Social Identity, Health and Well-Being:
An Emerging Agenda for Applied Psychology

S. Alexander Haslam*

University of Exeter, UK

Jolanda Jetten

University of Exeter, UK and University of Queensland, Australia

Tom Postmes

University of Exeter, UK and University of Groningen, The Netherlands

Catherine Haslam

University of Exeter, UK

The social environment comprising communities, families, neighbourhoods, work teams, and various other forms of social group is not simply an external feature of the world that provides a context for individual behaviour. Instead these groups impact on the psychology of individuals through their capacity to be internalised as part of a person's social identity. If groups provide individuals with a sense of meaning, purpose, and belonging (i.e. a positive sense of social identity) they tend to have positive psychological consequences. The impact of these identity processes on health and well-being is explored in the contributions to this special issue. In this editorial, we discuss these con-tributions in light of five central themes that have emerged from research to date. These themes address the relationship between social identity and (a) symptom appraisal and response, (b) health-related norms and behaviour, (c) social support, (d) coping, and (e) clinical outcomes. The special issue as a whole points to the capacity for a social identity approach to enrich academic understanding in these areas and to play a key role in shaping health-related policy and practice.

* Address for correspondence: Alex Haslam, School of Psychology, The University of Exeter, Exeter EX4 4QG, UK. Email: A.Haslam@exeter.ac.uk

Composé de communautés, de familles, de voisins, d'équipes de travail ainsi que d'autres formes de groupes sociaux, l'environnement social n'est pas seulement un élément externe du monde qui fournit un contexte au comportement individuel. Au contraire ces groupes ont un impact sur la psychologie des individus par leur capacité à être intériorisés comme une part de l'identité sociale de la personne. Si les groupes donnent aux individus un sens, un but et un sentiment d'appartenance (I.A. un aspect positif à l'identité sociale), leurs conséquences psychologiques sont positives. L'impact de ces processus identitaires sur la santé et le bien-être est exploré dans les contributions de ce numéro spécial. Dans cet éditorial, nous discutons ces contributions à la lumière de cinq thèmes centraux ayant émergé de la recherche à ce jour. Ces thèmes examinent la relation entre l'identité sociale et (a) l'apparition d'un symptôme et d'une réponse, (b) les normes de santé et le comportement (c) le soutien social, (d) les stratégies de faire-face et (e) les résultats cliniques. Ce numéro spécial envisagé dans sa totalité rend compte de la capacité pour l'approche de l'identité sociale d'enrichir la compréhension académique dans ces domaines et de jouer un rôle clé dans la formation en matière de politique de santé et de pratique.

INTRODUCTION: WHY SOCIAL IDENTITIES MATTER

Humans are social beings. The most important expression of this sociality is that we live, and have evolved to live, in social groups. This basic fact has shaped not only what we do but also how our minds have evolved to enable us to do it. Groups are not simply external features of the world that provide a setting for our behaviour. Instead they shape our psychology through their capacity to be internalised and contribute to our sense of self. That is, groups provide us with a sense of *social identity*: "knowledge that [we] belong to certain social groups together with some emotional and value significance to [us] of this group membership" (Tajfel, 1972, p. 31).

Accordingly, when we relate to important social entities in our lives—family and friends, work and sports teams, community and religious groups, regional and national entities—we do not necessarily see their members as "other", but instead routinely embrace them as "*us*". Psychologically, therefore, we relate to these various social entities as *groups*, defined in a broad sense as relational structures with which we engage and which help to define who we are. One prime reason why we are willing to embrace others in this way is that such groups have the capacity to enrich our lives in various ways: they are a source of personal security, social companionship, emotional bonding, intellectual stimulation, and collaborative learning. Critically too, groups have qualitative advantages over individuals as they also allow us to achieve goals and levels of agency that would otherwise be unattainable.

Groups that provide us with a sense of place, purpose, and belonging tend to be good for us psychologically. They give us a sense of grounding

and imbue our lives with meaning. They make us feel distinctive and special, efficacious and successful. They enhance our self-esteem and sense of worth. These effects can buffer well-being when it is threatened, and can also help people cope with the negative consequences of being a member of a devalued group (although at other times group membership can compromise health because the content of social identity is inconsistent with health-enhancing activity). Thus, far from being "just another" factor that impinges upon the health of individuals, social identities—and the notions of "us-ness" that they both embody and help create—are central to health and well-being.

THE PRESENT ISSUE

The aim of this special issue is to bring together and showcase recent research from a number of different disciplines that examines this relationship between social identity, health, and well-being. The contributions that follow serve as vivid illustrations of the potential for ideas elaborated within a social identity framework to be used as a basis for understanding issues of health and well-being. In common with seminal work in the social identity tradition, at a theoretical level they serve to reconnect issues of clinical, health, social, and cognitive psychology within a vision of humans as social beings whose well-being and intellect is bound up with their ability to lead fulfilling social lives under conditions where this is more or less difficult. At a practical level, such work has the potential to inform developments in the delivery, management, and promotion of health care (e.g. Craddock, 2000; Harwood & Sparks, 2003). More generally, it provides an integrative vision that we hope serves to generate enthusiasm and provide direction for a much larger body of work that is to follow.

From the features of the papers that are summarised in Table 1 it can be seen that the contributions to this special issue are characterised by considerable breadth in geographical location, participant samples, and dependent measures. Yet for all their diversity, one thing that the papers have in common is that they speak to significant and challenging issues that are at the forefront of contemporary debate—not only in psychology but in the world at large: professional practice and social policy, emigration and education, war and peace. So, in the vast majority of cases, these are not simply issues of health and well-being. Instead, the authors' treatments are interwoven with matters of power and politics, conflict and controversy, pride and prejudice. To us this seems entirely fitting, since, as originally conceived, the thrust of social identity theorising was not to turn psychologists away from the broader world, but precisely to encourage engagement with its complexities and richness (Tajfel, 1972; Turner, 1999).

A key point in all this work is that group life—and the social identities that underpin it—proves to be central to our state of mind and to our

TABLE 1
Summary of Papers in this Special Issue

Authors (and Theme)	Sample	Location	N	Age	Method	IVs	DVs (m) = mediator
St Clair & He (1)	Older adults	UK	50	51–78	Experiment	Identification with elderly group; hearing difficulty	Perceived need for hearing aid
Falomir-Pichastor, Toscani, & Despointes (2)	Nurses	Switzerland	531	21–79	Survey	Identification with professional group; Knowledge of flu and vaccination	Perception of vaccination as professional duty (m); Intention to take flu vaccination
Kellezi, Reicher, & Cassidy (3)	War survivors	Kosovo Albanians	127	17–66	Survey	Whether war is identity-affirming	Depression; Anxiety; Coping; Self-efficacy; Support
Latrofa, Vaes, Pastore, & Cadinu (4)	School students	Southern Italy	167	19	Survey	Identification with stigmatised minority	Self-stereotyping (m); Affect; Self-esteem; Inclusion; Depression; Life satisfaction
Jasinskaja-Lahti, Liebkind, & Solheim (4)	Immigrants from USSR	Finland	293	20–36 (t1)	8-year longitudinal survey	Discrimination (t1)	National identification (m); Ethnic identification (m); Stress; Discrimination (t2)
Muldoon, Schmid, & Downes (4)	Residents in conflict-affected regions	Northern Ireland + Ireland	2,612	18–92	Telephone survey	Exposure to violence	National identification (m); Well-being; Mental health
Outten, Schmitt, Garcia, & Branscombe (4)	Black Americans	USA	120	18–73	Survey	Identification with racial group	Coping options (m); Self-esteem; Life satisfaction
Bizumic, Reynolds, Turner, Bromhead, & Subasic (5)	School students + staff	Australia	113 + 693	12–17 + 21–60	Survey	Identification with school	Self-esteem; Depression, Anxiety; Emotional control; Disruptive behaviour

capacity to engage effectively with the world at large. These are strong claims, so we will start by summarising some of the main premises of the two related theories from which they are derived and which together comprise the social identity approach: *social identity theory* (Tajfel & Turner, 1979, 1986) and *self-categorisation theory* (Turner, 1982, 1991; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987; Turner, Oakes, Haslam, & McGarty, 1994; for original source material see Postmes & Branscombe, in press).

   After this short overview, we then provide a short summary of the papers included in this special issue. These summaries are organised with reference to five distinct themes that have been explored in work to date. In this way, we hope it becomes apparent not only how these contributions are representative of a growing body of research that examines the relationship between social identity and well-being, but also how and why the emerging agenda that they embody promises to be so important and so exciting.

UNDERSTANDING THE RELATIONSHIP BETWEEN SOCIAL IDENTITY AND HEALTH: THEORETICAL PERSPECIVTES

Social Identity Theory

Social identity theory postulates that in many social contexts people define their sense of self in terms of group membership (i.e. in terms of social identity). This means that a person's psychology often depends on the state of the groups that define the self (i.e. ingroups). If these groups provide a person with stability, meaning, purpose, and direction, then this will typically have positive implications for that individual's mental health.

   It is therefore not surprising that if our sense of social identity is compromised in some way (e.g. if we leave or change groups, if we are rejected by an ingroup, or if the ingroup changes in important ways), then this tends to have negative psychological consequences. Regardless of whether changes to social identities are positive or negative, the important point is that they require some adjustment on the part of the individual because, at least temporarily, they are likely to lead to a loss of psychological "footing". Indeed, evidence suggests that changes that compromise valued social identities (e.g. moving home, losing one's job) can be at least as devastating as the upside of group life is positive (Iyer, Jetten, & Tsivrikos, 2008).

   Tajfel and Turner (1979) hypothesise that people's evaluations of their ingroups are relative in nature. Our sense of who we are is enhanced by knowing not only that we belong to certain groups (e.g. as a Catholic, an academic, an Australian), but also that we are different from members of other groups (e.g. Protestants, administrators, British). "Us" versus "them" distinctions not only help us understand ourselves, but also impact upon our self-evaluations and our sense of worth. In particular, an ingroup's

perceived superiority relative to other groups in a relevant domain (achieved through positive intergroup comparisons) should tend to enhance self-esteem, well-being, and mental health. In contrast, if individuals belong to a group that is seen as in some way inferior to others (e.g. because it is disadvantaged or stigmatised), then negative intergroup comparison is likely to pose a threat to well-being.

What should be obvious from this is that social identities are more than a list of the socio-demographic groups that can be used to classify individuals (e.g. gender, age, ethnicity, religion). Social identities are relative, they differ in the extent to which individuals perceive them as psychologically meaningful descriptions of self (i.e. they are more or less central to our self-definition), and their function and meaning can change over time.

It is the theorising surrounding these dynamics that makes the notion of social identity such a powerful tool in helping researchers go beyond previous examinations that treat social groups simply as one of many demographic factors that are associated with physical and mental health conditions (e.g. Cockerham, 2007). Specifically, social identity theory helps to explain how social identities can be associated with positive or negative health outcomes by focusing on the way in which individuals understand and respond to the social structural conditions in which they find themselves.

In particular, the theory focuses on the importance of three key structural elements: 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). Without going into great detail, if members of low-status groups believe that group boundaries are *permeable*, then in order to deal with negative intergroup comparisons they should favour strategies of *individual mobility* whereby they try to dissociate themselves from their negative or stigmatised group. In a health context (e.g. where individuals are suffering from mental illness or physical disability) this may involve working on one's own (rather than with others who also suffer from the condition) to pursue treatment or other recovery strategies (e.g. exercise, therapy) that enable the person to (re)join a high-status (healthy) group (Crabtree, Haslam, Postmes, & Haslam, 2008).

However, if individuals perceive group boundaries to be impermeable (so that group membership is fixed and one's low status is inescapable) such strategies are ruled out. Here, if social relations are *secure* (in the sense of being seen as both stable and legitimate), members of low-status groups are predicted to engage in *social creativity*. For example, where an adverse health condition is intractable or untreatable, one way to deal with this is to try to improve the group's situation through denial of its inferiority—for example, by rejecting prevailing negative stereotypes and labels of the ingroup and seeking to replace them with more positive ones. However, if relations are impermeable and *insecure* (i.e. seen to be unstable and/or illegitimate), then

members of low-status groups are more likely to define themselves in terms of their group membership and strive to produce some form of *social change*. Among other things, this may involve participation in political action designed to secure improved rights or better treatment for one's ingroup (Branscombe, Schmitt, & Harvey, 1999).

Importantly, when individuals perceive group boundaries as impermeable, they are likely to define themselves in terms of social identity and hence to act in line with their social demographic status (e.g. as an elderly person). However, this is less likely to be true when boundaries are perceived to be permeable, since here the relevant group membership tends not to inform individuals' self-definitions and hence their behaviour. The important point to take from this is that an appreciation of the way in which social contextual factors determine individuals' internalisation of particular social identities is critical for understanding the meaning of socio-demographic factors and individuals' responses to the various stressors and threats with which those factors are associated (Haslam & Reicher, 2006). This process in itself can affect the way people respond to their illness and affect health, regardless of the seriousness of their condition. This is a point we will expand upon below with reference to contributions to this special issue that demonstrate the centrality of social identities to processes of adjustment and coping.

Self-Categorisation Theory

From the above discussion it can be seen that social identity theory relates largely to the operation of social identity as a determinant of group members' responses to the context in which they find themselves. Self-categorisation theory extends these insights by probing much more forensically into the social psychological dynamics of the self. When do we define ourselves as group members rather than as individuals? What determines which group memberships define our sense of self in any given context? What are the consequences of self-definition in group-based terms?

Self-categorisation theory's answer to such questions builds on three key insights. As we have already intimated, the first of these is that social identity is what allows group behaviour to occur at all. As Turner (1982) famously put it, "social identity is the cognitive mechanism that makes group behaviour possible" (p. 21). For example, it was only when people suffering from Asperger's syndrome defined themselves in terms of a shared group membership (as "we Asperger's sufferers") that they and their supporters were able to work together as a group in order to address issues that affected them collectively (e.g. promoting awareness, disseminating information, lobbying for funding, challenging stigma; Baron-Cohen & Clin, 2006; see also Clare, Rowlands, & Quin, 2008).

A second core insight is that the self system reflects the operation of a categorisation process in which, depending on the context in which people are located, they see themselves as either sharing category membership with others (i.e. in terms of a shared social identity, "us"), or not (seeing those others either as "them" (vs. us) or "you" (vs. me); Turner, 1985). Whether, and which, social identities become salient is seen to be an interactive product of the fit of a particular categorisation and a person's readiness to use it (Oakes, Haslam, & Turner, 1994). For example, a person is more likely to define themselves as an asthmatic (sharing category membership with other asthmatics) if this self-categorisation maps on to what he or she sees and understands about the patterns of similarity and difference between asthmatics and non-asthmatics (e.g. in terms of symptomatology), and if he or she has prior knowledge about the condition (e.g. through health campaigns or previous diagnosis; Adams, Pill, & Jones, 1997; Levine & Reicher, 1996; St Claire, Clift, & Dumbelton, 2008).

Following up on these ideas, a third insight is that shared social identity is the basis for mutual social influence (Turner, 1991). When people perceive themselves to share group membership with other people in a given context they are motivated to strive actively to reach agreement with them and to coordinate their behaviour in relation to activities that are relevant to that identity. Again, they do this because it is the group that defines their sense of self—so in advancing the group (and its members) they are acting *for* the self, not against it.

For this reason, shared social identity can be seen as the basis for all forms of productive social interaction between people—including leadership, motivation, communication, cooperation, helping, trust, and organisation (Ellemers, de Gilder, & Haslam, 2004; Haslam, 2001; Haslam, Postmes, & Ellemers, 2003; Postmes, 2003; Reicher, Haslam, & Hopkins, 2005; Turner & Haslam, 2001). It is also the basis for people to take on roles, and for them to exercise collective power (Drury & Reicher, 1999; Reicher & Haslam, 2006a; Turner, 2005). If one reflects, for example, on interactions between medical practitioners and their clients, then these should be more productive to the extent that these parties share some relevant group membership. Among other things, this helps explain why treatment that occurs across social category boundaries (e.g. of ethnicity, culture and class) tends to be less satisfactory and less effective that that which occurs within those boundaries (Cooper, Gonzales, Gallo, Rost, Meredith, Rubenstein, Wang, & Ford, 2003; Tucker & Kelley, 2000).

SOCIAL IDENTITY, HEALTH, AND WELL-BEING: AN OVERVIEW OF RESEARCH

What, then, has been the contribution of work that links social identity to issues of health and well-being? A survey of the work that has been

conducted to date suggests that advances have been made on several fronts, each of which applies and extends insights contained within original statements of social identity and self-categorisation theories. The papers included in this special issue relate to five core strands of research. We will now consider these contributions briefly in turn and outline how they relate to broader themes—noting that due to the volume of work in the area, this review is far from exhaustive.

1. Social Identity as a Determinant of Symptom Appraisals and Responses

The contribution by St Claire and He to this special issue demonstrates how in the area of physical health, people's appraisal of physical symptoms is moderated by salient social identifications. In particular, St Claire and He demonstrate that older adults are more likely to think that they suffer from hearing loss and require a hearing aid if they are encouraged to self-categorise as "elderly people". Importantly, the researchers also show that these perceptions are independent of audiological measures of participants' objective hearing acuity.

This work builds upon a body of previous work which has explored how social identity affects and determines symptom appraisal. For example, research by Levine and Reicher (1996) found that female sports science students perceived a knee injury to be much more serious (and were much more likely to seek medical attention) if experimental instructions encouraged them to define themselves as sports students rather than as women. However, the opposite pattern emerged when the ailment in question was a facial rash: this was seen as much more serious when participants were encouraged to define themselves as women rather than sports students.

Work by Adams and colleagues (1997) has also shown that whether or not people take prescribed medication in response to a specific set of symptoms is affected by processes of social identification. Specifically, these researchers found that asthma sufferers were much more likely to take their medication if they categorised themselves as members of a group that suffered from asthma (i.e. so that asthma informed their sense of social identity) than if they did not. Along similar lines, earlier experimental research by St Claire et al. (2008) has also shown that people are far more likely to report symptoms of cold and to request medication when they are primed to think of themselves in terms of a social identity as a cold sufferer.

2. Social Identity as a Determinant of Health-related Norms and Behaviour

Social identity plays a significant role in determining whether people engage in behaviour that places their (and others') health at risk. This is true, for

example, of smoking, drug-taking, and sexual activity. In all of these areas there is abundant evidence that relevant behaviours are driven by norms associated with identities that become salient for people in particular contexts. So, for example, when one social identity is salient (e.g. the family) a person may be far less willing to smoke (and to be influenced by other smokers) than when another is (e.g. the teenage peer group; Kobus, 2003; Schofield, Pattison, Hill, & Borland, 2003). Along these lines, work by Campbell (1997) observed that when miners' masculine identity as working men (rather than family men) was salient, they were far more likely to have unprotected sex.

In this special issue the practical importance of such ideas is powerfully brought home by the research of Falomir-Pichastor, Toscani, and Despointes. This shows that nurses' decisions to have flu vaccinations are predicated in part upon their identification with a professional identity that is defined in terms of patient protection. More generally, then, the research makes the point that the behaviour of health professionals depends very much on the norms that they internalise as a result of identification with their professional group.

This finding is consistent with research that has observed that junior nurses tend to define their identity very differently from senior nurses (in terms of patient-focused care delivery rather than profession-focused instrumentality) and that, as a result, the two groups evince very different orientations to their work in hospital settings (Millward, 1995). More recently, an impressive series of seven studies by Oyserman, Fryberg, and Yoder (2007) has also shown how members of ethnic minority groups who do not identify with the mainstream majority are likely to react against the health-related messages that emanate from this source and display health-compromising social creativity. Specifically, in these studies, African Americans and American Indians who were exposed to messages about dieting that they saw as emanating from White middle-class sources came to see health-related behaviour as non-normative for their group (as if to say "health is not a thing we do"), and expressed less desire and intention to pursue healthy lifestyles. They were also more fatalistic about their health.

As a corollary of this point, researchers have also shown that identity-related processes underpin people's participation in health-*promoting* activities. For example, Laverie (1998) found that people's willingness to attend aerobics classes was associated with the development, through social interaction, of a social identity (and associated positive social comparisons and emotions) defined in terms of membership of an aerobics group. And in a very different cultural context, Hogan and Biratu (2004) observed that identification with a particular religion (rather than simply the demographic variable of religion) was a key predictor of southern Ethiopians' willingness to use contraception.

3. Social Identity as a Basis for Social Support

Social identity and self-categorisation processes do not only impact upon the psychology of individuals in isolation. Because they serve to structure social interaction they are also central to the accumulation of health-related social capital (Campbell & Jovchelovitch, 1997)—lying at the heart of helping behaviour and the dynamics of effective social support. Indeed, this is one key reason why social identification proves to be a strong predictor of well-being in a wide range of contexts (e.g. organisational, clinical, educational; Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; Wegge, Van Dick, Fisher, Wecking, & Moltzen, 2006). Here, then, a growing body of work indicates that social support is more likely to be given, received, and interpreted in the spirit in which it is intended to the extent that those who are in a position to provide and receive that support perceive themselves to share a sense of social identity.

In the present issue these ideas are extended through studies of individuals involved in full-scale intergroup conflict. In particular, Kallezi, Reicher, and Cassidy show how the mental health of Kosovans involved in the 1999 Kosovan conflict is positively predicted by their membership of a group for whom that conflict is identity-affirming rather than identity-negating (in this case, members of groups who supported the war rather than opposed it). Their evidence suggests that this is because where the conflict was identity-affirming, those who are affected by the disturbing events of the war feel more comfortable discussing their experiences openly with other ingroup members. As a result, they receive more support from others and are less likely to have to suffer in silence and alone.

This work by Kallezi and colleagues builds upon previous evidence that shared social identity has a positive impact on work and life satisfaction because it serves as a basis for the receipt of effective support from ingroup members (e.g. one's work colleagues or family; see Cohen & Wills, 1985). This idea is supported by correlational studies among (a) hospital patients recovering from heart attacks and (b) professional groups exposed to work-related stressors (bomb disposal experts and bar staff; Haslam et al., 2005). It also emerges clearly from cleverly crafted experimental studies conducted by Levine, Prosser, Evans, and Reicher (2005). These show that a person's willingness to come to the assistance of a stranger in distress is enhanced when the stranger in question shares a salient social identity with the prospective helper (see also Levine, Cassidy, Brazier, & Reicher, 2002). Other experimental research by Haslam, Jetten, O'Brien, and Jacobs (2004) also shows that positive responses to support (in this case messages providing potentially helpful information about stress) are themselves predicated upon shared social identity.

Consistent with this point, recent longitudinal research indicates that social identification with a workgroup has a positive long-term impact on

individuals' health, well-being, and morale because it is associated with factors (e.g. support and appreciation) that protect individuals from burnout during demanding phases of group activity (Haslam, Jetten, & Waghorn, in press). Evidence of related patterns also emerges from studies of participants with cognitive deficits. Specifically, Jones, Williams, Haslam, Jetten, and Morris (2008) conducted a large-scale study of individuals who had experienced traumatic brain injury (TBI) and unexpectedly found a small but significant *positive* correlation between the severity of TBI and life satisfaction. Resolving this seemingly paradoxical finding, follow-up analysis revealed that this relationship could be explained by the fact that TBI tended to increase individuals' sense of personal identity strength by bringing them closer to family and other social networks from whom they received social support in the process of recovering from their trauma.

4. Social Identity as a Coping Resource

Alongside evidence of the relationship between social identity and social support, research has also shown that a sense of shared identity underpins the capacity for members of disadvantaged groups to work together to buffer themselves from the negative consequences of their circumstances (Blaine & Crocker, 1995; Branscombe et al., 1999; James, Lovato, & Khoo, 1994; Schmitt & Branscombe, 2002; Postmes & Branscombe, 2002). In particular, this is the central plank of Schmitt and Branscombe's influential rejection-identification model. In line with evidence discussed above (e.g. Levine et al., 2002), this argues that the shared social identity of members of stigmatised groups provides a basis for giving, receiving, and benefiting from social support that provides individuals with the emotional, intellectual, and material resources to cope with and resist the injustice of discrimination, prejudice, and stigma (see also, Iyer, Jetten, Tsivrikos, Postmes, & Haslam, in press).

Work that elaborates on these points is particularly well represented in this special issue. The contribution of Latrofa and colleagues shows how southern Italians' capacity to resist discrimination is predicted by social identification with their ingroup, and especially by self-stereotyping oneself as an ingroup member (so that the self is defined as "us"; Turner, 1982). Amongst a sample of immigrants from Russia to Finland, the longitudinal study by Jasinskaja-Lahti, Liebkind, and Solheim also points to the important (but complex) role that (a) maintenance of identification with an ethnic group of origin and (b) development of identification with a new national group play in determining people's experiences of discrimination and the stress that they feel as a result (as well as exploring the reverse impact of feelings of stress on identifications and perceptions of discrimination). Along related lines, an ambitious survey study by Muldoon, Schmid, and

Downes shows that in Northern Ireland the degree to which proximity to conflict predicts negative well-being depends upon whether exposure to the stressors associated with conflict is buffered by national identification. Finally, Outten, Schmitt, Garcia, and Branscombe revisit the issue of Black Americans' responses to prejudice and show how levels of racial identification predict the coping options that individuals see as feasible (in particular, their sense that their ingroup can deal collectively with its problems) and, through this, those individuals' well-being.

These findings elaborate programmatically upon previous studies of Black Americans' responses to prejudice (Branscombe et al., 1999; see also James, 1997; Williams, Spencer, & Jackson, 1999). In other respects, the contributions brought together in this special issue also add to a small but growing body of work in health contexts which indicates that social identity-based support groups help people with mental illness (e.g. bipolar depression or high-functioning autism) cope with the stigma of their condition (e.g. so that they see themselves as creative and insightful rather than disturbed and withdrawn) and to reject the negative stereotypes that others hold of them in the process of coming to hold more positive views of themselves and their potential (Camp, Finlay, & Lyons, 2002; Crabtree et al., 2008; Hall & Cheston, 2002; Jacoby, Snape, & Baker, 2005; Shadden & Agan, 2004).

Also noteworthy in this context is a growing body of work which indicates that processes of social identification have an impact not only on individuals' self-reported mental and clinical states but also on their physiological responses to various potentially problematic exigencies. This has proved particularly true in circumstances where people are exposed to stressors that pose an identity-relevant threat. Experimental work by Matheson and Cole (2004) provides a particularly elegant demonstration of this point. This found that when a threat to participants' social identity as students at a particular university was perceived to be controllable (so that it was something the ingroup could overcome), this was associated with greater use of problem-focused coping, greater optimism, and lower levels of salivary cortisol (a physiological indicator of stress).

Related evidence also emerges from Haslam and Reicher's (2006) nine-day examination of prisoners and guards in a simulated prison environment (the BBC Prison Study; Reicher & Haslam, 2006b). This found that as prisoners developed a sense of shared social identity and collectively resisted the stressors they faced, their well-being increased (as evidenced on measures of burnout and depression) and levels of cortisol remained stable. On the other hand, over the same period, guards' well-being declined and their cortisol levels increased because they failed to develop a sense of shared identity and consequently experienced failure as a group (being unable to resist the threat posed by the prisoners). As Reicher and Haslam (2006b) note, work of this form points to the capacity for social identity (and the

socially structured mind) not only to shape individual psychology but, through this, to impact upon "basic" autonomic functioning.

5. Social Identity as a Determinant of Clinical Outcomes

Work discussed in the previous section points to a close link between social identity and well-being in a range of social and clinical groups. However, other work points to similar processes impacting on the actual clinical outcomes for members of at-risk groups. Cole, Kemeny, and Taylor (1997) provide a particularly poignant demonstration of this point in their research on the development of HIV among gay men. This found that the progression of HIV was significantly faster among those members of this group who were sensitive to rejection on the basis of their inability to sustain particular social identities.

In the present issue, related ideas are explored in an educational context by Bizumic, Reynolds, Turner, Bromhead, and Subasic. In a study that has major implications for educational practice and policy, they observe that teachers' and students' identification with their school is a strong positive predictor not only of individuals' anxiety and depression, but also of their ability to maintain emotional control and eschew disruptive behaviour. In this way, social identification is observed to have import not only for individuals' mental health but also for the well-being and sustainability of the institutions and societies in which they are embedded (see also Reicher & Haslam, 2006b; Putnam, 2000).

Related work has also begun to examine the implications of social identity *continuity* for mental functioning (e.g. Bonanno, Papa, & O'Neill, 2001; Sani, 2008). Here there is evidence that social identity *loss* (e.g. as a result of retirement, work restructuring, or illness) can have a dramatic negative impact on well-being and mental health (e.g. Jetten, O'Brien, & Trindall, 2002). For example, among a sample of stroke sufferers, Haslam, Holme, Haslam, Iyer, Jetten, and Williams (2008) found strong associations between life satisfaction and (a) membership of multiple groups prior to stroke and (b) fewer perceived cognitive failures post-stroke. Here, though, the relationship between these factors and well-being was mediated by participants' membership of multiple groups post-stroke—a finding which suggests that pre-existing group memberships and preserved cognitive ability were important *because* they increased the likelihood of people being able to *maintain* valued social identities after their stroke.

In line with the rejection-identification model, it would thus appear that maintained social identification can play a role in sustaining the health of vulnerable populations. Further evidence that supports this idea emerges from a six-year longitudinal study of older adults in rural Canada

conducted by Bailis, Chipperfield, and Helgason (2008). This found that high levels of group-based self-esteem (associated with retention of control over one's own fate) were a major protective factor against chronic illness (see also Chandler & Lalonde, 1998; Michinov, Fouquereau, & Fernandez, 2008).

Accordingly, it would appear that there might be scope for the well-being and mental functioning of vulnerable groups to be enhanced through *interventions* that aim to maintain or increase individuals' sense of shared social identity. This possibility has been supported by the findings of studies that have recently been conducted with groups of older adults. In one such study, Knight, Haslam, and Haslam (2008) found that residents who were involved *as a group* in decisions surrounding the décor of communal spaces in a new care home into which they were being moved showed increased social identification with staff and fellow residents, and increased life satisfaction. They were also four times more likely to use communal areas than residents in a control condition who were not involved in decisions surrounding their new environment. Likewise, Clare et al. (2008) found that the creation of an internet-based self-help group for dementia sufferers helped them to overcome a sense of loss and uncertainty and to develop a sense of collective voice and political agency that had a range of positive consequences for well-being.

In another intervention study, Haslam, Bevins, Hayward, Tonks, Haslam, and Jetten (2008) randomly assigned care home residents to one of three experimental conditions in which, over a six-week period, they participated in either group-based reminiscence therapy, individual reminiscence therapy, or group skittle playing. As predicted, relative to the individual reminiscence condition, participants in the other two conditions showed increased social identification (a reduced sense of isolation). Importantly, though, this was associated with modality-specific improvements in residents' psychological functioning over the course of the study. For those in skittles groups it was associated with lower levels of depression and enhanced quality of life; for those in reminiscence groups it was associated with improved memory performance. In stark contrast, individual reminiscence therapy had neither clinical nor cognitive benefits for participants.

These developments are exciting and important for at least two reasons. First, they point to the capacity for social identity theorising to inform practical strategies aimed at maintaining and enhancing well-being—particularly among at-risk populations. Second, they point to ways in which cognitive function and dysfunction is structured by social factors that determine both who people think they are and what they are capable of (Jetten, Haslam, Pugliese, Tonks, & Haslam, 2008). It is not just that because we are well we are more likely to participate in group life, but also that because we participate in group life we are more likely to be well (Putnam, 2000).

THE EMERGING AGENDA

Over the last two decades the impact of the core ideas of social identity and self-categorisation theories has been phenomenal. Indeed, core statements of the two theories (Tajfel, 1981; Tajfel & Turner, 1979, 1986; Turner, 1982, 1985, 1991; Turner et al., 1987, 1994) have been referenced over 10,000 times by over 2,000 scientists in over 50 countries, in over 80 research fields (from Applied Linguistics to Zoology), and in over 300 journals (from *Accounting Review* to *Zeitschrift für Soziologie*;[1] see Haslam, Ellemers, Reicher, Reynolds, & Schmitt, in press).

One major feature of this impact has been a dramatic upsurge of interest in the study of social identity processes in applied contexts, and in the extension of insights from the corpus of work in the social identity tradition to areas of applied psychology. Paralleling this trend, there has been increasing interest in the specific role that group memberships (and the social identities associated with them) play in determining people's health and well-being.

The scale of this growth can be gauged by considering the increase over time in the number of articles whose titles, abstracts, or keywords jointly reference "social/organisational/ ethnic identity/identification" and "health and/or well(-)being". The trend line plotted in the top panel of Figure 1 reveals a logarithmic increase in the number of publications that include those terms, while the trend line in the bottom panel points to a quadratic increase in the number of times these publications have themselves been cited (with both trends explaining more than 90% of the variance in the data). As the contributions to the present issue testify, the number of major research groups that are turning their attention to these topics is also increasing. Such developments seem destined to herald increased interest in issues of social identity and health in years to come.

Most recently, these trends have been signalled by the inaugural issue of *Applied Psychology: Health and Well-Being* (Schwarzer & Peterson, 2008), which featured a number of papers focusing on the importance of groups and group life to physical and mental health (e.g. Nikitin & Freund, 2008; Peterson, Park, & Sweeney, 2008). As Peterson and colleagues observe in their contribution to this issue, "it is in groups that we live, work, and play, and groups should therefore be a primary focus of researchers interested in health and well-being" (p. 19; see also Contrada & Ashmore, 1999; Orford, 1992).

We would extend this point to argue that the quality of group life should be a primary focus for health professionals and policy-makers interested in

---

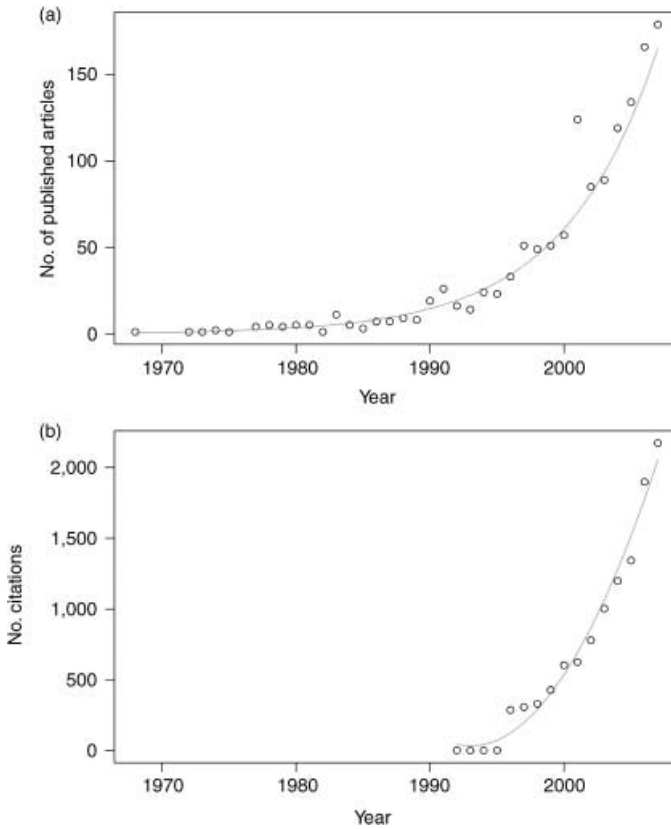[1] Data abstracted from Google Scholar and Web of Science, 21 August 2008.

FIGURE 1.   (a) Number of published articles on "social/organisational/ethnic identity/identification" and "health and/or well(-)being" by year; (b) Number of citations to these published articles by year.

Note: Data abstracted from Scopus, 21 August 2008.

the welfare of their clients. Indeed, in this vein, a contemporaneous special issue of *Neuropsychological Rehabilitation* on "Self and Identity" identifies this as a central factor in patients' ability to recover from brain injury and related forms of neuropsychological insult. As the editors remark in their summary of work in this area, the social (group-based) context of recovery emerges as an "overwhelming theme" that has given particular impetus to researchers' rapidly growing interest in this area (Gracey & Ownsworth, 2008, p. 526).

It is worth noting too that these developments are of interest not only for researchers working in fields of applied psychology who are turning to the social identity approach for the first time, but also to those theorists who

have been working within this tradition for many years (in some cases several decades). There are at least three reasons for this. First, this newly emerging area of inquiry serves as a novel testing ground for social identity and self-categorisation theories. Second, it provides scope for the elaboration and extension of those theories by using them to address problems and phenomena beyond the realm of traditional social identity work. More importantly still, it provides an opportunity not only to enrich academic understanding, but to inform and transform policy and practice in a vital sphere of human experience.

These are points to which all the contributions in this special issue bear testament. In this, one of their key messages is that social identities—and the sense of psychological community associated with them—constitute much of what we live *for* and of what we live *by*. Indeed, it is for this reason that they are such a fundamental part of our lives and so central to our well-being. It is for this reason, too, that the research agenda that this work sets is truly radical. For not only does this involve a rethinking of the source of well-being, but so too it forces us to rethink the means by which it can be promoted and maintained.

REFERENCES

Adams, S., Pill, R., & Jones, A. (1997). Medication, chronic illness and identity: The perspective of people with asthma, *Social Science and Medicine*, *45*, 189–201.

Bailis, D.S., Chipperfield, J.G., & Helgason, T.R. (2008). Collective self-esteem and the onset of chronic conditions and reduced activity in a longitudinal study of aging. *Social Science and Medicine*, *66*, 1817–1827.

Baron-Cohen, S., & Klin, A. (2006). What's so special about Asperger Syndrome? *Brain and Cognition*, *61*, 1–4.

Blaine, B., & Crocker, J. (1995). Religiousness, race, and psychological well-being: Exploring social-psychological mediators. *Personality and Social Psychology Bulletin*, *21*, 1031–1041.

Bonanno, G.A., Papa, A., & O'Neill, K. (2001). Loss and human resilience. *Applied and Preventive Psychology*, *10*, 193–206.

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 and Social Psychology*, *77*, 135–149.

Camp, D.L., Finlay, W.M.L., & Lyons, E. (2002). Is low self-esteem an inevitable consequence of stigma? An example of women with chronic mental health problems. *Social Science and Medicine*, *55*, 823–834.

Campbell, C. (1997). Migrancy, masculine identities and AIDs: The psychosocial context of HIV transmission on the South African gold mines. *Social Science and Medicine*, *45*, 273–281.

Campbell, C., & Jovchelovitch, S. (1997). Health, community and development: Towards a social psychology of participation. *Journal of Community and Applied Social Psychology*, *10*, 255–270.

Chandler, M.J., & Lalonde, C.E. (1998). Cultural continuity as a hedge against suicide in Canada's first nations. *Transnational Psychiatry*, *35*, 191–219.

Clare, L., Rowlands, J., & Quin, R. (2008). Collective strength: The impact of developing a shared social identity in early-stage dementia. *Dementia: The International Journal of Social Research and Practice*, *7*, 9–30.

Cockerham, W. (2007). *The social causes of health and disease*. New York: Polity.

Cohen, S., & Wills, T.A. (1985). Stress, social support and the buffering hypothesis. *Psychological Bulletin*, *98*, 310–357.

Cole, S.W., Kemeny, M.E., & Taylor, S.E. (1997). Social identity and physical health: Accelerated HIV progression in rejection-sensitive gay men. *Journal of Personality and Social Psychology*, *72*, 320–335.

Contrada, R.J., & Ashmore, R.D. (1999). *Self, social identity, and physical health: Interdisciplinary explorations*. Oxford: Oxford University Press.

Cooper, L.A., Gonzales, J.J., Gallo, J.J., Rost, K.M., Meredith, L.S., Rubenstein, L.V., Wang, N.-Y., & Ford, D.E. (2003). The acceptability of treatment for depression among African-American, Hispanic, and White primary care patients. *Medical Care*, *41*, 479–489.

Crabtree, J.W., Haslam, S.A., Postmes, T., & Haslam, C. (2008). Mental health support groups, stigma and self-esteem: Positive and negative implications of social identification. Unpublished manuscript, University of Exeter.

Craddock, S. (2000). Disease, social identity, and risk: Rethinking the geography of AIDS. *Transactions of the Institute of British Geographers*, *25*, 153–168.

Drury, J., & Reicher, S. (1999). The intergroup dynamics of collective empowerment: Substantiating the social identity model. *Group Processes and Intergroup Relations*, *2*, 381–402.

Ellemers, N. (1993). The influence of socio-structural variables on identity enhancement strategies. *European Review of Social Psychology*, *4*, 27–57.

Ellemers, N., De Gilder, D., & Haslam, S.A. (2004). Motivating individuals and groups at work: A social identity perspective on leadership and group performance. *Academy of Management Review*, *29*, 459–478.

Gracey, F., & Ownsworth, T. (2008). Editorial. *Neuropsychological Rehabilitation* (Special Issue on "Self and Identity"), *18*(5–6), 522–526.

Hall, S., & Cheston, R. (2002). Mental health and identity: The evaluation of a drop-in centre. *Journal of Community and Applied Social Psychology*, *12*, 30–43.

Harwood, J., & Sparks, L. (2003). Social identity and health: An intergroup communication approach to cancer. *Health Communication*, *15*, 145–159.

Haslam, C., Bevins, A., Hayward, S., Tonks, J., Haslam, S.A., & Jetten, J. (2008). Connecting with groups: The benefits of group reminiscence and social activity on the cognitive performance and well-being of older adults in residential care. Unpublished manuscript, University of Exeter.

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, S.A. (2001). *Psychology in organizations: The social identity approach*. London: Sage.

Haslam, S.A., Ellemers, N., Reicher, S., Reynolds, K., & Schmitt, M. (in press). The social identity perspective: An assessment of the impact and trajectory of its core

ideas. In T. Postmes & N. Branscombe (Eds.), *Rediscovering social identity: Core sources*. New York: Psychology Press.

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*, *20*, 3–9.

Haslam, S.A., Jetten, J., & Waghorn, C. (in press). Social identification, stress, and citizenship in teams: A five-phase longitudinal study. *Stress and Health*.

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*, 355–370.

Haslam, S.A., Postmes, T., & Ellemers, N. (2003). More than a metaphor: Organizational identity makes organizational life possible. *British Journal of Management*, *14*, 357–369.

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

Hogan, D.P., & Biratu, B. (2004). Social identity and community effects on contraceptive use and intentions in southern Ethiopia. *Studies in Family Planning*, *35*, 79–90.

Iyer, A., Jetten, J., & Tsivrikos, D. (2008). Torn between identities: Predictors of adjustment to identity change. In F. Sani (Ed.), *Self-continuity: Individual and collective perspectives* (pp. 187–197). New York: Psychology Press.

Iyer, A., Jetten, J., Tsivrikos, D., Postmes, T., & Haslam, S.A. (in press). What's left behind: Group identification as a facilitator and barrier in times of change. *British Journal of Social Psychology*.

Jacoby, A., Snape, D., & Baker, G.A. (2005). Epilepsy and social identity: The stigma of a chronic neurological disorder. *Lancet Neurology*, *4*, 171–178.

James, K. (1997). Worker social identity and health-related costs for organizations: A comparative study between ethnic groups. *Journal of Occupational Health Psychology*, *2*, 108–117.

James, K., Lovato, C., & Khoo, G. (1994). Social identity correlates of minority workers' health. *Academy of Management Journal*, *37*, 383–396.

Jetten, J., Haslam, C., Pugliese, C., Tonks, J., & Haslam, S.A. (2008). Declining autobiographical memory and the loss of identity: Effects on well-being. Unpublished manuscript, University of Queensland.

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

Jones, J., Williams, W.H., Haslam, S.A., Jetten, J., & Morris, R. (2008). That which does not kill me makes me stronger: How an increased sense of social identity explains a positive relationship between traumatic brain injury and well-being. Paper presented at the International Neuropsychology Society Conference, Buenos Aires, 2–4 June.

Knight, C., Haslam, S.A., & Haslam, C. (2008). Whose home is it anyway? Evidence that collective decision making enhances older adults' social identification, well-being, and use of communal space when moving into a new care facility. Unpublished manuscript, University of Exeter.

Kobus, K. (2003). Peers and adolescent smoking. *Addiction*, *98*, 37–55.

Laverie, D.A. (1998). Motivations for ongoing participation in a fitness activity. *Leisure Sciences*, *20*, 277–302.

Levine, R.M., & Reicher, S.D. (1996). Making sense of symptoms: Self-categorization and the meaning of illness and injury. *British Journal of Social Psychology*, *35*, 245–256.

Levine, R.M., Cassidy, C., Brazier, G., & Reicher, S.D. (2002). Self-categorization and bystander non-intervention: Two experimental studies. *Journal of Applied Social Psychology*, *32*, 1452–1463.

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

Matheson, K., & Cole, B.M. (2004). Coping with a threatened identity: Psychosocial and neuroendocrine responses. *Journal of Experimental Social Psychology*, *40*, 777–786.

Michinov, E., Fouquereau, E., & Fernandez, A. (2008). Retirees' social identity and satisfaction with retirement. *International Journal of Aging and Human Development*, *66*, 175–194.

Millward, L.J. (1995). Contextualizing social identity in considerations of what it means to be a nurse. *European Journal of Social Psychology*, *25*, 303–324.

Nikitin, J., & Freund, A.M. (2008). The role of social approach and avoidance motives for subjective well-being and successful transition to adulthood. *Applied Psychology: An International Review*, *57*, 90–111.

Oakes, P.J., Haslam, S.A., & Turner, J.C. (1994). *Stereotyping and social reality*. Oxford: Blackwell.

Orford, J. (1992). *Community psychology*. Chichester: John Wiley.

Oyserman, D., Fryberg, S.A., & Yoder, N. (2007). Identity-based motivation and health. *Journal of Personality and Social Psychology*, *93*, 1011–1027.

Peterson, C., Park, N., & Sweeney, P.J. (2008). Group well-being: Morale from a positive psychology perspective. *Applied Psychology: An International Review*, *57*, 19–36.

Postmes, T. (2003). A social identity approach to communication in organizations. In S.A. Haslam, D. van Knippenberg, M.J. Platow, & N. Ellemers (Eds.), *Social identity at work: Developing theory for organizational practice* (pp. 81–97). Philadelphia, PA: Psychology Press.

Postmes, T., & Branscombe, N. (2002). Influence of long-term racial environmental composition on subjective well-being in African Americans. *Journal of Personality and Social Psychology*, *83*, 735–751.

Postmes, T., & Branscombe, N. (Eds.) (in press). *Rediscovering social identity: Core sources*. New York: Psychology Press.

Putnam, R.D. (2000). *Bowling alone: The collapse and revival of American community*. New York: Simon & Schuster.

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

Reicher, S.D., & Haslam, S.A. (2006b). Tyranny revisited: Groups, psychological well-being and the health of societies. *The Psychologist*, *19*, 146–150.

Reicher, S.D., Haslam, S.A., & Hopkins, N. (2005). Social identity and the dynamics of leadership: Leaders and followers as collaborative agents in the transformation of social reality. *Leadership Quarterly*, *16*, 547–568.

Sani, F. (Ed.) (2008). *Individual and collective self-continuity*. Mahwah, NJ: Erlbaum.

Schmitt, M.T., & Branscombe, N.R. (2002). The meaning and consequences of perceived discrimination in disadvantaged and privileged social groups. *European Review of Social Psychology*, *12*, 167–199.

Schofield, P.E., Pattison, P.E., Hill, D.J., & Borland, R. (2003). Youth culture and smoking: Integrating social group processes and individual cognitive processes in a model of health-related behaviours. *Journal of Health Psychology*, *8*, 291–306.

Schwarzer, R., & Peterson, C. (Eds.) (2008). Special issue on "Health and well-being". *Applied Psychology: An International Review, 57*.

Shadden, B.B., & Agan, J.P. (2004). Renegotiation of identity: The social context of aphasia support groups. *Topics in Language Disorders*, *24*, 174–186.

St Claire, L., Clift, A., & Dumbelton, L. (2008). How do I know what I feel? Evidence for the role of self-categorisation in symptom perceptions. *European Journal of Social Psychology*, *38*, 173–186.

Tajfel, H. (1972). Experiments in a vacuum. In J. Israel & H. Tajfel (Eds.), *The context of social psychology: A critical assessment* (pp. 69–119). London: Academic Press.

Tajfel, H. (1981). *Human groups and social categories*. Cambridge: Cambridge University Press.

Tajfel, H., & Turner, J.C. (1979). An integrative theory of intergroup conflict. In W.G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–47). Monterey, CA: 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* (2nd edn., pp. 7–24). Chicago, IL: Nelson-Hall.

Tucker, J.L., & Kelley, V.A. (2000). The influence of patient sociodemographic characteristics on patient satisfaction. *Military Medicine*, *165*, 72–76.

Turner, J.C. (1982). Towards a cognitive redefinition of the social group. In H. Tajfel (Ed.), *Social identity and intergroup relations* (pp. 15–40). Cambridge: Cambridge University Press.

Turner, J.C. (1985). Social categorization and the self-concept: A social cognitive theory of group behaviour. In E.J. Lawler (Ed.), *Advances in group processes* (vol. 2, pp. 77–122). Greenwich, CT: JAI Press.

Turner, J.C. (1991). *Social influence*. Milton Keynes: Open University Press.

Turner, J.C. (1999). Some current issues in research on social identity and self-categorization theories. In N. Ellemers, R. Spears, & B. Doosje (Eds.), *Social identity: Context, commitment, content* (pp. 6–34). Oxford: Blackwell.

Turner, J.C. (2005). Explaining the nature of power: A three-process theory. *European Journal of Social Psychology*, *35*, 1–22.

Turner, J.C., & Haslam, S.A. (2001). Social identity, organizations and leadership. In M.E. Turner (Ed.), *Groups at work: Advances in theory and research* (pp. 25–65). Hillsdale, NJ: Erlbaum.

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

Turner, J.C., Oakes, P.J., Haslam, S.A., & McGarty, C.A. (1994). Self and collective: Cognition and social context. *Personality and Social Psychology Bulletin*, *20*, 454–463.

Wegge, J., Van Dick, R., Fisher, G.K., Wecking, C., & Moltzen, K. (2006). Work motivation, organizational identification, and well-being in call centre work. *Work and Stress*, *20*, 60–83.

Williams, D.R., Spencer, M.S., & Jackson, J.S. (1999). Race stress and physical health: The role of group identity. In R.J. Contrada & R.D. Ashmore (Eds.), *Self, social identity, and physical health: Interdisciplinary explorations* (pp. 71–100). Oxford: Oxford University Press.