Advancing the Social Identity Approach to Health and well-being:

Progressing the Social Cure Research Agenda

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Abstract

The health of people's body and mind is powerfully conditioned by social factors that affect their social identity. Consistent with this notion, there is a growing interest in the way that group memberships (and the social identities derived from belonging to these groups) affect health and well-being. To the extent that group memberships provide individuals with meaning, support, and agency (i.e., a positive sense of social identity), health is positively impacted, constituting a "social cure". However, when group membership is not associated with these positive psychological resources or when social identity is challenged in other ways (e.g., group membership is devalued or stigmatized), social identities may become a curse, threatening and potentially harming health and well-being. In a range of social contexts, novel examples of these processes are brought together in the contributions to this special issue. In this editorial, we link the findings from these contributions to a set of hypotheses that emerge from the social identity approach to highlight the nuanced ways in which *social* identity processes are key to understanding health and well-being (Haslam, Jetten, Cruwys, Dingle, & Haslam, forthcoming). The contributions in this special issue point to fruitful ways to develop the social cure agenda. Together they highlight the importance of social identities as powerful psychological resources that have an important role to play in managing and improving health.

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Many people will be familiar with the African aphorism that “it takes a village to raise a child”. This aphorism hits home at least two points. First, it is not only the case that people live, and have evolved to live, in social groups, but also that social groups are essential determinants of important outcomes in people’s lives — in particular, those that relate to individual health and well-being. Rearing a child so that he or she becomes a healthy adult is a collective enterprise. What is more, the impact of the collective on health outcomes does not cease after childhood, but continues over the course of a person’s life. Indeed, in all stages of life, the individual is not detachable from the broader community and groups around them, but is shaped and formed by them in powerful and profound ways. In this sense, the health of every person is intimately tied to the conditions of group life. While a supportive and nurturing community is a prerequisite for an individual to flourish and be well, the absence of such community or the inability of the community to provide support and instil purpose and meaning into an individual’s life is likely to contribute to poor mental and physical health.

Second, according to this aphorism, the community has a direct responsibility for the health of a child. That is, if health is determined in large part by the communities and groups in which individuals find themselves, then responsibility for their health lies not with one person alone but also with his or her groups, community, and society. An individual can only grow into a healthy adult (physically and mentally) when the community and groups in which he or she is immersed are actively engaged in their upbringing and when the

community takes seriously its obligation to provide individuals with the building blocks for a healthy future. Achieving and maintaining health is therefore not simply a responsibility that falls on the individual; this responsibility lies just as much in the hands of the various collectives to which the individual belongs. This in turn requires interventions and policy decisions that are sensitive to the social dimension of health and that capitalise effectively on the potential for the collective (and group memberships in particular) to promote health and well-being.

Together, these two points capture key elements of the research agenda that is brought together in this special issue — research that embodies an approach to health and well-being that has come to be known as “the social cure” (after Haslam, Jetten, Haslam, & Postmes, 2009; Jetten, Haslam, & Haslam, 2012). The core premise of this approach is that because people’s self-understanding and behaviour is fundamentally intertwined with the social groups to which they belong, those group memberships (and the social identities that people derive from them) have important consequences for their health and well-being.

This work builds on a growing body of research that has used social identity and self-categorization principles to advance theory and practice in a range of areas of applied research (e.g., Haslam, 2014; Jetten, Haslam, Haslam, Dingle, & Jones, 2014). This is a significant development for a number of reasons. First, while the social identity approach (SIA; consisting of social identity theory, Tajfel & Turner, 1979, and self-categorization theory, Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) has traditionally been concerned with the way in which social identity is heavily implicated in intergroup relations (e.g., discrimination and prejudice), it is increasingly clear that other consequences and correlates

of group-based identification — in particular, those that relate to resilience and adaptive psychological functioning more generally — can be understood from this perspective. And as an ever-growing corpus of research attests, these developments have presaged a significant expansion in the scope and impact of social identity theorising.

Related to this, it is clear that this expansion has served to make important new connections between social psychology and cognate disciplines — in particular, with the work of epidemiologists, sociologists, political scientists, and economists that has provided compelling evidence of the social determinants of health and well-being (e.g., Helliwell, 2006; Helliwell & Barrington-Leigh, 2012; Marmot, 2015; Putnam, 2000; Wilkinson & Pickett, 2009). Amongst other things, this work has been enormously influential in showing that social status, inequality, poverty, and disadvantage are powerful predictors of health and well-being. As a result, calls for governments and policy makers to step up to their responsibility to attend to the social dimensions of health and well-being have become ever louder over the last decade (Marmot, 2015). Yet in light of these developments it has also become clear that social psychology — and the social identity approach to health and well-being in particular — has a critical role to play in advancing this agenda. This is because while much of the epidemiological and sociological work has focused on showing just how potent social factors are in determining health, social psychologists are uniquely positioned to show and explain (a) *why* exactly this is the case, and hence both (b) *when* we might expect the impact of social factors to be most pronounced, and (c) *how* we might intervene to greatest effect.

Given this, it is perhaps not surprising that, in a comparatively short time, the

evidence base and reach of social cure research has increased exponentially, so that there are now well over 400 publications that speak broadly to the relevance of social identity for health and well-being (Figure 1). In addition, over the past five years there have been three (biennial) international conferences on social identity and health (ICSIH) held in Europe, Northern America, and Australia to foster the exchange between hundreds of researchers and practitioners across the globe. Yet even though this research endeavour is clearly flourishing, it is also apparent that much more needs to be understood. At the same time, precisely because so much social cure research has already been conducted, the task of taking stock and determining how contributions fit into the larger picture has become increasingly challenging. Given this abundance of trees, it is necessary now to step back in order to see the forest.

In an attempt to lend some structure to this effort, we have chosen to focus this editorial on structuring the key premises of the social identity approach to health around 15 key hypotheses. The logic and evidence base for these are developed and explored in greater detail in the forthcoming book *The New Psychology of Health: Unlocking the Social Cure* (Haslam, Jetten, Cruwys, Dingle, & Haslam, in prep). Here, though, we will pay particular attention to the way in which the hypotheses are informed by the various contributions to this social issue (as summarized in Table 1). Our hope is that the hypotheses will provide a roadmap for researchers as they set about extending the insights of the social identity approach to health in years to come. Moreover, by using these hypotheses to organize the research that is showcased in this special issue, we hope to reinforce awareness of the integrative and generative power of this approach — to demonstrate its capacity to provide a

consolidated framework for making sense of, and advancing, research across a broad front (e.g., in ways encouraged by Ellemers, 2013).

A Social Identity Analysis of Health and Well-being

The social identity approach starts from the assumption that developing an understanding of a person's thoughts, beliefs, and actions requires insight into how they categorize themselves in relation to others. Individuals can self-define in terms of their own unique individual traits and features (as "I" and "me"), or in terms of their social identity — the group memberships they share with others (as "we" and "us"; Tajfel & Turner, 1979). When a person's personal identity is salient, they focus on ways in which the self, as an individual, is different from other individuals (Turner, 1982). However, when social identity is salient, people are attuned to their similarity to others with whom they share group membership (ingroup members, e.g., "us psychologists") and to their difference from those with whom they do not share group membership (outgroup members, e.g., physicists; Turner et al., 1987).

Shared group memberships impact on the psychology of individuals (including their health and well-being) through their capacity to be psychologically internalized as part of self. As a result, like the child in the African aphorism, the health and well-being of any individual is intimately tied to the conditions of the groups to which they belong. In particular, group memberships can be enriching and make people stronger and healthier because they provide them, amongst other things, with self-esteem, belonging, meaning, and a sense of purpose, control, and efficacy in life (e.g., see Cruwys, Haslam, Dingle, Haslam & Jetten, 2014; Greenaway et al., 2015; Jetten et al., 2015). In this way groups have the

capacity to act as “social cures” and group memberships to impact positively on health and well-being (Haslam et al., 2009; Jetten et al., 2012). However, group membership can also be a source of stress that is detrimental to health and well-being. This is the case, for example, when people belong to stigmatised groups, when groups promote toxic and unhealthy norms, or when people belong to groups that do not provide them with social support (e.g., Dingle, Stark, Cruwys & Best, 2015). In the latter instances, then, rather than being a “social cure”, groups can be a “social curse” (Kellezi & Reicher, 2012). This, then, is the basis for a first hypothesis:

H1: The social identity hypothesis. Because it is the basis for meaningful group life, social identity is central to both good and ill health.

There is now a considerable body of research that has provided support for this hypothesis and, in the process, provides insight into a range of processes germane to health and well-being. For example, social identity has been shown to be central to the appraisal of health (Adams, Pill, & Jones, 1997; Jetten et al., 2012; Levine & Reicher, 1996) and to the way that group memberships buffer people against the negative well-being consequences of exposure to stressors (e.g., group-based discrimination, as in the rejection-identification model; Branscombe, Schmitt, & Harvey, 1999). Along closely related lines, social identities have been shown to underpin effective social support (Haslam, O’Brien, Jetten, Vormedal, & Penna, 2005), as well as the absence of social support (Kellezi & Reicher, 2012), a sense of personal control (Greenaway et al., 2015; Greenaway, Cruwys, Haslam, & Jetten, 2016), the development of depression (Cruwys, South, Haslam, & Greenaway, 2015; Sani, Madhok, Norbury, Dugard & Wakefield, 2015), and even post-retirement mortality (Steffens, Cruwys, Haslam, Jetten, & Haslam, 2016).

Not surprisingly, given its centrality to the social cure project, this basic hypothesis is central to all nine of the papers that are included in this special issue. The way that social identification and group membership is key to health and well-being outcomes is examined in studies in a diverse range of contexts, focusing on ethnic and sexual minorities (Begeny & Huo), refugees and immigrants (Bobowik, Martinovic, Basabe, Bartsies, & Wachter; Çelebi, Verkuyten, & Bagci), individuals diagnosed with a range of cognitive or mental health conditions (Cooper, Smith, & Russell; McNamara et al.), residents in deprived urban areas (Heath, Rabinovich, & Barreto), earthquake survivors (Muldoon et al.), and participants in mass gatherings, including suicide prevention fundraisers (Hopkins & Reicher; Kearns, Muldoon, Msetfi, & Surgenor). Adding to this breadth, these diverse samples are studied in eight different countries: the USA, the Netherlands, Spain, Turkey, England, India, Ireland, and Nepal (see Table 1).

However, it is important to bear in mind that this first hypothesis is conditional. That is, many groups that we belong to do not affect our health and well-being for the simple reason that, when we do not identify highly with these groups, group memberships are not internalized as an important part of self and hence the group in question will have little or no impact on an individual's health. In line with the social identity approach, for group memberships to affect individuals' psychology, they should generally be perceived as meaningful and relevant to the self, and, more particularly, be psychologically internalized categories that provide a basis for the person to understand their place in the world (Turner et al., 1987, see also Cruwys et al., 2014; Jetten et al., 2014). H1 therefore needs to be qualified with the following:

H2: The identification hypothesis. A person will experience the health-related benefits or costs of a given group membership only to the extent that they identify with that group.

At least as far as the positive effects of group identification on health are concerned, there is now considerable empirical support for this prediction. Indeed, the findings of recent meta-analyses provide evidence that these effects are reliable and quite large. For example, Cruwys and colleagues (2014) identified 14 studies (including more than 2,600 participants) in diverse locations and types of groups — ranging from heart surgery patients (Haslam et al., 2005) to Australian school students (Bizumic, Reynolds, Turner, Bromhead, & Subasic, 2009). In every case, higher social identification was associated with lower levels of depression and fewer depressive symptoms (mean $r = -.25$). Likewise, Steffens, Haslam, Schuh, Jetten, and van Dick (2016) examined the relationship between social identification and health in organizational settings (based on 58 independent samples and close to 20,000 participants) and found that higher workgroup identification and higher organisational identification were reliably associated with better health (in each case, $r = .21$). Furthermore, the social identification–health relationship for indicators of both psychological and physical health were positive ($r = .23$ and $r = .16$, respectively).

Exploring the basis of this relationship, research has focused on showing that social group memberships are an important psychological resource because they provide the basis for such things as social support, a sense of belonging, control, self-efficacy and purpose (see Haslam et al., in prep, for an extended discussion). Moreover, there is now considerable evidence that the power of these psychological resources is unlocked and becomes much more pronounced to the extent that individuals identify strongly with the groups in question

(Greenaway et al., 2015, 2016; Haslam et al., 2005). For example, in seven studies with a diverse range of samples (e.g., former residents of a homeless shelter, school children in Britain and Australia, older adults in China and university students in the USA and China), Jetten and colleagues (2015) showed that it is primarily when people identify strongly with their group (and hence had internalised the group membership or social category as an important part of their self) that group membership predicted enhanced well-being (here measured as self-esteem). Similarly, in two longitudinal studies with recreation and therapy groups, Cruwys et al. (2014) found that the positive impact of joining these groups (i.e., lower depression) was more apparent for those who identified strongly with the group. On this basis Cruwys and colleagues conclude that “it would seem that it is not groups per se that cure depression, but rather groups with which we identify” (p. 145).

The role of group identification in affecting health and well-being is again central to all of the contributions in this special issue. Most of these examine the way that higher levels of identification predict or mediate a diverse range of positive health and well-being effects (see Table 1). For example, in a study of refugees in the Netherlands and immigrants in Spain, Bobowik and colleagues show that higher ethnic and host-society identification is associated with greater happiness and enhanced well-being. Likewise, in a sample of participants with autism, Cooper and colleagues find that even though these participants have lower personal self-esteem than controls, taking on board an autism identity is positively predictive of personal self-esteem.

At the same time, Bobowik and colleagues also provide evidence that the effects of group identification on well-being are dampened when higher perceptions of group

discrimination lead to disidentification with a targeted minority group or when perceived discrimination reduces identification with those that engage in the rejection (e.g., a host-society). In other circumstances, group identification has also been found to be more directly associated with harmful health and well-being effects. This is seen in Begeny and Huo's contribution to this special issue. On the one hand, this shows that among a sample of ethnic and sexual minority groups the more valued that individuals feel within their minority group, and the higher they perceive their status within the group (i.e., the more prototypical they are for the group), the higher their health and well-being. On the other hand, though, Begeny and Huo also show that higher intragroup status is associated with costs. Precisely because the individual feels valued by the minority group, the group becomes more important for defining their sense of self (so that they show enhanced minority group identification) and this enhances the likelihood that people will be sensitive to the negative treatment that their group receives. This counteracts (but does not entirely negate) the positive effect of group identification on health and well-being. Here then, it appears that precisely because the group is an important lens through which minority group members understand their lives, it is more difficult for them to not be affected by the discrimination and prejudice of others. As Begeny and Huo outline, the extent to which the benefits of group identification for health and well-being outweigh the costs thus depends on the nature of the identity and the broader social and historical context in which the group finds itself. These are points upon which we elaborate in the next section.

The Contribution of Intergroup Processes to Health and Well-being

The hypotheses that follow are all concerned with classic social identity theorising which states that the influence of the group on the individual will not be isolated from the broader intergroup context in which the group finds itself. This follows social identity theory's social comparison principle — that all groups determine their worth and standing by reflecting on how the ingroup compares to relevant outgroups (Tajfel & Turner, 1979). By extension, as the following hypothesis suggests, intergroup comparisons are consequential for the health and well-being of those who identify with the ingroup:

H3: The group circumstance hypothesis. When, and to the extent that, a person defines themselves in terms of a given social identity, their well-being will be affected by the state and circumstances of the group with which that identity is associated.

In particular, the status of a person's ingroup vis-à-vis other groups should be an important determinant of the extent to which group membership is associated with positive health and well-being consequences. It is easier to derive a positive identity from membership in a higher- than a lower-status group because high status confers benefits that enhance a sense of positive identity (e.g., power, resources, wealth). Consistent with this reasoning, generally speaking, research provides clear evidence that higher perceived social status is associated with higher self-esteem, life satisfaction, and general well-being as well as lower levels of anxiety and depressive symptoms (Anderson, Kraus, Galinsky & Keltner, 2012; Begeny & Huo, 2016; Sani, Magrin, Scrignaro & McCollum, 2010; Singh-Manoux, Marmot & Adler, 2005; Smith, Tyler, & Huo, 2003).

The effects of group status can also be clearly observed in the realm of sport and team performance. For example, Branscombe and Wann (1994) showed that sports fans' well-being (in terms of self-esteem) was enhanced when their team performed well, but

compromised when it performed poorly. In line with H2, these effects were also more pronounced to the extent that fans identified highly with their team. Relatedly, there is also a large body of research which shows that belonging to stigmatised groups, and being exposed to stigma and discrimination on this basis, is a particularly toxic threat to positive health and well-being (for meta-analyses see Paradies et al., 2015; Pascoe & Smart Richman, 2009; Schmitt, Branscombe, Postmes, & Garcia, 2014).

In educational contexts, there is also evidence that well-being is negatively affected for minority students whose low status becomes salient when they enter universities that are dominated by White students (Ethier & Deaux, 1994) or by middle- and upper-class students (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009). Along similar lines, Zhang, Jetten, Iyer, and Cui (2013) found that the self-esteem of low-status country workers' children in Shanghai primary schools was significantly lower than the self-esteem of advantaged city children (although the difference in well-being was less marked in integrated schools).

Not surprisingly, given the positive implications that high status has for well-being, group members generally try to make favourable, positive intergroup comparisons with outgroups. If they succeed, they will be able to achieve or maintain a positive identity and this will be reflected in higher well-being and higher self-esteem. However, if they fail and can only make negative intergroup comparisons that reinforce their ingroup's low standing, this will tend to have negative consequences for their well-being and self-esteem will be harmed. More specifically, we hypothesize:

H3a. When the group that defines a person's social identity is enhanced in some way (e.g., by success, high status, or advancement), social identity becomes a beneficial

psychological resource and tends to have positive consequences for their health and well-being.

- H3b. When the group that defines a person's social identity is compromised in some way (e.g., by stigma, low status, or failure), the capacity for social identity to function as a beneficial psychological resource is reduced and this will tend to have negative consequences for their health and well-being.

These two hypotheses lie at the heart of a number of the contributions brought together in this special issue. In line with H3a, Hopkins and Reicher show how taking part in mass gatherings and identifying with others who participate in them can enrich people's lives in ways that boost physical and mental health. Likewise, Kearns and colleagues show how identification with others who take part in a suicide prevention fundraiser can enhance positive affect (in particular, among those who have lost someone close as a result of suicide). Yet, in line with H3b, five papers show that well-being can be compromised by perceptions of group discrimination and stigma (Begeny & Huo; Bobowik et al.; Çelebi et al.; Cooper et al.; McNamara et al.) and two papers show that it can be compromised by threats to an ingroup's existence (Heath et al.; Muldoon et al.). Moreover, in the latter case, precisely because the social identity itself is under threat, the capacity for group identification to enhance health and well-being is significantly diminished (see also Crabtree, Haslam, Postmes, & Haslam, 2008).

However, it is important to bear in mind that even if the initial comparison with other groups is unfavourable, group members do not simply abandon the goal of trying to achieve a positive social identity (and thereby enhance their well-being). Indeed, much of group life involves engaging in strategic behaviour that aims to present one's own group in the most favourable light relative to other groups. Therefore, even when the broader social context

challenges a person's ability to derive a positive sense of social identity (e.g., because the ingroup is devalued or has low status), individuals will be motivated to engage in activities that enhance ingroup status (and, through this, their own status):

H4: The identity restoration hypothesis. People are motivated to restore positive identity when this is compromised by events that threaten or undermine their social identities (e.g., group failure, stigma, low status, or loss of valued group membership).

These processes are explored in the contribution by Muldoon and colleagues where, perhaps reflecting evidence of successful identity restoration, in the aftermath of an earthquake, victims report positive outcomes such as post-traumatic growth. Importantly for our present purposes, such positive outcomes are directly predicted by the extent to which individuals identified with the affected community and the extent to which they felt their community was effective in dealing with the disaster.

The way that group circumstances affect individuals' strategies for seeking to restore a threatened social identity are determined by the social structural conditions in which the group finds itself. The social identity approach focuses on three key structural features in particular: the perceived *permeability* of group boundaries, and the perceived *stability* and *legitimacy* of an ingroup's position in relation to other groups (Tajfel & Turner, 1979; see also Ellemers, 1993; Haslam et al., 2009). Permeability refers to the ease with which the boundaries between groups can be traversed (Armenta et al., 2017; Ellemers & van Rijswijk, 1997; Ellemers, van Knippenberg, & Wilke, 1990; Lalonde & Silverman, 1994; Wright, Taylor, & Moghaddam, 1990). When group boundaries are perceived to be permeable, members of a low-status group or a group that faces stigma and discrimination may aim to protect their health and well-being

by seeking out membership in a higher-status group. For example, smokers might see group boundaries between smoking and non-smoking groups to be permeable when they believe that they can pass into the non-smoking group by quitting smoking (see Jetten, Schmitt, Branscombe, Garza, & Mewse, 2011). Likewise, those who find themselves in substance-abusing groups may try to leave these groups and join a non-user group in an attempt to improve their health and the quality of their life more generally (Best et al., 2016; Dingle, Cruwys & Frings, 2015; Dingle, Stark, Cruwys, & Best, 2015). This leads to the following hypothesis:

H5: The social mobility hypothesis. When circumstances threaten, undermine, or preclude positive social identity, if people perceive group boundaries to be permeable they are likely to respond to the threat to positive identity through strategies of personal mobility.

Fernández and colleagues (2012) provide support for this hypothesis, revealing how having limb-lengthening surgery can be a strategy of individual mobility for people who suffer from skeletal dysplasias (a medical condition that leads them to have disproportionately short stature in the form of dwarfism). In particular, they found that in a sample of people in Spain who had this condition people were more likely to have limb-lengthening surgery to escape stigma and discrimination. In line with this, there was a negative correlation between the success of the surgery (i.e., people's limbs becoming longer) and perceptions of discrimination (Branscombe, Fernández, Gómez, & Cronin, 2011; Fernández, Branscombe, Gómez, & Morales, 2012).

Nevertheless, it turned out in this case that successful surgery was not associated with improved well-being. This is consistent with other evidence which indicates that health and

well-being are sometimes best protected by sticking with a devalued group and responding *collectively* to perceived discrimination. For example, Postmes and Branscombe (2002) found that Black Americans who engaged in individual mobility and tried to improve their status by moving out of Black communities were less accepted by their (new) ingroup and had lower levels of psychological well-being than those who did not move away. This was because by leaving their minority group behind, they had also lost an important source of social support. Indeed, the failure of strategies of individual mobility to boost well-being may help to explain why members of disadvantaged groups often forego opportunities to engage in individual mobility, even when these are clearly available (Tajfel, 1978).

To understand whether individuals will pursue opportunities for individual mobility and whether permeability of intergroup boundaries will be associated with poorer or better health outcomes, it is also important to consider the extent to which the relations between groups are perceived to be *secure* in the sense of being legitimate and stable (i.e., unlikely to change; Tajfel & Turner, 1979). In line with classic social identity theorising, this is associated with the following hypothesis:

H6: The social creativity hypothesis. When circumstances threaten, undermine, or preclude positive social identity, if people perceive group boundaries to be impermeable but group relations to be secure, they are likely to respond to the threat to positive identity through strategies of social creativity.

In particular, social identity theory suggests that members of low-status or disadvantaged groups can protect themselves from the negative consequences that ingroup status has for well-being by changing (a) the dimensions on which they compare their group with others, (b) the groups with which they compare their group, or (c) the way in which they

define the nature of ingroup identity. Support for this hypothesis is again found in studies of people who suffer from skeletal dysplasias — particularly in the US, where limb-lengthening surgery is rarely practiced. Here, those who have this condition are observed to respond to their condition by (a) defining themselves in terms of happiness rather than height, (b) comparing themselves with people who have other medical conditions rather than those who do not, and (c) self-defining as “Little People” rather than “Dwarfs”, (see Branscombe et al., 2012, p.124).

Yet when boundaries between groups are impermeable and status relations are *insecure* (because status differences are perceived to be illegitimate and/or the intergroup context is more unstable), members of lower-status groups are more likely to strive to protect or enhance health and well-being by engaging in social competition. This point is captured by the following hypothesis:

H7: The social competition hypothesis. When circumstances threaten, undermine, or preclude positive social identity, if people perceive group boundaries to be impermeable and group relations to be insecure they are likely to respond to the threat to positive identity through strategies of social competition.

Speaking to the efficacy of this strategy, Molero, Fuster, Jetten, and Moriano (2011) found that among people living with HIV in Spain the perception of group-based discrimination was associated with enhanced identification with this group. This then facilitated the willingness to tackle group-based discrimination collectively (i.e., collective action) which in turn was associated with enhanced well-being.

Although Hypotheses 4 to 7 are not directly tested in any of the papers in this special issue, taking account of these processes can help us understand when group identification is good for health as well as when it is harmful. Recognising this, Bobowik and colleagues

show that it is important to consider the role of the broader social structural context when seeking to understand the implications of group identification for health. In particular, to understand mixed findings for Latino, African, and Romanian immigrants in explaining how ethnic identification buffers well-being for some ethnic groups but not for others, these authors point to the importance of (a) the status of an ethnic group relative to the host-society, (b) historical and language factors that determine perceptions of group boundary permeability (and hence passing opportunities for members of ethnic minority groups), and (c) the security of group boundaries.

Self-Categorization Processes and Health and Well-being

Self-categorization theory (Turner, 1982; 1985; Turner et al., 1987, Turner, Oakes, Haslam, & McGarty, 1994) extends social identity theory by exploring the process that lead people to define themselves in terms of a particular social identity as well as the consequences of this for social perception and behaviour. With its focus on the *social cognitive determinants of self-definition and self-categorization*, self-categorisation theory is uniquely suited to helping us understand how the health and well-being of individuals is structured by a person's relationship to, and interaction with, social groups. In particular, at least three hypotheses can be derived from self-categorisation theory that are directly relevant to the question of how and why group memberships affect people's health (Turner et al., 1987; see also Haslam et al., in prep. for an in-depth discussion).

First, Turner and colleagues propose that the more that an individual self-categorises in terms of a given group membership at a particular point in time, the more likely they are to perceive themselves as categorically interchangeable with others who share that same group

membership — a process referred to as *depersonalisation* (Turner et al., 1987).

Depersonalisation does not mean that individuals are no longer able to recognise their own unique features (see Postmes & Jetten, 2006), but that at a given moment they are more focused on the ways in which they are similar to other ingroup members than on the ways in which they are different from them. In this way, depersonalisation heightens an individual's receptivity to the norms, beliefs, and values that ingroup members share (as opposed to those that are held individually or by outgroups). What is more, this receptivity in turn leads to a greater motivation to conform to, and act in accordance with, these group norms — particularly for those group members who identify highly with the group. This leads to the following hypothesis:

H8: *The norm enactment hypothesis.* When, and to the extent that, a person defines themselves in terms of a given social identity they will enact — or at least strive to enact — the norms and values associated with that identity.

This hypothesis can help us to understand when and why individuals sometimes engage in behaviour that is associated with positive health consequences (e.g., eating healthily, regular exercise) but also in behaviour that is damaging for health and well-being (e.g., binge drinking, drug taking). In line with this point, a growing body of research (some of which is conducted within the framework of the Theory of Planned Behaviour) provides evidence for the importance of group norms in shaping health behaviour (e.g., Åstros & Rise, 2001; Cruwys et al., 2012; Guendelman, Cheryan, & Monin, 2011; Louis, Davies, Smith, & Terry, 2007; Oyserman, Fryberg & Yoder, 2007; Smith, Louis & Tarrant, 2016; Tarrant, Hagger, & Farrow, 2012; White, Smith, Terry, Greenslade, & McKimmie, 2009, see also Cruwys, Bevelander & Hermans, 2015).

In this special issue, Hopkins and Reicher explore the implications of this hypothesis in an article that discusses normative influences on health behaviour in the context of one of the largest mass gatherings in India — the Prayag Magh Mela. More specifically, the research they review shows how the behaviour of pilgrims who attended this religious festival was structured by normative expectations that posed both risks and benefits for their health (e.g., drinking contaminated water from the Ganges water to cleanse and purify the soul).

Although the norm enactment hypothesis can explain why and when individuals conform to group norms (with potentially positive or negative consequences for their health), a question that remains is how these group norms develop and how they take hold. It is here that a second hypothesis from self-categorisation theory is important — one which suggests that shared social identity is crucial for processes of social influence (Turner, 1991). More specifically, the theory argues that perceiving oneself to share social identity with others is a basis for mutual influence. Shared identity is thus a basis for individual group members to influence other group members (e.g., through leadership) but also for them to be *influenced* (e.g., displaying followership that leads them to behave in ways that are consistent with group values, beliefs and norms; Haslam, Reicher, & Platow, 2011; Hogg, 2001; Reicher, Haslam, & Hopkins, 2005).

H9: *The influence hypothesis.* When, and to the extent that, people define themselves in terms of shared identity, they will be more likely to influence each other.

Nevertheless, it is also clear that ingroup members do not all have the same capacity to exert social influence: some are more influential than others. According to a third

hypothesis derived from self-categorization theory, this is because group members differ in the degree to which they are *prototypical* of the group — in the sense of features that define the group's meaning at a particular moment in time (Turner, 1985). Compared to more peripheral members, group members who are prototypical are therefore more successful in shaping the attitudes of others (Platow & van Knippenberg, 2001; van Knippenberg & Wilke, 1992) as well as in defining group norms (Oakes, Haslam, & Turner, 1999). This does not mean that peripheral group members cannot exert influence. Rather, the extent to which they influence others tends to be more conditional and depends on strategic and contextual considerations (e.g., Morton, Postmes, & Jetten, 2007, see also Ellemers & Jetten, 2013; Jetten & Hornsey, 2014). These various points thus lead to the following hypothesis:

H10: *The prototypicality hypothesis.* People will have more influence in defining the meaning of a given social identity to the extent that they are seen to be representative of that identity.

Compelling evidence that accords with the two preceding hypotheses is provided by Oyserman and colleagues (2007) in studies which found that health communication was more effective when communicators and recipients shared social identity than when they do not (see also Greenaway, Wright, Reynolds, Willingham, & Haslam, 2015). More particularly, a series of studies by Oyserman et al. (2007), showed that when the ethnic identity was salient for members of minority groups in the United States, they were more likely to reject healthy eating messages that emanated from outgroup sources (i.e., white middle-class sources).

Points pertaining to these hypotheses are also addressed in the research of McNamara and colleagues in this special issue with adolescents with a mental health diagnosis who are transitioning into an adult mental health service. In line with the influence hypothesis, their

thematic analysis suggests that service engagement depends to a large extent on the degree to which service providers are able to develop a sense of shared identity with these adolescents.

Social Identities as Psychological Resources

By applying principles derived from the social identity approach to the analysis of health and well-being it becomes evident that there is more to social identities than the applications to prejudice and stereotyping that were originally envisaged in classical statements of social identity and self-categorization theories. Indeed, and as noted above, in focusing on the relationship between social identities and health we have argued that it becomes important to consider the capacity for social identities to act as psychological *resources* (Greenaway et al., 2016; Jetten et al., 2012; 2014). That is, because social identities define who we are, provide us with meaning, purpose, and belonging, they provide us with important psychological ground on which to stand. When we are confronted with the slings and arrows of life's various identity-relevant challenges and threats (especially those which have adverse implications for health), this ground becomes particularly important because it provides us with the stability and strength to fight back.

It also follows from this idea that if one social identity has the capacity to act as a psychological resource, up to a certain extent, then there should also be a 'the more the merrier' effect such that further health benefits accrue to the extent that one has access to more than one social identity. Two social identities should thus be better than one, three should be better than two, and so on. Consistent with this reasoning, there is now considerable evidence for the additive health and well-being effects of an increasing number of social identities in a range of settings. The pattern is observed, for example, in patients

recovering both from stroke (Haslam et al., 2008) and from depression (Cruwys et al., 2013), in students entering university (Iyer et al., 2009; Jetten et al., 2015), in the cognitive health of older adults (Haslam, Cruwys & Haslam, 2014; Haslam, Cruwys, Milne & Haslam, 2014; Jetten et al., 2015) and retirement (Steffens et al., 2016), and in people who reside in homeless shelters (Jetten et al., 2015; Walter, Jetten, Dingle, Parsell, & Johnstone, 2015). There is also experimental evidence for a ‘the more the merrier effect’ whereby participants who are primed with a greater number of group memberships are subsequently found to be more resilient (Jones & Jetten, 2011). Importantly, though, these beneficial effects of multiple group memberships on health and well-being are only observed to the extent that the identities in question are compatible, positive, and important for the individual in defining themselves (see Brook, Garcia, & Fleming, 2008; Iyer et al., 2009). These ideas are integrated in the following hypothesis:

H11: *The multiple identities hypothesis.* Providing they are compatible with each other, important to them, and positive, the more social identities a person has access to, the more psychological resources they can draw upon and the more beneficial this will be for their health.

These observations raise two further questions. First, what exactly are the psychological resources that group membership provides? And, second, what are the processes through which these resources are unlocked?

Previous research informed by the social identity approach to health points to four key processes that are particularly important in helping us to answer these questions (see also Greenaway et al., 2016). First, one of the key psychological resources that is derived from social identity is a sense of *social connection* — the sense that one is psychologically close

to, and entwined with, other members of one's ingroup (e.g., Alnabulsi & Drury, 2014; Berkman & Syme, 1979; Cruwys et al., 2004; see also Cacioppo & Patrick, 2008). Second, because groups also spend much (in many cases most) of their time working towards particular collective outcomes this not only channels their attention and energy (Hopkins et al., 2016) but also gives them a sense of *common direction, meaning, and purpose* (Cruwys et al., 2014). More concretely, third, a sense of shared identity also lies at the heart of the provision and receipt of *social support* (Haslam, Reicher & Levine, 2012). This means, on the one hand, that individuals are more likely to give support to others to the extent that they recognise them as "one of us" (Levine, Prosser, Evans, & Reicher, 2005). Likewise, on the other hand, a sense of shared identity is a basis for interpreting support in the spirit in which it is intended and being in a position to benefit from it (Haslam et al., 2012). Finally, fourth, precisely because shared social identity tends to imbue individuals with the conviction that they have access to psychological resources that give them charge over their own fate, shared social identity is a basis for perceived personal control (Greenaway et al., 2015) as well as a *sense of collective efficacy, agency, and power* (Avanzi, Schuh, Fraccaroli, & van Dick, 2015; Drury & Reicher, 2005).

These four types of resource thus suggest the following hypotheses:

H12: *The connection hypothesis*. When, and to the extent that, people define themselves in terms of shared identity they will be more likely to perceive themselves as similar and connected and to be positively oriented towards (e.g., trusting of) each other.

H13: *The meaning hypothesis*. When, and to the extent that, people define themselves in terms of shared social identity, that identity will focus their energies and imbue them with a sense of meaning, purpose, and worth.

H14: *The social support hypothesis*. When, and to the extent that, people define themselves in terms of shared social identity, they will (a) expect to give each other support, (b) actually give each other support and (c) construe the support they receive more positively.

H15: *The agency hypothesis*. When, and to the extent that, people define themselves in terms of shared identity, they will develop a sense of collective efficacy, agency and power.

Most of the papers in this special issue provide support for these hypotheses in one way or another. However, this is seen especially in studies which observe groups or communities coming together to tackle collective challenges. For instance, in line with the connection hypothesis, Kearns and colleagues show that those who have lost someone close to suicide are better able to cope with their loss (in the sense of having enhanced positive affect after participating) the more they identify with, and feel a sense of shared identity among, others who take part in a suicide awareness event. In line with the meaning hypothesis, this in turn is likely to give them a greater sense of purpose and conviction. Cooper and colleagues also report for the connection hypothesis in the context of autism diagnosis. Here, greater identification with others who have autism is shown to be associated with a greater sense of worth as well as reduced anxiety and depression.

In line with the social support hypothesis, Hopkins and Reicher describe a series of studies among Kalpwasis (i.e., participants at mass gatherings) in which the various difficulties that these individuals confront (e.g., illness, coldness) are perceived by high identifiers as collective challenges that invite and facilitate social support provision and social support acceptance. In line with the meaning hypothesis, shared identity as pilgrims is also shown to enhance the significance of the event so that the health challenges it presents

are not simply endured, but actively enjoyed and cherished — precisely because they are experienced as identity-affirming (see also Hopkins & Reicher, 2016; Srinivasa, Tewari, Makwana, & Hopkins, 2015).

Further support for these hypotheses is provided by the work of Çelebi and colleagues with Syrian refugees in Turkey. Here Syrian identity is found to only unlock positive well-being effects for highly identified refugees who derive psychological resources from their identity in the form of a sense of belonging and continuity. In line with the agency hypothesis, this research also shows that deriving a sense of efficacy from Syrian identity is an important protective factor when it comes to responding to group-based discrimination. Specifically, perceived ethnic discrimination was generally associated with poorer mental and physical health (as one would expect), but this harmful relationship was less pronounced for those whose strong sense of Syrian identity gave them a sense of enhanced self-efficacy.

Several other contributions provide further support for the support and agency hypotheses in the process of drawing attention to the way in which social identity allows people to stand strong in the face of adversity. In particular, Muldoon and colleagues show that perceptions of collective efficacy in the aftermath of the 2015 Nepalese earthquakes were not only associated with greater post-traumatic stress, but also with post-traumatic growth. Likewise, in the context of residential regeneration, Heath and colleagues show that processes of regeneration which enhance community voice and identification, are associated with positive implications for well-being because they are positively associated with perceptions of social support and self-efficacy.

Advancing the Social Cure Agenda

It is clear from the foregoing review of its contents that this special issue of the *European Journal of Social Psychology* brings together exciting new research that explores and further articulates the role of social identity processes in health and well-being. As we noted at the outset, this is partly a reflection of a recent surge of interest in health phenomena among social psychologists. In particular, however, it is testament to widespread recognition that the social identity approach — a body of theory originally proposed to understand problems of prejudice and intergroup conflict (Turner & Reynolds, 2001) — has broad applicability to domains that were previously dominated by medical and other health practitioners.

The contributions in this special issue not only are indicative of the excellent work that is being done to explore the role of social identity in health and well-being, but also serve to showcase the enormous breadth of questions, samples, and applications to which the approach can be turned. Yet despite this diversity, it is also clear that each of these contributions speaks more or less directly to key hypotheses that can be derived from classic social identity theory and/or self-categorization theorising. Our hope is that organizing the contributions around these hypotheses serves to highlight their unique contributions to specific social cure hypotheses as well as their connection to this broader theorising.

Clearly too, these hypotheses — and the lines of research that speak to them — define an ongoing agenda for social cure research. The work we have brought together here advances that agenda and enhances understanding of the social identity-based determinants of health in at least three important ways. First, it draws attention to the idea that although social identities have the capacity to act as social cures, they can also constitute social curses that

have harmful consequences for health. Second, in this it helps us to understand *when* social identities are likely to have these divergent consequences. Third, by exploring the processes that are implicated in these different outcomes, it helps us to understand *why* they emerge.

In short, by clarifying the specific psychological resources that social identities unlock we are now in a much better position to understand their role in a range of settings and health and well-being outcomes. And so it is that while the previous special issue we edited on this topic referred to “an emerging agenda” (Haslam et al., 2009), eight years on, we can now say that this agenda has well and truly emerged. Thankfully, as one can see from this special issue, the task of responding to, progressing and advancing this agenda is one to which an increasing number of accomplished researchers are turning their hand.

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Table 1: Overview of articles included in this special issue

<i>Authors</i>	<i>Hypotheses addressed</i>	<i>Sample (location)</i>	<i>N</i>	<i>Method</i>	<i>IVs</i>	<i>DVs</i>	<i>Mediators (Med) & Moderators (Mod)</i>
1. Begeny & Huo	1, 2, 3b	Ethnic & sexual minorities (USA)	150 + 249	Longitudinal and cross-sectional surveys	Intragroup status	Mental health	Med = Identity centrality/importance, identity salience and perceived discrimination
2. Bobowik, Martonovic, Basabe, Barsties, & Wachter	1, 2, 3b, 4-7	Refugees (Netherlands); Immigrants (Spain)	2446 + 1234	Cross-sectional surveys	Perceived discrimination	Well-being	Med = Ethnic identification and host national identification
3. Çelebi, Verkuyten, & Bağcı	1, 2, 3b, 12, 13, 15	Syrian refugees (Turkey)	361	Cross-sectional survey	Syrian identification; Perceived discrimination	Life satisfaction; Physical health; Depression; Anxiety	Mod = Identity needs (efficacy, belonging)
4. Cooper, Smith, & Russell	1, 2, 3b, 12	Individuals with autism and controls (England)	272 + 267	Cross-sectional surveys	Autism identification	Personal self-esteem; Anxiety; Depression	Med = Collective self-esteem
5. Heath, Rabinovich, & Barreto	1, 2, 3b, 14, 15	Residents living across five deprived urban areas (England)	104	Cross-sectional survey	Regeneration type,	Well-being; Resilience; Willingness to pay back	Med = Identification, self-efficacy, collective self-esteem, personal esteem, social support

6. Hopkins & Reicher	1, 2, 3a, 8, 12, 13, 14	Participants in mass gatherings (the Prayag Magh Mela in India)	37	Ethnographic observation and interviews as well as longitudinal and cross-sectional surveys and experiments	Shared identity; Identity challenge (e.g., loud noise, physical hardship)	Well-being; Positive affect, Normative behaviour	Med = Identification, social support, meaning making
7. Kearns, Muldoon, Msetfi, & Surgenor	1, 2, 3a, 12, 13	Participants in a suicide prevention fundraiser (Ireland)	3595 + 121	Cross-sectional and longitudinal surveys	Positive affect at Time 1	Positive affect at Time 2	Med = Crowd identification, Mod = Exposure to suicide
8. McNamara, Coyne, Ford, Paul, Singh, & McNicholas	1, 2, 3b, 9, 10	Adolescents, and their parents attending Child & Adolescent Mental Health Services; Child and adult psychiatrists (Ireland)	11 + 5; 11 + 8	Thematic analysis	Adoption of an illness identity	Service engagement and disengagement	Med = service engagement as identity congruent
9. Muldoon, Acharya, Jay, Adhiikari, Pettigrew, & Lowe	1, 2, 3b, 15	Earthquake survivors (Nepal)	399	Cross-sectional survey	Community identification; Earthquake experience	Post traumatic stress; Post-traumatic growth	Med = Collective efficacy, community identification

Figure 1. Number of journal articles on social identity and health from 1990-2015, as captured by Web of Science in 2016

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