Unlocking the social cure

S. Alexander Haslam introduces a special collection with his ‘Lists for Life’: what will kill you and what will make you stronger?

Over the past 50 years a huge body of evidence, dating back to Tajfel’s famous minimal group studies, has built up support for the idea that social identity – a sense of ‘us-ness’ – is central to the dynamics of intergroup relations. But in the last decade a new body of work has built up around the idea that social identity is also critical for health: it’s the basis for a sense of connection and an associated sense of meaning, support, purpose and agency. This special collection features five researchers who have spearheaded this so-called ‘social cure’ research. As the former President of the Academy of Royal Medical Colleges, Dame Sue Bailey, said in the foreword to their new book The New Psychology of Health, this is a revolution we should all want to be part of.

In 2009 Umberto Eco, the Italian semiologist and novelist, observed in an interview with Der Spiegel that lists are the origin of culture: they serve ‘to make infinity comprehensible’. More provocatively, he went on to note that because they allow us to engage with things that are limitless and boundless (such as knowledge), lists give us the capacity to deal with the one aspect of our lives that is most discouragingly limiting: death. So, in blunt terms, he argues that ‘humans beings make lists because we don’t want to die’. This point is interesting in itself, but it also raises the question of what types of lists people create when they are explicitly interested in staving off death.

Giving some credence to Eco’s observations, it is clear that people – not least researchers and policymakers – invest an enormous amount of energy and effort in creating and circulating such lists. Two years ago the Chief Medical Officer in Queensland, the Australian state I now call home, invested a considerable sum of money in the production and dissemination of a glossy pamphlet entitled ‘Simple steps to better health’. This contained a list of nine behaviours that Queenslanders could engage in to stay healthy and prolong their lives. It included such things as staying physically active, having a healthy diet, saying no to tobacco, and being sun safe all year round. Its content would be recognisable to any reader of The Psychologist. Indeed, it corresponds very closely to the list (see box) compiled by the Chief Medical Officer in England in 1999 (although understandably, this makes no mention of the dangers of year-round sunshine).

Advice of this form is eminently sensible and clearly well grounded in medical science. It’s familiar, and most of us have, at least to some extent, taken it on board. Testament to this, in a study that we recently conducted with a large community sample of people from the US and UK we found that their judgements of the degree to which various health behaviours (e.g. not smoking, exercising, having a good diet) increased life expectancy corresponded quite closely to the results of studies that have quantified this (Haslam et al., 2018). More specifically, there was a strong positive
correlation between people’s subjective estimates of how important key health behaviours were for life expectancy and their actual contribution, as revealed in an influential 2010 meta-analysis of 148 relevant studies by Julianne Holt-Lunstad and her colleagues. As lists go, then, these are ones that are both credible and given wide credence.

**What traditional lists leave out**

Familiar as lists like these are, they have a very particular focus: health behaviours that are well studied and well understood by medical researchers. In the process, they leave out causes of death that fall outside the traditional purview of medical science.

There are two key classes of these causes. The first encompasses a range of *social determinants of health* such as poverty, unemployment and poor housing. As Jolanda Jetten explores in her article in this collection, when one takes stock of these causes of ill health, this leads people to construct lists that look very different from the one above. A second class relates to issues of *social connection and social isolation*. These are interesting for at least two reasons. The first and most basic is that it turns out that they are at least as important for health as the most important health behaviours that are identified in traditional lists. Going back to Holt-Lunstad and colleagues’ meta-analysis, we find that social support and social integration make a contribution to life expectancy that exceeds that of all of the traditional factors (such as smoking, alcohol consumption, exercise, air pollution, etc.). But it gets really interesting when we add in the data from our community sample: we find that the importance of these social factors is not well appreciated by the general public. Indeed, our respondents judged social support and social integration to be two of the three *least* important predictors of life expectancy. So whereas members of the community were quite good at judging the benefits of various health behaviours,
they were spectacularly bad at recognising the benefits of these social factors. One reason for this, of course, is that they never appear on the lists that Chief Medical Officers send them, or that they see in doctors' surgeries.

**A new psychology of health**

Of course, though, the fact that lists produced by Chief Medical Officers do not refer to the importance of social integration for health is not the only reason why people overlook this. Indeed, this can be seen to be symptomatic of a bigger problem, which is that the reasons why social connectedness is so important for health are not well understood, especially within medical science. Moreover, partly as a result of this, social disconnection is a problem that proves hard to tackle practically. Once we have understood that smoking causes cancer, the intervention is easy: stop. Once we have understood that exercise reduces the risk of heart disease, the intervention is easy: start. (Although, for reasons we discuss further below, it turns out that these behaviours are not quite so easy to change as one might think.)

Yet how does one start to become socially integrated? And how does one stop becoming socially disconnected? These are thorny questions, and, moreover, they are not ones that psychologists have found it easy to answer. Part of the reason for this, we suggest, is that the way our discipline has traditionally oriented to matters of health (and much else besides) is by seeking to understand the psychology of individuals as *individuals*, when to tackle challenges of social isolation we need instead to understand how people function as *group members*. As the title of our new book suggests, this requires us to develop a ‘new psychology of health’. At the core of this new psychology is a recognition that people’s sense of self – and the perceptions and actions that flow from it – is often dictated at least as much by their group memberships and an associated internalised sense of *social identity* (a sense of ‘we-ness’) as it is by their personal identity as individuals (a sense of ‘I-ness’).

But why does this matter for health? A core reason is that humans are social animals who live, and have evolved to live, in social groups. Accordingly, like hunger and thirst, physical and psychological isolation are inimical to our make-up and design. In this regard, the fundamental significance of social identity is that, as John Turner (1982) first observed, it is what makes group behaviour possible.

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**Key sources**


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**Ten social identity tips for better health**

1. If you feel socially isolated try to join a group.
2. If you can, join more groups.
3. Try to hold on to positive group memberships, especially if you are going through a challenging time.
4. If you lose membership in an important group, seek out a new one.
5. Invest in groups that are important to you and in groups by which you are valued.
6. Be wary of groups that make unhealthy choices.
7. Get support from your groups, but also give support to others in your groups.
8. Recognise that it can sometimes be healthy to try to leave disadvantaged and stigmatised groups, while at other times it can also be healthy to stay.
9. Challenge the stigma and disadvantage that produce health inequality.
10. If you experience health problems seek professional help — ideally from a source with which you identify.

Because this is such a pivotal point, it’s worth pausing for a moment to flesh it out with an example, albeit a rather trivial one. Imagine that you wanted to engage in a relatively simple form of group behaviour: as part of a community-based social club. What, psychologically, would allow you to do this? As Turner argued, the answer hinges on your having the capacity to define yourself, and hence to behave, as a club member. That is, rather than simply seeing yourself and other club members as individuals (i.e. in terms of *personal identities* as Alex, Bill, Cath, etc.), in order to engage in meaningful club activities you need to be able to see yourself and fellow team members as exemplars of the same social category (in terms of your shared social identity as ‘us Club members’). Amongst other things, then, your sense of yourself (technically, your *self-categorisation*) as a club member would mean you would be friendly to other club members and would go out of your way to help them (e.g. by giving them a lift to club meetings, doing their shopping if they are unwell). And of course, this same self-categorisation process means they would do the same for you, and that, when they did, you would appreciate their efforts (rather than see them as patronising, say). At the same time, the fact that this sense of shared identity is *context-sensitive and negotiated* would mean that if the club merged with another club, you might treat its members in the same way too.

Importantly, this internalisation of social identity
provides the essential platform for a range of attitudinal, perceptual and behavioural phenomena. These include a sense of similarity, commonality and connectedness (i.e. a sense that members of your group are in some sense alike and ‘in the same boat’ as you) and the ability to influence and coordinate the thinking and behaviour of those ingroup members (but not outgroup members – which, incidentally, explains why a lot health advice falls on deaf ears; see Oyserman et al., 2007).

In this relatively mundane example we can see not only that social identity underpins group behaviour, but also that it is this that allows us to access whatever benefits a particular group activity affords. Accordingly, if it is the case that being in a club is good for you and your health (and there is plenty of evidence that it is), then it is also the case that social identity is a gateway to these benefits. More particularly, it is the fact that group members see themselves (i.e. self-categorise) as being ‘in the same club’ (in terms of a shared social identity) that allows them to work together in meaningful ways: to contribute to collective achievements, and to support each other effectively in the face of adversity (Haslam et al., 2018). Moreover, the more that group members define themselves in this way – that is, the higher their social identification – the more true this is.

More generally, this example also allows us to see that social identity is a fundamental basis for a range of psychological states that are critical to health and wellbeing. Amongst other things, this is because feeling that we are ‘part of a group’ engenders a sense of trust and support, a sense of self-esteem, control and agency, and a sense of purpose, direction and meaning. This also has material consequences in shaping the way we interact with other people: whether we love them, whether we lead them, whether we help them. In the most general sense, then, we can say that social identity is what allows us to fulfil our potential as human beings.

These are points that are fleshed out in the other contributions in this issue. As Jolanda Jetten shows in her article, people’s perceptions of, and responses to, disadvantage are fundamentally shaped by their standing within a group, and the relationship between their group and others. As Genevieve Dingle shows, whether or not people smoke or misuse other substances – and whether or not they stop – is heavily predicted by the groups they are members of and identify with. As Tegan Cruwys shows, depression can be understood to be a function of a person’s (changing) group memberships that lead them to experience social identity loss. And finally, as Catherine Haslam shows, just as the loss of meaningful group life is a harbinger of psychological difficulty, so too efforts to (re)build group-based social connection constitute a royal road to recovery from the scourge of social isolation.

A new list for life

In many ways, our contributions to this issue only scratch the surface of the large and growing body of work that is informed by the social identity approach to health – work to which a large and growing body of researchers around the world have contributed. Thus, as well as work on social disadvantage, addiction, depression and intervention, *The New Psychology of Health* also addresses issues of stress, trauma, ageing, pain, eating behaviour, chronic mental health and long-term physical health. Importantly, this work not only documents the ways in which social identities can adversely affect health, but also the fundamental role they play in securing positive health outcomes.

But returning to the issue with which we started, how might we distil these ideas into health advice that speaks to the alternative realities that Holt-Lunstad and her colleagues capture, but that traditional guidance overlooks? Our list (see box) is a way of drawing together some of the key lessons that can be learned from social identity research, and thereby capturing important determinants of life and death that traditional approaches to health fail to embrace.

As with medical lists, the advice here is not always easy to heed. It is hard to join groups when you move to a new city, or work around the clock. It is hard to avoid groups that make unhealthy choices when these are the only groups you know and have access to. The idea of challenging discrimination is often more appealing than the task of actually doing something. Most particularly, though, these are things that it is particularly hard for people to do on their own. It is here, then, that groups really come to the fore and where we can bring the skills and insights of social, clinical, health and organisational psychologists to bear with particular potency.

It’s time to unlock the social cure.