Personality and Social Psychology Compass

When Groups Help and When Groups Harm: Origins, Developments, and Future Directions

of the 'Social Cure' Perspective of Group Dynamics

Juliet R .H. Wakefield

Mhairi Bowe

Blerina Kellezi

Niamh McNamara

&

Clifford Stevenson

Department of Psychology, Nottingham Trent University, England

Word count (excluding Title Page, Abstract, and References):4995

Corresponding Author: Juliet R. H. Wakefield, Department of Psychology, Nottingham Trent

University, 50 Shakespeare Street, Nottingham, NG1 4FQ. Email: juliet.wakefield@ntu.ac.uk

Abstract

A substantial literature supports the important role that social group memberships play in enhancing health. While the processes through which group memberships constitute a 'Social Cure' are becoming increasingly well-defined, the mechanisms through which these groups contribute to vulnerability and act as a 'Social Curse' are less understood. We present an overview of the Social Cure literature, and then go beyond this to show how the processes underpinning the health benefits of group membership can also negatively affect individuals through their absence. First, we provide an overview of early Social Cure research. We then describe later research concerning the potential health benefits of identifying with multiple groups, before moving on to consider the 'darker side' of the Social Cure by exploring how intra-group dynamics can foster Curse processes. Finally, we synthesise evidence from both the Cure and Curse literatures to highlight the complex interplay between these phenomena, and how they are influenced by both intra- and inter-group processes. We conclude by considering areas we deem vital for future investigation within the discipline.

1. Introduction

Our social worlds seem larger, more connected, and more instantaneously available to us than ever before. Nevertheless, research suggests that large subsets of the population, at least in the Western world, are experiencing the detrimental effects of loneliness and isolation (Durcan & Bell, 2015; APA, 2017). Labelled a present-day 'social epidemic' (Killeen, 1998), loneliness has been linked with chronic illnesses such as dementia (Wilson et al., 2007), heart disease (Valtorta, Kanaan, Gilbody, Ronzi, & Hanratty, 2016), and depression (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006), and both loneliness and isolation have been linked with increased mortality (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Tackling isolation and loneliness is thus high on policy-makers' agendas, and movements that recognise social and environmental predictors of ill-health (e.g., 'social prescribing'; Brandling & House, 2009; Halder et al., 2018) have gained momentum. Until recently, however, little consideration has been given to *why* isolation and loneliness might be so problematic.

Social psychologists have begun to remedy this over the last decade, developing theories that allow policy makers to appreciate the importance of meaningful connection with others. In this article, we present a growing body of work in the social identity tradition, aptly labelled the 'Social Cure' (Jetten, Haslam, & Haslam, 2012), that has provided an inherently social analysis of health and well-being. However, we also present research that explores the costs of group life. Together, these bodies of work recognise the dual potentials of group identities as both 'Social Cures' and 'Social Curses'. We also seek to explore the complex interplay between these phenomena, and how they are influenced by intra- and inter-group processes.

Extending sociological theory, Social Cure researchers suggest that simple social integration (i.e., being a member of various social groups, and experiencing contact with

members of those groups) cannot account for observed relationships between social networks and health (e.g., Cohen, 2004). Instead they provided a theoretical framework that rests on the notion of *social identity* (Tajfel & Turner, 1986). Together, Social Identity Theory (Tajfel & Turner, 1979) and Self-Categorisation Theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) have defined and elucidated this social dimension of self, and evidenced the emotional, cognitive, and behavioural impact of the sense of 'we-ness' that results from belonging to the groups that form our social worlds (see Hornsey, 2008). Social Cure researchers suggest that social groups have a positive impact on individuals because processes of social identification make them meaningful and psychologically valuable (Jetten et al., 2012). These assertions have been supported by research evidence demonstrating that group identification (the subjective sense of belonging to one's group) is connected to well-being, even after controlling for social integration (e.g., Sani, Herrera, Wakefield, Boroch, & Gulyas, 2012). Over the last decade, a wealth of research has added further weight to the claim that identification with meaningful social groups is associated with a vast array of both physical and psychological health outcomes.

However, social psychology has also highlighted the potential for social groups to foster conditions that are detrimental to well-being. Existing research shows that social processes such as stigma, discrimination, and inequality can lead to poor health outcomes (e.g., Major & O'Brien, 2005), and Social Cure research is beginning to reveal the potential for group experiences more aligned with so-called *Social Curse* phenomena (Kellezi & Reicher, 2012) than *Social Cure* phenomena. For example, while receiving social support is integral to Social Cure processes, very different outcomes occur when support is actively withheld (e.g., Kellezi & Reicher, 2012; Stevenson, McNamara, & Muldoon, 2014). These findings suggest there is much left to understand about the impact of group processes and social context on experiences of Social Cure and Curse phenomena.

Given these considerations, our aims are three-fold. First, we summarise the social identity approach to health by drawing together the primary insights of Social Cure research from its inception to present-day developments. Second, we present observations from the growing literature on Social Curse processes. Third, we synthesise evidence from both bodies of literature to highlight the complex interplay between these phenomena, and conclude by considering areas we deem vital for future investigation.

2. Early Work: Social Group Memberships and Stress Appraisal

Much of the early Social Cure research focussed on the idea that social groups have the potential to affect the extent to which we perceive situations as stressful. This work developed from the transactional model of stress (Lazarus & Folkman, 1984), which posits that when a person encounters a stimulus, they engage in *primary appraisal* by deciding whether the stimulus is threatening. If they decide it is threatening they engage in *secondary appraisal* by considering whether they feel able to cope with the threat. Stress levels remain low if they decide they can cope, but become high if they decide they cannot. This model has been influential in developing understandings of stress and coping (e.g., Trawalter, Richeson, & Shelton, 2009).

There is much potential for social identity factors to influence stress appraisal, and this was a key theme within early Social Cure research. Haslam, Jetten, Cruwys, Dingle, and Haslam (2018) note that as well as engaging in stress appraisal from an individualistic perspective ('*Is this a threat to me? Can I cope?*') we also engage in appraisal from the perspective of our currently-salient ingroup membership ('*Is this a threat to me as a member of my family? Can we cope?*'). This means there is potential for appraisal to be intimately related to our social group memberships.

This is demonstrated in work by Haslam, Jetten, O'Brien, and Jacobs (2004). Before engaging in a potentially-stressful mathematics task, participants watched a video of a woman talking about her experiences of the task. She either described it as stressful or as enjoyable. Importantly, the woman was presented to some participants as an ingroup member (a fellow student) or as an outgroup member (a person with a stress disorder). Participants in the ingroup condition who heard the woman describe the task as stressful experienced more task-related stress than those who heard the woman describe the task as enjoyable. In the outgroup conditions, participants' stress levels were relatively high (although not as high as in the ingroup stressful message condition) and were unaffected by message contents. This finding has been replicated by Gallagher, Meaney, and Muldoon (2014), who also showed that the manipulations affected blood-pressure and heart-rate in the same way as perceived stress levels. Thus, compared to outgroup members' opinions, ingroup members' opinions regarding threat levels are given more credence, and thus have more impact on primary appraisal.

Social identity processes can also affect secondary appraisal, predominantly through social support provision (e.g., emotional, instrumental, or informational support). We are more likely to provide social support to ingroup than outgroup members (Levine, Prosser, Evans, & Reicher, 2005; Wakefield et al., 2011), and are more likely to accept help from ingroup members in the positive sprit in which it was intended (Haslam, Jetten, Postmes, & Haslam, 2009). The Social Cure perspective highlights the potentially transformative nature of the social support we receive from group members, and how such support helps us cope with stress. For instance, Haslam, O'Brien, Jetten, Vormedal, and Penna (2005) recruited participants recovering after heart surgery, as well as participants with stressful jobs (bar staff and bomb disposal officers). The more participants identified with their social group (family/friends and work group respectively), the more social support they perceived

themselves as receiving, the higher they rated their life/job satisfaction, and the lower they rated their stress levels. Further evidence for the important effects of social identity processes on secondary appraisal is provided by Ysseldyk, McQuaid, McInnis, Anisman, and Matheson (2018), who showed that ingroup ties were negatively associated with the use of ruminative coping to deal with stressful events, which in turn was negatively associated with stress-related inflammatory immune-system responses. Together, these findings suggest that group identification can shield people from the negative effects of stress, allowing them to feel more able to cope.

This is also seen in Branscombe and colleagues' Rejection-Identification Model (Branscombe, Schmitt, & Harvey, 1999), which proposes that perceived discrimination from the majority group can result in minority group members experiencing increased ingroup identification, which in turn buffers them from the negative health consequences of discrimination. This effect has been observed in international students (Schmitt, Spears, & Branscombe, 2003), multiracial groups (Giamo, Schmitt, & Outten, 2012), and women in traditionally 'masculine' occupations (Redersdorff, Martinot, & Branscombe, 2004).

Both primary and secondary social identity-related appraisal processes have also been investigated in the aftermath of extreme events. In their survey research with war survivors, Kellezi, Reicher, and Cassidy (2009) found that those who primarily appraised the war as national-identity affirming (understanding the suffering as having the purpose of ending oppression and fostering freedom) experienced less depression and anxiety (and received more family support) than those who did not appraise the war as national-identity affirming. This relationship between appraisal and well-being was mediated by family support (i.e., secondary appraisal). The meaning given to the experience is therefore important, but so is the connection that comes from sharing the hardship. Supporting this, Drury and colleagues (2009, 2016) showed the importance of shared experiences in creating a sense of common

fate and encouraging help-giving in emergencies such as the 2005 London bombing and the 2015 Chilean earthquake.

3. Later Developments: Multiple Group Memberships, Group Norms, and Groups4Health

There is also evidence to support the idea that there is an additive effect of identifying with *multiple* groups, and much of the later Social Cure work has focussed on this. For instance, Sani, Madhok, Norbury, Dugard, and Wakefield (2015a, 2015b) recruited a large community sample and found a positive relationship between number of group identifications and healthy behaviour, and between number of group identifications and mental health. Similar findings have been obtained in adolescent samples (Miller, Wakefield, & Sani, 2015; 2016).

Haslam et al. (2008) suggests that multiple group identifications are particularly beneficial because different groups provide different types of social support, meaning that the individual can feel more confident in the belief that relevant social support will be forthcoming when needed. The 'healthy' norms of some groups may also outweigh the 'unhealthy' norms of other groups, encouraging healthy behaviour (Miller et al., 2016). Moreover, if a membership is lost, other memberships will be available to compensate for this loss. This is particularly relevant during life transitions (where group loss is likely), such as becoming a student (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009), a mother (Seymour-Smith, Cruwys, Haslam, & Brodribb, 2017) or recovering from stroke (Haslam et al., 2008). The Social Identity Model of Identity Change (Iyer et al., 2009) outlines how group memberships can both promote and undermine well-being during transitions, and shows that gaining new group memberships and maintaining old ones is key to promoting well-being during these times. Acquiring a new group membership promotes adjustment to transition by providing access to psychological resources. This can replace the support that is

lost when circumstances surrounding the transition make it difficult to maintain important group memberships. It is also likely that the nature of the transition dictates whether the health benefits flowing from group memberships are driven by maintaining or acquiring groups. For instance, research illustrates that multiple identities post-retirement are particularly important for retirees' health and well-being (Steffens, Cruwys, Haslam, Jetten, & Haslam 2016), while maintaining existing groups is important for new mothers (Seymour-Smith et al., 2017).

There is also evidence that some group memberships may be 'gateways' that promote membership of other groups, thereby enriching one's social landscape. For instance, Kearns, Muldoon, Msetfi, and Surgenor (2018) found that religious group identification was associated with stronger community identification. Moreover, Walsh, Muldoon, Gallagher, and Fortune (2015) recruited participants with acquired brain injury and found that affiliative identity (driven by belonging to a social group) fostered social support, which in turn enhanced 'self-as-doer' identity (driven by things that one does). There can thus be complex interactions between the groups in one's social network, especially during transitions.

Moreover, ingroup support processes can be actively harnessed with the aim of improving well-being or assisting individuals during difficult transitions. The Groups4Health social identity intervention is designed with this aim in mind, and has been shown to result in mental health improvements amongst young adults with affective disturbances by helping them to develop new group memberships and strengthen pre-existing ones (Haslam, Cruwys, Haslam, Dingle & Chang, 2016).

4. The Darker Side of the Social Cure: Intragroup Social Curse Processes

While the range of benefits afforded by group identification is well-documented, there is also evidence of ingroup processes being detrimental for well-being. Described by Kellezi

and Reicher (2012) as The Social Curse, these contexts involve groups being a burden rather than a resource, and can thus negatively affect both primary and secondary stress appraisal. As discussed earlier, group dynamics are integral to stress appraisal, and while groups can help us feel worthy, capable, and supported in the face of stressors, they can also make us feel unworthy, incapable, and unsupported. As with Social Cure, these processes are dynamic and likely to impact through various mechanisms. The Integrated Social Identity Model of Stress (Haslam & Reicher, 2006) provides clear predictions concerning the contexts within which these differing outcomes may occur. For instance, if group boundaries are perceived as permeable then group members are unlikely to identify strongly with the group, and are likely to leave the group to avoid stressors. However, if group boundaries are perceived as impermeable then group members must stay and address stressors, and are thus likely to identify strongly with the group. Collectivistic strategies therefore occur, such as social creativity (e.g., denial of inequalities) or social competition (e.g., confronting the outgroup), and ingroup support will be relatively high, thus facilitating positive secondary appraisal. In the BBC Prison Study (where the model has been tested most extensively; Reicher & Haslam, 2006) the 'guards' within the simulated prison environment are an example of the former type of group, while the 'prisoners' are an example of the latter. Once the prisoners realised they could not escape their stressor (inequality and poor treatment by the guards) they worked together and supported each other, leading to higher group identification and a sense of being able to challenge the source of their stress (the guards). Ultimately, the Integrated Social Identity Model of Stress indicates that the experience of stress within group contexts is multi-faceted: while groups can be an important source of strength when members are able to band together and work effectively at solving/reframing stressors (so they feel supported and capable), groups can exacerbate (and even create) stress if such processes fail to occur (so they feel distressed and incapable).

Even the availability of social support does not inevitably prevent Social Curse processes, as evidenced by Kellezi et al.'s (2018) work with immigrants in UK Immigration Removal Centres. Despite reporting high distress, some detainees did not want to share their negative experiences with family and friends for fear of upsetting them, which led to a lack of desperately-needed social support. Many individuals avoided interaction with fellow detainees for the same reason (or because observing others' distress upset them), even though these detainees were ideally positioned to provide meaningful support: a finding consistent with Johnstone, Jetten, Dingle, Parsell, and Walter's (2016) research with homeless people in shelters. Thus, group support can be beneficial unless individuals become concerned with the cost this support has on the group's members. This has implications for primary appraisal (i.e., perceived severity of the situation) and secondary appraisal (i.e., coping strategies) in times of distress or transition.

Another way that groups may negatively affect members is through 'unhealthy' norms. Strongly-identifying members are particularly motivated to adhere to group norms, even though these behaviours have the potential to foster ill-health and to increase the individual's vulnerability to stressors at both stages of the appraisal process. For instance, Livingstone, Young, and Manstead (2011) found that UK students who strongly identify with their student group (where drinking is a group norm) reported stronger drinking intentions, while Howell et al. (2014) showed that students who were more central within the emerging student network tended to engage in more binge drinking. This is also true for stigmatised groups with unhealthy or anti help-seeking norms, such as Cruwys and Gunaseelan (2016) showing that identifying as depressed is a negative predictor of well-being, or Kearns, Muldoon, Msetfi, and Surgenor's (2015) finding that students who identified strongly with their university perceived help-seeking from the university mental health service particularly stigmatising. Such norms thus have the potential to negatively affect both primary and

secondary stress appraisal, thereby increasing the chances of group members experiencing ill-health and reduced well-being.

5. The Complex Interplay Between Cure and Curse Processes

While we have outlined how groups can be both cures and curses to their members, this can be seen as a false dichotomy. Rather than classifying groups as unproblematically beneficial or costly for health, recent studies provide a more nuanced understanding of how group memberships both enhance resilience and contribute to vulnerability, and how to promote the Social Cure and defeat the Social Curse. While more work is needed on these topics, we present current research in three key areas: (1) the fluid and contested boundaries of groups, (2) the creation of ingroup divisions, and (3) the dynamic interplay of inter- and intra-group processes.

Fluid & Contested Boundaries of Groups

Groups are not static: they evolve over time and in response to social context. Members can actively construct and negotiate their group's boundaries to be more or less inclusive. This re-defining of who 'we' are can have significant implications for health and well-being. One way in which groups can benefit a broader number of people is through the active or strategic extension of their boundaries. This can result in inclusion of former outgroup members (e.g., Gaertner, Dovidio, Anastasio, Bacham, & Rust's (1993) Common Ingroup Identity Model). In Social Cure terms, this means that greater numbers of people receive ingroup support, as evidenced by Levine et al. (2005), who showed that making a soccer supporter identity salient can serve to extend help to all soccer fans, regardless of their competing teams. Similarly, Stevenson and Sagherian-Dickey (2016) showed how incomers who came to identify with their newly-desegregated neighbourhoods in post-conflict Northern Ireland were able to avail themselves of the advice and support of their new

neighbours. This new identity was neighbourhood-based and transcended traditional ethno-political divides. This extension of group boundaries can even have life-saving implications: Reicher, Cassidy, Wolpert, Hopkins, and Levine (2006) analysed documents from World War II and showed how constructing the boundaries of the Bulgarian nation to explicitly include the vulnerable subgroup of Jewish Bulgarians served to protect them against deportation. In effect, the Social Cure and the health benefits that arise from ingroup processes can be expanded by extending group boundaries to include former outgroup members.

Some caution is needed when assuming that this boundary extension automatically results in the former outgroup beginning to perceive themselves as ingroup members. As seen in previous Social Cure research, particularly in the context of Northern Ireland, groups may differ in the degree to which they see themselves and others as belonging to a common category (Lowe & Muldoon, 2014; McNicholl, Stevenson, & Garry, 2018). Moreover, as the Optimal Distinctiveness Model posits, members may strive for differentiation if they feel they have been forced to join a large and undefined social category (Brewer, 1991). There is also the possibility of members of smaller subordinate groups projecting their own characteristics onto the superordinate group, which can cause conflict between subordinate groups (Wenzel, Mummendey, & Waldzus, 2008). Therefore, it is not re-categorisation per se, but the *reason* for re-categorisation that is predictive of health and well-being outcomes. If re-categorisation is forced upon groups (as in the case of organisational restructuring and mergers, see Jetten, O'Brien, & Trindall, 2002) and members are highly identified with their subgroup, then well-being will likely suffer as a consequence.

While group boundaries can be extended, groups can also strategically *withdraw* membership of the group from select group members, thereby creating ingroup divisions. While a subgroup might intentionally break away from a larger group (Sani, 2008), and

indeed this might be beneficial for these group members' well-being, the *active exclusion* of former ingroup members can have detrimental effects.

The Creation of Ingroup Divisions

When groups splinter and divide (such that some group members are actively excluded from the group) former group members lose ingroup support. Not only that, but support is actively denied to these individuals on the basis of a new inter-group divide. Kellezi and Reicher (2012) evidenced this amongst war survivors in work inspired by classical Black Sheep Effect studies (where norm-violating ingroup members are treated even more harshly than outgroup members seen to violate these norms; Marques, Yzerbyt, & Leyens, 1988). They found that those who considered their war experiences to run counter to societal norms (e.g., a man who felt he had failed to protect his family in a society that values male protectors or a woman who experienced sexual assault in a society that values sexual purity) experienced shame and guilt, and perceived the events as more severe. Moreover, they were refused ingroup support and experienced social exclusion, thereby making the war an act of aggression perpetrated by members of the outgroup (via gender-based violence) *and* the ingroup (via social exclusion): a 'double insult' (Kellezi & Reicher, 2014).

Such divisions are also seen in the everyday context of service use. In most societies, health, education, and other vital services are provided to all citizens. However, successful service engagement depends on the identity dynamics between user and provider, with a shared sense of identity between both parties leading to positive interactions (Haslam, Branscombe, & Bachman, 2003; Haslam, Reicher, & Levine, 2012). This can be undermined by ingroup divisions, however. For example, the wider community can be divided along ethnic lines, with potentially negative outcomes for service users in minority groups. Indeed, White patients report greater service satisfaction and more trust in specialist mental health services than Black and Minority Ethnic patients (Singh et al., 2013), while General

Practitioners hold longer appointments and exchange more information with patients with whom they share a similar socio-economic status and ethnic background (Johnson, Roter, Powe, & Cooper, 2004).

This sense of exclusion is exacerbated by stigma. Stevenson et al. (2014) analysed disadvantaged community members' accounts of negative interactions with service providers, demonstrating that stigmatisation serves to reverse Social Cure processes. Stigma effectively creates ingroup divisions and transforms a supportive ingroup encounter into a strained inter-group encounter, as service users come to expect negative treatment from service providers on the basis of their community background. This undermines trust and co-operation, and leads to a vicious circle of misunderstandings, disengagement, and conflict. Such conflict can be overcome, however, as Bowe et al. (2018) has shown in the context of UK foodbanks. By reinforcing inter-group commonalities such as shared humanity, volunteers were able to foster positive foodbank helping transaction experiences for clients (a highly stigmatised identity), thereby paving the way for Social Cure processes.

The Dynamic Interplay of Inter- and Intra-group Processes

The study of Social Cure processes at group boundaries captures dynamic and evolving processes occurring between, as well as within, groups. Social Psychology is typically poor at examining the interactions between intra-group processes and inter-group dynamics (Dovidio, 2013). However, recent research in this field can attest to the ways in which the Social Cure approach can transcend these artificial divisions by exploring how intra-group processes are both shaped by, and shape, inter-group dynamics. A good example of this is the Social Identity Model of Identity Change analysis of identity transition discussed above (e.g., Iyer et al., 2009), whereby individuals exit one group (e.g., employee) and enter another (e.g., retiree).

Such transitions can be complicated by poor inter-group relations between pre- and post-transition groups (McNamara et al., 2017). Strained inter-group relations can undermine the quality of ingroup support provided to individuals experiencing a life transition. This has been illustrated in recent research that explores the transition from child to adult mental health services from a social identity change perspective (McNamara et al., 2017). Fractious inter-group relationships between clinicians in child and adult mental health services meant that each healthcare team had little understanding of the other's service delivery model, or the care packages provided by the other team. This undermined the quality of support provided by the child mental health team to transitioning young people. Poor informational support from an ingroup combined with the suggestion from that trusted (ingroup) source that the adult service (the post-transition group) will be ill-prepared to help them manage their illness deepened the anxiety experienced by these young people. The nature of inter-group relationships thus undermined the ability of the ingroup to support a successful transition in this instance.

Residential diversification is also a process best understood by considering the dynamics occurring both within and between groups. Residential moves are often experienced by the mover as a single identity transition, but may be perceived by the local community as part of the wider experience of diversification and inter-group contact. Stevenson et al.'s (2018) analysis of community integration in Northern Ireland shows that inter-group behaviour between long-term residents and newcomers (welcoming or rejecting) depends on residents' perceptions of the new arrivals as compatible or incompatible with their community. Thereafter this forms the context for the experience of incomers attempting to fit into their new locale. In sum, Social Cure/Curse processes often occur within the context of complex inter- and intra-group processes. Further research is needed to gain a fuller understanding of the impact of these phenomena.

6. Discussion and Future Directions

The Social Cure perspective sheds light on the much-evidenced (but poorly understood) link between groups and well-being. The evidence underpinning the perspective is substantial: across the domains of healthcare, employment, community life, and sporting achievement, psychologically meaningful group memberships have been shown to impact positively on well-being (Haslam et al., 2012, 2018). In their recent book *The New Psychology of Health*, Haslam and colleagues group this evidence under 15 broad hypotheses, presenting research showing that groups are central to well-being and ill-health (H1) and can provide members with meaning and self-worth (H13), and that members will be motivated to restore their identity if it is lost (H4). However, the effects of groups on their members are contingent upon members' identification (H2) and so, for example, healthy or unhealthy norms will be enacted to the extent that members identify with the group (H8). Groups also impact upon well-being through transforming relations between group members, such that sharing an identity will facilitate social influence (H9), and leadership by prototypical members who are seen to best exemplify the group (H10). Shared identity is also predicted to facilitate perceptions of similarity and trust between members (H12) as well as fostering reciprocal bonds of support (H14) and collective agency (H15). The impact of groups upon members' health also depends upon inter-group relations: enhancements or declines in relative group status will impact upon member well-being (H3) while, in situations of inequality, group members will exit if group boundaries are permeable (H5), engage in social creativity if boundaries are impermeable or stable (H6), and engage in competition if boundaries are impermeable or unstable (H7). This framework of hypotheses therefore clearly sets out the processes whereby groups impact upon the health of their members, as well as the boundary conditions under which groups will fail to benefit members, or even negatively affect their health.

The initial sections of our review explored these processes, while the final section built upon this framework by highlighting three broad areas where research within the Social Cure tradition can be developed and enhanced. The first is the fluid and contested boundaries of groups; the second is the division that can occur within groups; the third is the dynamic interplay of inter- and intra-group processes. We end this concluding section by discussing a final topic we feel to be worthy of future research: the *transformative power* of the Social Cure.

We argue that the Social Cure approach could provide a more politically transformative model of group processes than has been hitherto considered. The development of interventions such as Groups4Health allowed group processes to be actively harnessed towards helping individuals cope with loneliness and transition. We suggest that this could be taken further by considering how groups can be empowered to identify, address, and overcome societal challenges. Following on from Haslam et al.'s (2018) H9 (that shared identity facilitates leadership processes), H15 (that shared identity can give rise to efficacy, agency, and empowerment) and H7 (that groups can engage in competition), we suggest that attention be paid to the processes underpinning the emergence of collective action and social change. Indeed, groups could use Social Cure dynamics (as outlined in the hypotheses above) to harness the positive potential of their group, (re)define their identities towards collective action, set their own agenda, and ultimately overcome social challenges.

A good example of this is the fate of deprived communities facing identity-based stigma (Stevenson et al., 2014). Often a community's social disadvantage is compounded by stereotypes of dependency, aggression, or criminality. A key challenge is thus how to mobilise a community which possesses a stigmatised identity so that it can begin to enhance its status. The reality is that redefining a reputation from a position of powerlessness is complex and painstaking, but an understanding of Social Cure processes could provide a

starting point. For instance, identifying potential community leaders and scaffolding activities

to help the community muster its identity resources could be transformative, and in turn could

strengthen community members' coping abilities and resilience, as well as ultimately

enhancing their health and well-being. While this is primarily a political rather than a

therapeutic goal, we argue that by transforming the social structure and challenging

conditions of disadvantage, the Social Cure could also become a Societal Cure, thereby

allowing the group-related benefits we have discussed in this paper to enhance the lives of

people living in communities across the globe.

References

American Psychological Association. (2017, August 5). Social isolation, loneliness could be greater threat to public health than obesity. *ScienceDaily*. Retrieved from www.sciencedaily.com/releases/2017/08/170805165319.htm

Bowe, M., Wakefield, J. R. H., Kellezi, B., McNamara, N., Harkin, L., & Jobling, R. (2018). "Sometimes, it's not just about the food": The Social Identity dynamics of foodbank helping transactions. *European Journal of Social Psychology*. DOI: 10.1002/ejsp.2558.

Brandling, J., & House, W. (2009). Social prescribing in general practice: adding meaning to medicine. *British Journal of General Practice*, *59*(563), 454-456.

Brewer, M. B. (1991). The social self: On being the same and different at the same time. *Personality and Social Psychology Bulletin*, *17*(5), 475-482.

Branscombe, N. R., Schmitt, M. T., & Harvey, R. D. (1999). Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. *Journal of Personality & Social Psychology*, *77*, 135-149.

Cacioppo, J. T., Hughes, M. E., Waite, L. J., Hawkley, L. C., & Thisted, R. A. (2006). Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. *Psychology and Aging*, *21*(1), 140.

Cohen, S. (2004). Social relationships and health. *American Psychologist*, *59*(8), 676-684.

Cruwys, T., & Gunaseelan, S. (2016). "Depression is who I am": Mental illness identity, stigma and wellbeing. *Journal of Affective Disorders*, *189*, 36-42.

Dovidio, J. F. (2013). Bridging intragroup processes and intergroup relations: Needing the twain to meet. *British Journal of Social Psychology*, *52*(1), 1-24.

Drury, J., Brown, R., González, R., & Miranda, D. (2016). Emergent social identity and observing social support predict social support provided by survivors in a disaster:

Solidarity in the 2010 Chile earthquake. *European Journal of Social Psychology*, *46*(2), 209-223.

Drury, J., Cocking, C., & Reicher, S. (2009). The nature of collective resilience: Survivor reactions to the 2005 London bombings. *International Journal of Mass Emergencies and Disasters*, *27*(1), 66-95.

Durcan D., & Bell, R. (2015) *Reducing social isolation across the lifecourse: Institute of Health Equity Public Health England*. Retrieved from www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

Gaertner, S. L., Dovidio, J. F., Anastasio, P. A., Bachamn, B. A., & Rust, M. C. (1993). The common ingroup identity model: Recategorisation and the reduction of intergroup bias. *European Review of Social Psychology*, 4, 1-26. doi: 10.1080/14792779343000004

Gallagher, S., Meaney, S., & Muldoon, O. T. (2014). Social identity influences stress appraisals and cardiovascular reactions to acute stress exposure. British Journal of Health Psychology, 19(3), 566-579.

Giamo, L.S., Schmitt, M.T., & Outten, H.R. (2012). Perceived discrimination, group identification, and life satisfaction among multiracial people: A test of the rejection-identification model. *Cultural Diversity & Ethnic Minority Psychology*, *18*, 319-328.

Halder, M. M., Wakefield, J. R. H., Bowe, M., Kellezi, B., Mair, E., McNamara, N., ... & Stevenson, C. (2018). Evaluation and exploration of a social prescribing initiative: Study protocol. *Journal of Health Psychology*. Doi: 10.1177/1359105318814160.

Haslam, S. A., Branscombe, N. R., & Bachman, S. (2003). Why consumers rebel: Social identity and the etiology of adverse reactions to service failure. In S. A. Haslam, D.

van Knippenberg, M. J. Platow, & N. Ellemers. (Eds.), *Social identity at work: Developing theory for organizational practice* (pp.293-310). New York: Psychology Press.

Haslam, C., Cruwys, T., Haslam, S. A., Dingle, G., & Chang, M. X. L. (2016). Groups4Health: Evidence that a social-identity intervention that builds and strengthens social group membership improves mental health. *Journal of Affective Disorders*, *194*, 188-195.

Haslam, C., Holme, A., Haslam, S. A., Iyer, A., Jetten, J., & Williams, W. H. (2008). Maintaining group memberships: Social identity continuity predicts well-being after stroke. *Neuropsychological Rehabilitation*, *18*(5-6), 671-691.

Haslam, C., Jetten, J., Cruwys, T., Dingle, G., & Haslam, A. (2018). *The new psychology of health: Unlocking the social cure*. London: Routledge.

Haslam, S. A., Jetten, J., O'Brien, A., & Jacobs, E. (2004). Social identity, social influence and reactions to potentially stressful tasks: Support for the self-categorization model of stress. *Stress and Health: Journal of the International Society for the Investigation of Stress*, *20*(1), 3-9.

Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social identity, health and well-being: An emerging agenda for applied psychology. *Applied Psychology*, *58*(1), 1-23.

Haslam, S. A., O'Brien, A., Jetten, J., Vormedal, K., & Penna, S. (2005). Taking the strain: Social identity, social support, and the experience of stress. *British Journal of Social Psychology*, *44*(3), 355-370.

Haslam, S. A., & Reicher, S. (2006). Stressing the group: Social identity and the unfolding dynamics of responses to stress. *Journal of Applied Psychology*, *91*(5), 1037-1052.

Haslam, S. A., Reicher, S. D., & Levine, M. (2012). When other people are heaven, when other people are hell: How social identity determines the nature and impact of social

support. In J. Jetten, C. Haslam & S. A. Haslam. (Eds.), *The social cure: Identity, health and well-being* (pp. 157-174). Hove: Psychology Press.

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. Per*spectives on Psychological Science*, *10*(2), 227-237.

Hornsey, M. J. (2008). Social identity theory and self-categorization theory: A historical review. *Social and Personality Psychology Compass*, *2*(1), 204-222.

Howell, J. L., Koudenburg, N., Loschelder, D. D., Weston, D., Fransen, K., De Dominicis, S., ... & Haslam, S. A. (2014). Happy but unhealthy: The relationship between social ties and health in an emerging network. *European Journal of Social Psychology*, *44*(6), 612-621.

Iyer, A., Jetten, J., Tsivrikos, D., Postmes, T., & Haslam, S. A. (2009). The more (and the more compatible) the merrier: Multiple group memberships and identity compatibility as predictors of adjustment after life transitions. *British Journal of Social Psychology*, *48*, 707-733.

Jetten, J., Haslam, C., & Haslam, S. A. (Eds.). (2012). *The social cure: Identity, health and well-being*. Hove: Psychology Press.

Jetten, J., O'Brien, A., & Trindall, N. (2002). Changing identity: Predicting adjustment to organisational restructure as a function of subgroup and superordinate identification. *British Journal of Social Psychology*, *41*, 281-297.

Johnson, R. L., Roter, D., Powe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health*, *94*, 2084-2090.

Johnstone, M., Jetten, J., Dingle, G. A., Parsell, C., & Walter, Z. C. (2016). Enhancing well-being of homeless individuals by building group memberships. *Journal of Community & Applied Social Psychology*, *26*(5), 421-438.

Kearns, M., Muldoon, O. T., Msetfi, R. M., & Surgenor, P. W. (2015). Understanding help-seeking amongst university students: the role of group identity, stigma, and exposure to suicide and help-seeking. *Frontiers in Psychology*, *6*, 1462.

Kearns, M., Muldoon, O. T., Msetfi, R. M., & Surgenor, P. W. (2018). Identification Reduces Stigma of Mental Ill-Health: A Community-Based Study. *American Journal of Community Psychology*, *61*(1-2), 229-239.

Kellezi, B., Bowe, M., Wakefield, J. R. H., McNamara, N., & Bosworth, M. (2018). Understanding and coping with immigration detention: Social identity as cure and curse. *European Journal of Social Psychology*. DOI: 10.1002/ejsp.2543.

Kellezi, B. & Reicher, S. (2012). Social cure or social curse? The psychological impact of extreme events during the Kosovo conflict. In J. Jetten, C. Haslam, & S. A. Haslam (Eds.), *The social cure: Identity, health and well-being* (pp. 217-233). Hove: Psychology Press.

Kellezi, B., & Reicher, S. (2014). The double insult: Explaining gender differences in the psychological consequences of war. *Peace and Conflict: Journal of Peace Psychology*, *20*(4), 491.

Kellezi, B., Reicher, S., & Cassidy, C. (2009). Surviving the Kosovo conflict: A study of social identity, appraisal of extreme events, and mental well-being. *Applied Psychology*, *58*(1), 59-83.

Killeen, C. (1998). Loneliness: An epidemic in modern society. *Journal of Advanced Nursing*, *28*(4), 762–770.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer Publishing Company.

Levine, M., Prosser, A., Evans, D., & Reicher, S. (2005). Identity and emergency intervention: How social group membership and inclusiveness of group boundaries shape helping behavior. *Personality and Social Psychology Bulletin*, *31*(4), 443-453.

Livingstone, A. G., Young, H., & Manstead, A. S. (2011). We drink, therefore we are" The role of group identification and norms in sustaining and challenging heavy drinking culture. *Group Processes & Intergroup Relations*, *14*(5), 637-649.

Lowe, R. D., & Muldoon, O. T. (2014). Shared national identification in Northern Ireland: An application of psychological models of group inclusion post conflict. *Group Processes & Intergroup Relations, 17*(5), 602-616.

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psycholog*y, *56*, 393-421.

Marques, J. M., Yzerbyt, V. Y., & Leyens, J. P. (1988). The "black sheep effect": Extremity of judgments towards ingroup members as a function of group identification. *European Journal of Social Psychology*, *18*(1), 1-16.

McLaren, S., Belling, R., Paul, M., Ford, T., Kramer, T., Weaver, T., ... & Singh, S. P. (2013). 'Talking a different language': an exploration of the influence of organizational cultures and working practices on transition from child to adult mental health services. *BMC Health Services Research*, *13*(1), 254.

McNamara, N., Coyne, I., Ford, T., Paul, M., Singh, S., & McNicholas, F. (2017). Exploring social identity change during mental healthcare transition. *European Journal of Social Psychology*, *47*(7), 889-903.

McNicholl, K., Stevenson, C., & Garry, J. (2018). How the 'Northern Irish' national identity is understood and used by young people and politicians. *Political Psychology*. DOI: 10.1111/pops.12523.

Miller, K., Wakefield, J. R. H., & Sani, F. (2015). Identification with social groups is associated with mental health in adolescents: Evidence from a Scottish community sample. *Psychiatry Research*, *228*(3), 340-346.

Miller, K., Wakefield, J. R. H., & Sani, F. (2016). Greater number of group identifications is associated with healthier behaviour in adolescents. *British Journal of Developmental Psychology*, *34*(2), 291-305.

Redersdorff, S., Martinot, D., & Branscombe, N. (2004). The impact of thinking about group-based disadvantages or advantages on women's well-being: An experimental test of the rejection-identification model. *Cahiers de Psychologie Cognitive/Current Psychology of Cognition*, *22*, 203-222.

Reicher, S., Cassidy, C., Wolpert, I., Hopkins, N., & Levine, M. (2006). Saving Bulgaria's Jews: An analysis of social identity and the mobilisation of social solidarity. *European Journal of Social Psychology*, *36*(1), 49-72.

Reicher, S., & Haslam, S. A. (2006). Rethinking the psychology of tyranny: The BBC Prison Study. *British Journal of Social Psychology*, *45*(1), 1-40.

Sani, F. (2008). Schism in groups: A social psychological account. *Social and Personality Psychology Compass*, *2*(2), 718-732.

Sani, F., Herrera, M., Wakefield, J. R. H., Boroch, O., & Gulyas, C. (2012). Comparing social contact and group identification as predictors of mental health. *British Journal of Social Psychology*, *51*(4), 781-790.

Sani, F., Madhok, V., Norbury, M., Dugard, P., & Wakefield, J. R. H. (2015a). Greater number of group identifications is associated with healthier behaviour: Evidence from a Scottish community sample. *British Journal of Health Psychology*, *20*(3), 466-481.

Sani, F., Madhok, V., Norbury, M., Dugard, P., & Wakefield, J. R. H. (2015b). Greater number of group identifications is associated with lower odds of being depressed: Evidence from a Scottish community sample. *Social Psychiatry and Psychiatric Epidemiology*, *50*(9), 1389-1397.

Schmitt, M. T., Spears, R., & Branscombe, N. R. (2003). Constructing a minority group identity out of shared rejection: The case of international students. *European Journal of Social Psychology*, *33*(1), 1-12.

Seymour-Smith, M., Cruwys, T., Haslam, S. A., & Brodribb, W. (2017). Loss of group memberships predicts depression in postpartum mothers. *Social Psychiatry and Psychiatric Epidemiology*, *52*(2), 201-210.

Singh, S. P., Islam, Z., Brown, L. J., Gajwani, R., Jasaru, R., Rabiee, F., & Parsons, H. (2013). Ethnicity, detention, and early intervention: reducing inequalities and improving outcomes for black and minority ethnic patients: The ENRICH programme, a mixed methods study. *Programme Grants Applied Research*, *1*(3), 1-165.

Steffens, N. K., Cruwys, T., Haslam, C., Jetten, J., & Haslam, S. A. (2016). Social group memberships in retirement are associated with reduced risk of premature death: evidence from a longitudinal cohort study. *BMJ Open*, *6*(2), e010164.

Stevenson, C., McNamara, N., & Muldoon, O. (2014). Stigmatised identity and service usage in disadvantaged communities: Residents', community workers' and service providers' perspectives. *Journal of Community and Applied Social Psychology*, *24*(6), 453-466.

Stevenson, C., McNamara, N., Kellezi, B., Easterbrook, M., Shuttleworth, I., & Hyden, D. (2018). Re-identifying residential mixing: Emergent identity dynamics between incomers and existing residents in a mixed neighbourhood in Northern Ireland. *European Journal of Social Psychology*. DOI: 10.1002/ejsp.2529.

Stevenson, C., & Sagherian-Dickey, T. (2016). Collectively coping with contact: The role of intragroup support in dealing with the challenges of intergroup mixing in residential contexts. *British Journal of Social Psychology*, *55*(4), 681-699.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. Tajfel, H., & Turner, J. C (1979). In W. G. Austin & S. Worchel (Eds.), The social psychology of intergroup relations (pp. 33-47). Monterey: Brooks/Cole.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behaviour. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (pp. 2–24). Chicago: Nelson-Hall Publishers.

Trawalter, S., Richeson, J. A., & Shelton, J. N. (2009). Predicting behavior during interracial interactions: A stress and coping approach. *Personality and Social Psychology Review*, *13*(4), 243-268.

Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). Rediscovering the social group: A self-categorization theory. London: Basil Blackwell.

Valtorta, N. K., Kanaan, M., Gilbody, S., Ronzi, S., & Hanratty, B. (2016). Loneliness and social isolation as risk factors for coronary heart disease and stroke: Systematic review and meta-analysis of longitudinal observational studies. *Heart*, *102*(13), 1009-1016.

Wakefield, J. R., Hopkins, N., Cockburn, C., Shek, K. M., Muirhead, A., Reicher, S., & van Rijswijk, W. (2011). The impact of adopting ethnic or civic conceptions of national

belonging for others' treatment. *Personality and Social Psychology Bulletin*, *37*(12), 1599-1610.

Walsh, R. S., Muldoon, O. T., Gallagher, S., & Fortune, D. G. (2015). Affiliative and "self-as-doer" identities: relationships between social identity, social support, and emotional status amongst survivors of acquired brain injury (ABI). *Neuropsychological Rehabilitation*, *25*(4), 555-573.

Wenzel, M., Mummendey, A., & Waldzus, S. (2008). Superordinate identities and intergroup conflict: The ingroup projection model. *European Review of Social Psychology,* *18*(1), 331-372.

Wilson, R. S., Krueger, K. R., Arnold, S. E., Schneider, J. A., Kelly J. F., Barnes L. L., Tang Y., & Bennett D. A. (2007). Loneliness and risk of Alzheimer disease. *Archives of General Psychiatry*, *64*, 234–240.

Ysseldyk, R., McQuaid, R. J., McInnis, O. A., Anisman, H., & Matheson, K. (2018). The ties that bind: Ingroup ties are linked with diminished inflammatory immune responses and fewer mental health symptoms through less rumination. *PloS One*, *13*(4), e0195237.