with victims, which in turn predicted post-traumatic stress. Cumulative sexual trauma also positively predicted identification with survivors, but this was associated with post-traumatic growth. Taken together, these findings suggested that victim identification was associated with poorer mental health outcomes, whilst survivor identification was associated with more positive mental health outcomes.

Following this, it remained unclear how these identities and the experience of sexual violence interacted with pre-existing identities to shape mental health, and the meaning derived from these identities. To address this, I interviewed 25 adults who had experienced sexual

violence on their relationship to these identities, and their mental health subsequent to their assault(s) experiences. Using reflexive thematic analysis, I identified four broad themes: 1) Trauma identities as a resource for self-protection and self-preservation; 2) Ongoing social isolation: Narrowing of identities; 3) Identity incoherence; 4) The power of (re)connection: Reshaping and expanding identity. These interviews provided insight into how identities help people making meaning of sexual assault, and also may be impacted by sexual assault experiences.

From these interviews it also became clear that a subgroup of people *dis*identify from other victim-survivors (that is, actively reject this group as self-defining), and that this may be linked to other forms of disconnection (from the body, other people, and the world). My final study sought to clarify this using a cross-sectional survey design to measure disidentification, dissociation, disembodiment, social isolation, and mental health in a sample of 215 adults who had experienced sexual violence. I found that disidentification from victim-survivors predicted (complex) post-traumatic stress symptoms, and this relationship was mediated via dissociation, social isolation, and disembodiment.

In sum, my PhD explored experiences of sexual violence through a social identity lens. I found that social identity processes are closely related to how victim-survivors make meaning of sexual assault experiences. Social identities, such as being a “victim” and “survivor”, appear to be profoundly linked to mental health and wellbeing, including one’s ability to connect with themselves and others. These findings have implications for supporting victim-survivors following sexual assault. In particular, holistic approaches beyond traditional clinical mental health models to “recovery” from sexual violence may be necessary. Fostering connection to oneself and others, building an understanding of one’s identity as a victim-survivor that supports growth, and promoting compassionate conversations about what it means to be a victim-survivor within the public sphere, are all likely to have positive effects.

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Chapter 1: The impact of sexual violence on mental health

Sexual violence is widespread and pervasive, and has devastating mental health impacts. It is defined by the World Health Organisation as: "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (Garcia-Moreno et al., 2012). Globally, it is estimated that around one in three women will experience sexual violence within their lifetime, but these numbers are likely an underestimate (World Health Organisation, 2021). Sexual violence against men is much less widely acknowledged, with higher rates of underreporting, but estimates are thought to be lower than that of women (Borumandnia et al., 2020). Barriers to reporting (such as stigma, threat of retaliation, or lack of awareness on how to report), along with variations in how sexual violence is defined across different jurisdictions, mean that prevalence estimates are difficult to determine (Krahé, 2024). The purpose of the current chapter is to provide an overview of sexual violence as a potentially traumatic event. First, this chapter will provide background information on the nature of sexual violence, before next addressing how sexual violence may impact mental health. Finally, this chapter will conclude by presenting some of the gaps and limitations of the current literature to provide a rationale for the central research questions, aims, and scope of the current thesis.

1.1 Understanding and defining sexual violence: The scope of the problem

Sexual violence is an umbrella term that incorporates a multitude of different acts. Broadly, sexual violence occurs along a spectrum from unwanted touch of a sexual nature through to forced sexual intercourse (Krug et al., 2002). The definition provided by the World Health Organisation also includes sexually violent acts such as human trafficking, conflict-related violence, denial of rights relating to sex or sexuality (e.g., forced abortion, denial of right

to contraception or sexual healthcare, female genital mutilation), and sexual harassment (Krug et al., 2002). Sexual violence can occur in any context, to any person, and by any perpetrator, including within intimate relationships, within the workplace, within families, or in the form of systematised abuse (Krug et al., 2002). Although sexual violence can and does occur to any person, certain groups of people are more at risk. Women are overwhelmingly at an increased risk of experiencing sexual violence in comparison to men, as are those with marginalised genders or sexualities (Coulter et al., 2017). Among sexual minority women, prevalence rates are particularly high: a recent review by Canan and colleagues (2021) found that 63% of bisexual women in a nationally representative sample in the United States had experienced rape, compared to 49% of lesbian women. Other vulnerable groups, such as children, disabled people, and elderly populations, are also at increased risk, as sexual violence is thought to reproduce existing power inequalities (Armstrong et al., 2018). Geographically, prevalence rates vary so widely as to be difficult to summarise effectively, which may in part be due to lack of standardised reporting, differences in cultural norms, and variations in how sexual violence is defined and understood (Dworkin et al., 2021). A recent systematic review suggested that in countries outside the US and Canada, past-year sexual assault prevalence rates for women may range from 0% to 59.2% for women, in comparison to 0.3% to 55.5% for men (Dworkin et al., 2021).

Research on sexual violence to date has largely focussed on the experience of women who are victims and men who are perpetrators (Turchik et al., 2016). Indeed, earlier conceptualisations of sexual violence focussed so heavily on heteronormative, gendered conceptualisations that in many jurisdictions, legal definitions of sexual violence meant that men were unable to be recognised as victims of rape (Turchik & Edwards, 2012). Further, feminist conceptualisations of sexual violence, such as in Susan Brownmiller's (1975) seminal work, *Against Our Will: Men, Women, and Rape,* emphasised and promoted sexual violence as a gendered social phenomenon. This conceptualisation is consistent with prevalence rates of

sexual violence victimisation, and highlights the overarching social structures which foster a culture of gendered oppression that permits high levels of sexual violence perpetration against women. However, I argue that focussing solely on the experience of women as victims narrows our understanding of how sexual violence pervades across social structures. In addition, failing to recognise non-normative experiences of sexual violence strengthens rape myths (Suarez & Gadalla, 2011). Rape myths are false beliefs about rape that promote cultural hostility towards rape victims, including fostering victim-blaming attitudes that fail to recognise the responsibility of perpetrators (e.g., "many women have an unconscious wish to be raped"; Burt, 1980). This cultural tendency to blame victims is one of the many ways in which experiencing sexual violence may lead to negative psychological sequelae.

Further, focussing solely on (predominantly heterosexual, White) women's experiences of sexual violence victimisation by perpetrators who are men risks the possibility that resources to support those who have experienced sexual violence are tailored only to this experience. Experiences of sexual violence which occur outside this paradigm (e.g., to men, or those with marginalised genders or sexualities) are often not accounted for in traditional reporting methodologies (Krahe, 2024). For example, experimental research has highlighted large discrepancies in rates of male victimisation when measures use dichotomous versus scaled response formats (Anderson & Cuccolo, 2022). These researchers theorised that the unique stigma and cultural under-acknowledgement associated with men's experience of sexual assault interacts more strongly with how sexual assault is framed in measures, to produce greater variability across studies. In addition, measures that describe specific sexual acts, versus those that utilise more general phrasing (e.g., "sexual assault"), have been found to produce similar differences in prevalence rates (Krahe, 2024). This may have particularly strong implications for non-stereotypical acts of assault, such as those perpetrated by women, which may go unacknowledged (Artime et al., 2014). Collectively, these limitations result in a

constricted understanding of the nature of sexual violence, including the potential impacts of experiences outside stereotypical depictions of rape.

Given these limitations, there is clearly a need for more research across a variety of nonconsensual sexual experiences, including those that occur to men or people of other genders, by same-gender perpetrators, or involving sexual acts other than forced intercourse (i.e., rape). These experiences all fall within the scope of this PhD, which will utilise a very broad definition of sexual violence as provided by the World Health Organisation (see above) and will not exclude cases based on perpetrator gender or the nature of the sexual act. Nevertheless, it is anticipated that certain types of experiences, such as women's experience of victimisation by men, will be overrepresented.

1.2 Psychological impacts of sexual violence

1.2.1 Early understanding of adverse consequences

Experiencing sexual violence is associated with a wide range of negative psychological consequences. Prior to the 1970s, these psychological impacts went largely unrecognised, in keeping with current victim-blaming cultural beliefs that sexual assault was provoked (Burgess, 1983). Coinciding with an increase in feminist psychology, Sutherland and Scherl (1970) were the first to conceptualise rape as an external event that happened *to* a person, rather than incited by them, and detail psychological consequences that could arise as a result. They described a three-phased response pattern to experiencing sexual assault: phase one consisted of acute reactions of "shock, disbelief, and dismay", followed by a second phase in which the victim-survivor[1] experienced an apparent adjustment and returned to their usual

[1] The term "victim-survivor" will be used throughout this thesis to refer to people who have experienced sexual violence. I recognise that many people who have experienced sexual violence do not refer to themselves as such, or have alternative preferences for terminology and identity, and indeed exploring these preferences is central to my thesis. I acknowledge this diversity but for ease of expression, have opted to use the term "victim-survivor" inclusively for all people who have experienced sexual violence. Alternatively, the term "victim/survivor" will be used throughout this thesis when referring to the distinction between victim and/or survivor identities. These findings speak to the power of language to shape and be shaped by identity throughout, and I hope that the nuanced discussion of language emphasised here will support better terminology in future.

activities, and finally a third, "integration" phase in which the victim-survivor truly came to terms with the event, often experiencing feelings of depression and wanting to discuss their experience with others (Sutherland & Scherl, 1970). In response to these findings, Sutherland and Scherl argued for a greater understanding of the *breadth* of responses to sexual assault that could arise, and the need for provision of appropriate mental health intervention and support.

This early work was followed by a landmark study in which Burgess and Holstrom (1974) recognised a "rape trauma syndrome". Over the course of one year, Burgess and Holstrom identified a pattern of psychological responses to sexual assault following observation of 109 child, adolescent, and adult victim-survivors who were admitted to hospital. In comparison to Sutherland and Scherl's three-phased model, rape trauma syndrome consisted of two phases: the acute reaction, and a longer-term readjustment period (Burgess & Holstrom, 1974). The defining characteristic of this syndrome was an overwhelming fear response, with outward disruptive impacts on physical, psychological, social, and sexual wellbeing (Burgess & Holstrom, 1974). Later, Burgess (1983) recognised that the responses characteristic to rape trauma syndrome mapped neatly onto DSM-III classifications of post-traumatic stress disorder (PTSD). This recognition of the potential severity of psychological consequences associated with experiencing sexual assault refocussed much of the existing literature on PTSD, which, until this point, had predominantly been studied in relation to military and veteran experiences (Rothbaum et al., 1992). This research also increased awareness of the widespread prevalence of sexual assault, which until this point had been seen as relatively rare (Marx, 2005).

These early studies were followed by an explosion of research on the psychological correlates of experiencing sexual violence. A recent meta-analytic review found that experiencing sexual assault is associated with increased risk of most major mental health conditions (Dworkin et al., 2017). Particularly strong links have been found between experiencing sexual assault and PTSD, depression and anxiety disorders, eating disorders, and substance use disorders (Chen et al., 2010; Dworkin et al., 2020). Exact causal mechanisms

underlying these links are unknown, however, several possibilities have been hypothesised: (a) sexual violence may increase general psychological vulnerability to mental illness, (b) may exacerbate existing mental health concerns, (c) may increase incidence of certain mental health disorders (e.g., PTSD), or (d) may lead to expression of mental health concerns in those with pre-existing genetic vulnerability (Dworkin et al., 2017). In this way, sexual violence is framed as a potentially traumatic stressor. In one of the most widely accepted models of mental health and psychopathology, the diathesis-stress model, mental health conditions are the result of one's unique underlying predisposing vulnerability (e.g., genetics) interacting with a sufficient level of "stress" (i.e., life events, environmental factors) (Kendler, 2020). In this model, mental health is a spectrum, under which anyone, with sufficient stress in interaction with their unique level of vulnerability, can develop a diagnosable psychological disorder (Ingram & Luxton, 2005). This is in line with contemporary research on the dimensionality of most psychological "disorders". Psychological disorders have largely been classified categorically, where an individual must meet criteria to receive a diagnosis. However, contemporary research supports that symptoms of psychopathology exist on a spectrum (Haslam et al., 2020). Further, there is a substantial degree of overlap across diagnoses, such that certain nonspecific criteria which are central to multiple diagnoses have been suggested to reflect a psychological stress response, rather than a symptom of "illness" (Forbes et al., 2024). Based on this model, mental health is not only relevant to a subgroup of vulnerable people, but instead is relevant to all people, noting that stressors might push anyone above an arbitrary cut-off point denoting a formal "disorder".

1.2.2 Sexual violence and PTSD

By far, the mental health condition most commonly associated with experiencing sexual violence is PTSD. Indeed, sexual violence is listed as a possible Criterion A trauma for a diagnosis of PTSD within the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V-TR*;

American Psychiatric Association, 2022). A "Criterion A" stressor refers to a traumatic event and exposure to such an event is essential to be diagnosed with PTSD. That is, without exposure to a Criterion A event, even someone with all other symptoms of PTSD and eligible as per other criteria would be unable to a receive a diagnosis. Slight variations in definition and conceptualisation of PTSD exist across the two major diagnostic taxonomies (the *DSM-V-TR* and the *International Classification of Diseases, 11th Edition*; *ICD-11*), however, it is widely acknowledged that PTSD is a disorder characterised by three broad symptom clusters: (1) re-experiencing symptoms, (e.g., flashbacks, nightmares), (2) avoidance of traumatic stimuli, (3) changes in arousal, mood, and cognition (Bryant, 2019).

Understanding risk factors for PTSD has been the focus of considerable research. A systematic review of longitudinal research examining pre-trauma risk factors in PTSD populations found that many of the symptoms associated with PTSD were found to be present (perhaps to a lesser extent) prior to experiences of trauma (DiGangi et al., 2013). For example, heightened startle reactivity was found to be both a pre-trauma risk factor for PTSD *and* associated with a PTSD diagnosis. However, this review also found that many social-contextual factors (e.g., socioeconomic status, family and community support) increased vulnerability for PTSD (DiGangi et al., 2013). As such, individual and social factors that influence a person's vulnerability to developing PTSD may also be exacerbated as a result of a traumatic experience.

As it became recognised that "rape trauma syndrome" mirrored many of the classic symptoms of PTSD (as listed in the DSM at the time; Burgess, 1983), the link between sexual violence exposure and subsequent development of PTSD received increasing attention within the literature. As a potentially traumatic event, experiencing sexual violence is a direct risk factor for developing PTSD (Dworkin et al., 2017; Dworkin et al., 2023). Furthermore, growing evidence suggests that, compared with experiencing other traumatic events, interpersonal traumas have been associated with increased likelihood of developing PTSD compared to non-interpersonal traumas, and even more so for sexual traumas (Creamer et al., 2001; Forbes et

al., 2013). This suggests that there is a unique link between sexual trauma and PTSD (Creamer et al., 2001; Kessler et al., 1995). Several theories have been suggested to account for this. One of the dominant contemporary theories is that sexual violence has more profound consequences for one's self-concept and their experiences of interpersonal relationships (Schnittker, 2022). That is, sexual violence may be perceived as a more total and personal attack on oneself compared to other forms of violence or other traumatic experiences. In addition, the pervasive "rape culture" that permits and drives a significant proportion of sexual violence creates a high level of vigilance among women and other marginalised populations towards the threat of sexual violence (Schnittker, 2022). This "rape culture" also prevents access to adequate support in the aftermath, which may in turn reinforce beliefs that such experiences were deserved or the fault of the victim-survivor (Schnittker, 2022).

However, not everyone who experiences sexual violence will go on to develop PTSD. Rather, the most common response after any potentially traumatic event is one of resilience, where people "bounce back" to their baseline mental health (Bonanno, 2004; Galatzer-Levy et al., 2018). Resilient trajectories do not necessarily involve a lack of distress, but rather, this distress does not cause ongoing and persistent impacts to one's ability to engaged in valued activities. Estimates suggest that as many as two-thirds of people will experience a "resilient" trajectory following trauma exposure (Bonnano et al., 2011). Compared to research on the deleterious outcomes of sexual violence, there is considerably less research concerning the percentage of people who will experience a "resilient" trajectory. However, some estimates suggest that between 10 to 53% of victim-survivors who experienced sexual abuse in childhood will have relatively few longstanding adverse psychological consequences (Domhardt et al., 2015). In sum, there is a need for research integrating the social and structural factors surrounding sexual violence that contribute to variations in psychological trajectories alongside individual-level factors and outcomes.

1.2.3 Post-traumatic growth

Additionally, a subset of people who experience traumatic events (such as sexual violence) will go on to develop post-traumatic growth (PTG). Post-traumatic growth is a phenomenon characterised by positive psychological changes, above and beyond that of one's pre-trauma mental health (Tedeschi & Calhoun, 2004). These positive changes often involve enhanced sense of purpose and meaning in life, strengthened interpersonal relationships, improved connection with spirituality and/or faith, openness to new experiences, and a greater sense of personal strength (Tedeschi & Calhoun, 1996). While PTG was once thought to be a distinct trajectory in comparison to PTSD, more recent research suggests that PTG is *more* likely to occur in those who have experienced post-traumatic stress (PTS; Joseph et al., 2012). That is, a degree of distress may be a necessary precursor to experiencing PTG. It is important to differentiate here that PTS is distinct from PTSD, in that PTSD denotes a "disorder" according to diagnostic taxonomies, whereas many people will experience symptoms of PTS without meeting criteria for PTSD, or without receiving a diagnosis. In this way, PTS can be considered a continuum of symptoms of ongoing distress following a traumatic event, whereas PTSD denotes a categorical diagnosis. Further, PTG appears to, in part, occur sometime after the emergence of PTS (Schubert et al., 2016). In this way, PTS likely precedes PTG, but may not be fully resolved prior to its emergence.

Taken together, mental health trajectories following an experience of sexual violence broadly follow three pathways: (1) resilience, (2) ongoing distress and impairment (e.g., PTS(D) or other mental health condition), or (3) ongoing distress and impairment and *also* PTG. Research examining which pathway someone will take has largely focussed on the role of intra-individual factors (e.g., coping behaviour), *or* social-contextual factors (e.g., social support) in buffering against PTS or promoting PTG. However, it has been suggested that the interplay of both individual and social-contextual factors has the greatest influence on post-trauma mental health, relative to the influence of any singular factor alone (Bonanno et al., 2011). As such,

research that cohesively integrates both social and psychological factors is likely to provide a more robust explanation of how and why these pathways occur. To date, research that examines trauma through this lens has largely been missing from the literature.

1.2.4 Complex PTSD

One well-established factor not yet explored in this chapter that influences post-trauma mental health is the degree of trauma exposure. It is widely acknowledged that trauma exposure has a cumulative effect, whereby increasing exposure to trauma predicts increasingly severe impacts on mental health and increases the likelihood of developing post-trauma mental health conditions such as PTSD (Kilpatrick et al., 2013). Additionally, cumulative trauma exposure has been found to increase symptom *complexity* (Cloitre et al., 2009). That is, trauma experiences have been found to compound on each other, where those who experience ongoing or recurrent trauma are more likely to develop more complex and severe mental health presentations. In response to this large body of research, a relatively new diagnosis of Complex PTSD (CPTSD) was added to the most recent version of the *ICD*, recognising the deleterious effects of cumulative trauma (World Health Organisation, 2019). CPTSD includes identical symptom clusters as PTSD as well as three further symptom clusters: (1) challenges with interpersonal relationships, (2) a pervasive negative self-concept, and (3) difficulties with emotion regulation, which cause significant distress and impairment across multiple domains of functioning (World Health Organisation, 2019). The addition of this new CPTSD diagnosis has both recognised the extent of distress that repetitive trauma exposure can create, and has also promoted advancements in research for people who have experienced recurrent trauma.

This is particularly important in the context of sexual violence. An experience of sexual violence is in itself a risk factors for future experiences of sexual violence (Classen et al., 2005; Jaffe et al., 2019). Additionally, experiencing sexual abuse in childhood is a risk factor for adult sexual assault, meaning that those who experience adult sexual violence are both more likely to

have experienced violence previously in childhood, *and* are at risk for future experiences of harm (Messman-Moore & Long, 2003). As such, CPTSD is a particularly relevant diagnosis in the context of sexual violence, perhaps even more so than that of PTSD.

1.3 Beyond mental health: Situating sexual violence within a social framework

At its core, sexual violence is a social phenomenon that is enabled by broader social structures. Despite often being an interpersonal experience, sexual violence is thought to reflect broader *intergroup* dynamics (Dworkin & Weaver, 2021). That is, it is widely understood that sexual violence reproduces existing power inequalities (Armstrong et al., 2018). For example, during times of conflict, rates of sexual violence escalate and often are used as "weapons of war" against politically marginalised groups (Boesten et al., 2017). In addition, those most at risk of sexual violence during wartime are women and children – those who are not only in the political or civil minority but are *also* vulnerable in other ways (Boesten, 2017). That is, sexual violence occurs at the intersection of layers of oppression and marginalisation.

This is also the case outside of conflict and wartime contexts. Sexual assault is highly stigmatised (Kennedy & Prock, 2018), and victim-survivors often report that this experience is *intersectional* in various ways. If choosing to disclose sexual assault, victim-survivors may be stigmatised against not only for the experience itself, but also for other marginalised identities that they hold, such as their gender or sexuality. A study by Lanthier and colleagues (2023) examining anonymous online narratives of sexual assault stigma posted to the online forum Reddit found that victim-survivors frequently cited experiencing multiple forms of stigma and discrimination. Not only did they report stigma regarding having experienced sexual assault, but also that this experience often led to stigma related to their gender, sexuality, body size or shape, and more (Lanthier et al., 2023). In turn, this impacted their decision to seek help from formal supports – often preventing them from further disclosure and help-seeking (Lanthier et al., 2023). In this way, sexism, racism, and other forms of oppression all interact to enable

sexual violence (McCauley et al., 2019). That is, there are very real *social* determinants both of sexual violence, but also of how sexual violence is experienced, including individual post-trauma mental health mental health.

Despite this, social group memberships and identities are rarely accounted for when considering how to support victim-survivors. When considering the mental health impacts of sexual violence, there is considerable research focussing on the role of *personal* identity (i.e., sense of self, based on individual characteristics or personality). Changes to personal identity following sexual violence are well-documented, and indeed, confronting negative beliefs about the self that have arisen as a result of the trauma (such as beliefs that one is powerless, weak, or blameable for the trauma, etc.), is a core component of many evidence-based treatments for PTSD (Dalgleish, 2004). Yet, there is very little research examining how one's *social* identity (i.e., sense of self, based on one's group memberships impacts and is impacted by sexual trauma.

In the current cultural context, the relevance of social identities to sexual violence is increasingly salient. Over the last ten years, advocacy movements such as #metoo and #TimesUp have highlighted the prevalence of sexual violence and emphasised the need for cultural and structural reform. Crucially, these movements have consisted of significant collective action that has perhaps not been seen previously on a similar scale in this context (Rottenberg, 2019). Not only have these movements increased awareness about sexual assault, but they have also driven social change. For example, within the United States, research suggests that reporting of sex crimes to police has increased since #metoo – with evidence that this elevation reflects increased reporting rates, rather than increased incidence of sexual assault (Levy & Mattsson, 2023).

However, it is important to note that these movements can also *reflect* the very power structures which they seek to dismantle. For example, a common criticism of #metoo is that it has situated sexual violence within the western, educated, industrialised, rich and democratic (WEIRD) world and privileged majority voices over the most marginalised (Boyd & McEwan,

2024). This risks fundamentally undermining the dialogue surrounding the intersectional nature of sexual violence by espousing that all experiences of sexual violence are the same and require the same resources. In turn, this has furthered oppression of minority groups by defining sexual violence as a (primarily) White, middle-class experience, effectively silencing those who are most at risk and with the least access to resources (Boyd & McEwan, 2024). While #metoo has been an important driver of social change, it cannot be disentangled from the social world in which it was created. As such, when exploring the mental health impacts of sexual violence through a social psychological framework, it is important to account for how these social identities may be relevant in a post-#metoo era.

1.4 Aims

The overall purpose of this thesis was to explore the relationship between social identities and mental health following sexual violence. This thesis will examine mental health outcomes following sexual assault using the social identity approach (details of this approach will be explored in Chapter 2). In particular, this thesis seeks to understand how trauma-related social identities, such as being a sexual assault "victim" or "survivor", are experienced and shape mental health responses. Building on from this, this thesis will explore how other relevant social identities, such as those of gender and sexual identity, or non-trauma social identities developed *after* sexual assault, relate to post-trauma mental health outcomes. This includes a consideration of how the absence or *rejection* of social identities shape mental health.

As an additional, process-related aim, this PhD aims to emphasise the lived and living experience of victim-survivors across a broad range of social identities. Social psychology has a history of imposing majority frameworks and ideas on marginalised communities, gatekeeping research findings, or appropriating ideas (and profiting) from minority groups (Reddy & Amer, 2022). This PhD aims to be explicit about its position in contributing to this dialogue and the inherent biases upon which it is built, while attempting to emphasise a range of victim-survivor

perspectives that may have previously been excluded. Despite this, we recognise the inherent limitations of research from academic institutions to provide an accurate and unbiased account of the most marginalised voices.

Following from these overall aims, this PhD raises three underlying research questions:

1. How do "victim" and "survivor" identities relate to mental health following sexual violence?
2. How do people make meaning of their identity in the aftermath of sexual violence?
3. How does disidentification relate to mental health outcomes in sexual assault victim-survivors?

1.5 Scope

The scope of this PhD is limited primarily to the Australian context, but may also have some generalisability to other primarily westernised cultures. Further, this PhD explores mental health in adult populations (18 years and above), while recognising that many victim-survivors within this research and beyond have experienced childhood sexual abuse and this will have likely impacted on their experience of identity and mental health. Finally, this PhD is primarily concerned with the relationship of *social* identity and mental health, rather than personal identity, however recognises that these conceptualisations of identity are not necessarily in complete opposition but may interact.

Chapter 2: The Social Identity Approach and its relevance to trauma

2.1 Chapter overview

This chapter will review the literature on the Social Identity Approach (SIA), which provided the theoretical foundation for investigating the research questions outlined in Chapter 1. I will cover the key theories within this framework, before examining how it has been applied to health and wellbeing with a particular focus on applications to understanding trauma. Finally, this chapter will outline how and why this framework has been used to address the current research questions, and provide an overview of the methodological approach taken in the empirical chapters.

2.2 The Social Identity Approach: Key theories

SIA is an umbrella term for a conceptual framework incorporating social identity theory (Tajfel, 1974) and self-categorisation theory (Turner et al., 1987) to understand how group dynamics and social contexts influence behaviour. *Social identity* refers to the aspect of one's self-concept which is defined by their internalisation of the groups to which they belong and felt of affiliation with fellow ingroup members (Tajfel, 1974). In this way, social identity is distinct from one's personal identity, which refers to self-concept defined in terms of individual attributes and traits. In contrast, one's social identity is determined by their group memberships, and, crucially, how they perceive these groups in relation to other groups (Tajfel, 1974).

Categorising oneself as a member of a group involves awareness of how one is similar to other ingroup members and how ingroup members are distinct from outgroup members (Turner et al., 1987). That is, self-categorisation inherently involves seeing oneself as similar to some

people and different from others, and this is enhanced when the group differences are salient. For example, when a person self-categorises as a member of the group, they perceive themselves not in terms of their *personal* characteristics, but in terms of the characteristics of the group, including group norms, attributes, and status (e.g., "women"; "students"; "psychologists") (Tajfel, 1974). That is, their experience of both themselves and the world will be perceived via the lens of their salient social category, rather than by their individual attributes and characteristics. Importantly too, when one self-categorises as a member of the group (i.e., when a particular social identity is *salient*), their behaviour informed by the group (Turner & Onorato, 1999). For example, self-categorising as one's gender identity is likely to lead to very different behavioural outcomes compared to self-categorising in terms of one's religious identity. When self-categorising via the lens of gender, one may dress or present themselves in a way that matches this identity, whereas self-categorising via the lens of religious identity may lead one to engage in spiritual practices, attend places of worship, et cetera.

Social identity theory posits that people are motivated to maintain a positive sense of self, which affects how they relate to their groups (Tajfel, 1974). For example, early experimental research found that sorting people into groups based on near-arbitrary information was sufficient to induce ingroup favouritism and outgroup derogation (Tajfel et al., 1971). In these early experiments, young boys were asked to express their preference for a series of abstract artworks by two famous painters (Klee and Kandinsky). Following this, their preferences were rated such that they could be sorted into two groups, those who mostly preferred paintings by Klee and those who preferred Kandinsky. In reality, these groups were based on random assignment rather than artist preference. They were then asked to assign money to each of the groups. Even under these so-called "minimal" conditions (i.e., where there are no pre-existing relationships between the groups, and categorisation into groups is based on very little information), the boys assigned money to their own group and the outgroup in a way that maximised the *difference* between their own group's profit (favouring their own group) and that

of the outgroup. Further, even when they were presented with options to maximise their *joint* profit, such that both groups would receive fairly equal amounts of money, they still acted in favour of maximising the benefits to their ingroup and the costs to the outgroup. This early experimental work provided initial evidence that people are motivated to act in favour of their own group and positively distinguish their group from other outgroups (Tajfel et al., 1971).

Given that social identification and self-categorisation inherently involve comparison between one's own groups and others, belonging to a group that is low status threatens this positive self-concept. People will use a variety of strategies to combat this. First, if possible, they may choose to leave the group, either literally or psychologically (*individual mobility*; e.g., a woman may choose to suppress her femininity and traditionally feminine characteristics in male-dominated environments). Alternatively, they may evaluate their own group and others based on alternative dimensions in which their own group is more successful (*social creativity*; e.g., women may focus on skills or attributes where they traditionally succeed or are perceived as being "better", such as in caring roles, capacity to nurture etc.). Finally, they may compete with other groups to change their own group's position and status (*social change*; e.g., women may attend protests or engage in collective action advocating for gender equality; Tajfel & Turner, 1978).

Further, social identification is also a continuum, in that people can feel more or less identified with the groups to which they belong – membership alone is not necessarily sufficient to foster social identification. That is, simply being a woman by virtue of demographics does not constitute *social identification as a woman*. The extent to which a person socially identifies as a member of a group involves both a cognitive and affective component: broadly, one must see themselves and other group members as belonging to a similar entity as we as feel psychologically *invested* in being a part of the group (Leach et al., 2008). The more highly identified one is with their group, the more psychologically meaningful that group becomes, with more significant implications for one's behaviour and experience of the world (Ellemers et

al., 2002). That is, higher social identification with a group is associated with greater influence of the group on one's behaviour.

2.3 Applying the SIA to health and wellbeing

Thus, many decades of research have demonstrated that there are qualitatively different psychological processes that arise from seeing ourselves in terms of our social identities. More recently, researchers have begun to focus on the effects that these same social identity processes might have health and wellbeing, for better and worse (e.g., Jetten et al., 2012; Haslam et al., 2018). Early research in this area found that *internalising* group-based identities into one's self-concept yielded powerful positive benefits for wellbeing. For example, in two separate studies, participants in a recreation group and a psychotherapy group were found to have lower levels of depression over time, and that this was predicted by social identification with the group (Cruwys et al., 2014). That is, depression was not reduced by just being "in" the group, but rather, participants had to *feel* like they were part of the group in order to receive benefits, i.e., improved mental health. These findings were bolstered by the fact that only one of the groups received psychological therapy (and hence the reduced depression scores were not attributable only to receipt of therapy) whereas the other was purely based around recreational activities (Cruwys et al., 2014).

Broadly, social identities have the power to provide a sense of purpose and meaning, belonging, and meaning, as well as being beneficial for self-esteem and sense of control and agency – key constituents for psychological wellbeing (Greenaway et al., 2016). Experimental research suggests that high levels of social identification with meaningful groups provides global benefits to psychological wellbeing (Greenaway et al., 2016). In a study by Greenaway and colleagues (2016), participants were randomly assigned to one of three groups: (1) an identity gain condition, where participants were asked to write about a time where they gained an important group-based identity (e.g., joining a team), (2) an identity loss condition, where

participants were asked to write about a time where they *lost* an important group-based identity, and (3) a control condition, where participants wrote about a part of their daily routine. All participants then completed measures of psychological need satisfaction, describing the extent to which psychological needs such as belonging, positive self-esteem, control, and sense of meaning were met while completing the writing tasks. It was found that participants in the identity gain condition scored higher on psychological need satisfaction in comparison to participants in the identity loss or control conditions. Similarly, participants in the identity loss condition reported lower levels of psychological need satisfaction compared to the control condition (and identity gain condition). These results suggested that holding valued and positive social identities can, in and of themselves, promote positive psychological outcomes (Greenaway et al., 2016). This power of groups to provide positive health benefits is termed the "social cure" effect (cf. Jetten et al., 2012; Wakefield et al., 2019).

Further, the benefits of social identification go beyond simply promoting global positive psychological benefits. Belonging to valued groups can provide much-needed social support, that buffers the effect of stress (Wakefield et al., 2019). That is, during times of stress or hardship, ingroup members can offer multiple types of support – emotional, tangible, informational, etc. – thereby increasing access to resources that allow one to cope with the stress (Haslam et al., 2009). Once again, this is likely to be particularly beneficial when social identification with a group is high. For example, following the war in Kosovo, those who were highly identified with their nationality and perceived the war as *affirming* this identity were more likely to seek support from others, rather than utilise individual coping strategies that promoted ongoing isolation (Kellezi et al., 2009).

Identifying with one's group may be particularly (psychologically) beneficial when a group is facing discrimination or rejection. Discrimination involves negative treatment towards a person or group based on their identity, and may be conceptualised as the behavioural enactment of stigma (Link & Phelan, 2001). The *rejection-identification* model suggests that,

when faced with *pervasive* discrimination or stigma, one way that group members will cope with this is to more strongly identify with their (stigmatised) social identity (Branscombe et al., 1999, 2011). For example, experimental research has shown that when women are asked to reflect on instances of gender-based discrimination, women show decreases in wellbeing, but this is buffered by social identification with their gender identity (Schmitt et al., 2002). That is, gender-based discrimination *harms* wellbeing, but some of these detrimental effects are offset by the benefits of increased identification as women. This may be in line with social change strategies highlighted above (Tajfel & Turner, 1978), where perceiving negative treatment as being due to one's gender and thus increasing identification with one's gender is empowering, motivating women to engage in collective action. One core tenet of this model is that group members are aware of their position in the social hierarchy, and this will impact what they perceive to be discriminatory (Branscombe, 1998). For example, women tend to perceive more serious events as discriminatory compared to men (e.g., fearing sexual assault versus limitations on being able to express emotions, respectively) (Branscombe, 1998). By increasing identification with their stigmatised group, group members become more intertwined with this identity and other group members who face similar rejection and who are unlikely to also enact this discrimination (Branscombe et al., 2011). Perceiving there to be pervasive discrimination against one's group-based identity is detrimental to wellbeing, but increasing identification with the stigmatised group can protect against some of these effects (Schmitt et al., 2014).

However, just as groups have power to promote positive wellbeing via "social cure" effects, so too can group-based processes lead to detriments to wellbeing. As seen above in Branscombe and colleagues' (1999) rejection-identification model, not all groups are viewed or treated positively, but rather are the source of stigma and discrimination. For example, Cruwys and Gunaseelan (2016) found that, in line with the rejection-identification model, when faced with discrimination, people experiencing depression identified more strongly as depressed. In turn, however, they experienced *negative* impacts to their wellbeing – i.e., higher levels of

depression. The researchers theorised that, because the content associated with a "depression" identity is one of poorer wellbeing, stronger identification with this group led to increases in symptomatology (Cruwys & Gunaseelan, 2016). Similar findings have been found in research with service users of a homeless shelter. Walter and colleagues (2015) found that those who self-categorised as "homeless" while accessing the shelter had poorer wellbeing and reported less life satisfaction than those who did not (Walter et al., 2015). That is, the significant stigma associated with the "homeless" identity held harmful implications for wellbeing, thus rejecting this identity protected against these impacts. It is important to note here that discrimination or stigma against certain groups may less likely to be overtly challenged and may be perceived as more legitimate (e.g., stigma against those who are unhoused, versus against gender or ethnic minorities). Taken together, when the content of social identities is inherently detrimental to wellbeing, social identification can be harmful, rather than helpful, for health.

Further, social identities that are otherwise positive and meaningful may become sources of pain when they are negated or undermined. The more that a particular social identity is valued, the more that threats to this identity can have significant detrimental effects. This power of group-based processes to lead to poor health outcomes is referred to as the "social curse" effect. Returning to the example of the war in Kosovo, women who experienced sexual violence during the conflict faced significant negative impacts to their psychological wellbeing (Kellezi & Reicher, 2011). Experiencing sexual violence, while traumatic in itself, was particularly psychologically damaging in this context because it deeply undermined normative content associated with being a woman. That is, the patriarchal culture of Kosovo at the time meant that gender was a highly salient and culturally-valued identity; further, women were socially valued for their moral virtue and purity. Thus, the experience of sexual violence, for many women, was perceived to irreparably damage this identity (Kellezi & Reicher, 2011). Similar impacts were found among women who experienced wartime sexual violence in Bosnia-Herzegovina:

interpreting these acts as crimes against them as *women* was associated with poorer psychological wellbeing, post-traumatic stress, and isolation. By contrast, those who interpreted the sexual violence as a war crime against them as *Bosnians* had better outcomes (Skjelsbaek, 2006). Suffering sexual violence, when interpreted as a war crime, allowed these women to more readily uphold the values associated with their gender identity and *also* affirmed their national identity, enabling them to connect with others over shared trauma and hardship following the war (Skjelsbaek, 2006).

One related and relevant application of SIA to the issue of sexual violence has been research into perpetration. A large body of empirical work has found evidence that sexual harassment may be motivated or triggered by misogynistic attitudes. This was highlighted in a seminal experimental study which investigated male participants' propensity to sexually harass women (Dall'ara & Maass, 1999). In this experiment, male university students exchanged images back and forth via computer with who they thought was a female university student (in reality, no such student existed). In one condition, the fictitious female student presented herself as holding more traditional attitudes towards gender roles (e.g., emphasised her values around family and nurturing others, downplayed her occupational worth), compared to a second condition where she presented herself as having more feminist and progressive attitudes (e.g., championed the rights of women as being equal to that of men; Dall'ara & Maass, 1999). The researchers found that the male participants were more likely to harass the (fictional) woman when she held endorsed feminist attitudes. This was particularly likely when the male participant already held sexist views and was strongly identified with their gender identity. One interpretation of these findings was that the feminist norms challenged the male participants' status in the gender hierarchy (Dall'ara & Maass, 1999). This previous research provides a meaningful counterpoint from which sexual violence as a phenomenon can be understood. Building on this evidence, this thesis also understands sexual violence as reflecting broader intergroup (as opposed to interpersonal) dynamics, including sexism and misogyny.

Most importantly, it once again demonstrates that individual acts of sexual violence are micro-reflections of broader social dynamics. The current project is specifically concerned with how sexual violence is experienced by victim-survivors, rather than with what drives it.

2.4 The power of the group to influence responses to trauma

SIA recognises that social groups can promote positive psychological wellbeing and buffer against stress and hardship (i.e., a social cure effect), or alternatively, be a source of distress and harm (a social curse effect). This is thus a highly relevant framework for understanding responses to extreme stressors and traumatic events. SIA can be used to derive several propositions that are relevant to trauma specifically. First, belonging to certain groups may elevate one's risk of experiencing trauma. Belonging to a group that is stigmatised, discriminated against, or persecuted, increases the likelihood of experiencing group-related violence or harm (Muldoon et al., 2012). For example, as outlined in Chapter 1, women and girls are at a disproportionate risk (compared to men and boys) of experiencing sexual violence (Coulter et al., 2017). Further, trauma exposure is disproportionate across intersecting categories, such that belonging to multiple marginalised groups further increases the likelihood of trauma exposure *and* reduces the resources available to recover in the aftermath (Muldoon et al., 2019). For example, compared to heterosexual women, sexual minority women are at increased risk of experiencing sexual violence (Balsam et al., 2005; Eisenberg et al., 2021). That is, although women in general are more at risk of being sexually assaulted compared to men, this risk is even higher for women who are also a minority sexuality. When disclosing or accessing support services for sexual assault, sexual minority women also report receiving more negative reactions compared to heterosexual women (Sigurvinsdottir & Ullman, 2015). Taken together, trauma experiences such as sexual violence are inherently intertwined with group membership status, influencing both potential for exposure to trauma and resources for recovery following it.

Second, although demographic factors such as gender or sexual identity status are by themselves risk factors for sexual violence exposure, understanding how these demographics operate as meaningful social identities (rather than just social categories) provides insight into how trauma is experienced and interpreted. Self-categorising as a member of a marginalised group is more likely to occur when contextual factors such as political unrest or threats to one's group's status make these identities salient (Ellemers et al., 2002). That is, self-categorisation processes are more easily facilitated when intergroup differences are stark, and experiences of trauma are more likely to be interpreted through the lens of one's (marginalised) identity. For example, research with children in Northern Ireland during a time of political unrest found that children from the minority group (i.e., Catholics) rated negative life events such as bomb threats or being picked up by the police as more stressful than their majority counterparts (i.e., Protestants; Muldoon, 2003). The political climate of Northern Ireland meant that ongoing conflict between the two religious groups increased the salience of these religious identities, which in turn informed how these children interpreted negative experiences, with differential impacts on their wellbeing.

More recently, research has highlighted how social identity processes may facilitate different mental health outcomes following trauma. As previously emphasised, research by Kellezi and Reicher (2011) found that trauma experiences which undermine a meaningful identity (such as gender identity) are likely to have negative impacts on psychological wellbeing. Further, taking on a new identity as a result of trauma may be harmful for wellbeing when the content of that identity is associated with the trauma itself. For example, qualitative research with people who have experienced childhood sexual abuse highlights that acquiring a stigmatised identity (such as victim or survivor of childhood sexual abuse) can promote feelings of "otherness" and isolation (Muldoon et al., 2024). In the context of sexual violence, being a "victim" or "survivor" of sexual assault defines one's identity in terms of their trauma history; self-categorising as a victim or survivor necessitates acknowledging an experience of violence

and integrating this into one's self-concept (Thompson, 2000). Therefore, we can derive a third SIA prediction relating to trauma: trauma experiences may result in the acquisition of new and distressing identities which can be detrimental to wellbeing.

However, the relationship between acquiring a new, trauma-related identity and wellbeing is not always straightforward. Trauma-related identities may be associated with positive wellbeing outcomes when they facilitate connection with others. For example, qualitative research with immigrant detainees in the United Kingdom found that taking on an identity as a "detainee" allowed participants to connect with others in the centre over shared experiences of suffering (Kellezi et al., 2019). Despite the "detainee" identity being associated with profound trauma and loss of autonomy, identification as a detainee served to help participants cope with this trauma via their shared experience. Yet simultaneously, this identity was a source of distress, serving as a reminder of both the participants' current circumstances and the threat of deportation (both of themselves, and their fellow group members) (Kellezi et al., 2019). Additionally, when a trauma-related identity provides the basis for engaging collective action and activism, as was found with victim-survivors of violence and abuse in South Africa, this identity may become a platform for PTG (Haslam et al., 2022). It appears, therefore, that a fourth prediction applying SIA to trauma is that trauma-related identities may hold multiple forms of meaning that can lead to both positive and negative outcomes.

Fifth, social identities may promote post-traumatic growth in the wake of trauma. This is expected when trauma experiences result in gain of new and positive social identities, or lead to positive changes in the way existing identities are experienced. Following the Australian bushfires in the summer of 2019-2020, those who found a renewed sense of identity with their community or gained new identities following the bushfires had higher levels of PTG – but simultaneously, gaining new identities was also associated with increased distress (Craig et al., 2022; Cruwys et al., 2024). Similarly, research with people who have experienced sexual assault has found that engagement with anti-sexual assault activism is associated with increased

psychological wellbeing and post-traumatic growth (Muldoon et al., 2023; Swanson & Syzmanski, 2020; Swanson & Syzmanski, 2021). In one study, participants identified that engagement with others who had a shared lived experience of trauma, in service of a collective action goal, promoted increased feelings of connection, empowerment, and meaning in life (Swanson & Syzmanski, 2020). That is, redefining a trauma-related identity to promote connection with others and drive for change can be associated with positive psychological outcomes. However, as seen again above in the bushfire example, this does not necessarily occur in the *absence* of psychological distress, but rather alongside it.

Finally, a relatively novel application of SIA to trauma has investigated the relationship between *disidentification* and trauma-related outcomes. Disidentification is the process via which a group-based identity is rejected (Becker & Tausch, 2014). Often, this occurs because the identity is a significant source of distress. That is, disidentification does not refer to low levels of identification, or a lack of identification, but rather is an active *rejection* of a group-based identity, involving both affective and cognitive distancing from the group (Becker et al., 2011). In an experimental study, students were randomly assigned to one of four groups and asked to imagine participating in collective action against increased tuition fees. One group was a control condition, and the other three groups differed in the severity of the imagined collective action scenario (e.g., from participating in a peaceful demonstration to arson). It was found that participating in more radical collective action was associated with disidentification from the broader ingroup (Becker et al., 2011). That is, those who imagined themselves participating in radical action began to reject the broader in-group, potentially because the extremist behaviour was at odds with broader in-group norms, or may have even been condemned by the ingroup. Although this is not a trauma-relevant example, this study provides empirical support that when one holds a group-based identity but feels *rejected* by other group members or feels that the defining characteristics of the group do not align with the way they embody this identity, then they may disidentify from this group. This may be relevant in the context of trauma as victim-

survivors often downplay or minimise the severity of their experience (Littleton et al., 2007), and as such may not feel that they are aligned with other in-group members (i.e., other trauma victim-survivors).

2.5 The current research agenda: Overview of empirical chapters

It is apparent from the previous literature that trauma and its mental health after-effects (including PTS, PTG, CPTSD etc.), are inherently linked to social identity processes. Further, it is also clear that *sexual* trauma is highly relevant to social identity processes. As outlined in Chapter 1, sexual trauma reflects existing intergroup power dynamics of gender, race, and sexuality (among others; Armstrong et al., 2018), and as such involves many intersecting group-based identities. Finally, there is some existing research suggesting that social identity processes play a role in how experiences of sexual trauma are interpreted, with consequences for subsequent mental health (e.g., Kellezi & Reicher, 2011; Skjelsbaek, 2006). However, there are several gaps in the existing literature, which this current PhD is aiming to address.

First, it remains unclear how sexual trauma-related (social) identities, such as "victim" and "survivor", shape mental health outcomes following sexual violence. The current social context provides a unique opportunity to examine this. The prominence of recent anti-sexual assault advocacy movements has fostered a growing awareness of how language such as "victim" and "survivor" impacts perceptions of those who have experienced sexual violence, with connotations of "survivors" being generally more positive compared to that of "victims" (see Chapter 1). What is currently missing from the literature is an examination of how these identities are integrated (or not) with pre-existing identities to shape mental health. That is, sexual assault does not occur in the absence of pre-existing experiences of social identification, and these prior identities are likely to play a role in shaping responses to sexual violence. SIA therefore provides a unique framework through which to examine how intersecting social identities serve to help or hinder recovery from sexual violence and influence mental health

outcomes. The first empirical chapter (Chapter 3) details findings from a large cross-sectional study investigating associations of "victim" and "survivor" labels on mental health outcomes, primarily post-traumatic stress and growth, in a sample of adult women who had experienced sexual assault. To my knowledge, this was the first study to examine the relationships between mental health outcomes and "victim" and "survivor" identities specifically through a social identity lens in the context of sexual trauma. As such, utilising a cross-sectional design allowed for initial examination of the relationships between these identities and mental health variables.

Further, SIA allows for understanding how people make *meaning* of their identities in the aftermath of sexual trauma. As noted above, many intersecting group-based identities are relevant and may be affected by sexual trauma. However, these identities hold vastly different meaning (e.g., one's gender identity as a woman may be associated with femininity for one person, sexual purity for another, or feminism for a third). What remains unclear is how one's understanding of their social identities impacts how they make meaning of sexual violence experiences. This is addressed in my second empirical chapter (Chapter 4), where I utilised qualitative methods to explore how people understand their social identities (both pre-existing social identities and acquired trauma-related identities) to make meaning of sexual violence experiences. In this study, I interviewed 25 victim-survivors of sexual violence about their experiences of sexual assault, their relationship to social identities, and their mental health experiences, to uncover *how* these identities interact to shape mental health.

Finally, SIA's recent application to trauma suggests that social identities are fundamentally tied to differences in mental health trajectories, namely that of PTS and PTG (e.g., Muldoon et al., 2019). However, this has not yet been examined in relation to other trauma-related mental health impacts, such as CPTSD, or in the context of sexual assault. There is also a considerable gap in the literature concerning how *disidentification* affects mental health outcomes following trauma, including sexual violence. This may be a particularly relevant social identity process for sexual assault victim-survivors, as failing to acknowledge

one's experience as sexual assault is a very common response (Holland et al., 2020). As such, it is very possible that sexual assault victim-survivors may choose to reject identities related to their trauma experience (such as "victim" or "survivor" identities, gender or sexual identities, etc.), and it is likely that this impacts subsequent mental health. My final empirical chapter (Chapter 5) utilised a cross-sectional survey design to examine how *disidentification* from victim and survivor identities impacts mental health trajectories. In this study, I explored the relationship between disidentification from trauma-related identities and CPTSD in a sample of 215 sexual assault victim-survivors. Given the dearth of research examining disidentification and mental health outcomes in the context of trauma, or examining how social identity processes are associated with CPTSD, the relationships between these variables were largely unknown. Therefore, it was fitting to use cross-sectional methodology to provide initial insight into how disidentification relates to mental health in the context of sexual violence. This would provide an appropriate platform for future experimental or longitudinal research that could provide further insight into causal mechanisms underlying these phenomena.

Chapter 3: Identifying as a survivor versus a victim after sexual violence predicts divergent post-trauma pathways

3.1 Chapter overview

Chapter 3 presents findings addressing my first research question. In this study, I investigated the relationships between social identification with "victims" and "survivors" and mental health (post-traumatic stress and growth) in a sample of Australian adults who had experienced sexual violence.

3.2 Publication status

These findings were presented at the Society of Australasian Social Psychologists and the Australasian Congress on Personality and Individual Differences (SASP-ACPID) combined conference in 2023.

These findings have also been published as follows:

Western, K. A. B., Cruwys, T., & Evans, O. (2024). Identifying as a survivor versus a victim after sexual violence predicts divergent posttrauma pathways. *Violence Against Women*, 10778012241279817. https://doi.org/10.1177/10778012241279817

3.3 Author contributions

Western: Conceptualisation, methodology, investigation, formal analysis, investigation, writing – original draft, writing – review & editing, project administration.

Cruwys: Supervision, formal analysis, writing – review & editing.

Evans: Writing – review & editing.

3.4 Abstract

The present study investigated social identification with “survivors” versus “victims” following sexual violence and the degree to which this predicted post-traumatic growth versus post-traumatic stress. Participants (*N*=290) were adult women who had experienced sexual violence. As predicted, cumulative sexual trauma was positively associated with symptoms of *both* post-traumatic stress and post-traumatic growth. Further, people who had experienced more cumulative sexual trauma were more likely to identify with victims, which in turn predicted post-traumatic stress. Similarly, people who had experienced more cumulative sexual trauma were also more likely to identify with survivors, and this in turn predicted post-traumatic growth.

3.5 Introduction

The psychological ramifications of sexual violence are well-documented: sexual violence places people at a high risk for mental illness, including post-traumatic stress disorder, depression, and anxiety disorders (Forbes et al., 2013; Landrine et al., 1995; Ullman & Relyea, 2016). Increasing evidence points to a cumulative effect of trauma on mental health, where repeated or more severe traumas compound these detrimental effects on psychological wellbeing (Cloitre et al., 2009; van der Kolk et al., 2005). While it is well-documented that the majority of people will be resilient in the wake of a traumatic event (Bonanno, 2004), a sizeable minority of people will experience detriments to wellbeing that constitue clinically significant distress. Post-traumatic stress disorder (PTSD) is the primary mental health condition associated with experiencing trauma, and is characterised by prominent intrusive symptoms (such as recurrent memories or flashbacks of the trauma), heightened arousal, disruptions in emotion regulation, and avoidance of reminders of the traumatic event (APA, 2013). Although the majority of people who experience traumatic events will not go on to develop PTSD, sexual violence exposure is more strongly linked to PTSD incidence than any other type of trauma (Creamer et al., 2001; Forbes et al., 2013; Kessler et al., 1995). Further, experiencing sexual violence is itself a risk factor for future revictimisation, compounding the risk that a person will develop PTSD (Classen et al., 2005; Ellis et al., 1982).

While these devastating impacts of traumatic experiences are well-established, there is evidence that many trauma survivors also report post-traumatic growth, a phenomenon where people experience positive psychological changes following a trauma. These positive changes typically include fundamental shifts in an individual's sense of meaning in life, enhanced interpersonal relationships, and an increased understanding of one's values (Tedeschi & Calhoun, 2004). Notably, post-traumatic growth is more than simply resilience or "bouncing back" after trauma, and instead constitutes a shift towards enhanced psychological functioning compared to one's pre-trauma state (Tedeschi & Calhoun, 1996). Whereas prior research has

focussed on the individual psychological factors that determine post-trauma mental health, more recently social factors have also been found to play a substantial role (Muldoon et al., 2019).

3.5.1 The social identity approach

Experiences of sexual violence are profoundly isolating events, and it is therefore unsurprising that the psychological sequelae of these experiences are often viewed through an individualistic lens, where coping skills, personality, and prior psychopathology have been considered to be the primary predictors of post-trauma mental health. Yet an increasing body of evidence points to the need for a *social* psychological understanding of responses to trauma. The social environment dictates the type of traumas that people are likely to experience and the resources that they will have to respond to this experience (Muldoon et al., 2019; Muldoon et al., 2021). Therefore, experiences of trauma cannot be fully understood through an individualistic lens, but rather, these individual factors need to be considered in a broader social context. The social identity approach (SIA) provides a theoretical framework for understanding how and why trauma experiences may lead to diverging pathways in terms of individual mental health.

The social identity approach is based on the premise that one's social identities (i.e., one's sense of self, based on their group memberships) substantially affect both physical and psychological health (Haslam et al., 2018; Jetten et al, 2012). Belonging to groups not only provides connection to others, but is also an important source of self-esteem and meaning in life (Greenaway et al., 2016). This power of groups to promote wellbeing is known as the *social cure* effect (Jetten et al., 2012; 2017), and is the basis for a psychological intervention that has demonstrated effectiveness in reducing loneliness and social anxiety and improving social connectedness, Groups 4 Health (Haslam et al., 2016b; Haslam et al., 2019). Groups themselves are not always beneficial, however, and some group memberships may do more harm than good. In contrast to the social cure effect, certain group memberships may be

damaging to wellbeing, constituting a *social curse* effect (Kellezi & Reicher, 2011). More specifically, being part of groups that are stigmatised or discriminated against is detrimental to one's sense of self-worth, particularly when one cannot easily (or does not wish to) leave the group (Wakefield et al., 2019). For example, many women strongly identify with their gender identity and do not desire to change it, yet being a woman puts people at risk of sexism, discrimination, and sexual violence. Perceiving discrimination as being due to one's group memberships, such as when women attribute negative treatment as sexism, can be harmful to one's identity and sense of self-esteem. In response to such treatment, people may in turn *increase* their identification (and thus their sense of belonging) with the stigmatised group, as a source of psychological protection against the negative effects of discrimination, known as the *rejection-identification* model (Branscombe et al., 1999; 2011).

Traumatic experiences are inextricably tied to social identities. Simply belonging to particular groups puts people at differential risk of trauma exposure and also influences the resources that one can draw on to recover from a potentially traumatic event. For instance, during wartime, women face a disproportionate risk of sexual violence compared to men, where rape is used as a form of social and political control that reinforces traditional gender stereotypes (Milillo, 2006). In patriarchal societies, the social and psychological aftereffects of these crimes are exacerbated, where the resulting shame and "dishonour" isolates women from their communities and families, thereby preventing them from accessing social and economic resources that may help them to recover (Milillo, 2006). As such, identity *as a woman* can interact with other important social identities (e.g., cultural identity) to increase both the likelihood of experiencing a trauma and the resources that can be drawn upon in the aftermath.

While group membership alone may be sufficient to increase the risk of exposure to potentially traumatic events, subjective identification with one's group memberships may impact how a traumatic event is perceived. Traumatic experiences are more likely to cause substantial psychological harm (e.g., post-traumatic stress) when they call into question a

group membership that is subjectively valued (a social identity; Muldoon et al., 2019). For example, sexual violence may have particularly adverse psychological consequences in more patriarchial societies, as it undermines values of sexual purity that are strongly tied to one's identity as a woman (Kellezi & Reicher, 2011). Conversely, post-traumatic growth responses are more likely when one's social identity is *extended* with the creation of a new (positive) social identity, or when one reconnects with a pre-existing valued identity (Muldoon et al., 2019). Evidence illustrating this comes from survivors of violence and abuse in South Africa. After abuse and/or violence, people who identified with anti-violence activists were more likely to experience post-traumatic growth (Haslam et al., 2022).

3.5.2 Sexual violence through a social identity lens

Despite these promising findings, the social identity approach has only recently been applied to trauma and there is a paucity of research examining sexual trauma using this model. Along with drawing attention to the pervasiveness of sexual violence, the #metoo movement has shed light on the use of survivor and victim terminology to label people who have experienced sexual violence. While the term "victim" was historically used (i.e., victim of crime; van Dijk, 2009), the term survivor has gained traction in recent years, in reaction to the connotations of passivity and lack of agency associated with "victim" (metoo Movement, 2022). This shift is supported by research: whether someone is portrayed as a survivor or a victim leads others to make different attributions of blame (Schwark & Bohner, 2019) and to differences in judgements of the severity of the assault experience (Papendick & Bohner, 2017). Researchers themselves are not immune to these biases: A meta-analysis of research on "rape victims" versus on "rape survivors" found that researchers who used the term "victims" predominantly investigated the negative mental and physical health consequences associated with the trauma experience (Hockett & Saucier, 2015). Conversely, researchers who used the term "rape survivors" were more likely to investigate outcomes such as resilience and post-traumatic

growth, alongside the negative psychological consequences (Hockett & Saucier, 2015). The authors concluded that framing participants as "victims" predisposed researchers towards a narrower and more negative conceptualisation of their participants, as opposed to those who used the term "survivors", which predisposed researchers towards viewing their participants more holistically.

These early findings are promising, yet focus predominantly on *others*' perceptions of victims and survivors. Although there is little research investigating the impacts of these labels on the victim/survivors' own self-perception, some early research indicates that people who have experienced sexual assault may have preferences for a particular label (i.e., survivor or victim), or indeed may reject these labels altogether (Williamson, 2023; Williamson & Serna, 2018). Rejection of victim/survivor labels has also been found in research with people who have experienced childhood sexual abuse (Hunter, 2010), with some researchers arguing that such labels are reductive and ignorant to the broader social and political frameworks under which sexual violence occurs, over-emphasising the role of the individual in both experiencing and healing from victimisation (Ovenden, 2012; Spry, 1995). Here, social identity research can fill the gap of understanding the factors that influence self-perceptions as a victim or survivor (or both/neither).

It is clear from social identity research that identifying with labels that denote a shared group identity has implications for how people perceive and respond to their experiences (e.g., Haslam et al., 2012; Levine & Reicher, 1996). Findings from qualitative research indicate that perception of oneself as a victim or survivor may be associated with differences in mental health outcomes. Thompson's (2000) seminal work interviewing individuals who had experienced rape found that the majority of participants identified with both labels, however, identification with each term varied across time. In order to construct a positive self-image, participants described the need to adopt a survivor identity, as this evoked a sense of having recovered and regained control. Yet participants also reported the importance of assuming a

victim identity when disclosing their trauma experiences, in order to be taken seriously. Victim identities also helped people to shift blame for the event from themselves to the perpetrators. However, these identities were also associated with negative effects: participants felt that survivor identities minimised the significance of the event and prevented them from eliciting care and support from others, whereas victim identities diminished feelings of autonomy (Thompson, 2000). Both identities therefore were seen to have distinct merits and drawbacks.

Similar results were found in qualitative research with victim/survivors who experienced sexual violence during the Bosnian war (Skjelsbaek, 2006). Here, women who interpreted their experience in terms of their gender identity (i.e., saw their rape as an attack on them as *women*), were more likely to endorse a victim identity. These women were also more likely to blame themselves for the event and were less likely to have disclosed the violence. Therefore, victim identification was associated with isolation from community supports and poor mental health outcomes (Skjelsbaek, 2006). Conversely, women who interpreted their experience in terms of their ethnic identity (i.e., interpreted their rape as a crime against them as *Bosnians*) endorsed survivor identities, which connected them to other war survivors, including those who had had different experiences of victimisation (e.g., men who were injured during the war). Further, this interpretation of their experience allowed these women to uphold and protect a valued social identity, that of being a woman, and also that of their valued ethnic identity (Skjelsbaek, 2006). This interpretation of their trauma experience appeared to yield more positive mental health trajectories.

More recent quantitative research suggests that the relationship between survivor/victim self-labelling and emotional experiences is complex: for example, Boyle and Clay-Warner (2018) found that self-labelling as a victim was positively associated with shame and post-traumatic stress symptoms, whereas self-labelling as a survivor was associated with anger and fear. In contrast, research by Williamson and Serna (2018) found that self-labelling as a victim/survivor following sexual assault was not associated with differences in self-

compassion or self-blame. It is clear from these findings that the relationship between self-labelling as a victim/survivor and mental health outcomes is more complex than simply one term being better than the other. One possible reason for this is that self-labelling as a victim/survivor is distinct from self-categorisation and social identification processes. Compared to merely self-labelling, social identification is a more nuanced process of identifying with a *collective* of others, where one takes on board the norms, beliefs, and values that one associates with that particular group. Thus social identification with victims and/or survivors is broader than simply preferring one label over another; it involves recognition of the properties inherent to the group and an evaluation of oneself as fitting in with those properties (Turner & Onorato, 1999). Social identification with a group also facilitates distinct processes within and between groups: for example, it highlights similarities and differences between groups and enables processes of social influence from other ingroup members (Tajfel & Turner, 2004). Endorsing a label is therefore necessary but insufficient for social identification to occur.

The social identity approach has only recently been applied to sexual violence, with emerging evidence that these processes are in fact associated with differences in post-trauma mental health. For example, in a sample of university student sexual assault victim/survivors, victim identification, or combined victim and survivor identification, was associated with higher levels of depression and lower self-esteem, compared to survivor-only identification (Boyle & Rogers, 2020). Further, thematic analysis with publicly available narratives of women who have experienced sexual violence suggests that some victim/survivors may subsequently engage in a process of identity redefinition and advocacy in order to improve outcomes and experiences for the collective (Muldoon et al., 2023). This early research provides further support to suggest that mental health trajectories following sexual assault experiences are linked to social identity processes.

3.5.3 The present study

The literature to date suggests that the terms "survivor" and "victim" constitute social identities which influence both one's own and others' perceptions of a sexual assault experience. Although there are promising findings suggesting that survivors and victims are perceived differently by others, there is very little research examining the impacts of social identification with survivors/victims on mental health. There are at least four reasons why research is needed that examines sexual violence through a social identity lens. First, there is strong evidence suggesting sexual violence is an intergroup rather than interpersonal phenomenon, motivated by hostility towards an outgroup (e.g., women; Hitlan et al., 2009). Second, advocacy movements such as #metoo seek to mobilise survivors (and allies) *as a group* towards collective action to eradicate sexual violence (metoo Movement, 2022). This broadens the perception of individuals who have experienced sexual violence as belonging to a discrete community with similar others. Third, prior social identity research has provided evidence for the role of social identities in impacting psychological responses to traumatic experiences (e.g., Muldoon et al., 2019; Muldoon et al., 2021), therefore it is likely that social identification plays a similar role in experiences of sexual violence, given that these experiences have a higher incidence of resulting in PTSD. Finally, research on others' perceptions of survivors and victims highlights public perceptions of these labels as separate, group-based identities that are associated with different interpretations of sexual trauma, which once again suggests that social identity processes are likely to impact one's *own* perception of a sexual trauma experience. Taken together, this emphasises the need for quantitative research that examines the effects of identifying as a survivor or a victim, using the social identity approach.

The present study investigated the impact of social identification with survivors and victims on mental health outcomes following experiences of sexual violence. In line with prior research on the effects of trauma (Cloitre et al., 2009; van der Kolk et al., 2005), we expected that sexual trauma would have a cumulative effect, such that more severe and more frequent

experiences would be associated with higher levels of post-traumatic stress and post-traumatic growth. However, the main aim of this study was to investigate whether survivor and victim identification intervened in this relationship to predict different psychological sequelae. Given that the term "victim" has been associated with passivity and weakness, we predicted that stronger identification with victims would be linked with higher levels of post-traumatic stress, such that:

H1: Victim identification will positively mediate the relationship between cumulative trauma and post-traumatic stress, such that cumulative trauma will predict greater identification with victims, which will in turn predict higher levels of post-traumatic stress.

In contrast, we predicted that the connotations associated with being a "survivor", including those of empowerment and agency, would be linked with post-traumatic growth. Specifically, we hypothesised the following:

H2: Survivor identification will positively mediate the relationship between cumulative trauma and post-traumatic growth, such that cumulative trauma will predict greater identification with survivors, which will in turn predict higher levels of post-traumatic growth.

3.6 Method

3.6.1 Participants

An a priori power analysis indicated that 250 participants would be sufficient to detect an effect size of 0.2 (a small effect; Cohen, 1988). Participants were 290 Australian adult women ranging in age from 18 to 81 years (M=31.23, SD=12.30). All participants self-identified as having experienced a form of sexual trauma (see *Procedure* for details). Participants were majority White (77.59%), heterosexual (62.14%), with an education level of Bachelors degree or below (79.64%). Full demographic details of participants are listed in Table 1 (see Results).

3.6.2 Procedure

The ethical aspects of this research were approved by the ANU Human Research Ethics Committee (Protocol 2021/474). Participants were invited to take part in a survey called *Identity and Wellbeing After Trauma Experiences*. This survey was advertised online to female-identifying people via Prolific, an academic research recruitment platform, and pre-registered at the following link: https://aspredicted.org/blind.php?x=7VR_3RF

Upon providing consent participants were screened for eligibility using the Trauma History Questionnaire (THQ; Hooper et al., 2011), which assesses for exposure to 24 different types of trauma, including crime-related events, general disaster and trauma, and physical and sexual experiences. All items correspond to Criterion A traumas in the DSM-5 (American Psychiatric Association, 2022). Participants were eligible to participate if they had experienced a sexual trauma, as indicated by answering "yes" to any of the following items (listed in decreasing order of severity[2]):

Has anyone ever made you have intercourse or oral or anal sex against your will? (3)

Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? (2)

Other than incidents mentioned [above], have there been any other situations in which another person tried to force you to have an unwanted sexual contact? (1)

A control variable, total trauma exposure, was created by summing the number of items across the entire questionnaire to which participants responded "yes".

Eligible participants completed follow-up questions regarding the nature of their sexual trauma experience(s), followed by questions about their experience of disclosing the trauma,

[2] The term "severity", as used here, refers to how sexual victimisation is *legally* conceptualised, with some acts being considered more severe than others. This term is problematic in practice, as individuals who experience supposedly "less severe" victimisation may nevertheless be significantly traumatised and experience severe distress. However, there does not yet appear to be a more appropriate term with the same utility, and therefore it is used here throughout, despite this limitation. Severity scores were created by coding the most severe experience indicated by a participant (indicated in brackets above). For participants who reported experiencing more than one of the events listed above, a severity score corresponding to the most severe event was given.

social identification with survivors and victims, measures of post-traumatic stress and post-traumatic growth, and demographic information.

3.6.3 Measures

3.6.3.1 Assault characteristics

Given the sensitive nature of the subject material, participants were only asked follow-up questions regarding their most severe experience of sexual violence. Participants indicated their age(s) at the time of the experience, the number of times they experienced this (frequency), and their relationship to the perpetrator. Frequency and severity of sexual trauma experiences were multiplied to create a combined score, cumulative sexual trauma, such that people who had experienced more frequent and/or more severe sexual trauma events had higher scores on cumulative sexual trauma.

3.6.3.2 Disclosure experiences

Participants were asked if they ever told anyone about their experience of sexual violence. Participants who indicated having disclosed were asked to identify who they had told from a list of sources, using an adapted version of the General Help-Seeking Questionnaire (GHSQ; Wilson et al., 2005). The sources listed in this questionnaire were a priori divided into formal sources (healthcare, legal, and professional supports) and informal sources (family and friends). As with the assault characteristics questions, participants were only asked about their disclosure experiences for their most severe assault.

3.6.3.3 Social identification

To measure social identification with survivors and victims, participants completed the Multicomponent Measure of In-group Identification (Leach et al., 2008). Eleven of the original 14 items in this scale were retained for use; three of the four items from the satisfaction subscale were deemed inappropriate for the context: *It is pleasant to be a victim; I am glad to be a victim;*

Being a victim gives me a good feeling. The scale uses a 7-point Likert format (*1=Strongly disagree* to *7=Strongly agree*). The scale was completed twice, once using the term "victim" and once with "survivor".

3.6.3.4 Mental health

Participants reported frequency of PTSD symptoms over the last month using the Post-traumatic Stress Disorder Checklist for DSM5 (PCL5; Blevins et al., 2015), a 20-item Likert scale (*1=Not at all* to *5=Extremely)*. Participants also completed the Post-Traumatic Growth Inventory, a 21-item Likert scale measuring endorsement of post-traumatic growth symptoms resulting from the trauma experience (*1=Not at all* to *6=A very great degree;* PTGI; Tedeschi & Calhoun, 1996). Participants were also asked to provide any current or historical diagnoses of mental illness.

3.6.3.5 Demographics

Participants were asked to provide the following demographic characteristics: gender identity; sex assigned at birth; sexual orientation; age; ethnicity; education level.

3.6.4 Data analysis

Analyses were conducted in SPSS (version 25.0.0.1). Correlations between key dependent variables (victim identification, survivor identification, post-traumatic growth, and post-traumatic stress) were assessed. To test the hypotheses, PROCESS version 3.5 (Model 4 using 5000 bootstrapped samples; Hayes, 2017) was used to test two mediation models using the hypothesised predictor (cumulative trauma), mediators (victim identification and survivor identification), and dependent variables (post-traumatic stress and post-traumatic growth). All models included the following covariates: current age, highest attained education level, total

types of trauma endorsed (i.e., to control for degree of exposure to non-sexual forms of trauma), and ethnicity (coded as 0 = *Ethnic minority, 1= Ethnic majority/White*[3].

3.7 Results

3.7.1 Descriptive statistics

Demographic information and descriptive statistics for each of the key variables (assault characteristics, social identification, mental health outcomes) are provided in Table 1. The most common experience of sexual trauma reported was rape (*Has anyone ever made you have intercourse or oral or anal sex against your will?*), reported by 112 participants (39.6%). The most common perpetrator was listed as a friend or acquaintance, reported by 112 participants (39.6%). The majority of participants reported at least one disclosure (59.01%).

[3] The term "ethnic minority" is in line with current APA guidelines (American Psychological Association, 2020), however, we acknowledge that combining multiple ethnicities into the category "ethnic minority" and comparing this to White participants is problematic. For the purpose of this analysis, we have used this grouping in order to compare the effect of having a socially privileged racial background (i.e., being White) relative to a more socially marginalised racial backgrounds on mental health outcomes following victimisation. See Table 1 for an overview of ethnic backgrounds included in this category.

Table 1

Descriptive statistics for key variables

Demographics		
Gender identity	99.64% Woman	
	0.36% "I identify as": [free response]	
Assigned sex at birth	100.00% Female	
Sexual orientation	62.14% Heterosexual	
	23.21% Bisexual	
	5.36% Homosexual	
	5.00% Chose to self-describe	
	4.29% Asexual	
Ethnicity	1.03% Aboriginal and/or Torres Strait Islander	
	0.69% African	
	15.52% Asian	
	0.69% Hispanic/Latin/x	
	1.38 % Middle Eastern	
	77.59 % White	
	2.41 % Chose to self-describe	
Highest level of education	1.07% Some secondary school	
	12.86% Secondary school	
	17.86% Certificate or diploma	
	13.21% Some university	
	34.64% Bachelor degree, Graduate certificate, Graduate diploma	
	20.36% Higher degree (e.g., Masters degree, Doctoral degree)	
Mental illness diagnoses	49.82% Yes	
	46.59% No	
	3.58% Unsure	
Disclosure		
Any disclosure	59.01% Yes	
	40.99% No	
Disclosure to formal source	18.28% (as percentage of total participants)	
Disclosure to informal source	56.21% (as percentage of total participants)	
Assault characteristics		
Severity	1=30.74%	
	2=29.68%	
	3=39.58%	
Perpetrator[a]	0.35% Primary caregiver	
	24.03% Partner (including boyfriend, girlfriend), sibling	
	12.72% Teacher, older relative/family member (e.g. uncle, grandparent)	
	39.58% Friend, acquaintance	
	23.32% Stranger	
Age at time of assault (years)	*M*=16.98	*SD*=6.91
Total number of assaults[b]	*M*=2.96	*SD*=3.06
Cumulative trauma	*M*=6.91	*SD*=8.57
Social identification		
Survivor	*M*=3.77	*SD*=1.07
Victim	*M*=3.51	*SD*=1.02

Mental health		
Post-traumatic stress	*M*=27.02	*SD*=19.93
Non-specific psychological distress	*M*=25.19	*SD*=10.06
Post-traumatic growth	*M*=38.07	*SD*=23.77

Note. *N*=282.

[a] Participants' responses were recoded on a scale from 1 to 5 using the listed categories representing levels of emotional intimacy. For participants who reported more than one perpetrator, the closest perpetrator was coded (e.g., if stranger and friend were both reported, the response was coded as friend).

[b] Participants were provided with a free response text box to input the total number of assaults sustained, resulting in variability across the format of responses. If greater than 10 experiences were reported, this was coded as 10 to prevent a disproportionate effect of outliers on analyses.

Correlations between key dependent variables are presented in Table 2. Social identification scores for survivors and victims had a significant strong positive correlation with one another (*r*=.781). Survivor identification had a significant weak positive correlation with both post-traumatic stress (*r*=.201) and post-traumatic growth (*r*=.334). Similarly, victim identification had a significant weak positive correlation with both post-traumatic stress (*r*=.259) and post-traumatic growth (*r*=.230).

Table 2

Correlation matrix of key dependent variables using Pearson's r

	Post-traumatic stress	Post-traumatic growth	Survivor identification	Victim identification
Post-traumatic growth	.115	-	-	-
Survivor identification	.201**	.334**	-	-
Victim identification	.259**	.230**	.781**	-

** Correlation is significant at the .01 level.

3.7.2 The effect of victim identification on post-traumatic stress

Cumulative sexual trauma positively and significantly predicted victim identification (β = .19, *p* = .002) and survivor identification (β = .16, *p* =.009). However, only victim identification in turn significantly and positively predicted post-traumatic stress (β = .22, *p* =.009). Consistent with H1, the indirect effect of victim identification was positive and significant (β = .04, 95% CI: .004, .10), see Figure 1. This was such that individuals with more cumulative sexual trauma were more likely to identify with victims, which in turn predicted greater post-traumatic stress. The indirect effect via survivor identification (β = -.01, 95% CI: -.04, .02) was non-significant.

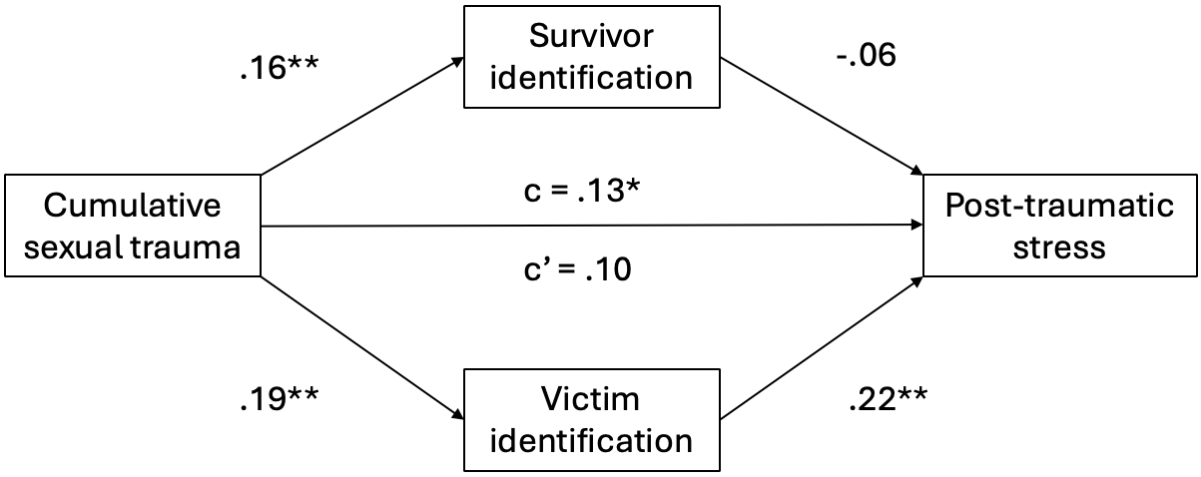

Figure 1
Path diagram depicting the indirect effect of victim identification on post-traumatic stress
* significant at the .05 level
** significant at the .01 level
Note. The effect of cumulative sexual trauma on post-traumatic stress symptoms is mediated by victim identification. Also included are covariates of highest attained education level, total trauma exposure, current age, and ethnicity. Note that ethnicity was coded categorically as *0=Ethnic minority*, *1=Ethnic majority/White*. Education level was coded continuously, from *1=Some secondary school* to *6=Higher degree (Masters Degree, Doctoral Degree*). Education level significantly negatively predicted victim identification, β = -.13, *p* = .030. Current age significantly negatively predicted post-traumatic stress, β = -.28, *p* < .001. Total trauma exposure significantly positively predicted post-traumatic stress, β = .44, *p* <.001.

3.7.3 The effect of survivor identification on post-traumatic growth

Cumulative sexual trauma positively and significantly predicted victim identification (β = .19, *p* =.002) and survivor identification (β = .16, *p* = .009). However, only survivor identification in turn significantly and positively predicted post-traumatic growth (β = .39, *p* < .001). Consistent with H2, the indirect effect of survivor identification was positive and significant (β = .06, 95% CI: .008, .13), see Figure 2. This was such that individuals with more cumulative sexual trauma were more likely to identify with survivors, and this in turn predicted greater post-traumatic growth. The indirect effect via victim identification (β = -.02, 95% CI: -.07, .02) was non-significant.

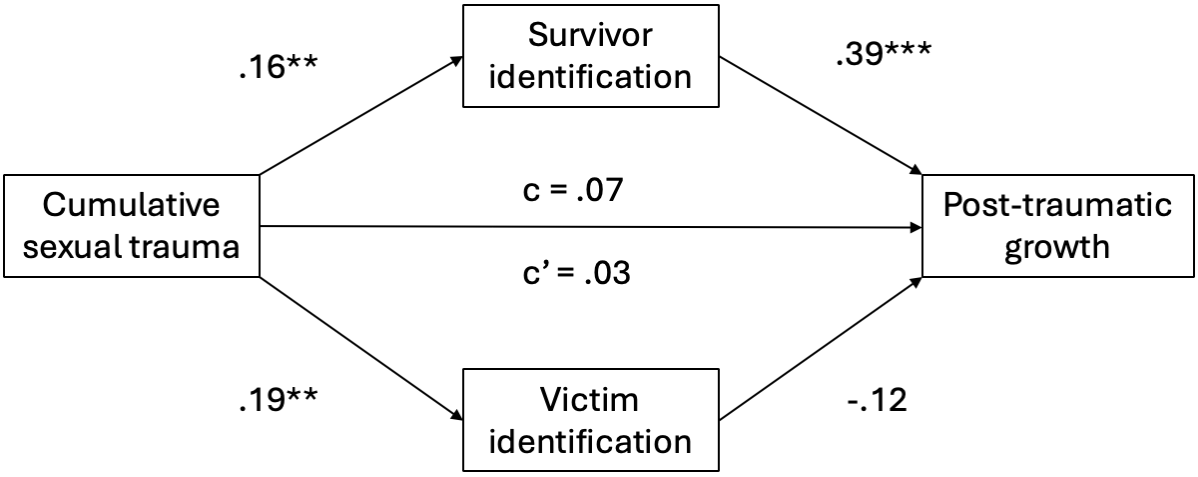

Figure 2
Path diagram depicting the indirect effect of survivor identification on post-traumatic growth
* significant at the .05 level
** significant at the .01 level
*** significant at the .001 level
Note. The effect of cumulative sexual trauma on post-traumatic growth is mediated by survivor identification. Also included are covariates of highest attained education level, total trauma exposure, current age, and ethnicity. Note that ethnicity was coded categorically as *0=Ethnic minority*, *1=Ethnic majority/White*. Education level was coded continuously, from *1=Some secondary school* to *6=Higher degree (Masters Degree, Doctoral Degree*). Education level negatively and significantly predicted victim identification, β = -.13, *p* = .030. White background negatively and significantly predicted post-traumatic growth, β = -.25, *p* < .001.

3.8 Discussion

Results of the current study found support for a cumulative effect of sexual trauma on both post-traumatic stress and post-traumatic growth, with more frequent and more severe sexual trauma experiences predicting higher levels of both post-traumatic stress and growth. This finding is consistent with prior research on the cumulative effects of trauma (van der Kolk et al., 2005). However, for the first time, we found evidence that these distinct pathways were partially accounted for by the social identities that are associated with traumatic experiences. Supporting H1, mediation analyses found that greater cumulative trauma predicted increased victim identification, which in turn predicted post-traumatic stress. At the same time, greater cumulative trauma also predicted increased survivor identification, which in turn predicted post-traumatic growth, supporting H2. Interestingly, in the mediation models containing both kinds of social identities, victim identification did *not* predict post-traumatic growth, and likewise survivor identification did not predict post-traumatic stress. Therefore, despite being highly positively correlated, it appears that victim identification is uniquely associated with post-traumatic stress (and not growth), while survivor identification is uniquely linked to post-traumatic growth (and not stress).

Taken together, these results speak to the value of exploring trauma trajectories through a social identity lens. Specifically, the findings suggest that victim identification may yield social curse effects, accounting for some of the harmful psychological effects of prolonged or severe trauma. In contrast, survivor identification may yield social cure effects by promoting post-traumatic growth. Identification with others who have overcome similar types of traumas may facilitate positive mental health outcomes that go beyond merely resilience and recovery. Notably, our results found the indirect effects of victim and survivor identification on post-traumatic stress and post-traumatic growth persisted despite controlling for the total amount of (nonsexual) trauma experienced. That is, the effects of victim and survivor identities in this study were specific to sexual trauma. One possibility is that the #metoo movement has

influenced the development of these terms as group memberships and identities, rather than simply labels. #metoo has not only increased awareness of the prevalence of sexual violence, but has actively promoted a view of survivors as agentic and as a community. It is possible that identification with survivors encourages people to view themselves as capable of healing from their trauma, whereas identification with victims inhibits the possibility of recovery. Further, identifying with survivors may provide access to community of people with similar experiences of trauma. This may lead to enhanced social relationships, which is a key facet of post-traumatic growth. Also possible is that the #metoo movement has emphasised the use of survivor terminology to such a degree that negative connotations associated with the term "victim" have become increasingly salient.

The strong correlations between survivor and victim identities also suggest that these identities are not separate but intertwined, and replicates prior work (Boyle & Clay-Warner, 2018). It is likely that many people who have had experiences of sexual violence endorse both identities to some extent, as was the case for participants in Thompson's (2000) study. Novel to this study, however, we found that a social identity lens can help us to understand the distinct effects of these intertwined ways of self-defining following sexual trauma.

3.8.1 Implications

One of the key implications of these findings is that identification with survivors or victims of sexual violence is likely to have real consequences for subsequent mental health. Based on these findings, a survivor narrative, in comparison to a narrative of victimisation, may be associated with more positive mental health outcomes, which could prove useful in informing strategies for recovery from sexual violence. In the current chapter, identifying as a survivor was associated with a trajectory of growth, while identifying with victims was linked to psychological distress. This suggests that survivor terminology (as opposed to victim terminology) may be less harmful in discourse regarding sexual violence, including in media,

criminal/legal, and health settings. However, we note that caution is warranted in application of these findings. Prioritising survivor terminology over victim is not without risk, as many people do not identify as survivors after sexual violence (e.g., Thompson, 2000,) and could feel alienated or invalidated by emphasis of this language. As such, although these early findings do suggest that survivor language may be relatively less harmful in comparison to victim, an appropriate application of these findings would be ensuring that survivor terminology is equally present alongside that of victim in public discourse. In addition, further research into the impacts of victim and survivor terminology is warranted, and this thesis builds on this in subsequent chapters.

The shift in conceptualisation of sexual violence over time from a purely interpersonal issue to a broader social concern has been mirrored in organisational structure and policy, and the current findings both reflect this and could be used to support further structural change. Where "crisis response" was once the sole focus of anti-violence efforts, organisations today understand the need for a broader approach that spans a greater duration, with consequences persisting beyond the immediate event (Lee et al., 2024). Use of survivor terminology (as opposed to victim) supports this perspective by encouraging not only a more holistic but also a less "static" identity following sexual violence, thereby acknowledging the temporal complexity of this issue. The current findings support the use of survivor-based language in organisations and public policy to facilitate more positive and empowering outcomes for individuals and communities.

Further, it is possible that survivor identities could also be harnessed as a psychological resource to promote recovery from sexual violence. Social identities are not fixed, but dynamic and malleable, and are therefore effective targets for intervention. Indeed, psychotherapy interventions that utilise social identity models have been shown to effectively reduce depression and promote long-term positive mental health outcomes (Haslam et al., 2016;

Haslam et al., 2019). Our findings thus point to the potential utility of mental health interventions for sexual trauma survivors that are based on social identity principles.

3.8.2 Strengths and limitations

The strengths of the current project include pre-registration, a priori power analysis, and the use of a large sample who all reported experiencing sexual trauma. Despite online recruitment, we were able to access a vulnerable population that had experienced significant trauma. Beyond the current study, the success of our methodology indicates that online recruitment tools may be a fruitful avenue for accessing vulnerable populations. Further, our sample also included a diverse range of participants across ethnicity and sexual orientation status. This is of considerable importance given that people of marginalised ethnicities and sexualities may be more at risk of experiencing sexual violence (Balsam et al., 2005; Black et al., 2011), and enables us to be more confident in generalising our results to a wider population.

Further, the use of a multi-component social identification scale to measure identification with survivors and victims helps increase our confidence that even partial identification as a survivor or victim is likely to impact mental health. It is likely that our sample included a subgroup of victim-survivors who reject labelling themselves as such (i.e., as seen in work by Williamson & Serna, 2018), yet even with inclusion of these participants in our analyses, we still found support for our hypotheses. Using a multi-component and continuous measure of identification (rather than simply asking participants about their labelling preferences) therefore provides us with a more nuanced understanding of how social identification processes are linked to mental health symptoms, perhaps over and above that of simply labelling effects alone.

This study was also the first to investigate survivor and victim identities through a social identity lens, and the findings support the utility of conceptualising survivor and victim identities using this framework. However, the use of a correlational design precludes attributing

causation to any of the findings discussed, and is a limitation of the project. Further, note that this mediation model only tested one directional pathway, such that identity-related variables (i.e., "victim" and "survivor") predicted mental health outcomes. This decision was based on previous SIA research which has conceptualised social identities as driving or predicting health and wellbeing outcomes. However, other pathways are plausible, such that post-traumatic stress or growth may predict or reinforce identification with victims and survivors respectively. Our understanding of this relationship is therefore limited by the cross-sectional nature of the data.

Additionally, we use the term "cumulative sexual trauma" to describe the experiences of our sample, in line with current evidence which suggests that the effects of trauma are not merely additive, but increasingly detrimental with repeated exposure. However, our study is cross-sectional in design, and our analysis is based on participants' most severe experience of violence, meaning that our findings are unable to fully capture the longitudinally unfolding effects of ongoing experiences of trauma. Nevertheless, our finding that cumulative trauma predicted higher levels of post-traumatic stress replicates prior research (e.g., Cloitre et al., 2009; van der Kolk et al., 2005). Therefore, what remains unclear is at what point along one's recovery trajectory that survivor and victim identities develop. Although we have theorised here that identification with survivors and victims leads to mental health impacts, another possibility is that the mental health consequences of sexual violence affect social identification with survivors and victims.

3.8.3 Future directions

Although the current findings are promising and speak to the role of social cure and social curse processes in recovery from trauma, more research is needed to understand *how* survivor and victim identities develop. Our results indicated that there is an association between the cumulative effects of sexual trauma and these social identities, which are then

associated with different mental health outcomes. However, longitudinal research could be beneficial to uncover how such identities change over time, which may also clarify causal pathways between mental health outcomes and identification.

While survivor and victim terminology dominates the discussion around sexual violence, it is also possible that neither term is preferable. Both terms risk reducing a person's conceptualisation of themselves to their trauma experience alone. To our knowledge, there is no current research investigating victim/survivors' terminology preferences, which is a significant gap in this literature. Along this same vein, there is also a need for research that emphasises intersectionality, and examines how survivor and victim identities interact with other identities, such as ethnic and racial identities, sexual orientation, and gender. It is possible that the normative content of one's other valued identities may lead to differences in mental health symptoms associated with survivor and victim identification. For example, identities that emphasise norms of traditional femininity and purity may contradict the norms and content associated with survivor identification. It is possible that holding an identity which values purity and subservience may prevent identification with survivors, or may hinder on one's ability to engage meaningfully with a survivor identity. As such, there is a need for research which examines the contexts in which survivor and victim identification is helpful and harmful.

In sum, our research illustrates that trauma and identity are inextricably linked. Cumulative sexual trauma fundamentally alters one's sense of self; it is not just a violation of bodily autonomy, but a violation of one's core being. Therefore, research exploring identity processes is crucial to understanding how one recovers from such events. More pressingly, we have a responsibility to care for and support sexual trauma survivors. These survivors should not have to bear the burden alone and our research suggests that indeed, we can use the power of social groups to promote recovery and wellbeing among people who have experienced these unspeakable acts.

Chapter 4: “It completely demolished my sense of who I was”: Navigating identity in the aftermath of sexual violence

4.1 Chapter overview

This chapter addresses my second research question. In this study, I interviewed 25 Australian adult victim-survivors of sexual violence on their experiences of (social) identity and mental health. Reflexive thematic analysis (Braun & Clarke, 2021) was used to analyse the data.

4.2 Publication status

This chapter is currently under review at the *Journal of Community and Applied Social Psychology*, in collaboration with co-authors Prof Tegan Cruwys, Dr Olivia Evans, and Prof Michelle Ryan.

4.3 Author contributions

Western: Conceptualisation, methodology, investigation, formal analysis, data curation, writing – original draft, writing – review & editing, project administration.

Cruwys: Supervision, formal analysis, writing – review & editing.

Evans: Writing – review & editing.

Ryan: Writing – review & editing.

4.4 Abstract

Sexual assault often has significant deleterious consequences for how people see themselves and how they are perceived by others. The purpose of this study was to explore how people make sense of their (social) identity following sexual assault. We sought to represent diverse experiences of sexual assault and broaden contemporary narratives. We interviewed 25 adults who had experienced sexual violence on their experiences of identity and subsequent mental health. Reflexive thematic analysis identified four overarching themes: 1) *Trauma identities as a resource for self-protection and self-preservation*; 2) *Ongoing social isolation: Narrowing of identities*; 3) *Identity incoherence*; 4) *The power of (re)connection: Reshaping and expanding identities*. Findings suggest that how people relate to their identity in the aftermath of sexual violence is functional and agentic. However, the contemporary narratives surrounding sexual assault (including ongoing stigma) can isolate people from valued supports and prevent authentic enactment of identity. Positive social connections are fundamental to preventing against distress and building a holistic sense of self in the aftermath of trauma.

4.5 Introduction

Experiencing sexual violence is associated with profound negative consequences for mental health and wellbeing (Dworkin et al., 2017). One of the major consequences for many victim-survivors is a sense of identity change (Boyle, 2017). Although there is considerable research surrounding changes to *personal* identity following traumas such as sexual assault (e.g., Kouvelis & Kangas, 2021), much less is known about the impacts to *social* aspects of one's identity. The purpose of the current study is to explore how identity is experienced following sexual violence, and the social factors that shape this process. Note that for ease of expression, those who have experienced sexual violence will be referred to as "victim-survivors" throughout this chapter, with the hyphenated term used to indicate the breadth of identity experiences that can arise in response to sexual trauma.

4.5.1 How does sexual violence impact personal identity?

One of the common impacts of traumatic events such as sexual violence is changes to self-perception and increased negative self-evaluation (American Psychiatric Association, 2022). Victim-survivors often experience intense feelings of shame and defectiveness, believing themselves to have somehow caused their experience (Hassanpour et al., 2025). Many of these beliefs may be partly due to victim-blaming cultural narratives which suggest that victim-survivors, rather than perpetrators, are at fault (Hassanpour et al., 2025). That is, victim-survivors may internalise these narratives, leading to feelings of shame negative self-evaluation (Bhuptani & Messman, 2023).

However, qualitative work with victim-survivors suggests that this is not the only way in which identity may be impacted post-assault. An early seminal study with victim-survivors found that one of the significant consequences of sexual violence was the acquisition of an identity as someone who had experienced sexual assault, and that this identity needed to be managed when interacting with others (Thompson, 2000). In this study, five women who had

experienced rape were interviewed about their recovery trajectories post-assault. One of the themes that we derived was that the women felt like they were now both "victims" *and* "survivors" of sexual assault, and that how they enacted these identities was highly dependent on the context. For example, participants identified that assuming the "victim" identity allowed them to be taken seriously by others, but also positioned them as someone who was "powerless" and still affected by their assault. In contrast, the "survivor" identity gave them a sense of agency, but minimised the trauma of the event (Thompson, 2000). Participants spoke about how they were forced to manage these two identities, both privately and when interacting with others. As such, it appears that one of the consequences for people who have experienced sexual assault is a need to reconcile this experience with their internal self-concept, and that this may go beyond simply feeling "bad" or "defective".

4.5.2 Contemporary understandings of sexual violence: Social factors influence identity

One area that has been largely understudied in relation to the impact of sexual assault on identity is the influence of the social context. Within the last ten years, there has been growing awareness that *social* (as opposed to individual) factors are key to a person's ability to respond and recover from sexual violence. For example, cultural beliefs surrounding sexual violence can have profound impacts on how someone will interpret their experience (Dworkin & Weaver, 2021). Societal norms that endorse traditional gender roles and rape myths may encourage more self-blame in victim-survivors, leading to greater negative self-evaluation (Dworkin & Weave, 2021). Conversely, feminist or progressive attitudes towards sex and sexual violence may be protective, provoking less self-blame and internal stigma (Holland et al., 2020). That is, the social context and cultural narratives surrounding sexual violence appear substantially impact on how victim-survivors are perceived by others and by themselves.

The last ten years have seen significant shifts in these narratives. For example, advocacy movements such as #metoo have been highly influential in encouraging a more agentic and less

stigmatising view people who have experienced sexual violence. One of the consequences of this has been a shift away from using victim-based language towards *survivor*-based language. This has been argued to promote a more holistic view of those who have experienced sexual violence; sexual assault "survivors" are perceived as having more agency in comparison to "victims" (Papendick & Bohner 2017). However, as highlighted by Thompson's (2000) qualitative work, for victim-survivors themselves, navigating "victim/survivor" identities after sexual violence remains complex, and there is still substantial variation in how people choose to identify (e.g., as victims/survivors/both/neither; Boyle & Rogers, 2020). Complicating this process further, how people identify may fluctuate across time and context (Anderson & Gold, 1994), and these identities must be integrated with one's pre-existing self-concept.

The research surrounding how people integrate victim and survivor identities with their pre-existing self-concept has yielded mixed findings in relation to mental health. While some research suggests that, in general, identifying even moderately as a victim (compared to a survivor) is associated with poorer mental health outcomes (Boyle & Rogers, 2020; Western et al., 2024), other research has found no differences in mental health consequences between those who choose to identify as victims versus as survivors (Williamson & Serna, 2018). Further, it is important to note that victim and survivor identities are not opposite ends of a single spectrum, and positioning them as such risks reducing people to their trauma experiences alone (Spry, 1995). Nevertheless, the differences in public perceptions of victims versus survivors (Papendick & Bohner 2017) highlights the significance of these words in being seen as meaningful representations of a person's character.

4.5.3 A social identity approach: Identities shape trauma experiences

Applying a social psychological lens to this provides insights into how the social context, including contemporary narratives around what it means to be a "victim" or "survivor", may impact one's sense of self following sexual assault. The *social identity approach* broadly

focuses on the processes by which people classify themselves into some groups and distinguish themselves from others, and the outcomes of these processes (Tajfel & Turner, 2004; Turner & Onorato, 1999). That is, our *social identities* are made up of our sense of self as it is derived from the meaningful groups to which we belong. Importantly, self-categorising as a member of a group can have flow-on effects to how we think, feel, and behave (Abrams et al., 1990; Turner & Onorato, 1999). Further, our social identities are directly intertwined with our mental health and wellbeing, both in that we are motivated to maintain a positive sense of social identity (i.e., a positive sense of self; Tajfel & Turner, 2004), *and* belonging to groups that are personally meaningful can facilitate positive health and wellbeing outcomes (Greenaway et al., 2016).

However, the power of our social identities and group memberships to influence our mental health can be negative as well as positive, dubbed the "social curse" (Kellezi & Reicher, 2011). Belonging to groups that are socially stigmatised or rejected can be detrimental to wellbeing, (Branscombe et al., 1999; Cruwys & Gunaseelan, 2016), particularly when the stigmatised group is incompatible with, or rejected by, one's other valued groups (Kyprianides et al., 2019). Indeed, not all of our group memberships are freely chosen, and people can belong to groups that they did not choose and of which they do not wish to be a part. This can lead to *disidentification*, a process where people actively reject and try to distance themselves from certain group memberships (Becker & Tausch, 2014). Usually, this occurs when it is not possible to leave the group. That is, disidentification is not a *lack* of identification with a group but a rejection of a group that one perceives as a central part of their identity. Disidentification has recently been found to occur in populations of trauma survivors, where the trauma is seen as stigmatised (e.g., survivors of childhood sexual abuse), and is associated with mental health symptoms including dissociation (Lashkay et al., 2023).

A growing body of social identity research has enabled greater understanding of the link between trauma exposure and post-trauma mental health, particularly post-traumatic stress

and/or growth. Social identity and self-categorisation processes have been found to play a role in how people interpret their own experiences, particularly for those who see their trauma as being central to their identity as a member of the group (Muldoon et al., 2019). Trauma is unable to be disentangled from the social context in which it occurs; and traumatic events are more likely to occur along lines of existing inequities. When the trauma event is interpreted as being attributable to one's identity as a member of a group, or is interpreted via the lens of social group membership, the identity itself can be undermined (Muldoon & Lowe, 2012). For example, qualitative work with women who had been raped during the Kosovo War found that many women interpreted this event an act devalued that them *as women* in a society that emphasised sexual purity and patriarchal gender norms (Kellezi & Reicher, 2011). By alienating them from this valued identity, the women were in turn unable to access the afforded by it in the aftermath of the event resources (e.g., social support, psychological resources such as sense of belonging inherent to positive social identity).

Similarly, interviews with women who had experienced rape during the war in Bosnia-Herzegovina found differential mental health and wellbeing impacts depending on the identity via which their experience was interpreted (Skjelsbaek, 2006). Interpretations of rape via the lens of ethnic identity (i.e., an act against them as Bosnians) allowed these women to draw on the resources of the group (other Bosnians) and uphold this valued identity. Rape, when interpreted as a war crime, *affirmed* their ethnic identity and connected them to the broader community who had experienced collective suffering in the name of this identity. When interpreted via their gender identity, however, being raped *subverted* this identity by directly undermining the associated identity content (i.e., values of sexual purity). In turn, they felt alienated from this identity and the group itself.

The victim-survivor identity itself may also be a catalyst for post-traumatic growth (or stress). Recent qualitative work with publicly available data on women's experiences of pursuing legal action following sexual assault found that these women experienced a profound

sense of connection to other victim-survivors, and came to view their own individual experience within a broader social framework of violence (Muldoon et al., 2023). Their decision to pursue legal action and speak out about their experience was primarily motivated by altruism to support the collective, and promote positive change by reducing collective shame and stigma (Muldoon et al., 2023). In this way, the victim-survivor identity directly shaped the women's understanding of their own experience, and in turn facilitated behavioural actions that would positively benefit their group.

4.5.4 The present study

It is clear from prior research that sexual assault can substantially impact one's identity. This may be via acquisition of an identity as a victim or survivor, or via the ways that the victim-survivor identity undermines or affirms other valued identities. In addition, it appears that these changes to identity are in part driven by social narratives. For example, seeing oneself as a victim or survivor goes beyond merely self-labelling, and instead involves seeing oneself as being part of a group (of other victims/survivors) that is defined by having experienced sexual violence. In a post #metoo era with a changing narrative around sexual violence – including how, why, and to whom it occurs – the (social) identities of victim and survivor are likely to have unique impacts on how these events are experienced and interpreted. Seeing oneself as a victim/survivor explicitly links one to (1) their assault experience, (2) others who have experienced sexual assault, *and* to (3) the dominant social narratives of victimhood/survivorship. Through this lens, it makes sense why some people might be drawn to one identity over the other, while others reject both labels or see themselves as both victim and survivor. It also explains why identifying as a victim/survivor or both/neither are associated with varied health and wellbeing outcomes. However, what is not yet clear is *how* these identities are integrated or constructed into a person's broader (social) identity.

The current study aims to fill this gap by exploring how people construct and reconstruct their sense of self following sexual assault, including processes of integrating (or not) victim and survivor identities into their sense of self. Of particular interest was how people make meaning of sexual assault through the lens of (social) identities. This included the impact of sexual violence on pre-existing social identities (such as gender, sexual orientation, or ethnicity) and formation of new identities (e.g., sexual-assault related identities such as victim and/or survivor, in addition to other, non-trauma identities), and how these identities overlap and are integrated.

4.6 Method

4.6.1 Principles of design

In designing the current project, the research team were informed by the principles of feminist and trauma-informed interviewing, as outlined by Alessi and Kahn (2023) and Campbell and colleagues (2009). Central to this was emphasising felt safety for interviewees (both physical and psychological) throughout the process, including by (a) attending to the relationship between the interviewer and the interviewee (including awareness of the inherent power differential and the interviewer's own biases and responses), and (b) responding flexibly to the needs of the participants throughout the process. This involved allowing participants to have autonomy in deciding how much of their story to share, asking participants directly what they would like the interviewer to know or for the research to emphasise in sharing their story, and following the participant's lead in the structure and pacing of the interview. Beyond the interviews themselves, participants were also invited to stay up to date with the status of the project.

4.6.2 Participants

Participants were twenty-five Australian adults who reported having had at least one unwanted sexual experience since the age of eighteen and not within the last twelve months. Six

further respondents were interviewed, but subsequently excluded from analysis due to being ineligible (two reported an unwanted sexual experience within the last twelve months; two were under eighteen years at the time of the assault; and the interview was incomplete for two participants). Participants mostly identified as women, and the majority identified as heterosexual. See Table 3 for further demographics.

Table 3

Participant demographics

Participant	Gender identity	Sexual orientation	Race/ethnicity	Age (years)
Alana	Woman	Heterosexual	White	25
Amelia	Woman	Unsure	Asian	26
Ava	Woman	Unsure	White	29
Caroline	Woman	Heterosexual	White	30
Chelsea	Woman	Heterosexual	White	56
Connor	Man	Homosexual	White	26
Darcy	Agender	Homosexual	White	55
Eliza	Woman	Heterosexual	White	33
Gabrielle	Woman	Bisexual	Asian	44
Georgia	Woman	Heterosexual	Asian	30
Hazel	Woman	Heterosexual	Aboriginal	23
Holly	Woman	Unsure	White	23
Katherine	Woman	Bisexual	White	46
Linda	Woman	Heterosexual	White	56
Lindsey	Woman	Asexual	Mixed	42
Maya	Woman	Heterosexual	White	57
Michelle	Woman	Heterosexual	White	52
Miriam	Woman, Agender	Bisexual	White	29
Natalie	Woman	Heterosexual	White	54
Nicola	Woman	Heterosexual	White	46
Romi	Woman	Homosexual	White	39
Sarah	Man/Woman	Heterosexual	White	67
Sky	Woman	Heterosexual	White	40
Tahlia	Woman	Pansexual	White	24
Zephyr	Trans masculine non-binary	Bisexual	White	22

Note. Participants provided their own responses to demographic questions; some specific details have been omitted to ensure anonymity. Names listed are pseudonyms.

4.6.3 Procedure

Ethical approval was granted by the ANU Human Research Ethics Committee (Protocol 2022/628). A paid advertisement for the study was distributed online via large social media platforms, which directed participants to a secure link to provide their contact information if

they were interested in being interviewed about their experiences. Participants were contacted by the first author to organise a time for the interview. All interviews were conducted by the first author, a provisional psychologist undertaking postgraduate training in clinical psychology. Interviews were conducted either via phone call or online video conference (Zoom) based on participant preference.

Interviews were semi-structured in design and consisted of questions across five domains: (1) the participant's experience of sexual violence, (2) disclosure experiences, (3) post-assault mental health, (4) impacts to identity, with a focus on social identities, and (5) reflections on the current social context (see Appendix A for an interview schedule and sample questions). The semi-structured design allowed the interviewer to respond reflexively to participant responses, such that the five interview domains were covered across the duration of the interview but in no specific order. This approach also reduced directive input from the interviewer and increased participant autonomy in telling their story. Interviews were audio-recorded via a portable recording device and ranged in duration from 38 minutes to 165 minutes (*M* = 86 minutes).

Upon signing up for an interview, participants were provided with an information sheet detailing the procedures and protocols of the interview process (including inclusion/exclusion criteria), risks and benefits to participation, and privacy and confidentiality measures. These details were reviewed with the participants just prior to commencing the interview. Some respondents were excluded from analysis; in these cases the interviews were commenced but not fully completed as it became apparent throughout the interview that they did not meet all inclusion criteria despite reviewing this with them initially. Participants provided both written and verbal consent to be involved. Following the interview, participants provided their pronouns and were invited to either choose a pseudonym or alternatively have one assigned randomly from an online generator, which would be used throughout analysis and dissemination of findings. Participants' identifying details were subsequently destroyed.

Given the sensitivity of the interview content, a risk management protocol was followed to manage risk of harm to participants during the interviews (see Appendix B). This protocol outlined the actions that the interviewer would take in response to potential risk scenarios (e.g., participant experiencing significant distress, disclosure of current exposure to violence or abuse, etc). The protocol was referred to throughout; no adverse events requiring further action were necessary.

4.6.4 Analysis

We used reflexive thematic analysis to explore and analyse the data. We sought to make sense of participants' understanding of their identity following sexual assault, while acknowledging the researchers' own assumptions, biases, and ideological and theoretical standpoints. Central to our assumptions was our feminist perspective on sexual violence. This includes understanding sexual violence as part of a spectrum of behaviours that intersects with multiple layers of stigma and discrimination against marginalised groups (e.g., sexism and misogyny, racism, ableism, etc.). We view sexual violence as a social issue that is typically an act of power over another that is informed by negative attitudes towards women (or people of another marginalised group). Instead of seeing these (often individual) acts of violence as driven primarily by personality characteristics or a specific interpersonal dynamic, we perceive these acts as micro-reflections of broader intergroup relations.

In analysing our data, we also reflected on our perspective women-identifying research team. From a theoretical standpoint, we also assume that: a) victimhood and survivorship are *social* identities, with their own unique identity content; and b) these social identities contribute both directly and indirectly to how individuals experience themselves and the world subsequent to sexual assault. Finally, two members of the research team have a background in clinical psychology, and approached this project via a mental health lens with an understanding of the pervasive, complex, and long-lasting impacts of experiencing interpersonal traumas.

Our process of data analysis consisted of six broad steps consistent with Braun and Clarke (2021). First, the first author (KW) independently immersed themselves in the data corpus to gain familiarity with the interview content. This involved transcribing the interviews verbatim and then re-listening to and re-reading the interviews. Second, initial codes were generated according to *a priori* research aims within the scope of this paper, with a focus on understanding how (social) identity is impacted by sexual assault and how identity functions to assist people to make meaning of sexual assault experiences. As such, our analytic process and the themes we derived were extensively informed by the social identity approach, a theoretical perspective which emphasises the group-based nature of collective identities and the outcomes of identifying as a member of a group. This theoretical standpoint was the basis from which we generated themes. We included all kinds of social identities in this exploration, but with an explicit focus on survivor and victim identities. Further, although our research questions and analyses were informed by social identity and self-categorisation theories, we did not limit our analyses to only extracting content about social groups, but also focussed on other identity-related processes. This stage was conducted collaboratively and iteratively by two members of the research team (KW and TC). Third, from these codes, initial themes were developed, and then (fourth) revised, by the same two researchers. Fifth and sixth, the full research team came together to refine the themes and write up the findings.

4.7 Results

We identified four themes: (1) *trauma identities as a resource for self-protection and self-preservation*, (2) *ongoing social isolation: narrowing of identities*, (3) *identity incoherence*, and (4) *the power of (re)connection: reshaping and expanding identity*. The first theme also comprised three subthemes.

4.7.1 Trauma identities as a resource for self-protection and self-preservation

Participants identified in diverse ways after their assault experience (i.e., as a victim, survivor, or both/neither). Their relationships to these identities functioned to protect and preserve their self-concept in the aftermath of the trauma.

4.7.1.1 Letting go of blame: Identifying as a victim

Overwhelmingly, participants spoke about the power of the victim identity to reposition blame with the perpetrator. This allowed them to release self-blame and validate their experience.

> *The word 'victim' is like someone else has done something that is illegal. And should be, you know, they should be facing the consequences of that.* (Holly)

Holly's focus on the criminal aspects of the assault emphasised the severity of her experience and drew attention to the perpetrator's ultimate responsibility. This may be an empowering position, given the pervasiveness of rape myths which place blame with victim-survivors (Zidenberg et al., 2022). Holly's quote also highlighted that the *consequences* of the sexual assault should be faced by the perpetrator. In reality, victim-survivors are often the ones "facing the consequences", with well-established ongoing negative impacts to psychological, physical, and social wellbeing (a "secondary victimisation"; Campbell & Raja, 1999).

For Katherine, identifying as a victim allowed her to acknowledge her experience, rather than minimise it:

> *[The victim identity is] a platform on which you stand to face the rage, and to face the sadness, to face all of that, 'cause it's so hard. If you don't have that platform to stand on, of – yes, this happened to me – you have nowhere stable in which to take on that rage and then find a good place to put it.* (Katherine)

Katherine described the victim identity as an essential starting point for recovery, where only by acknowledging one's status as a victim can one move forward. As with Holly's quote,

this positions the victim identity as one of *empowerment*. In contrast with previous conceptualisations of the victim identity (e.g., associations with vulnerability; Thompson, 2000), here the victim identity was framed as one that allowed for recognition of powerlessness at the time of the assault, but not ongoing *fragility*. In this way, the victim identity protected against negative self-evaluations that would arise from seeing oneself as helpless.

4.7.1.2 Becoming "more than": Identifying as a survivor

Endorsing a survivor identity served a similar protective function by allowing people to reposition themselves in relation to the trauma. Participants who identified as survivors spoke about the process of surviving as requiring intentional and active effort, allowing them to reclaim agency. Often this choice was a reaction against being a victim:

> *I think if I had stayed with him, I would have been a victim, would've carried on being a victim. Leaving him made me a survivor.* (Maya)

Similarly, Darcy reflected on having moved beyond the trauma while retaining key parts of their pre-trauma identity:

> *I'm more identifying with the survivor thing because I've put it behind me, and I've got on with my life. I haven't let it ruin me. And I'm still a compassionate person, I'm not a hard bitter person.* (Darcy)

This was echoed by Sky, who stated, "*I am a survivor because I have come out the other side*". In these reflections, participants saw the survivor identity as one that allowed them to position their trauma as a *past* event from which they had moved on. In distancing themselves *beyond* the trauma or as *more than* the trauma, this identity contained the event to the past, allowing them freedom of self-determination in the present.

4.7.1.3 Rejecting the trauma: Disidentification

Many participants rejected at least one of victim or survivor identities, often saying that they cognitively perceived themselves as belonging to those categories but felt emotionally

disconnected from them. This process of disidentifying from trauma-related identities was again protective, creating a distance from the distress associated with outright acknowledgement that they had been sexually assaulted.

> *I just don't see myself as qualifying for that… I just don't feel that my experience was horrific enough to fall in either of those boxes.* (Alana)

Alana's reflection that her experience was not severe enough to "qualify" her as a victim/survivor disconnects her from the emotional impact of the event, but also from other, "real" victim/survivors. Similar statements were echoed by many other participants:

> *[It's] not fair to group myself in with people who have experienced things that are much worse.* (Romi)

While many participants echoed this sense of not feeling like a true victim/survivor, others more consciously rejected the labels:

> *I kind of don't want to be either of them [victim or survivor identities] because I don't want to be referred to as anything from those events. Like, I went through it and I dealt with it, but I also like, I don't want to be a survivor. I don't want to be a victim. Because I don't want to have to have gone through it and I don't want that to have to be who I am.* (Hazel)

Hazel's reflection emphasised the finality of victim and survivor identities, where one's individuality and possibility for dynamic and fluctuating identity could be engulfed by their victim/survivor status. Similarly, Chelsea reflected that her decision to move after her assault experience was driven by a sense of constraint at being perceived as *only* a victim/survivor:

> *It also meant that I could assume the identity of someone who was not a victim or a survivor, I was just me…I could control the whole narrative: being genuine, being who I was, rather than what had happened to me.* (Chelsea)

Chelsea felt she had surpassed being a victim/survivor and was now "thriving". Her quote drew attention to the tendency for others to pigeonhole victim/survivors based on their

trauma experiences; disidentifying allowed her to "control the narrative", effectively reclaiming autonomy that had been lost during the trauma. Both Hazel and Chelsea highlighted that what it means to be a victim or survivor is driven almost entirely by others' beliefs, rather than the individuals themselves, and therefore rejection allowed for greater self-determination. When asked what her preferred term would be, Holly stated:

> *I guess a word kind of meaning – like I "endured" it. Or like I got through it. And it didn't necessarily make me stronger, I just experienced this… I think that would actually be my preferred, kind of, "someone who has experienced this". Because it doesn't imply anything other than, just the basic fact that they have gone through this experience.*
>
> (Holly)

In this way, disidentifying from both survivor and victim identities could be equally agentic as identifying with them, allowing participants to see themselves as separate from both their experiences of sexual assault and *also* from the constraints of others' perceptions.

In sum, although the trauma-related identities assumed by participants differed, with some preferring to identify as victims, others as survivors, and a further subgroup who rejected both, the motivations behind this choice were similar in that they all served a protective function. Participants understood these identities via the current narrative around sexual violence: "victims" were those who had been victimised and were *not* at fault, "survivors" were more than just their trauma, and choosing to reject these identities was a rejection of the constraining nature of both of them.

4.7.2 Ongoing social isolation: Narrowing of identities

Almost all participants spoke about feeling socially isolated since the trauma, and many had experienced poor reactions from others when disclosing their assault. This impaired their ability to connect and compounded the initial harm by narrowing their social world.

She just sat there and didn't say anything. And I felt like I sat there and I talked and talked and talked and talked and talked, and it just made me feel more alone. (Katherine)

For Katherine, the silence received at her disclosure was effectively "silencing"; revealing her trauma to another, without receiving connection in response, confirmed her belief that she was "alone" with it. This sense of isolation was echoed by Linda:

I feel like I can't talk to my sisters…they've just kind of gone: "no, we can't handle this", you know. (Linda)

Linda's reflection drew attention to the power of the trauma experience to disrupt valued connections. Although she does not reference identity directly, her sisters' unwillingness to hear her story highlights how trauma may lead to a sense of rejection from meaningful social groups (e.g., one's family). That is, the trauma experience (and perhaps one's new trauma-related identities) may be a barrier between the victim-survivor and their prior social connections.

For others, the stigma and shame surrounding sexual assault was encompassed in the identity of victim-survivor, and reflected back to them when disclosing their experience to others. Revealing one's trauma experience, and by extension their new identity as a victim-survivor, therefore, could lead not only to further trauma, but also to severing of relationships:

He said, "well, you put yourself in that situation". So that, at the end of that sentence, that was the end of that friendship … To hear that from somebody that I was once very very close to, it felt like I was being punched again, abused again. (Chelsea)

Social isolation was also compounded by a culture of shame and secrecy around sexual assault, which reinforced participants' own feelings of shame and inhibited meaningful connection with others. For many, this meant that they chose never to disclose the event, and participating in this research was the first time speaking about it with another person, as was the case for Sarah:

You're living with what happened and…the shame, the embarrassment, the psychological punishment, that just goes on and on and on, and there's nobody you can turn to, there's no one you can discuss it with. (Sarah)

Like Katherine, Sarah's quote highlighted that although the experience of sexual assault may have been a discrete event, it was experienced as an ongoing trauma by virtue of its power to create distance between oneself and others, marking them as irreparably distinct. Over time, many participants then began to see their isolation as protective, often becoming increasingly independent and fearful of connection:

It's made it even harder for me to want to open up to people and trust people… And I'm like, what is that about, what does that mean." (Connor)

Connor's quote also highlights the feelings of uncertainty and confusion that were reported by many participants in response to these changes in their behaviour. For others, social isolation was accompanied by feelings of *loss*:

I can see things happening that aren't going to happen but could *happen … I would always walk up to people before and I wasn't scared.* (Sky)

Taken together, social isolation following sexual assault was fundamentally an experience of loss: the trauma experience presented as a barrier between them and others, whether that was by overt messages discouraging them from speaking about their trauma (and as such refusing to acknowledge their experience and similarly their identity as a victim-survivor), internal feelings of shame or a sense of being different from others, or heightened fear of other people. In this way, social isolation prevented participants from being fully seen and accepted, or having their (social) identities fully realised by others.

4.7.3 Identity incoherence

Participants reported a lack of identity cohesion across their internal psychological sense of self, their embodied self-image, and the way they were perceived by others. They spoke about a mismatch across these domains, leading to a lack of cohesive sense of self:

> *Inside, I don't know who I am. I feel a little bit lost. Like, I like to be perceived a certain way, and I think because I've been doing it for so long I'm very good at masking and kind of acting how people want me to act, and I'm very good at putting on the persona of being a very happy, bright, supportive person, and at the heart of it, I'm like, is that who I am? …And I kind of try to convince myself that it is.* (Hazel)

Hazel reflected that the way she presented herself was a "mask" rather than her true, authentic self. She described this as being both for the sake of others ("how people want me to act"), but also for herself – a façade that allowed her to mitigate the feeling of being "lost". In this way, identity became a *performance for others*. In contrast with self-categorisation, which is an innate process, this performance was experienced as forced or *imposed* upon them from outside:

> *It just completely demolished my sense of the world and my sense of who I was for a long, long time.* (Chelsea)

Chelsea's quote draws attention to the power of trauma experiences such as sexual assault to "spoil" or *destroy* one's sense of self – a process that was associated with significant distress and ongoing consequences for mental health:

> *I don't look at mirrors anywhere, unless I absolutely have to, because it's not, I'm not, whether I'm not accepting of myself or whether it's shame.* (Sarah)

In response to this distress, many participants became more hypervigilant to their identity as perceived by themselves and others. Participants described multiple methods via which they attempted to control their external presentation of identity, such as eating disordered behaviour and expression of gender and sexuality.

Looking back I understand that eating disorder behaviour is, for me at least, usually about a loss of control, where I'm trying to regain some sort of control. So there was that element but also the element of wanting to shrink and hide. (Tahlia)

For Tahlia, efforts to "hide" her body highlighted how managing one's physical form was perceived as a method of controlling the facets of one's identity that were associated with distress (even at the cost of health). These efforts to "shrink and hide" from others allowed her to *conceal* her identity from others, and manage the interpretations of one's identity that would be made based on how she was perceived. Conversely, Hazel described feeling fused with her gender and sexual identities, such that she made significant efforts to have this part of her identity recognised by others:

I experienced a lot of hypersexuality post-trauma as well… I kind of went the opposite way where it was like very set in my mind, like being female and like my sexuality was like a very big part of my identity. (Hazel)

The mismatch and discomfort around identity as described by the participants resonated with some clinical and psychoanalytic models of identity. Within these frameworks, identity diffusion or fragmentation is considered one of the hallmarks of so-called borderline personality disorder (Jorgensen & Boye, 2022). These literatures assume that in people with good mental health, an "integrated" or "non-diffuse" identity is constructed around a stable and unchanging sense of self, and that this is key to psychological health and functioning. (Fuchs, 2007). Conversely, the social identity approach acknowledges that being able to flexibly switch between relevant and salient identities is adaptive, and assumes that the "self" is not stable, but rather dynamic and context-dependent. When viewed through a social identity framework, our participants reported a greater vigilance towards enacting (or *not* enacting) certain identities to control how they were perceived and protect themselves. As such, via this lens, their behaviour was functional and adaptive, reducing distress at least in the short term. However,

this was not without cost, as they described this process as involving significant effort, rather than occurring automatically.

4.7.4 The power of (re)connection: Reshaping and expanding identity

In contrast to the detrimental impacts of social isolation, participants also spoke about the power of positive social connections in recovering from the trauma. This connection helped to positively expand and reshape their identity:

> *Having good relationships too was very affirming, like, I have value and I'm not defined by this.* (Miriam)

Miriam's realisation that she is not "defined" by the trauma suggested that her identity as a victim-survivor, perhaps previously thought to be more dominant or inescapable, could now be flexibly integrated with other valued identities. Similarly, in contrast to the negative self-evaluations common to victim-survivors of trauma (e.g., feelings of defectiveness, Hassanpour et al., 2025), her realisation that she had "value" suggested that positive social connections had allowed her to perceive her worth. Contrary to shame and social isolation compounding each other, as we saw in Theme 2, positive relationships helped foster self-worth, and more globally assisted participants to move away from viewing themselves in terms of trauma-related identities (e.g., victim and survivor).

> *I think comparing myself now to [immediately after the trauma], I'm definitely a lot more social and I enjoy social activities, like I actually like being around people. I think before it was more that I was afraid, and now I don't have that fear.* (Holly)

As is emphasised in Holly's quote, developing a sense of belonging buffered against the mental health after-effects of the trauma, such heightened sense of others as threatening (as seen in Theme 2, and also a key symptom of post-traumatic stress disorder; Bryant, 2019).

For some participants, shared lived experience and identity as a sexual assault victim-survivor was one pathway via which they could reconnect to others:

I think there is some comfort in knowing that I'm not alone. But at the same time, it's like, obviously my heart hurts to know that so many of my friends and my family and stuff like that have had similar experiences. And it's like, again it's a double-edged sword, because it's community, but it's also like: god, why did we all have to go through this?

(Zephyr)

For Zephyr, the sense of "community" with others who had experienced similar traumas was both comforting and distressing; recognition that they were not alone allowed them to feel connected, but the *content* of this shared identity evoked pain. Similar to other groups where identity is based around a shared experience of hardship or trauma (e.g., immigrant detainees; Kellezi et al., 2019), this sense of not being "alone" with the trauma was a mixed blessing, enabling feelings of belonging while also serving as a reminder of the experience.

Maybe people with trauma are in the same group, like we just gravitate to each other.

(Hazel)

Like Zephyr, Hazel's quote highlighted the deep sense of empathy described by some participants towards other victim-survivors, highlighting that under the right circumstances and with the right people, trauma-related identities could be a resource for repositioning oneself in relation to the trauma. These quotes emphasised the power of valued social connections in promoting psychological wellbeing, which has already been well-established in the literature (Greenaway et al., 2016). Feeling part of a group where there are norms of acceptance and nonjudgement (as opposed to shame and blame) may have helped people to adopt these perspectives into their own identity as victim-survivors. This may have protected against or helped to lessen the negative mental health consequences that could occur.

4.8 Discussion

In this study, we sought to understand how adult victim-survivors of sexual assault navigated their experiences through the lens of identity. Specifically, we explored how identity

helps people to make meaning of sexual assault experiences, and how trauma-related identities are integrated with one's pre-existing self-concept. The first theme, *Trauma identities as a resource for self-protection and self-preservation*, highlighted that the way participants related to victim and survivor identities functioned to protect them from distress This protective function enacted itself in the ways that people chose to take on, not take on, or reject these identities. For many, acknowledging an identity as a *victim* of sexual assault allowed people to release self-blame: it helped them to see their experience as a crime committed against them, for which they were not responsible. In contrast, survivor identities allowed people to see themselves in a more empowered light, as someone who had overcome adversity. For others, disidentifying from trauma-related identities allowed people to reject the narrow view of victims and survivors that is portrayed in society and reclaim a sense of self that was not defined by their trauma experience.

Participants also spoke about how their identity was *narrowed* by ongoing experiences of social isolation after the trauma, as identified in our second theme. The stigma associated with sexual assault influenced many participants' decisions to disclose, and the responses received when disclosing. Some participants had never spoken about their sexual assault experience prior to the interviews. Over time, social isolation prevented people from being able to fully live out their identities and was associated with feelings of loss.

In the third theme, participants described a mismatch across their felt sense of self, their embodied physicality, and how they were perceived by others. For some, this presented as a sense of identity confusion. Many noticed feelings of hypervigilance towards how their physical form was perceived by others and the interpretations that would be made about them based on this presentation. In turn, participants described engaging in significant effort to control both how they were perceived and their own sense of distress.

Finally, participants described how positive relationships were essential in reshaping their sense of self, emerging as a fourth theme. Positive relationships helped participants to

rebuild their identity in a more holistic way and actively broaden their identity. For many, this involved connecting with others who had similar lived experience. This was experienced as bittersweet, providing a sense of community but also serving as a reminder of the trauma.

4.8.1 Implications

This study advanced the literature to date by exploring both *how* identities are shaped by trauma and also how they are utilised as *resources* (whether consciously or not), in the aftermath from sexual violence. Our findings highlight that sexual violence may disrupt a person's ability to experience a cohesive identity, leading them to engage in a variety of identity management strategies to regain a sense of control. What is clear from our findings is that the ways in which people choose to identify, *not* identify, or *disidentify* helps them to make meaning of themselves and their experience, and that this may differ from the common societal narratives of who trauma victim-survivors are. In particular, the process of rejecting trauma-related identities appeared to be a direct reaction to stereotypes of the so-called "ideal victim" (Christie, 1986), particularly for those who feel alienated or "undeserving" of the labels.

Further, when disclosing to others, many of our participants received unsupportive reactions, compounding their feelings of shame and isolation. This suggests that not only are people forced into being victim-survivors by the very nature of their trauma, but they can also be denied these identities when attempting to embody them. That is, participants who disclosed their experience of sexual assault were often silenced or shamed by those around them, which in turn led them to conceal these identities, inhibiting opportunities for meaningful connection. Indeed, there is some emerging longitudinal evidence that social isolation leads to greater post-traumatic stress, *which then in turn* increases one's sense of loneliness and isolation (Cruwys et al., 2025). It therefore appears that inability to fully enact one's identity is not only detrimental for wellbeing in the short-term, but also may have long-term effects for social connection and mental health.

Our participants' reflections around struggling to understand and accept their own identity speaks to the cultural pressure to know oneself and present this self coherently, consistently, and in a socially-acceptable format. This is likely challenging for many people, but may be even more so for sexual assault victim-survivors. Interestingly, many of our participants reported engaging in eating disordered behaviours, which have been theorised to reflect similar difficulties in embodying one's identity. Eating disorder sufferers often report viewing themselves in third person rather than from within (Stanghellini et al., 2015). This sense of *disembodiment* appears to be similarly common within sexual assault victim-survivors and may in part be due to the expectation that they conform to the dominant cultural narratives of victimhood/survivorship (which in turn reinforce the narrow framing of sexual violence victim-survivors; O'Neill et al., 2025).

The lack of *cohesion* across domains of identity (internal sense of self, embodied presentation, and others' perceptions of one's identity) described by our participants may partially speak to a challenge to maintain or regain autonomy after being restricted into this victim-survivor role. In addition, this has direct negative implications for recovery from sexual assault; continually being forced to enact their trauma identities reduces victim-survivors' autonomy in how they respond and move forward. Beyond this, however, these findings highlight that identity is often assumed to feel cohesive across domains (i.e., one's internal sense of self, embodied physical presentation, and identity as perceived by others), and the significant distress that can arise when this is not the case.

We found that people who have experienced sexual violence are being forced to navigate the social and political complexities of victim and survivor identities. This solidifies victimhood and survivorship as *social* identities, providing more evidence for the utility of using a social identity framework to examine these concepts. The social identity lens is not only an appropriate theoretical framework to investigate identity-related research questions, but also provides a non-pathologising alternative to the clinical literature on trauma. Our framework

recognises the functional benefits of engaging in identity management strategies and sees identity incoherence as an understandable and sometimes necessary adaptation to a society in which victim-survivors are provided with no viable options for identity enactment.

4.8.2 Strengths and limitations

A strength of the current study is the quality and depth of our data. Our use of qualitative methods, diverse sample, and an in-depth semi-structured interview process has provided an invaluable richness in understanding the diverse ways in which people respond to sexual assault via the lens of identity. Notably, we recruited across the gender identity spectrum, where prior research has often focussed exclusively on the experiences of women (e.g., Campbell et al., 2009; Thompson, 2000), and indeed may see sexual violence as (only) a crime against women (Brownmiller, 1975). Our study's focus – seeing gender identity as a contributing factor within a range of identity-related self-categorisations that may influence how someone responds to sexual violence – provides space for greater nuance in discussing sexual violence as a uniquely gendered crime that nevertheless can and does occur to people across the gender spectrum.

The breadth of our data and our participants' experiences is both a limitation and a strength of the current study. Many, if not most, of our participants had experienced additional traumas, including childhood sexual assault, domestic violence, or multiple adult sexual assaults. Disentangling the direct impact on identity of a singular experience of adult sexual assault from the multitude of experiences that collectively create someone's sense of self is impossible in the current study. Indeed, many of our participants struggled to identify discrete changes in their identity that were linked to (only) their named experience, instead reflecting that their identity today was a result of a combination of experiences, traumatic and non-traumatic. However, the complexity of our participants' life experiences allows us to be more confident that these findings hold external validity. Clinical literature has been criticised for its

limited generalisability to "real-world" experienced of mental ill-health, often excluding participants with more complex presentations (Zimmerman et al., 2002). In the case of sexual violence, childhood adversity (particularly childhood sexual assault) is a known risk factor for experiencing adult sexual assault (Classen et al., 2005). Our participants are therefore more likely to be representative of the wider population, and disqualifying those from research based on prior trauma experiences would likely not have been clinically or theoretically meaningful. Nevertheless, some caution is needed when interpreting the direct impact of adult sexual assault on identity based on our findings. Of particular note is the fact that many of our participants did not reference social identities directly when exploring the impact of sexual assault. Rather, we linked participants' experiences to social identity processes throughout the (reflexive) analytic process. Our theoretical position as a research team meant that we specifically focused on social identity-related processes when analysing the data, and derived themes based on our understanding of these. As such, our themes (and the quotes embodied by them) reflect both participants' narratives and our understanding of SIA. However, it appears that, broadly, those who have experienced sexual assault may utilise identity processes in a number of ways to protect from the distress of the trauma, and further, identity processes are likely to be similarly impacted following an experience of sexual assault.

4.8.3 Future directions

From the current study, social identities appear undeniably intertwined with sexual assault trauma. However, as seen in our third theme, many people report struggling to embody their identities in a way that provides them with a felt sense of authenticity. Our participants reported distress associated with this phenomenon, for example, via their efforts to control their sense of self as perceived by themselves and others. This finding is novel, but more research is needed to provide conceptual clarity about these experiences. For many, there was clearly a sense of "lacking" any identity at all and of feeling alienated from all prior identities

(and the groups that go along with them) that no longer fit. Given the pervasiveness of this underlying identity incoherence, as we have termed it, there is clearly a need for further clarification to operationalise this construct. Participants' efforts to control this experience (e.g., via eating disorder behaviours or gender presentation choices) speaks to the need for an understanding of this construct as it relates to clinical mental health concerns, which may provide further insight into the treatment and management of these conditions. Finally, a positive aspect of our findings is that they suggest that victim-survivors can and do experience reconnection, either with other victim-survivors, via positive interpersonal relationships, or with new and meaningful social groups. This reconnection may facilitate freedom from the constraints of the victim-survivor identity and allow for autonomously reshaping one's identity. Understanding the factors that support this reconnection is a promising avenue for future research.

4.8.4 Conclusions

Despite the efforts of anti-violence advocacy campaigns, the current study illustrates that the dominant social narrative of sexual violence is still one that reduces individuals to their trauma alone and prevents a holistic and multidimensional understanding of victim-survivors. The prolonged harm from sexual assault is likely not only the result of the experience itself, but also from the indirect impact on identity, and the ways in which identity must be navigated in a social context. Our participants' reflections emphasise that victim-survivors must continually operate from a place of self-preservation long after the trauma has passed. The dominant narrative of "who a victim-survivor is" has substantial impacts on how people respond to their experience and the distress they feel in the aftermath. Without diverse, multifaceted, and non-stigmatising representations of the variety of ways that people will respond to sexual assault (and the possibility that sexual assault can and does happen to anyone), this distress and further trauma is likely to continue.

It is encouraging, though, that for some of our participants, there appeared to be a pathway out of this place of ongoing self-preservation via positive social relationships, and we can only hope that the power of the relationships to promote wellbeing will continue to be emphasised in future literature. As our participant Katherine stated, *"There's like this huge gulf that opens up between you and other people. And so, if they're just still themselves with you, then that gulf is closed in."*

Chapter 5: Disidentification predicts complex post-traumatic stress following sexual violence

5.1 Chapter overview

This chapter addresses my third and final research question. In this chapter, I used a cross-sectional survey design to quantitatively examine phenomena that arose from themes in Chapter 4. From my interviews in Chapter 4, it became clear that many participants appeared to be struggling with a complex mental health presentation, describing symptoms and phenomena that seemed to align closely with CPTSD. In Chapter 4, participants also described a pervasive sense of *disidentification* and alienation from other victim-survivors. As such, I chose to examine these constructs via a social identity lens. This study examined the relationship between disidentification and CPTSD. Additionally, I attempted to quantitatively measure some of the phenomena that arose from themes in Chapter 4, namely, disembodiment, social isolation, and dissociation. This chapter proposes that disidentification underlies many of the symptomatology that distinguishes CPTSD from PTSD.

5.2 Abstract

The most recent version of the *International Classification of Diseases* (*ICD-11;* World Health Organisation, 2019) has recognised a new disorder termed "complex PTSD" (CPTSD). Thought to develop in response to recurrent interpersonal trauma, CPTSD encompasses the core symptoms of PTSD as well as an additional symptom cluster: disturbances in self-organisation (DSO). Of note, DSO is thought to reflect alterations in how the *self* is perceived and experienced, as a reaction to the *interpersonal* nature of the trauma that drives it. That is, at the core of DSO symptoms are disruptions to one's identity. This study utilised a social identity analysis of identity, drawing on conceptualisations of identity from a recent review (Cruwys et al., 2025a), to understand how the self is implicated in CPTSD. Specifically, I hypothesised that disidentification from a trauma-relevant group was associated with higher levels of CPTSD. Further, I anticipated that this relationship would be mediated by three facets of disconnection from "selfhood": disconnection from the body (disembodiment) disconnection from others (social isolation), and disconnection from the world (dissociation). I tested and found support for these hypotheses in a large sample of victim-survivors of sexual trauma. This study provides initial empirical support for our suggestion that the DSO aspect of CPTSD reflects underlying challenge to the social self-concept. I discuss the possibility that rejecting one's trauma experience (and the part of one's identity that this contains) *drives* these DSO symptoms.

5.3 Introduction

Clinicians and researchers have long observed that a subgroup of people who experience traumatic events will struggle with symptoms that go beyond post-traumatic stress disorder (PTSD) (Briere & Rickards, 2007). Responding to this, the most recent edition of the International Classification of Diseases (*ICD-11*; World Health Organisation, 2019) recognised a new disorder, termed "complex PTSD" or CPTSD. The diagnosis of CPTSD incorporates all PTSD symptom clusters (re-experiencing symptoms, avoidance symptoms, dysregulated arousal) as well as three additional other symptom clusters: (1) negative self-concept, (2) challenges with interpersonal relationships, and (3) emotion dysregulation. These additional clusters are termed "disturbances in self-organisation" (DSO; World Health Organisation, 2019). CPTSD often has a more chronic and intractable course compared to PTSD due to these DSO symptoms, often requiring a longer duration of therapeutic treatment (Maercker et al., 2022). Further, the added complexity of DSO symptoms means that current treatments for PTSD are usually less effective for those with CPTSD (Karatzias & Cloitre, 2019). There is therefore a need to understand the core drivers of DSO symptoms in order to provide appropriate and effective care and treatment for those who experience CPTSD.

CPTSD has been hypothesised to develop in response to prolonged or recurrent (rather than acute) trauma experiences (Cloitre, 2009; Herman, 1992). Additionally, CPTSD (compared to PTSD) appears to be independently linked with experiencing *interpersonal* traumas (Karatzias et al., 2019). Although CPTSD was initially associated almost entirely with childhood trauma and neglect (Hyland et al., 2017), more recent research suggests that CPTSD can also occur in response to trauma that is experienced in adulthood (Ford & Courtois, 2020; Palic et al., 2016). Interpersonal traumas often occur within social relationships, meaning that they are both more likely to be experienced repeatedly (as in situations of abuse or intimate partner violence), and may be qualitatively different in how they are interpreted in relation to one's sense of self within their world (Hyland et al., 2017). For example, interpersonal traumas are thought to disrupt a

person's sense of trust in others and induce profound feelings of shame and self-blame, where the self may be seen as more responsible for or deserving of the trauma experience (Courtois, 2008; Herman, 1992). Further, one's representation of themselves, as reflected in their chronic maltreatment by others, may come to be seen as fundamentally broken or even "nonhuman" (Herman, 1992). In sum, the DSO symptoms that distinguish CPTSD from PTSD are thought to reflect how the *self* is perceived and experienced, arise from significant harm from other people (Herman, 1992; Greenblatt-Kimron et al., 2023).

5.3.1 Adapting to chronic stress: CPTSD and the social self

Previous clinical research with self and identity (including CPTSD research) has focussed heavily on individual conceptualisations of the self, where having a core, stable sense of self is seen as integral to good mental health – and conversely, lacking a core sense of self is perceived as pathological (Fuchs, 2007; Jorgensen & Boye, 2022). For example, early theories of self-concept in CPTSD drew from psychoanalytic and social cognitive theories, suggesting that trauma experiences impacted one's ability to maintain a cohesive self-concept via their *self-capacities* (Pearlman, 1998). These self-capacities referred to one's ability to: 1) perceive the self as positive and worthy, 2) feel connected to others, and 3) experience and tolerate intense emotions (Pearlman, 1998). In non-traumatised populations, these self-capacities were thought to develop throughout childhood and into adolescence and adulthood via relationships with others (such as parents and caregiver). However, exposure to trauma, particularly interpersonal trauma, interrupted this natural development (Pearlman, 1998). That is, the DSO symptoms highlighted in the CPTSD diagnosis were thought to refer to alterations in these self-capacities, such that the self was viewed as overwhelmingly negative, incapable of connection with others, and unable to regulate strong emotions (Runtz & Briere, 2002).

In a recent systematic review, Kouvelis and Kangas (2021) investigated the relationship between trauma and identity. They found that, regardless of timing of exposure to trauma (i.e.,

in childhood, adolescence, or adulthood), research broadly supported that trauma has deleterious impacts on identity. They also found that significant heterogeneity in how self-concept is defined and assessed in the literature, with models of self and identity broadly supporting that the "self" is both personal and individual, but also defined in terms of one's relationship to others (Kouvelis & Kangas, 2021). The researchers called for further studies assessing and measuring self-concept in trauma populations, suggesting a need to delineate the specifics of the self and develop appropriate and theoretically-driven measurement tools (Kouvelis & Kangas, 2021). The Social Identity Approach (SIA) may be one such appropriate framework for understanding how the self is impacted in CPTSD. Built off social identity and self-categorisation theories, SIA's core premise is that our self-concept is derived not only from our individual qualities and distinct features, but also from our group memberships (Turner et al., 1994). Furthermore, SIA argues that identity is inherently dynamic and context-dependent (Turner & Onorato, 1999).

To our knowledge, SIA has not been previously studied in relation to CPTSD, however, there is early research which suggests the model is highly relevant to understanding the link between trauma experiences and subsequent mental health. Research by Muldoon and colleagues (2019) suggests that mental health trajectories following traumatic experiences is in part tied to how these traumas impact valued social identities. In particular, traumas that devalue one's meaningful social identities are more likely to cause distress, including PTSD (Kellezi & Reicher, 2011). Further, acquiring new social identities that are stigmatised or tied to traumatic experiences has been associated with poorer mental health and wellbeing outcomes (Muldoon et al., 2023). As such, it appears that trauma, (social) identity, and subsequent mental health, are fundamentally intertwined, and highlights the utility of applying SIA to understanding CPTSD (and DSO in particular).

A recent review proposed that disruptions to social identity processes are key to many mental disorders (Cruwys et al., 2025a), an analysis which provides insights into how selfhood

may be implicated in CPTSD via DSO. This model suggests that "self", as a concept, should be understood to exist along three dimensions: positivity (i.e., the extent to which oneself is viewed positively), inclusivity (i.e., the extent to which people incorporate social groups into their self-concept), and context-dependency (i.e., the rigidity vs flexibility of self-concept). Within a healthy (social) self-system, the self is largely viewed positively, optimally inclusive of others (i.e., *social* rather than wholly individual), and somewhat dynamic rather than static (Cruwys et al., 2025a). Conversely, mental health disorders (such as depression, schizophrenia, and social anxiety disorder) are thought to involve disruptions to identity processes along one or more of these domains (Cruwys et al., 2025a). Importantly, this framework suggests that these domains can be both too high as well as too low for optimal functioning (Cruwys et al., 2025a). For example, an extremely positive sense of self is likely maladaptive (e.g., mania; similarly for extremely inclusive or extremely context-sensitive). Conceptualising the self in this way, we argue, allows for enhanced understanding of how CPTSD impacts self-concept via DSO symptoms. That is, the DSO symptom cluster encompasses impairments in *socia*l as well as individual functioning (e.g., challenges with interpersonal relationships versus emotion dysregulation). Whereas most clinical models of mental illness distinguish between social and individual processes, the Cruwys et al. (2025a) model perceives that these processes are inherently intertwined, and that self-concept necessarily incorporates how one perceives themselves in relation to others. In line with this model, we propose that DSO symptoms may ultimately reflect impaired social identity processes.

5.3.2 The role of disidentification

One social identity process that may be particularly relevant to CPTSD is that of *disidentification*. Belonging to certain groups, such as being a victim-survivor of chronic or recurrent trauma, can cause pain and distress. For example, high levels of identification with a mental illness identity has been found to exacerbate distress and suffering, in part due to the

content of this identity (Cruwys & Gunaseelan, 2016). One way of coping with undesired group membership is via disidentification, the psychological process where people actively reject core aspects of their social identity (Becker & Tausch, 2014). Importantly, disidentification is distinct from low social identification (i.e., merely not identifying as a member of a particular group), and instead involves the active rejection of a threatening or distressing group (Becker & Tausch, 2014; Matschke & Sassenberg, 2010). Disidentification may be particularly relevant when one's group membership is not freely chosen, and when one is unable to leave the group (Becker & Tausch, 2014).

Disidentification processes may therefore be particularly relevant in the context of CPTSD and experiences of trauma. Victim-survivors of trauma, by definition, do not choose to belong to their group (and likely have low desire to belong), and are unable to easily leave their group. Further, interpersonal trauma is by its nature, unjust, and may be experienced as a rejection of one's self (Herman, 1992). It would therefore be a natural response to also reject the self – particularly the parts that "hold" the trauma (i.e., the trauma-related identity). Indeed, as highlighted in Chapter 4, interviews with people who have experienced sexual trauma have found that many people will reject both victim and survivor identities, feeling that they do not "deserve" these identities (i.e., that their experiences are not severe enough to warrant these identities), or that these identities limit their freedom to self-define in other ways. Feeling forced to accept an identity as a victim-survivor of trauma limits one's autonomy (Spry, 1995), and may increase the likelihood that one will reject this identity. Further, many victim-survivors minimise their own experience (Littelton et al., 2006; Wilson & Miller, 2016), or have their experiences dismissed or minimised by others (Reich et al., 2022). This minimisation may be interpreted as rejection from the group by fellow victim-survivors, people struggle to acknowledge their own experiences *as* trauma.

In addition, recent research suggests that disidentification may be related to poorer mental health and wellbeing outcomes following experiences of trauma. A study by Lashkay and

colleagues (2023) with victim-survivors of childhood sexual abuse found that adults who perceived there to be a stigma associated with their trauma were particularly likely to engage in disidentification. Higher levels of disidentification also predicted adverse mental health outcomes (Lashkay et al., 2023). As such, while rejecting an experience of trauma may feel preferable to acknowledging that one has experienced violence and is a member of a stigmatised group, it may actually lead to poorer mental health. However, this study did not measure CPTSD. Nevertheless, these early findings suggest that disidentification may be associated with higher levels of distress in the aftermath of trauma.

5.3.3 Disidentification may cause disturbances in self-organisation (DSO)

Central to disidentification is a rejection of a group-based identity that threatens or undermines one's sense of self (Becker & Tausch, 2014). That is, disidentification involves rejecting aspects of the self that are experienced as distressing. Similarly, at its core, DSO involves disruptions in how the (social) self is experienced and understood. Building on the framework of the social self-system detailed by Cruwys et al. (2025a), I suggest that DSO represent various kinds of disruption to this social self-system, and that *disidentification from one's trauma-related group* may underlie these disruptions.

The first DSO symptom cluster, negative self-concept, relates to disruptions at the personal or *embodied* level of identity. I suggest that one distinct element of this DSO component relates to the *disconnection from the body* or *disembodiment* often experienced by victim-survivors of trauma (as seen in the previous chapter). For example, victim-survivors often report discomfort with bodily sensations or awareness of one's body, as this can cause distress or trigger memories of trauma (Smith-Marek et al., 2018). In a large multi-method study with victim-survivors of sexual assault, those who had reduced accuracy at identifying interoceptive sensations were found to have increased post-traumatic stress (Reinhardt et al., 2020). Further, people who have experienced sexual violence have been found to have higher rates of eating

disorders (Brewerton, 2007; Brown et al., 1999; Convertino et al, 2022; Longo et al., 2021; Madowitz et al., 2015; Nilsson et al., 2020) and non-suicidal self-injurious behaviours (NSSIB; Ford & Gomez, 2015; Serafini et al., 2017). If viewed through a social self-system lens, these behaviours would reflect disruptions in identity at a personal or embodied level (Cruwys et al., 2025a). Indeed, researchers have suggested that these behaviours are a form of bodily *rejection*, or disconnection from one's body (Ataria, 2016). Although to our knowledge, there is no research linking these behaviours to disidentification, these findings together suggest the possibility of underlying mechanisms reminiscent of disidentification processes, where the target of one's disidentification is not a group or identity, but one's physical body. Negative self-concept is of course, broader than simply negative perception of one's physical body, but I argue that this symptom cluster involves disconnection from the body or rejection of one's physical form.

The second DSO component, challenges with interpersonal relationships, reflects a *disconnection from others*. Disidentification is clearly relevant to this process: given that disidentification involves rejection of group memberships, it follows that this would also entail rejection of others within those groups and increase the likelihood of social isolation. This is supported by longitudinal research: loneliness in the early aftermath of trauma predicted subsequent post-traumatic stress, which in turn predicted increasing loneliness (Cruwys et al., 2025b). As such, perceiving oneself to be socially isolated after trauma may become a vicious cycle, where it increases distress and mental health symptoms, and this in turn increases one's isolation as these symptoms become more entrenched. Notably, these findings were in relation to people who had experienced a natural disaster (Cruwys et al., 2025b). Conversely, victim-survivors of interpersonal traumas (as is often the case in CPTSD) may be at greater risk of loneliness and isolation given the stigmatised nature of their trauma experience (Kennedy & Prock, 2018).

The final DSO component is difficulties with emotion regulation, with one notable component of this being *dissociation* (World Health Organisation, 2022). Dissociation refers to a disconnection from reality, occurring along a continuum from normative and non-pathological (e.g., daydreaming) to more severe (Carlson & Putnam, 1993). In a recent review, dissociative symptoms were found to be common in CPTSD populations, and higher in CPTSD compared to PTSD groups (Fung et al., 2023). Dissociation is a form of *disconnection from the world*, such that victim-survivors of trauma must disconnect from their external reality when it is experienced as too distressing. Importantly, dissociation has already been found to be associated with disidentification in the study described above by Lashkay and colleagues (2023). Specifically, they found that greater disidentification from a trauma-related identity was positively associated with greater dissociation. These early findings provide some preliminary support for our hypothesis that disidentification from a trauma-relevant group may underlie DSO, furthering our argument that DSO involves disruptions of identity processes.

5.3.4 The present study

The purpose of the present study is to examine the relationship between disidentification and CPTSD. Given that CPTSD is distinguished from (classic) PTSD from the three clusters of DSO symptoms, I further expected that the link between disidentification and CPTSD will be mediated via three instantiations of DSO symptoms: disembodiment, social isolation, and dissociation (i.e., disconnection from the body, others, and the world, respectively). I aimed to explore these relationships in a group of victim-survivors of sexual assault. This sample was particularly relevant to our hypotheses, with population-based studies having found strong associations between CPTSD and sexual abuse in childhood, as well as adult sexual assault (Cloitre et al., 2019; Kairyte et al., 2022). Further, experiencing sexual violence is itself a risk factor for subsequent traumatic experiences (Classen et al., 2005), meaning that the risk for recurrent experiences of trauma (itself a risk factor for CPTSD) is high.

Nevertheless, I expected variability across our sample in all of our constructs of interests (including CPTSD), which provided the best opportunity to test our research questions.

In considering how to best represent the identity of this population, from which I would measure *disidentification*, I chose to use the term "victim-survivor". This was a carefully considered choice, particularly as there is to date some research suggesting that "victim" and "survivor" identities are distinct (as seen in Chapter 3, see also Hockett & Saucier, 2015), and therefore (dis)identification with "victims" may not equate to (dis)identification with "survivors", and vice versa. There were two main reasons for this decision: first, findings from Chapter 4 highlighted that participants who rejected their trauma experience tended to reject both identities of "victim" and "survivor". That is, they appeared to disidentify from the identity of *someone who had experienced sexual violence*, regardless of the terminology used. I therefore wanted to use a term which was optimally inclusive of all experiences to capture this specific phenomena, theorising that this would be most closely associated with CPTSD and DSO (see hypotheses below). Second, collapsing "victim" and "survivor" into the encompassing term "victim-survivor" minimised participant burden when completing the study, allowing them to respond to only one measure of disidentification.

I hypothesised that disidentification from victim-survivors (a trauma-relevant identity) would positively predict CPTSD (H1). Additionally, I aimed to explore three symptoms distinct to CPTSD as mediators of this relationship: disembodiment, social isolation, and dissociation. I posited that they are all forms of disconnection that might arise from the rejection of a trauma-related identity: disconnection from the body (disembodiment), disconnection from others (social isolation), and disconnection from the world or one's external reality (dissociation). I hypothesised that disidentification would predict disembodiment (H2), social isolation (H3), and dissociation (H4). Additionally, I hypothesised that each of the three DSO symptoms would predict increased CPTSD (H5). Finally, I predicted indirect effects of disidentification on CPTSD via the three mediators of disembodiment, social isolation, and dissociation (H6).

5.4 Method

5.4.1 Participants

Participants were *N*=215 adults (age: *M* = 38.73 years; *SD* = 12.82 years) currently living in Australia, who had experienced sexual violence in their lifetime. Demographics are provided in Table 4.

Table 4

Participant demographics

Demographic	%
Gender	
Woman	74.0
Man	24.2
Sex assigned at birth	
Female	74.9
Male	24.7
Ethnicity	
Asian	15.3
White	79.1
Another ethnicity not listed	9.7
Sexual orientation	
Heterosexual	72.6
Homosexual	7.4
Bisexual	14
A different sexuality	6.1
Highest education level achieved	
Secondary school certificate	7.0
Certificate or Diploma	19.1
Some university	7.9
Bachelor Degree, Graduate Certificate, Graduate Diploma	43.3
Higher degree (e.g., Masters Degree, Doctoral Degree)	20.9
Previous mental illness diagnosis by a health professional	
Yes	54.0
No	44.7

Note. *N*=215. Some categories have been collapsed or omitted due to extremely small cell sizes (>3%) to protect participant anonymity.

5.4.2 Measures

Participants completed multiple measures regarding mental health and wellbeing symptoms and identification, detailed below. Note that only the measures relevant to the

current chapter are listed; participants completed other measures of mental health and identification that are not reported here (please see Appendix C for a complete list).

5.4.2.1 Experiences of sexual violence

Sexual violence experiences were measured using the Trauma History Questionnaire (THQ; Hooper et al., 2011), a 24-item checklist of potentially traumatic events. For each item, participants indicated whether they have experienced it within their lifetime. Three items from this questionnaire pertained to sexual violence: 1) Forced sexual intercourse; 2) Forced or threatened sexual touch; 3) Another form of unwanted sexual contact. These items were used to determine inclusion criteria for the study. Participants who indicated having experienced at least one form of sexual violence as indicated above were directed to undertake the remaining measures, all other respondents were directed to a separate study (details are not covered in this thesis).

5.4.2.2 CPTSD

CPTSD was measured using the International Trauma Questionnaire (ITQ; Cloitre et al., 2018). The measure is designed to capture total symptoms of (complex) post-traumatic stress and degree of functional impairment. It can be used to differentiate between PTSD and CPTSD diagnoses as well as provide a total measure of symptomatology. Items correspond to key diagnostic criteria of PTSD and CPTSD as measured by the *ICD-11* (World Health Organisation, 2019). Participants rate the extent to which they have been distressed by symptoms from *0=Not at all* to *4=Extremely* over the past month. An example item is *I feel distant or cut-off from other people.* Additionally, participants rate the degree to which they have experienced functional impairment across work/study, personal, and interpersonal/social domains. In community populations, the ITQ has been found to have good internal consistency (Cronbach's *a* >=.79; Cloitre et al., 2018).

5.4.2.3 Disidentification

Disidentification was measured using Becker and Tausch's (2014) multicomponent disidentification scale, where participants rated the extent to which they disidentified with other victim-survivors across a seven-point Likert scale. The referent "victim-survivor" was chosen as both "victim" and "survivor" have been found to provoke specific connotations (as detailed above), which may unintentionally bias the results. Each subscale has been found to have good reliability (Cronbach's *a* >= .75 for each; Becker & Tausch, 2014).

5.4.2.4 Disembodiment

Disembodiment was operationalised using the Body Trust scale (Grunewald et al., 2024). This eleven-item questionnaire has three factors measured along a seven-point Likert scale: comfort with one's body, physical attractiveness, and comfort with internal sensations, with a total score providing an overall measure of body trust. Disembodiment was defined as the *inverse* of body trust, and as such we reverse-scored this measure such that higher scores corresponded to *greater* disembodiment. An example item is *Physical sensations in my body make me nervous/uncomfortable*. All subscales have been found to have good reliability (Cronbach's *a* >=.88 for all; Grunewald et al., 2024).

5.4.2.5 Social isolation

Social isolation was measured using the social isolation subscale from the short form of the Young Schema Inventory (YSQ-S3; Young et al., 2005). Participants rated the extent of their belief in the statements provided regarding their degree of state social isolation across a six-point Likert scale. An example item is *I feel alienated or cut-off from other people*. This subscale has been found to have good internal consistency (Cronbach's *a* =.74; Calvete et al., 2014).

5.4.2.6 Dissociation

Dissociation was measured using the Dissociative Experiences Scale (DES-II; Carlson & Putnam, 1993). This scale measures the extent to which participants experience dissociative experiences, including absorption, depersonalisation, and amnesia, using a Likert response format. Participants rate how often they experience symptoms as a percentage of time. An example item *is I felt as though I were a spectator watching what was happening to me, as if I were floating above the scene or observing it as an outsider*. Many of the items listed detail common dissociative symptoms that are found to occur at non-clinical levels within the general population, however as the measure provides frequency data, clinical levels of dissociative symptomatology can also be examined. The DES-II has been found to have good internal consistency (Cronbach's *a* =.95; Frischholz et al., 1991).

5.4.3 Procedure

This study received ethical approval from the ANU Human Research Ethics Committee (Protocol 2024/1145). A paid survey titled *An update to identity and wellbeing after trauma experiences* was advertised via the online survey research platform Prolific. Participants were screened for sexual violence experiences using the Trauma History Questionnaire (THQ; Hooper et al., 2011). Those who had experienced sexual violence subsequently undertook the remaining measures, while the remaining respondents were directed to a separate paid study (findings not detailed as part of this manuscript). All participants were debriefed and provided with contact details for local mental health and sexual assault crisis services following the study.

5.5 Results

5.5.1 Analytic plan

Data were analysed in SPSS v30.0.0. Respondents who did not meet eligibility criteria for inclusion (not currently residing in Australia – 7 respondents; did not respond to any items

detailing unwanted sexual experiences in the THQ – 19 respondents), had significant missing data, defined as missing all items of at least one of the focal measures (11 respondents), or failed one or more attention checks (9 respondents), were removed from the analysis. The final sample was *N*=215 participants who were retained for analysis. To test our hypotheses, a mediation model was run using the PROCESS macro for SPSS (v4.3; Hayes, 2017) using Model 4 and 5,000 bootstrapped samples.

5.5.2 Descriptive statistics

Of the 215 participants included in the analysis, over half (51.6%) had experienced forced sexual intercourse (see Table 5). The majority (54%) had received a lifetime diagnosis of mental illness by a health professional. Participants reported experiencing a mean of 7.44 different types of trauma experiences as measured by the THQ (*SD*=3.76). Means and standard deviations of key variables used for hypothesis testing are presented in Table 5.

Table 5

Descriptive statistics for key variables

	%	*M*	SD
Experiences of sexual violence[a]			
Forced sexual intercourse	51.6		
Forced or threatened unwanted sexual touch	54.9		
Another form of unwanted sexual contact	67.0		
Disidentification		3.70	1.07
CPTSD		19.83	14.73
Disembodiment		42.48	13.50
Social isolation		3.24	1.43
Dissociation		19.50	17.35

Note. *N*=215

[a] Participants selected all that apply; percentages shown are as a total of all participants.

5.5.3 Hypothesis testing

Supporting H1, disidentification significantly and positively predicted CPTSD (β = .12, p < .01). Disidentification significantly and positively predicted disembodiment (β = .22, p < .01), social isolation (β = .37, p < .01), and dissociation (β = .25, p < .01), supporting H2, H3, and H4

respectively. In turn, all three mediators significantly and positively predicted CPTSD (disembodiment: β = .21, p < .01; social isolation: β = .33, p < .01; dissociation: β = .38, p < .01), supporting H5. I found support for my hypothesised mediation model (H6), such that the indirect effects of disembodiment (β = .05, CI: .01, .09), social isolation (β = .12, CI: .07, .19), and dissociation (β = .10, CI: .03, .17) were each significant and positive. As such, individuals with higher levels of disidentification from victim-survivors reported more disembodiment, more social isolation, and more dissociation, which each in turn predicted increased complex trauma. This relationship is summarised in Figure 3.

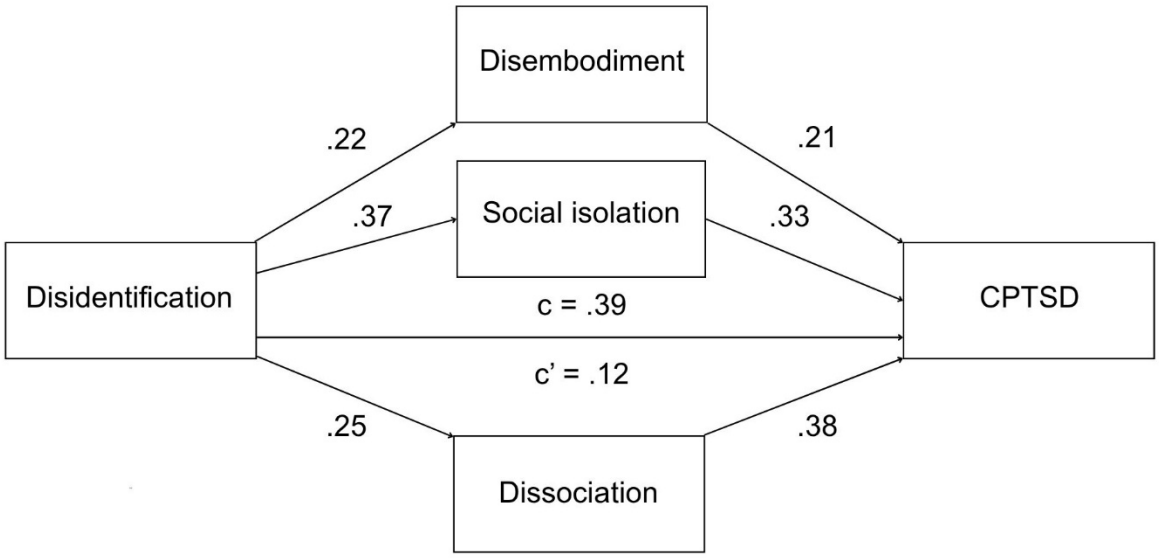

Figure 3
Path diagram depicting the relationship of disidentification on CPTSD via mediators of disembodiment, social isolation, and dissociation
Note. All coefficients are standardised and statistically significant, p <. 01. All indirect effects are statistically significant (disembodiment: β = .05, CI: .01, .09; social isolation: β = .12, CI: .07, .19; dissociation: β = .10, CI: .03, .17).

5.6 Discussion

The purpose of the current study was to explore the relationship between disidentification and CPTSD in victim-survivors of sexual assault. Supporting H1, higher levels of

disidentification were associated with increased CPTSD. Additionally, disembodiment, social isolation, and dissociation were all positively correlated with each other (supporting H2), with disidentification (supporting H3), and with higher levels of CPTSD symptoms (supporting H4). My hypothesised mediation model (H5) was also supported. Specifically, greater disidentification with victim-survivors predicted disembodiment, social isolation, and dissociation, which in turn predicted increased CPTSD. It is noteworthy that levels of disidentification and CPTSD were high in the sample overall, and that all of the effects are medium-large in size – overall, my mediation model was able to account for 39% of the variance in CPTSD.

The finding that disidentification predicts CPTSD via mediators related to one's (social) self-concept raises new questions regarding the nature of DSO and its origins. This study suggest that victim-survivors may be engaging in a more active form of rejection of each of these domains. This may speak to a more agentic disconnection from identity processes. Experiencing sexual violence is dehumanising on a very fundamental level, and it is unsurprising that for some, the body, others, and the world are experienced as too distressing or dangerous and must be actively pushed away. Further, this means to be understood not (only) as a flawed subjective judgement borne out of a mental illness diagnosis. Instead, it is crucial to recognise that victim-survivors have *objectively* experienced significant violence arising from their body, other people, and the world. Disidentification and the disconnection it entails may therefore be a very reasonable response and the safest method of coping – particularly in the face of the oppressive structures of harm that enable violence to continue.

5.6.1 Implications

Nevertheless, these findings suggest that disidentification following sexual violence is associated with significant psychological suffering. The current clinical literature conceptualises CPTSD as encompassing the symptoms of post-traumatic stress, in addition to

DSO symptom clusters: holding a negative self-concept, difficulties in interpersonal relationships, and affective dysregulation. Based on these findings, it is possible that disidentification from one's trauma identity may be a driving factor underpinning the symptoms which distinguish "complex" PTSD from PTSD. That is, it appears that in CPTSD populations, rejection of the parts of the self-system that are seen to "hold" the trauma, may be underlying DSO. Theoretically, I argue that this evidence suggests all three DSO symptom clusters may reflect social identity processes. Although I do not suggest that disidentification is the sole driver behind these symptoms, it does appear that the three states of disconnection measured in this study are inextricably linked to one another and to the rejection of the victim-survivor identity.

Clinically, if disidentification does indeed underlie many of these additional DSO symptoms, it provides a unified treatment target that may support recovery from sexual assault. Current models of treatment for CPTSD focus on a phased approach, where psychological stabilisation is emphasised initially (Cloitre et al., 2011). Often, the goal of the stabilisation phase is to reduce these DSO symptoms. More recently, a modular approach to treatment has been suggested, where core PTSD and DSO symptoms clusters are targeted sequentially according to individual client needs (Karatzias & Cloitre, 2019). However, these interventions focus largely on one-on-one, therapist-led approaches, which require therapists to be skilled a in a number of interventions to target individual symptom clusters (Karatzias & Cloitre, 2019). In contrast, given that disidentification is inherently a *social* construct, where a social component of the self is rejected, group-based therapies may be more appropriate. A key clinical advantage to using group-based therapy to treat CPTSD is that it would allow participants *in vivo* opportunity to connect with others including fellow victim-survivors, which, as the current findings suggest, may be key to dismantling DSO symptoms. Our findings suggest that therapeutically targeting disidentification could potentially provide a solution to some of these concerns. For example, group-based therapy interventions targeting key social identity

processes have previously been found to be effective at improving social connections reducing acute mental health symptoms (e.g., depression; Cruwys et al., 2022; Rathbone et al., 2025). Given that our current findings are preliminary, it remains to be seen whether similar would be possible in a CPTSD population. For example, there is a risk that group-based therapy could *increase* disidentification, if participants were unable to feel connected to other group members (the very people whom they may feel they "should" be able to connect). Nevertheless, these findings speak to the importance of evaluating group-based interventions as an alternative or adjunct to current treatment guidelines for CPTSD, or alternatively individual therapy that targets social identity processes.

5.6.2 Strengths and limitations

A key strength of the current research is our targeted and well-powered sample, a group of people who have all experienced significant interpersonal trauma. This is an ideal sample to test our hypotheses but historically have been a challenging population to reach in trauma research (Spinazzola et al., 2005). Additionally, best-practice guidelines in trauma research call for studies that are theoretically-driven (Jefferson et al., 2021), and our study's strong theoretical backing is a significant strength of the current work. However, despite their promise, the current findings are preliminary and cross-sectional, meaning that the importance of cautious interpretation cannot be overstated – particularly the direction of our hypothesised relationship. That is, we cannot be sure whether disidentification precedes and causes the DSO components of CPTSD, or whether their association is simply a byproduct of ongoing exposure to trauma and PTSD symptoms and the loneliness and isolation this creates (c.f. Cruwys et al., 2025b). Additionally, we measured disembodiment, social isolation, and dissociation, which capture *aspects* of the DSO components of negative self-concept, challenges with interpersonal relationships, and affective dysregulation, respectively. However, these DSO

components are multifaceted and so our evidence does not speak to the entirety of DSO as a construct.

In addition, as noted in the introduction of this chapter, I collapsed the identities of "victim" and "survivor" into an encompassing "victim-survivor" identity, and measured disidentification from this (total) identity rather than disidentification from either "victims" or "survivors" alone. It is possible that this decision obscured some of the nuances of the disidentification process; that is, we cannot ascertain whether the current findings truly represent disidentification from the identity of "a person who has experienced sexual violence" or whether participants who disidentified from either "victims" or "survivors" (but perhaps not both) are also included in these results. As seen in previous chapters and research, victim and survivor identities may be associated with markedly different identity content and mental health outcomes. It is possible that disidentifying from "victims", an identity associated in general with more distress and negative mental health outcomes in comparison to "survivors" (see Chapter 3), may actually relate to improved wellbeing outcomes such as post-traumatic growth. The current findings as such can only speak to disidentification from the more global identity of "victim-survivors", rather than the discrete identities that may be encompassed within this term.

Finally, it is important to acknowledge how the use of an online, anonymous research platform (Prolific) to collect our data may have influenced our findings. The anonymity of online recruitment is a key strength of this research given our population, as it may bypass some of the barriers (e.g., stigma) to in-person data collection. Indeed, qualitative research suggests that online recruitment may support stigmatised populations (e.g., those with stigmatised mental health conditions) to engage more readily with research (Iflaifel et al., 2023). Indeed, Prolific has been found to provide comparable data quality to in-person collection (Uittenhove et al., 2022) and higher data quality in comparison to other widely-used online research platforms (Albert & Smilek, 2023; Douglas et al., 2023; Peer et al., 2022). However, respondents on online survey

platforms may qualitatively differ from the general population. Some research suggests that regular users of online research platforms may be more isolated, spending comparatively more time alone and at home (Rinderknecht et al., 2025). In considering the current findings, particularly the extent of the social isolation reported by our participants, it is possible that our results may in part reflect our choice of recruitment. This does not necessarily detract from the validity of these findings but is worth considering in their interpretation.

5.6.3 Future research directions

The current study provides multiple avenues for future research. First, there is a clear need for longitudinal research examining the relationship between disidentification and CPTSD, to explore how these phenomena interact over time. Second, our research focussed on disidentification from other *victim-survivors*. The concept of disidentification necessitates that there be a specific group from which one disidentifies, however, if disidentification does underlie many of these DSO symptoms, it would be interesting to explore whether there are certain groups from which disidentification is more salient *or* whether people experience a general sense of disidentification from all other groups to which they belong. As mentioned above, disidentification from trauma-related groups may be protective and indeed necessary for psychological survival, and in which case, is it less distressing to disidentify from certain groups, such as victim-survivors, rather than identify with others who can collectively understand the unique pain associated with one's trauma? Future research might compare the relative experiences of identifying with victim-survivors versus disidentifying and the subsequent mental health impacts.

5.6.4 Conclusions

The current study explores the profound psychological consequences for people who have experienced violence, and must now live with its after-effects. Our findings point to the double-bind of trauma: sexual assault is an act of force against a person against their will, who

then, in turn, have a victim-survivor identity forced upon them. It is unsurprising that many people reject their trauma-related identities and the society which has enabled these identities to exist. However, the consequences of this rejection may be a sense of disconnection from body, other people, and the world, key components of CPTSD. For many people, victim-survivor identities are not chosen nor endorsed, but rather are an extension of the original act of harm. Disidentifying, then, may be the most autonomous act that a victim-survivor can take – even if it comes at significant personal cost.

Chapter 6: General Discussion

The purpose of the current chapter is to critically examine the findings from each of the three empirical chapters in addition to the overall findings from this PhD. First, I will review the original research questions, how they were addressed by the empirical chapters, and summarise key findings. Broadening out from the individual empirical chapters, I will then discuss findings arising from this PhD as a whole, including the theoretical and practical implications of this work. As part of this exploration, I will reflect on the strengths and limitations of this PhD. Finally, I will discuss remaining questions arising from this thesis and avenues for future research.

6.1 Research questions and aims

The purpose of this thesis was to utilise a social identity approach to investigate mental health following sexual violence. Three research questions were posed:

1. How do "victim" and "survivor" identities relate to mental health following sexual violence?
2. How do people make meaning of their identity in the aftermath of sexual violence?
3. How does disidentification relate to mental health outcomes in sexual assault victim-survivors?

Broadly, each of these research questions were answered by chapters 3, 4, and 5 respectively. Findings are summarised in brief below.

6.2 Summary of empirical findings

The purpose of the first empirical chapter was to examine the relationships between "victim" and "survivor" social identification with post-traumatic stress and growth, following experiences of sexual trauma. This study found a positive relationship between cumulative sexual trauma and both post-traumatic stress and post-traumatic growth. Additionally, the

relationship between cumulative sexual trauma and post-traumatic stress was mediated by social identification with "victims" (but not "survivors"), whereas the relationship between cumulative sexual trauma and post-traumatic growth was mediated by social identification with "survivors" (but not "victims"). Importantly, findings from this first empirical chapter added to an increasing body of literature suggesting that post-traumatic stress and growth are *intertwined* rather than distinct processes.

Building on from the initial findings of Chapter 3, in Chapter 4 I used qualitative methods to understand how people make meaning of their identities following sexual violence. I analysed the data using reflexive thematic analysis, which revealed four broad themes. First, participants used trauma-related identities (i.e., "victim" and "survivor") to protect from the distress associated with their experience. Victim identities were predominantly used to release self-blame and recognise the responsibility of the perpetrator. Survivor identities allowed participants to recognise the trauma as *past* event from which they had moved on. Disidentifying from victim and survivor identities allowed participants to minimise distress associated with the original trauma(s), distance themselves from the event, and maintain a sense of autonomy. The second theme was how participants' identities were effectively narrowed via the trauma, with ongoing experiences of isolation preventing participants from enacting prior valued identities or forming new ones. In our third theme, participants described feeling a mismatch between levels of their identity: their subjective internalised sense of self, their self-image and the way this was embodied by their physical presentation, and their perception of themselves as seen by others. This mismatch was highly distressing, and led to a range of identity management behaviours (predominantly related to controlling one's physical form). The final theme described how social connection was integral to expanding and reshaping identity in the aftermath of trauma, with some participants using trauma-related identities to connect with others over shared lived experience, and others developing positive

identities that were unrelated to trauma. These connections ultimately enabled them to rebuild their sense of self, promoting greater wellbeing.

The purpose of the final empirical chapter was to quantitatively examine some of the themes that we derived from the qualitative research of Chapter 4. In particular, Chapter 5 aimed to explore how disidentification from trauma-related identities (which was a prominent sub-theme in the previous chapter) related to mental health outcomes. Further, the previous chapter revealed that for many participants, social isolation and bodily distress played central roles in how they related to their identities in the aftermath of sexual trauma. As such, Chapter 5 sought to explore these phenomena quantitatively, and found that disidentification from trauma-related identities (i.e., rejection of being a sexual assault "victim-survivor"), was associated with severe and complex mental health outcomes (CPTSD). Additionally, disidentification predicted greater levels of disembodiment, social isolation, and dissociation, which in turn all predicted higher levels of CPTSD. This final empirical chapter drew together findings from both prior chapters. In particular, Chapter 5 provided initial evidence that disidentification from victim-survivor identities is a common process among people who have experienced sexual trauma and is associated with a more chronic and severe mental health presentation. That is, disidentification appears to drive rejection and *disconnection* from core parts of the self, and this may underlie many of the identity-related components of CPTSD.

6.3 Integrating the findings from this thesis

There are several further insights that can be gleaned from this thesis, beyond those specific to the individual empirical chapters. First, to my knowledge, this thesis and its constituent chapters is the first to utilise a social identity approach that focuses *specifically* on understanding mental health outcomes following sexual violence. In doing so, it builds on previous work in this space exploring how responses to sexual violence and abuse are in part determined via the lens of identity (e.g., Albanian women's experiences of sexual violence

during wartime; Kellezi & Reicher, 2009; South African women's experiences of abuse; Haslam et al., 2022). In doing so, this thesis highlighted that social identities are central to this process. Victim-survivors, even those who reject identities related to their trauma (and perhaps by extension, reject the trauma itself), appear to utilise social identities to understand their experience. "Victim" or "survivor" labels are not freely chosen, but must nevertheless be integrated with a person's pre-existing identities. Whether these identities are accepted or rejected may be one way in which victim-survivors are able to maintain or recover a sense of autonomy in the aftermath of sexual assault. Pre-existing social identities (e.g., gender identity, sexuality) that are valued and meaningful to a person may be disrupted by an experience of sexual assault. This may be via ongoing social isolation that hinders one's ability to connect and enact these identities, via incongruence with the new victim-survivor identity, or via a global disruption to a person's ability to cohesively integrate and enact the different facets of their identity.

Taken together, the findings across the three empirical chapters provide evidence that one's relationship to their trauma-related social identities is reflected in their mental health. First, it is interesting to compare findings across chapters. In Chapter 3, identification with victim and survivor identities was associated with post-traumatic stress and growth respectively. However, Chapter 4 found that many people reported not identifying with either victim or survivor labels. Building on this, Chapter 5 found that *disidentification* from victim-survivors was associated with complex post-traumatic stress. That is, disidentification from trauma-related identities was associated with more severe and complex mental health symptoms, in comparison to *identification* with these identities. Some caution is needed when interpreting these findings, as CPTSD symptoms were not measured in Chapter 3, and the wording of the trauma-related identity was subtly different across Chapters 3 and 5. Nevertheless, these findings do suggest that disidentifying from one's trauma experience may be associated with particularly poor mental health outcomes. It is possible that the unique

content associated with sexual trauma identities is in part responsible for this; as reported by participants in Chapter 4, the victim identity often allowed people to recognise their lack of responsibility for the event, whereas the survivor identity was associated with being able to move forward. In contrast, those who disidentified from both identities (as reported in Chapter 4) tended to minimise their distress and downplay the severity of their experience. This is a form of avoidance coping, a common response to traumatic events and is associated with higher levels of shame (Schmader & Lickel, 2006). As such, acceptance of trauma-related identities may be an important part of the recovery process.

Further, this thesis provides some support for the idea that there are discrete narratives associated with the experience of sexual trauma (at least within the Australian context, where this research was conducted). That is, the patterning of mental health responses associated with differences in social identification and the interpretation of these identities suggests that there are similarities across how people understand and interpret experiences of sexual violence. For example, it is interesting that in Chapter 3, survivor identification predicted post-traumatic growth, and participants in Chapter 4 discussed feeling *empowered* or more agentic when identifying as a survivor (feelings which may reflect post-traumatic growth, e.g., personal strength; Tedeschi & Calhoun, 2004). Similarly, it is encouraging that findings from Chapter 4, particularly the finding that a subgroup of victim-survivors will *reject* their trauma-related identity and may experience intense disconnection from parts of the self (such as the body, ability to form meaningful connections with others), were echoed quantitatively in Chapter 5. That is, these findings build on each other in a way that suggests a common narrative: experiencing sexual violence is fundamentally tied to one's identity, *even when this experience is rejected*, and this has very real links to wellbeing in the aftermath.

Returning to the overall aims of this thesis – specifically, to explore how social identities shape post-trauma mental health in the aftermath of sexual violence – several reflections can be made. First, as highlighted in the introductory chapters, the findings from this thesis

emphasise the importance of the social context in shaping how sexual violence is experienced and understood. Mental health outcomes are directly intertwined with one's experience of their (social) identities: that is, trauma-related identities are defined by the social context, which in turn influences how they will shape mental health. Further, these mental health outcomes may be significant and long-lasting. It is crucial to recognise that experiencing sexual violence may result in fundamental and possibly even lifelong shifts to one's sense of self. For example, many of the interview participants in Chapter 4 discussed experiences of sexual violence that occurred multiple decades ago, and some of them described having never previously disclosed their experience to anyone. This suggests that many victim-survivors are coping with the mental health consequences of an experience(s) for many years afterwards. This PhD is not the first to emphasise the longstanding effects of sexual violence; qualitative research with victim-survivors of war rape highlighted that many were dealing with ongoing direct impacts from sexual violence even twenty years afterwards (Shala et al., 2024). The stigmatised nature of sexual violence and the resulting social identities that must be integrated with one's sense of self (as created via the social context) may be directly responsible for prolonging the suffering of victim-survivors. Again, this is not a straightforward process, as pre-existing social identities (especially those that are marginalised, such as minority gender or sexual identities), and the existing narrative of sexual violence will likely influence how readily this integration can occur. The overall findings from this thesis underscore that the social context not only legitimises and permits sexual violence, but entrenches its devastating effects for individuals.

6.4 Implications

6.4.1 Theoretical implications

The findings across this thesis have important theoretical implications. First, identities related to sexual violence appear to have the power to both positively and negatively influence mental health – that is, they may play a significant role in how someone responds and

experiences traumatic events such as sexual violence. As seen in Chapters 3 and 4, these identities may be beneficial in enabling people who have experienced sexual violence to acknowledge their experience in relation to other important parts of themselves and the broader context of their life. For example, accepting one's identity as a survivor of sexual violence may allow people to regain a sense of agency and process the trauma of their experience. As part of this, accepting these identities (rather than rejecting or disidentifying from them) may help some people to connect with others with shared lived experience, which in turn may foster greater identity acceptance. Despite being linked to traumatic events, it appears that for many, taking on these identities is related to more positive health and wellbeing outcomes than choosing to distance from them. Like the immigrant detainees of Kellezi et al.'s (2019) study, identities that are associated with pain and distress can still promote social cure effects when identification is associated with increased adaptive coping, social support, and feelings of belonging.

Similarly, building on the combined findings from Chapters 3 and 4, these identities may be a source of distress and promote social curse type effects. For example, Chapter 3 found that victim identification was associated with increased post-traumatic stress, and Chapter 4 found a narrowing of identities and subsequent social isolation. Although there are similarities across how people relate to these identities, it also appears that the meaning associated with trauma-related identities may be more complex than other group identities where the content is more easily defined and widely recognised. That is, for some people, identifying as a victim may enable people to let go of shame and self-blame (as in Chapter 4), whereas for others, being a victim may be associated with feelings of powerlessness and fragility, promoting distress (in line with previous work, e.g., Thompson, 2000). It is possible that with the increase in awareness of sexual violence and the prominent, widespread advocacy movements of the last 10 years, current conceptualisations of victims and survivors are changing (e.g., such that there is increasing recognition that people are not at fault for their trauma experiences), but that this is a

fairly recent phenomenon and these narratives are not yet entrenched. As such, understanding *how* people make sense of these identities and relate to them is perhaps more important than which identity they choose. More broadly, choosing an identity (or a combination of identities), may be more likely to be associated with positive outcomes, than rejecting them altogether.

Additionally, findings from Chapters 4 and 5, in particular, suggest that for some people, social identification and self-categorisation processes themselves may be disrupted or impaired are somewhat disrupted or impaired after traumatic experiences such as sexual violence. For example, our finding that some people will report feeling significant discomfort with their body and the meaning that is derived from their physical presentation by others, or will feel a sense of alienation from other people, suggests that trauma may interfere with a person's ability to enact meaningful and valued parts of their identity. This in turn may inhibit them from seeing themselves as part of a group, feeling a sense of belonging with others, or developing shared bonds with other people. This is a notable finding with the potential for serious negative consequences, beyond that of the specific links with (complex) post-traumatic stress found here. For instance, as has been well-established previously, social identities in and of themselves can be highly beneficial for wellbeing (Greenaway et al., 2015). Further, the prominent social isolation reported by participants (see Chapters 4 and 5) suggests that even if social identity and self-categorisation processes are *not* disrupted, there is likely a stark lack of opportunity for people to experience the full curative effects of these identities. This is likely to have serious cumulative negative effects for wellbeing.

The finding that social identities are intertwined with how people experience and respond to sexual violence provides further support that, despite being (typically) an interpersonal act, sexual violence is interpreted at least in part through the lens of the *collective*. This means that victim-survivors are inherently, to some extent, recognising that these acts of violence are directed not (only) against them as individuals, but reflect broader social power dynamics (e.g., misogyny), in line with theories of drivers of sexual assault (for

example, see Armstrong et al., 2018). That is, there appears to be some recognition (even subconsciously) that sexual violence does not occur solely due to individual factors, but rather, it is reflecting broader collective dynamics of marginalisation and oppression. This marks a subtle shift from prior narratives of sexual violence that suggested these crimes occurred due to individual-level factors alone (including the victim-survivor's own culpability, e.g., Clay-Warner & McMahon-Howard, 2009; Randall, 2010). Although it is clear that rape myths and false narratives blaming victim-survivors still abound (e.g., PettyJohn et al., 2023; Stephens et al., 2016; Zidenberg et al., 2022), these findings may indicate marginal shifts towards recognition of the broader social and collective factors at play.

One final notable theoretical implication from this work is the link between disidentification from trauma-related identities to severe and complex mental health symptoms. Disidentification has only recently been researched in relation to mental health (e.g., Lashkay et al., 2023), and our findings build on this work to suggest that not only is it closely associated with mental health outcomes, but it may *underpin* some core mental health symptoms. For example, participants in Chapter 4 who disidentified from victim and survivor identities often minimised their severity of their experience and felt undeserving of these identities, which may be a way to protect against negative social responses or from one's own internalised feeling of shame (Carretta et al., 2015; Carson et al., 2020; Ullman et al., 2020). Yet, minimising one's experience may in fact be associated with particularly poor mental health outcomes, as *avoidance* of traumatic reminders is a symptom of both PTSD and CPTSD (World Health Organisation, 2019). Our finding from Chapter 5 that disidentification from trauma-related groups predicts increasing CPTSD builds on this to suggest that, at least in the context of sexual violence, rejecting one's trauma-related identity is detrimental to wellbeing. Disidentification as a construct may be greater importance for mental health and trauma than has been recognised in the literature to date. It is possible that disidentification may also be related to other mental health concerns that have a strong focus on identity (e.g., so-called

"personality disorders", dissociative identity disorder, eating disorders). This is particularly likely given that we found support in Chapter 5 for our hypothesis that disidentification predicts constructs closely related to the self (disembodiment, social isolation, and dissociation) using a self-categorisation model of self-concept (Cruwys et al., 2025a).

6.4.2 Practical implications

One of the primary purposes of conducting research into the mental health experiences of victim-survivors is to inform understanding of how best to support people following an experience of sexual assault. Within clinical models, receiving care as a victim-survivor typically requires diagnosis of an associated mental health condition, such as PTSD or CPTSD. Mental health services are largely gatekept by medical models of care, at least in Australia, meaning that trauma-specific psychological support can only be received by disclosing one's experience to a non-mental health expert (such as a general practitioner or police) who may lack awareness of the psychological consequences of interpersonal trauma, or may hold stigmatising or victim-blaming attitudes. This is particularly problematic for victim-survivors who do not wish to acknowledge their experience, as is common (e.g., Littleton et al., 2006; Wilson & Miller, 2016), or feel the need to minimise or downplay their experience (e.g., similar to many participants in Chapter 4). Feeling unable or unwilling to accept one's trauma-related identity, while understandable, may be associated with particularly poor mental health outcomes in part because this poses a barrier to accessing specialised services. Even if victim-survivors are able to receive more generalised mental health care (such as for a depressive episode), they may not respond well to these treatments.

One of the implications of the combined findings from these studies is that embracing trauma-related identities may be associated with better mental health outcomes compared to rejecting these identities, which has key practical implications. For clinicians and those working with people who have experienced sexual assault, it may be beneficial to seek to understand

how people are engaging with these identities and the unique meaning of these identities for each person. Assisting people to accept and acknowledge their experience (and, importantly, reduce self-blame), may help to promote integration of these identities and growth-related outcomes. Conversely, these findings also suggest that it may be particularly important for clinicians to monitor for disidentification, which may suggest a more complex mental health presentation.

Notably, however, individual clinical work with victim-survivors to promote growth narratives will be significantly positively impacted by structural change, including that by public health and advocacy organisations. That is, findings from this thesis have important implications for framing of sexual violence narratives by such organisations. It appears that trauma-related identities have importance and meaning for those who hold them, and it is therefore imperative that these identities are not dismissed. Although advocacy groups have long promoted survivor language and framing, these combined findings suggest that some may struggle to acknowledge this identity, or prefer a different identity (such as victim). Promoting acceptance of multiple kind of trauma-related identities, but also of one's right to choose their own identity which may change over time, may be the most helpful strategy for encouraging positive outcomes. This may enable people to take ownership of these identities in a way that best fits their own understanding of the identities and their relationship to their trauma experience, while still encouraging acceptance of these identities into their self-concept.

One of the key practical implications from these findings, therefore, is that current clinical models of care for victim-survivors may be improved by increasing wraparound support that emphasises multiple forms of connection. The combined findings from Chapters 5 and 6 emphasise that a subgroup of victim-survivors experience ongoing and pervasive isolation in the aftermath of sexual assault. In particular, this isolation appears to be tightly intertwined with identity; rather than being *merely* a sense of loneliness or lack of connection (which may also be present), it seems that the isolation experienced in these instances is more closely tied with a

sense of being fundamentally (and negatively) distinct from others. In a practical sense, services that foster connection with self, others, and community are likely to have global benefits to wellbeing. Services specific to sexual assault, such as rape crisis centres, are one avenue where such support could be offered. Many rape crisis centres do offer advocacy and peer support services, however, this is often focussed on provision of individual needs such as emotional support and direct assistance in navigating criminal and medical settings, and less so on developing shared identity with others (Wegrzyn et al., 2023). Further, the original feminist principles on which sexual assault centres were established are often diminishing, as centres become increasingly institutionalised and politically neutral (Maier, 2008). The findings from this thesis suggest that victim-survivors (and indeed the broader society) may benefit from services that promote collective action and advocate against sexual violence, in a way that is more in line with the original ideological principles of these organisations.

6.5 Strengths and limitations

As with all research, the current thesis has both strengths and limitations. A clear strength of this work is that the samples across all empirical chapters were people who had experienced sexual violence. This thesis made every effort to engage with people who had directly experienced sexual violence to ensure that findings were directly applicable and in support of these populations. Another notable strength of this work is the complementary integration of both quantitative and qualitative methods. In particular, findings from each of the successive empirical chapters built on the previous chapter. This is perhaps most clearly illustrated by the quantitative exploration in Chapter 5 of qualitatively themes that we found in Chapter 4. This is a strong example of using nuanced, qualitative findings to inform quantitative research in a way tied to the priorities and experiences of those with lived experience.

A further strength of the current work is the use of robust theoretical frameworks to understand applied problems. As detailed in the introductory chapters, aspects of this topic

have already been investigated, for example, how people choose to self-label in the aftermath of sexual assault. A strength of the current work is the conceptualisation of these applied issues through a social identity framework. Using a theory-driven approach allows for both greater generalisability of these findings to other populations, allows for drawing on empirical support beyond the current subject matter (e.g., "social curse" research, applications of SIA to trauma), and provides opportunity to *extend* theories based on current findings. In addition, there has been a growing consensus within the field that theory-driven trauma research is a noticeable gap in the current literature and an important avenue for current research efforts, meaning that this thesis is also contextually-relevant in the current literature and in line with best-practice guidelines (Jefferson et al., 2021).

However, this research is not without limitations. Perhaps the most significant methodological limitation of the current work is the lack of experimental and longitudinal methods. This thesis relied on cross-sectional and correlational data. It is difficult therefore to make inferences regarding causality or directionality of the findings, and any conclusions that are drawn must be cautiously interpreted based on the existing theories upon which this research was built. For example, it is impossible to say based on the current findings, whether social identification with victims or survivors *leads* to post-traumatic stress or growth, or whether disidentification from victim-survivors *causes* increased CPTSD symptomatology. It is important to recognise this as a limitation of the current work, while simultaneously acknowledging that much of the current work was exploratory and as such benefited from cross-sectional investigation was an appropriate first step. Nevertheless, many of the research questions that remain in this area (see *Future directions* below), will benefit from, and even require, use of a greater diversity of methodology.

Further, despite efforts to engage a diverse sample across a range of marginalised identities, there was a clear prominence of white women-identifying participants within the samples across the three empirical chapters. This is a significant limitation of the current work,

limiting generalisability of these findings to minority groups. It is highly likely that the experience of being a victim or survivor is different depending on one's other identities. Many of the more prominent advocates who have received widespread attention in this space hold some level of privileged identities, such as being white (also often young and able-bodied), and though these perspectives are highly important and relevant, it is also possible that the lack of equitable representation of diverse advocates, including in research, limits the ability of others to see themselves as victim-survivors. This may mean it is more challenging for those who do not hold as privileged majority identities to take on or enact these victim-survivor identities, or for others to recognise them as such. In turn, this is could mean that people from minority identities, or those who are unable to see themselves as victim-survivors based on lack of representation of *who* victim-survivors are, would be more likely to engage in disidentification from these identities. As such, they may be more prone to significant adverse mental health consequences. This thesis would have benefitted and been strengthened by engaging more comprehensively with marginalised groups for whom the issue of sexual violence may be prominent and who have traditionally been excluded from research (e.g., multiply marginalised populations).

6.6 Future directions

The exploratory nature of the current body of work suggests multiple avenues for future research. First, given that many of the findings detailed in this thesis are cross-sectional, there are many open questions regarding the temporality of identities related to experiencing sexual violence. It is possible, and indeed has already to some extent been suggested in prior literature (although not from a social identity perspective, e.g., Thompson, 2000), that victim identification is a *precursor* to survivor identification. Exploring the interrelationships between these identities longitudinally could provide further insight into how these identities develop.

In addition, much of the research in the current thesis has investigated the strength of social identification with victims/survivors, and much remains unknown about self-categorisation processes associated with these identities. For instance, are there different contexts in which people will choose to self-categorise as a victim versus survivor, for example, when interacting with the criminal or legal system, versus healthcare professionals or friends and family? Investigating the conditions under which people self-categorise as victims versus survivors, and the outcomes of this, could provide insight into how these identities shape people's experiences of disclosure, and further advance our understanding of the benefits and costs associated with these identities. It is clear that these identities are associated with vastly different content, and it is possible that this content influences both one's own self-perception and how they are perceived and responded to by others. This could have significant implications for receiving appropriate support and the types of reactions (compassionate, victim-blaming, etc.) that are received.

Further, one of the key overall findings from this thesis, as mentioned above, is that a subgroup of people disidentify from their trauma-related identities, and that this is associated with particularly poor mental health outcomes. This raises the question of whether those who disidentify are also less likely to acknowledge their experience or disclose to others. Nondisclosure of sexual assault is common, and research suggests that one of the main reasons people choose not to disclose is in effort to minimise or detach from the social stigma and distress associated with acknowledging one's experience as sexual violence. Rejecting the label of sexual assault or sexual violence might allow one to detach from potential distress, but might also prevent connection with others who have experienced similar traumas or garner appropriate support and resources for recovery (Ullman et al., 2020). As such, it is possible that disidentification is associated with nondisclosure, which may be a mechanism via which those who disidentify experience particularly poor mental health outcomes. That is, disidentification may be associated with lower levels of disclosure (and thus help-seeking), *or* disidentification

may follow disclosure that is met with poor or stigmatising reactions (e.g., victim blame). This is likely to provide further fruitful insights as to how disidentification is related to complex and severe mental health concerns.

Finally, the finding that disidentification was closely related to CPTSD, and in particular, to phenomena that pertained to the DSO symptom cluster (disembodiment, social isolation, and dissociation), raises many additional questions. In particular, an important next step would be exploring whether disidentification is associated with the specific DSO symptoms operationalised more broadly (negative self-concept, challenges with interpersonal relationships, affective dysregulation). This may provide further understanding of whether disidentification is the common thread underlying some of the complex symptoms that distinguish CPTSD from PTSD. Similarly, exploring these constructs in other CPTSD populations (i.e., those who have experienced other forms of trauma) would be a fruitful avenue for further research. The victim-survivor identity is often associated with sexual abuse, and rejection of this specific identity may be more closely tied to CPTSD compared to rejection of other trauma-based identities. More broadly, it could be interesting to explore whether *from whom* one disidentifies is an important factor, where for example it may be beneficial to disidentify in some circumstances. That is, although these findings suggested that disidentification from a trauma-related identity is associated with poor mental health, it is plausible that disidentifying from some groups or identities may actually be beneficial. For example, disidentifying from identities that are *overtly* negative (i.e., identities based on slurs or offensive language) may in fact support positive mental health.

6.7 Conclusions

The overall findings of this thesis are built on the cumulative efforts of victim-survivors, anti-sexual violence advocates, clinicians, and researchers. Experiencing sexual violence profoundly influences one's identity, not least by superimposing a new trauma-related identity

of victim, survivor, or some combination of these, onto a person's pre-existing self-concept. These identities hold significant meaning and are differentially associated with mental health trajectories, such that in general, seeing oneself as a survivor of trauma (as opposed to a victim) is related to greater growth and recovery – but crucially, *accepting* one's identity as a victim-survivor may be most important. It cannot be overlooked that many of the present findings echo statements made by activists and victim-survivors for many years, and that the research questions and interpretations of findings are just as much due to their work and efforts as to those of the direct research team, including this author. Any positive outcomes or benefits from this work are as much their accomplishment as that of this author, and any limitations are those of this author alone. It is devastatingly unjust that research into supporting sexual violence victim-survivors remains just as crucial today as it has for many years. Nevertheless, it is positive that so many victim-survivors were willing to come forward and participate in this research, and is perhaps "proof" of the collective power of groups to promote growth. This research is for victim-survivors and those who support them, and it is the hope of this author that the need for similar research will one day be obsolete.

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Appendix A: Interview schedule (Chapter 4)

Hi [name], thank you for taking the time to meet with me today and take part in this research. As discussed, my research is looking at how people's sense of identity might shift or change following an experience of sexual violence. I'm hoping that today we can have a chat about your experiences and what this has been like for you. Before we get started, did you have a chance to look through the information sheet I sent you?

Discuss audio recording, consent, limits to confidentiality and mandated reporting rules, risks (as outlined in Information Sheet), whether they have a support with them, other proposed safety measures including ability to cease interview at any point, what will happen to their data, etc.

If interviewed remotely, collect details of an emergency contact.

Do you have any questions for me?

Is it ok if we get started?

Can you tell me about yourself?
Can you tell me what interested you about this study?

Experience of sexual violence

- Can you tell me a bit about what was going on in your life [at the time of the experience of sexual violence]?

Follow up questions will include clarifying basic details about the experience including relationship to the perpetrator, participant's age at the time, number of times this occurred. Participants will not be asked to recount the details of the assault(s).

Disclosure

- Did you ever tell anyone about what happened?

If yes:

- Who did you tell?

- Why did you choose them?
- What was this experience like for you?
- How did they respond?
- Was this a response you anticipated? How did it make you feel?
- How would you have liked them to respond?
- Did some people in your life respond better than others?
    - What made these reactions better/worse?

If no:

- I'm wondering what led to your decision not to tell anyone about this?
- Was there someone that you wanted to tell, but chose not to?
- Sometimes people who have had experiences like this feel a lot of shame surrounding the event. Is that something that you experience?
- What has it been like for you to have had this experience but not talk about it with others?
- What is it like for you to speak about this now?
- Is this the first time that you have spoken about this with someone else?

Mental health

Thank you for sharing that with me. It sounds like it was a really difficult time for you.

- Are you able to talk a bit about what this experience has been like for you, in terms of any impacts it may have had on your wellbeing?
- How did you cope with this experience at the time?
- How are you coping now?
- Have you noticed any changes in how you have felt about this experience over time?

Follow up questions, may or may not be relevant depending on information gathered in "Disclosure" section:

- Did you have anyone supporting you during this time?
    - What was that like for you? Was it helpful?
- Did you ever seek any professional support, such as through a psychologist or counsellor?
    - Was it helpful?
- Did you ever consider reporting what had happened to you to the police?
    - Can you tell me about that experience? What was it like?

    - What would have made it easier for you to report?
- Sometimes people report experiencing some positive changes after a distressing experience such as this. For example, some people report that they have closer relationships with important people in their life such as family and friends, or that they have a better sense of what's important to them and their values. Did you notice any positive changes in yourself as a result of your experience?
    - Did you notice any changes in your relationships?
    - Did you notice any changes in your values?

Identity

- Could you tell me about how you see yourself and whether your identity has changed since the trauma?
    - Prompt: another way people can think about their identity is in terms of the groups they belong to, for example **we** can think of ourselves in terms of our gender identity (women), **sport**/religion/geographical location, professional identity (psychologist),
    - Sense of belonging (community, people)
    - Similarities with others
- When thinking about our identity, we can think about ourselves in terms of our personal characteristics and values, but also in terms of the groups we belong to. For example, I might think of myself as a researcher, or a woman, or a psychologist. After a trauma, the way we see ourselves in terms of our group memberships may change. I'm wondering if this has been the case for you?
- Has your sense of self in relation to others been impacted by this experience?
- Have you noticed changes in the way you relate to other people?
- Can you tell me about how you would describe yourself, before the trauma occurred?
    - How would you describe yourself now?
- When someone has had an experience like yours, we sometimes talk about them as being "victims" or "survivors". I'm wondering how you feel about these terms
    - Do you identify with these?
    - Do these terms resonate with you at all?
    - Has this changed at all over time (in the period of time since the trauma)?
    - What do you like about these terms? What don't you like about these terms?
    - Do you prefer one over the other?

    - Is there another way that you like to refer to your experience?
- Sometimes people notice changes in their sexual identity or gender identity. They may also notice changes in how they relate to these identities. Has this been the case for you?
  Prompt that we are particularly interested in social identity changes, such as changes to the above identities (i.e., gender identity).

Impact of current social context

- There has been a lot of discussion in the media lately about the MeToo movement, with lots of people coming forward and sharing their experiences of sexual violence. Has this movement had any impact on how you view your own experience?
- You mentioned that you spoke to [PERSON] about your experience. I'm wondering if this had any impact on how you view your own experience?
    - What about on your sense of identity?
- Do you know anyone else who has had similar experiences to you?
    - Have you shared your own experiences with them?
    - What was it like for you to talk with someone who had experienced something similar to you?
- What do you think it would be like for you to talk to someone else who had had similar experiences?
    - Do you think it would be easier to talk to someone who has similar experiences?
    - Do you think it would be harder to talk to someone who has similar experiences?
- What do you think of the term "recovery" when used in this context?
    - Is "recovery" an appropriate term?
    - What does "recovery" look like to you?
    - Where do you think you are at in your recovery journey?

Demographics

I would just like to confirm a few basic details with you, if that's okay. Please let me know if you would prefer not to share this information with me.

Confirm gender identity, sexual orientation, cultural background/ethnicity, age, current geographical location.

Pseudonym

Do you have a pseudonym you would like us to use? Otherwise, we will assign one to you now. We will de-identify your data during transcription, so if you later decide that you would like to withdraw your data, you may use this pseudonym to get in contact with us.

When closing the interview, ensure participant has access to the support services list.

Appendix B: Participant Distress Management and Risk Protocol: Identity after trauma experiences (Chapter 4)

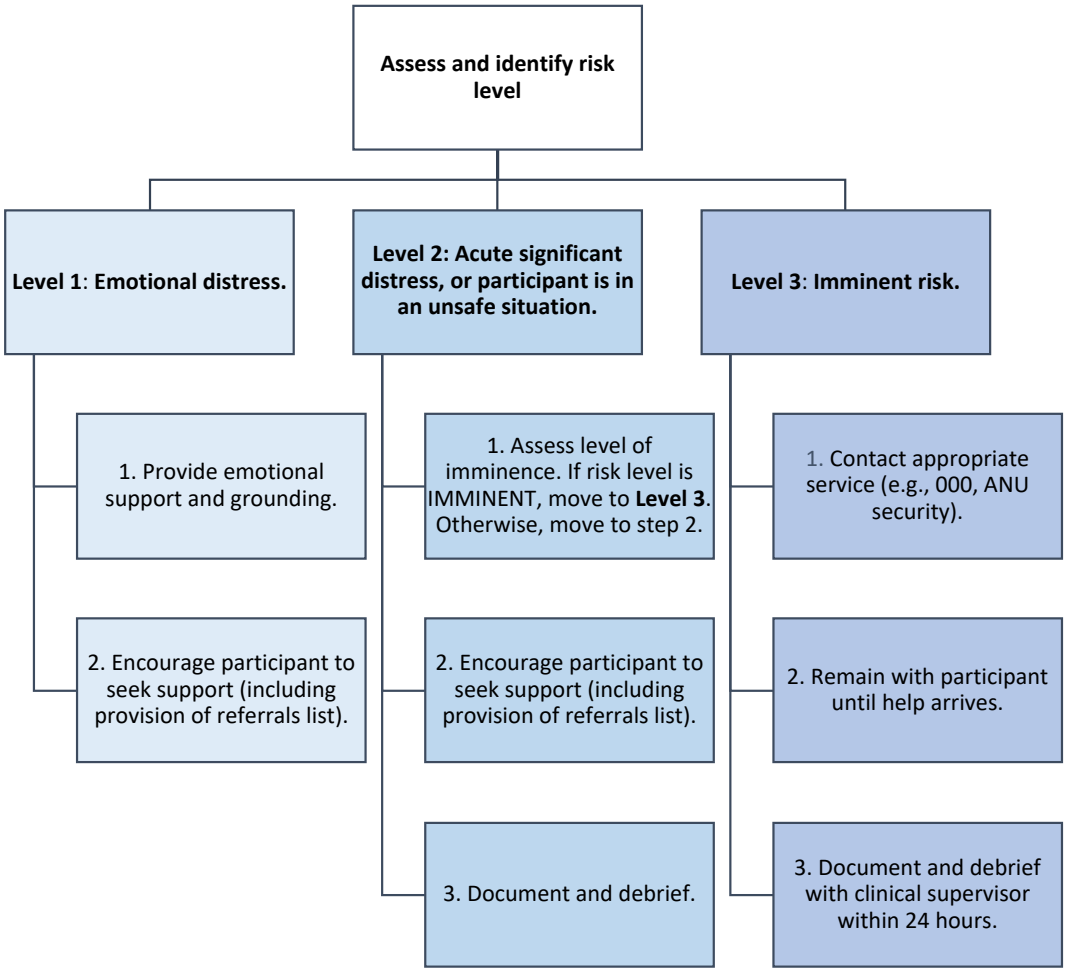

Figure 4

Participant distress and risk management protocol

All interviews are to be completed by a Provisional or Clinical Psychologist who has been trained and assessed as competent in risk assessment.

Level 1: Emotional distress

Example: Participant shows obvious signs of distress or discomfort, or becomes overwhelmed.

1. Provide emotional support and comfort.

Example script: I can see this is really hard for you to talk about. Let's pause for a moment and maybe take some deep breaths. I want to remind you that you're here in this room with me now, and we are talking about things that happened to you in the past.

- Offer tissues, water etc. as needed.
- Remind participant of options to pause the interview for a short break or to recommence another day, or to stop entirely.

2. Encourage participant to seek support (including provision of referrals list).

Example script: It seems like this is really tough for you. I'm wondering if you have people in your life at the moment who you can talk to if you need support? For example, do you have a close friend or family member, or perhaps a GP or other health professional who you could talk to if needed?
It often helps to talk to someone you trust about how you are feeling. There are people who are trained to help you with this. Would you be open to calling your doctor/GP and telling them how you have been feeling?
If you don't feel comfortable talking to a health professional, would you feel comfortable talking to a close friend or family member? How could you get in contact with them if you needed support?
We also have a list of services that may or may not be useful to you. You may have heard of them or even used some of them before. I'd like to give you this list to take home with you today, if that's okay, so that you have these numbers available should you need them in the future.

- Assess for current level of friend/family/professional supports. Encourage participant to ensure contact details of support people are accessible (e.g., numbers saved in phone).
- Provide with referrals list (see attached).

Level 2: Acute significant distress, or participant is in an unsafe situation

Example: Participants discloses risk of harm, either from self or other.

1. Complete thorough risk assessment to determine imminence and assess client safety, as outlined in the *APS Ethical Guidelines Relating to Clients at Risk of Suicide* (APS, 2014) and the *APS Ethical Guidelines for Psychological Practice with Women and Girls* (APS, 2012). If risk is imminent, move to **Level 3: Imminent risk.** Otherwise, move to step 2.

If the risk assessment determines that there is risk from self, the following standards from the *APS Ethical Guidelines Relating to Clients at Risk of Suicide* (APS, 2014) will inform this process:

> 3.1. *Psychologists* conducting suicide risk assessments with *clients* are guided by several factors, including the safety of the *client*; the safety of others; confidentiality; role clarity; *psychologist* competence; and the need for collaboration and consultation with *associated parties* (Daniel & Goldston, 2012; Esposito-Smythers et al., 2012; Ghahramanlou-Holloway, Cox, & Greene, 2012; Gipson & King, 2012; Linehan, 1993; Linehan, Comtois, & Ward- Ciesielski, 2012).
> 3.2. *Psychologists* ensure that their assessment and interventions take into account the need to maintain engagement with *clients* who are experiencing suicidal thoughts. They encourage *clients* to mobilise as much as possible their own resources and supports. *Psychologists* explore the *client's* resilience and the existence of any protective factors, and build on the *client's* strengths. However, *psychologists* also recognise that the *client* may exhibit temporary limits in their capacity to mobilise resources, and may demonstrate impaired or limited capacity to give informed consent, therefore requiring a more active role from those practitioners attending to the safety and wellbeing of the *client*.
> 3.3. *Psychologists* consider factors related to the immediate level of risk including a history of suicidal behaviour, suicide plans, access to means, evidence of impulsive behaviour, and the *client's* use of alcohol or drugs.
> 3.4. *Psychologists* act with care and skill in responding to a *client's* current and ongoing signs of suicide, which may include:
> i) taking steps to attend to the *client's* immediate safety;
> ...
> 4.1. Permission to contact other professional or social supports is obtained from the *client* where possible, and disclosure is, at least in the first instance, limited to information pertinent to the suicide risk. In situations where it has not been feasible to obtain the *client's* consent to inform other persons, then assessment of the degree of risk to the *client* and others will determine whether to disclose *client* information. The immediate safety of the person at risk is paramount. In the case of young persons, *psychologists* typically advise at least one relevant caregiver (e.g., parent, guardian, next of kin). In circumstances where advising a relevant caregiver is not appropriate, *psychologists* work with the *client* to identify one or more appropriate person/s or services (e.g., medical practitioner, Crisis Assessment and Treatment Team, or police) to contact.
> ...
> 4.5. *Psychologists* maintain responsibility for their *clients* at risk of suicide at least until an appropriate management plan has been developed and implemented and, if necessary, responsibility has been passed on by mutual agreement to an appropriate professional or agency. *Psychologists* ensure such an approach is performed in a supportive way that strengthens continuity of care.

If the risk assessment determines that there is current risk from other to themselves or any children (e.g., current domestic abuse), the interviewer will adhere to legal requirements in the first instance (i.e., mandatory reporting guidelines, as outlined in the *Children and Young People Act 2008* and in https://www.act.gov.au/__data/assets/pdf_file/0007/1397662/Failure-to-Report-Offence-Royal-Commission-Criminal-Justice-Legislation-Amendment-Act-2019.pdf). If the interviewer determines that there is a need to make a mandated report to Child and Youth Protective Services (i.e., where there is current harm to minors under the age of 18 years) or to police (where there is historical harm to a person under the age of 18 years), the interview will be ceased and this will be discussed with the participant. The mandated report will be made as soon as is possible and practical.

The following standard from the *APS Ethical Guidelines for Psychological Practice with Women and Girls* (APS, 2012) will inform this process:

> 4.4. *Psychologists* take *clients*' accounts of violence seriously, reinforcing their *clients*' awareness of their legal rights, referring them to appropriate legal and protective services, and supporting female *clients*' choices while acknowledging financial and socio-cultural constraints.

All interviews are to be completed by a provisional psychologist who has been trained and assessed as competent in completing risk assessment and who has sufficient knowledge and understanding of legal requirements regarding mandatory reporting obligations.

2. Encourage participant to seek support and provide referrals list. Assess for current level of friend/family/professional supports.

Example script: It seems like you are going through a really tough time. I'm wondering if you have people in your life at the moment who you can talk to if you need support? For example, do you have a close friend or family member, or perhaps a doctor or GP who you could talk to if needed?
It often helps to talk to someone you trust about how you are feeling. There are people who are trained to help you with this. Would you be open to calling your doctor/GP and telling them how you have been feeling?
If you don't feel comfortable talking to a health professional, would you feel comfortable talking to a close friend or family member? How could you get in contact with them if you needed support?
We also have a list of services that may or may not be useful to you. You may have heard of them or even used some of them before. I'd like to give you this list to take home with you today, if that's okay, so that you have these numbers available should you need them in the future.

3. Document and debrief with clinical supervisor.

- Incident report to be completed and provided to clinical supervisor within 24 hours, and include details of risk assessment and outcomes (including any requirement to make mandatory report), and of any supports provided.
- Clinical supervisor (AProf Tegan Cruwys) to debrief with interviewer at earliest convenience to provide support.

Reporting to CYPS:

Contact number: 1300 556 728 (mandated reporters)
Report online:
https://forms.act.gov.au/smartforms/servlet/SmartForm.html?formCode=1136
After hours crisis services/general public: 1300 556 729
Email: childprotection@act.gov.au

Level 3: Imminent risk

1. Contact appropriate service according to client level of risk and safety, in accordance with *APS Ethical Guidelines Relating to Clients at Risk of Suicide* (APS, 2014; e.g., 000, ANU Security).

Example script: Thank you for sharing that with me. I am really worried about you at the moment and I need to make sure you are safe. We are going to stop the interview now and I am going to call [000/ANU Security]. I will wait with you here while they arrive. Is there anyone you would like to contact in the meantime, maybe a friend or family member?

- Provide emotional support and grounding.
- Contact appropriate service:

  000 – Emergency Services
  02 6125 2249 – ANU Security

2. Remain with participant until help arrives.

3. Document and debrief with clinical supervisor within 24 hours.

- Clinical supervisor to be notified of Level 3 incident occurring via email/phone immediately following the event, once participant care has been transferred to a relevant authority.
- Incident report to be completed and provided to clinical supervisor within 24 hours. Incident report should include details of risk assessment and outcomes, and of any supports provided.
- Clinical supervisor (AProf Tegan Cruwys) to debrief with interviewer within 24 hours to provide support.

Contact number for ANU Security: 02 6125 2249

Contact information for clinical supervisor: AsProf Tegan Cruwys
0437 261 537
Tegan.cruwys@anu.edu.au

Support Services - Canberra

In an emergency:
Police, ambulance, fire: 000
Lifeline: 13 11 14
Suicide Call-Back Service: 1300 659 467

For immediate health and wellbeing support:
Lifeline: 13 11 14
Access Mental Health: (referrals, support, and information for mental health concerns, Canberra)
1800 629 354

National Sexual Assault & Domestic Family Violence Counselling Service (1800RESPECT):
1800 737 732

Kids Helpline: Free online and phone counselling for 5 to 25 year-olds
www.kidshelpline.com.au
1800 55 1800 (free to call)
Canberra Rape Crisis Centre: (02 6247 2525) – support available from 7am-11pm, 7 days a week
Domestic Violence Crisis Service ACT: (02 6280 0900) – 24/7 crisis line
Head to Health: 1800 595 212 (Canberra), or request a call back at
https://canberraheadtohealth.com.au/
Digital resources available at: https://www.headtohealth.gov.au/

MensLine Australia: Phone and online counselling service for men 1300 789 978
Beyondblue Support Service: Online, phone, and email support for anxiety and depression.
1300 224 636
www.beyondblue.org.au

Mindspot: Free online mental health care and digital support programs
https://www.mindspot.org.au/

People in my life I can talk to:

Name:	Number:
Name:	Number:
Name:	Number:

Support services by location

In an emergency:
Police, ambulance, fire: 000
Lifeline: 13 11 14
Suicide Call-Back Service: 1300 659 467

NATIONAL
National Sexual Assault & Domestic Family Violence Counselling Service (1800RESPECT): 1800 737 732
Sexual Abuse and Redress Support Service (for adult survivors of childhood institutional sexual abuse)**:** 1800 211 028
QLife: (1800 184 527) – crisis line for LGBTIQA+ people providing support and referrals, 3pm-12am every day
Lifeline: 13 11 14
13YARN: 13 92 76 – 24/7 crisis line for Aboriginal and Torres Strait Islander people to connect with Aboriginal and/or Torres Strait Islander crisis workers
Kids Helpline: Free online and phone counselling for 5 to 25 year-olds
www.kidshelpline.com.au
1800 55 1800 (free to call)
MensLine Australia: Phone and online counselling service for men 1300 789 978
Beyondblue Support Service: Online, phone, and email support for anxiety and depression.
1300 224 636
www.beyondblue.org.au
Mindspot: Free online mental health care and digital support programs
https://www.mindspot.org.au/

AUSTRALIAN CAPITAL TERRITORY
Canberra Rape Crisis Centre: (02 6247 2525) – support available from 7am-11pm, 7 days a week

NEW SOUTH WALES
New South Wales Sexual Violence Support Line: (1800 424 017) – 24/7 crisis line for anyone impacted by sexual assault, including friends, family, and supporters

NORTHERN TERRITORY
Ruby Gaea (Darwin): (08 8945 0155) – counselling and support line, Monday to Friday 8:30am-5pm
Sexual Assault Referral Centre (Darwin): (08 8922 6472) – support available 24 hours, 7 days a week
Sexual Assault Referral Centre (Alice Springs): (08 8955 4500) – support available 24 hours, 7 days a week

QUEENSLAND
Sexual Assault Helpline: (1800 010 120) – crisis line available 7 days a week, 7:30am-11:30pm

SOUTH AUSTRALIA
Domestic Violence and Aboriginal Family Violence Gateway Services: (1800 800 098) – 24 hours, 7 days a week
Yarrow Place Rape and Sexual Assault Services: (1800 817 421 or after hours line 08 8226 8787) – 24/7 crisis and counselling support

TASMANIA
Sexual Assault Crisis Line: (1800 697 877) – 24/7 crisis line

VICTORIA
Sexual Assault Crisis Line Victoria: (1800 806 292) – crisis line available weeknights 5pm-9am, weekends and public holidays

WESTERN AUSTRALIA
Sexual Assault Resource Centre Crisis Line: (1800 199 888 or 08 6458 1828) – crisis line available 8:30am to 11pm, 7 days a week

Appendix C: Complete list of measures (Chapter 5)

Table 6

Complete list of measures

Measure	Format	Response options	Example item
Trauma History Questionnaire (Hooper et al., 2011)	24-item Likert	Yes No	Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat?
Disclosure experiences (adapted from the General Help-Seeking Questionnaire; Wilson et al., 2005)	Multi-format, 15 items	Multiple response format	Who did you tell? Please select all that apply.
Single item measure of social identification (Postmes et al., 2013)	Single-item Likert	*1*=Strong disagree *7*=Strongly agree	I identify with survivors
Single item measure of social identification (Postmes et al., 2013)	Single-item Likert	*1*=Strong disagree 7=Strongly agree	I identify with victims
Multicomponent scale of ingroup identification (adapted from Leach et al., 2008)	11-item Likert	*1*=Strong disagree *7*=Strongly agree	I feel a bond with other victim-survivors
Multiple group memberships subscale, Exeter Identity Transition Scale (Haslam et al., 2008)	4-item Likert	*1*=Do not agree at all *7*=Agree completely	I belong to lots of different groups
PTSD Checklist for DSM-5 (Blevins et al., 2015)	20-item Likert	*0*=Not at all *4*=Extremely	Feeling very upset when something reminded you of a stressful experience
Post-Traumatic Growth Inventory (Tedeschi & Calhoun, 1996)	21-item Likert	*0*=Not at all *5*=A very great degree	I established a new path for my life
International Trauma Questionnaire (Cloitre et al., 2018)	Multi-format, 12 items	Multiple response format	I feel numb or emotionally shut-down
ULS-4 (Russell et al., 1980)	4-item Likert	*1*=Never *4*=Often	I feel in tune with the people around me

Measure	Format	Response options	Example item
Dissociative Experiences Scale II (Carlson & Putnam, 1993)	28-item Likert	*0%*=Never *100%*=Always	Some people have the experience of finding themselves dressed in clothes that they don't remember putting on
Mini-SPIN (Connor et al., 2001)	3-item Likert	*0*=Not at all *4*=Extremely	I avoid activities in which I am the centre of attention
YSQ-S3 (Young et al., 2005)			
Emotional Deprivation	5-item Likert	*0*=Completely untrue of me *5*=Describes me perfectly	I don't have people to give me warmth, holding, and affection
Abandonment	5-item Likert	*0*=Completely untrue of me *5*=Describes me perfectly	I need other people so much that I worry about losing them
Mistrust	5-item Likert	*0*=Completely untrue of me *5*=Describes me perfectly	I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me
Social isolation/ Alienation	5-item Likert	*0*=Completely untrue of me *5*=Describes me perfectly	I don't fit in
Defectiveness/ Unlovability	5-item Likert	*0*=Completely untrue of me *5*=Describes me perfectly	No one I desire would want to stay close to me if he or she knew the real me
PHQ-9 (Kroenke et al., 2001)	9-item Likert	*0*=Not at all *3*=Nearly every day	Feeling down, depressed, or hopeless
GAD-7 (Spitzer et al., 2006)	7-item Likert	*0*=Not at all *3*=Nearly every day	Feeling nervous, anxious, or on edge
Perceived discrimination (adapted from Schmitt et al., 2002)	10-item Likert	*1*=Strongly disagree *8*=Strongly agree	Victim-survivors as a group regularly encounter stigma
Trust (adapted from Robinson, 1996)	7-item Likert	*1*=Strongly disagree *5*=Strongly agree	I believe society has high integrity
Disidentification (Becker & Tausch, 2014)	11-item Likert	*1*=Strongly disagree *7*=Strongly agree	I feel detached from victim-survivors

Measure	Format	Response options	Example item
Body Trust (Grunewald et al., 2024)	11-item Likert	*1*=Strongly disagree *7*=Strongly agree	Physical sensations in my body make me nervous/uncomfortable