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Depression and Social Identity: An Integrative Review

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Abstract

Social relationships play a key role in depression. This is apparent in its etiology, symptomatology, and effective treatment. However, there has been little consensus about the best way to conceptualize the link between depression and social relationships. Furthermore, the extensive social-psychological literature on the nature of social relationships, and in particular, research on social identity, has not been integrated with depression research. This review presents evidence that social connectedness is key to understanding the development and resolution of clinical depression. The social identity approach is then used as a basis for conceptualizing the role of social relationships in depression, operationalized in terms of six central hypotheses. Research relevant to these hypotheses is then reviewed. Finally, we present an agenda for future research to advance theoretical and empirical understanding of the link between social identity and depression, and to translate the insights of this approach into clinical practice.

Keywords

social identity theory, self-categorization theory, depression, social capital, social isolation, mental health

Depression is the second most common mental health problem, with at least 20% of people in developed countries experiencing it at some point in their lives. It is the leading cause of disability worldwide (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006; World Health Organisation, 2012). Depression is one of the most common presentations to treating health professionals, and evidence indicates that its prevalence has been increasing for some time (Klerman & Weissman, 1989; Kruijshaar et al., 2005). Although evidence-based treatments do exist for the condition (both pharmacological and psychological), research suggests that only a minority of people with depression receive adequate acute care (Goldman, Nielsen, & Champion, 1999; Simon, Fleck, Lucas, & Bushnell, 2004; Young, Klap, Sherbourne, & Wells, 2001). Often, this is due to the expense of treatment (Simon et al., 2004) or the stigma associated with seeking anti-depressant medication or therapy (Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Phelan, Yang, & Cruz-Rojas, 2006). Furthermore, relapse rates remain high, such that the average person with a history of depression is expected to experience four episodes across his or her lifespan (Judd, 1997). Even among patients who receive the gold-standard treatment—comprising a combination of anti-depressant medication and cognitive-behavioral therapy (CBT)—25% are expected to relapse within 2 years (Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998). For these reasons, ongoing research that contributes to our understanding of the etiology and treatment of depression has been prioritized by the World Health Orgnaisation (Lopez et al. 2006). In this article, we outline how a social identity approach (SIA) can address both of these priority areas.

This review is divided into four broad sections. "The Important Role of Social Relationships in Depression" outlines the ample evidence that depression is a fundamentally *social* disorder, with reduced social connectedness[1] implicated as a cause, symptom, and target for treatment of depression. This section also draws attention to current gaps in knowledge and identifies three key questions to be resolved: Why social connectedness is so important in depression, how it should be measured, and how it might be most effectively enhanced through intervention. "The Social Identity Approach" section provides a social-psychological perspective on group processes that explains why social relationships are critical for the functioning of the self. This is used as a basis for developing six hypotheses that relate to key aspects of depression and speak to these questions of measurement, mechanism, and intervention. In the "Empirical Evidence: Social Identity and Depression" section, the

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existing literature is reviewed to assess the degree to which available evidence supports each of these hypotheses. Finally, "An Agenda for Research Into Social Identity and Depression" highlights current gaps in the evidence and sets out an agenda for future research, with a view not only to formulating a theoretical understanding of social connectedness and depression but also to enhancing clinical interventions that target its prevention and treatment. In this, our goal is to present a novel analysis of the role of social connectedness in depression capable of stimulating new and fruitful avenues of investigation and of informing clinical practice.

The Important Role of Social Relationships in Depression

Clinical depression is understood by researchers and practitioners alike to be more than simply low mood. In addition to feeling miserable, apathetic, and self-critical, a person experiencing an episode of major depression also exhibits a cluster of cognitive and behavioral changes, chief among which is social withdrawal. Depression is typically characterized by social isolation and reduced social connectedness (Wade & Kendler, 2000). One of its core symptoms (which is as central to diagnosis as low mood) is *anhedonia*—loss of interest or pleasure in previously enjoyed activities (American Psychiatric Association, 2000). This most typically manifests as withdrawal from social relationships, both formally (e.g., quitting sporting groups) and informally (e.g., seeing friends less often). Reduced social connectedness is thus a key characteristic of depression, such that impairment in this domain is significantly more common in this condition than in other physical and mental illnesses (Hirschfeld et al., 2000).

Critically, marked differences in social connectedness also emerge *prior* to the development of depression symptoms. Social isolation has therefore been observed to be a strong risk factor for the development and recurrence of depression (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Glass, De Leon, Bassuk, & Berkman, 2006; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). For example, in one study, Cacioppo, Hawkley, and Thisted (2010) found that perceived social isolation was a good longitudinal predictor of depression symptoms even after controlling for key candidate variables (demographic characteristics, personality, physical health, stress, and a number of objective indicators of social-relationship quality; Cacioppo et al., 2010). Lack of social support has also been found to predict suicidal ideation 1 year later (Handley et al., 2012). In a more fine-grained analysis, Bolger, DeLongis, Kessler, and Schilling (1989) found that interpersonal conflict was the most important stressor for predicting daily fluctuations in negative mood. In addition, these researchers observed that interpersonal conflict had escalating effects on mood if it continued over a number of days, whereas for other kinds of stressors, there was evidence of habituation such that mood returned to baseline (or better) within a day of the stressor commencing. It therefore appears that people are uniquely sensitive to social forms of stress (such as rejection or conflict) relative to other stressful life events.

Taken a step further, an episode of depression is often triggered by a specific negative event in the social sphere (Tennant, 2002). Most commonly, this is a social loss of some kind such as the death of a loved one, but it may also result from other factors such as family conflict, workplace bullying, or a relationship breakdown (Paykel, 1994). As a result, reduced social connectedness is not only symptomatic of depression but also appears to have a causal role in its development.

There is also a third way in which social connectedness is implicated in depression, and this pertains to processes of remission and recovery. Here, there is evidence that impaired social functioning often persists long after remission (Coryell et al., 1993; Kennedy, Foy, Sherazi, Mcdonough, & Mckeon, 2007) and increases the risk of relapse (George, Blazer, Hughes, & Fowler, 1989; Paykel, Emms, Fletcher, & Rassaby, 1980). Low social support also predicts poor response to treatment and early dropout (Trivedi et al., 2005).

As a corollary of this, social connectedness has also been found to play a role in the alleviation of depression symptoms and is a core component of effective depression treatment. More specifically, CBT for depression (Beck, 2011) acknowledges that social isolation is a central feature of presentation and often requires targeted intervention. In this regard, *behavioral activation* is a key CBT strategy that directly targets social connectedness (Cuijpers, Van Straten, & Warmerdam, 2007; Veale, 2008). This technique is predicated on the assumption that withdrawal from meaningful activities maintains depressive symptoms. Patients are therefore encouraged to schedule activities that bring them a sense of pleasure or success, particularly activities that were previously important to them. Speaking to the value of this approach, although it has not been a focus for research attention, there is some evidence that CBT improves social functioning relative to pharmacological treatments (Scott et al., 2012).

However, behavioral activation has a broad focus on all kinds of withdrawal or inactivity, and therefore each treatment and practitioner varies in the degree to which they target social connectedness specifically (e.g., by helping a patient rejoin a sports team) rather than other kinds of activity (e.g., by helping a patient recommence daily walks). This is because the proposed mechanism of behavioral activation is not social in nature but is rather theorized to be an increased rate of positive reinforcement (Dimidjian, Martell, Addis, & Herman-Dunn, 2008). Lack of effective social functioning in depression is also typically conceptualized as an individual-level deficit—associated with the individual *as an* individual (i.e., "me") rather than as a problem that is associated with the sense of the self derived from membership in a social group ("us"). For this reason, a range of

individual-focused interventions—including social skills training, assertiveness or conflict resolution training, and increased social activity—are variously recommended as adjuncts to standard treatment (Nilsen, Karevold, Røysamb, Gustavson, & Mathiesen, 2012; Segrin, 2000; Steger & Kashdan, 2009; Trivedi et al., 2005).

Although such interventions are increasingly prescribed (Lewinsohn & Clarke, 1999), currently, there is no coherent framework to understand these changes to social relationships that might allow treating professionals to address these concerns in a consistent and theoretically informed way. Furthermore, only a handful of studies have directly measured social functioning in relation to CBT for depression (e.g., Evans & Connis, 1995; Luk et al., 1991). Consequently, it is unclear whether CBT might be enhanced through a greater focus on social connectedness, or indeed, to what extent the success of strategies such as behavioral activation is in any sense attributable to the improvements in connectedness that they may bring about (Collins & Dozois, 2008; Cuijpers et al., 2007; Webb, Auerbach, & Derubeis, 2012). Similarly, it is unclear whether the efficacy of group CBT (which is just as effective in the treatment of depression as individual CBT, see Oei & Dingle, 2008) is attributable to the social components of the treatment. Nevertheless, researchers have reported that patients attribute much of their improvement to group factors (Covi, Roth, & Lipman, 1982).

Another key intervention for depression that has proven efficacy is interpersonal psychotherapy (IPT; Elkin et al., 1995). This approach places more emphasis on the critical role of social relationships than CBT (Weissman & Markowitz, 1994) and therefore speaks more directly to the evidence reviewed above. IPT proposes that depression is the outcome of problems in at least one of four interpersonal domains: grief, role disputes, role transitions, or interpersonal deficits (Weissman, Markowitz, & Klerman, 2000). However, we argue that although the efficacy of IPT (Weissman & Markowitz, 1994) speaks to the importance of addressing social factors in depression, it does not offer a theoretically derived model of social relationships in depression. In fact, because IPT was originally developed as a control verbal therapy condition for CBT in the Treatment of Depression Collaborative Research Project (Elkin et al., 1995), it is relatively weak in terms of theory. It espouses a medical "symptom" model of depression, and the goals of therapy are to alleviate symptoms and improve the social functioning of the individual (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman et al., 2000). Yet, IPT focuses on individual ties rather than group memberships, and no social factors are theorized or routinely monitored to show treatment outcome. Therefore, although IPT orients treatment toward social factors, it does not provide an explanatory model that might account for the central role of social relationships in the etiology, symptomatology, and effective treatment of depression. Below, we expand on what such a model might look like.

This section has outlined evidence that compromised social connectedness can precipitate, characterize, and maintain clinical depression. The fact that the literature has consistently found these effects is all the more surprising in light of the many different ways in which researchers have conceptualized and measured social connectedness. It is clear, for example, that an abundance of terms are used within the literature to capture the phenomena that we have collectively referred to as "social connectedness" or "social relationships." These include social support (Cohen & Wills, 1985), loneliness (Cacioppo et al., 2006), social capital (Putnam, 2001), social networks (Fowler & Christakis, 2008), and belonging (Baumeister & Leary, 1995). Moreover, these constructs have been operationalized in ways as diverse as measuring a person's living situation, their number of close friends, their employment status, their formal membership of community groups, and the frequency and intensity of their contact with family (Berry & Welsh, 2010; Holt-Lunstad, Smith, & Layton, 2010; Kikuchi & Coleman, 2012). In addition, a wide variety of formal scales have been used to measure the subjective quality of social experiences such as perceived support (Harpham, Grant, & Thomas, 2002; Heitzmann & Kaplan, 1988). This diversity in turn speaks to the absence of a unifying framework or model that might lend coherence to the analysis of social connectedness in depression. Indeed, although many researchers have recognized the importance of this relationship, it is apparent that there has been little agreement regarding three central issues:

Research Question 1 (RQ1): How should social connectedness be measured?
Research Question 2 (RQ2): Why and how does social connectedness affect depression (i.e., what is the mechanism of action)?
Research Question 3 (RQ3): What types of social connectedness are likely to be the most beneficial in treating (or reducing the likelihood of) depression?

It is with a view to providing a coherent and integrated answer to these questions that, in the following section, we outline a body of theory that has addressed similar issues within the field of social psychology.

The Social Identity Approach

The Social Identity Approach (SIA) encompasses both social identity theory (Tajfel & Turner, 1979) and self-categorization theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987; Turner, Oakes, Haslam, & McGarty, 1994). Originally developed to explain intergroup phenomena, particularly discrimination and prejudice (Tajfel, 1970), the approach has become a dominant social-psychological model of group processes that has been influential in the study of social and organizational topics as diverse as leadership, communication, motivation, and collective action (e.g., see S. A. Haslam, Ellemers,

Reicher, Reynolds, & Schmitt, 2010). It has also been increasingly used as a framework for understanding health phenomena (S. A. Haslam, Jetten, Postmes, & Haslam, 2009; Jetten, Haslam, & Haslam, 2012).

Unlike the models reviewed in the previous section, the SIA was not developed to explain the health benefits of social connectedness, and it did not emerge from a bio-medically oriented tradition (e.g., psychiatry). Instead, the approach is social-psychological in origin and is *first and foremost* a theory of social relationships grounded in a social model of self (Turner, 1999). For this reason, the approach, although not specific to depression, is relevant to its social dimensions and in this regard, offers a well-established and long-standing model supported by four decades of empirical research (and thousands of publications; for details, see Postmes & Branscombe, 2010). The goal of this section is to outline the core tenets of the SIA to clarify the relevance of these for depression and, ultimately, to formulate a series of testable predictions that might advance our understanding of the role of social connectedness in this condition (see Table 1).

Key Premise 1: Social Relationships Structure Individuals' Self-Concept and, Through This, Their Behavior

A key theoretical premise of the SIA is that people's sense of self is comprised of both *personal* and *social* identities. On one hand, this means that we can define and understand ourselves in terms of our personal identity—seeing ourselves in terms of interests, attitudes, and behaviors that differ in important ways from those of other *individuals*. On the other hand, there are also a range of contexts in which we define and understand ourselves in terms of one or more *social* identities—seeing our interests, attitudes, and behaviors as aligned with those of other members of the groups to which we belong (i.e., in-groups) but as different from those of groups to which we do not belong (out-groups; Turner & Oakes, 1997).

A key idea here is that, to the extent that a given group membership is contextually salient or provides an ongoing basis for social identification, it provides a basis for *self-categorization* whereby *the group becomes "self*." For example, to play a game of football, a woman (let us call her Jane) not only needs to be able to differentiate between those players who are on her team (Janet and Jill, say) and those who are not, but she also needs to be able to see her teammates as interchangeable representatives of a common in-group; that is, she needs to be able to see herself and them as "us." Indeed, in this way, a sense of shared social identity can be seen to provide the psychological foundation for most meaningful forms of social behavior. In simple terms, this is because, as Turner (1982) puts it, "social identity is what makes group behavior possible" (p. 21; see also S. A. Haslam, Postmes, & Ellemers, 2003).

From an SIA perspective, social relationships are therefore conceptualized not only as bonds of affiliation between individuals (e.g., friendships) that provide a pleasant accompaniment to ongoing personal activity. Instead, they have a fundamental bearing on a person's understanding of *who they are* and, as a result, on *what they are able to do.* In the above example, then, it is Jane's relationship with Janet and Jill—and her capacity to define the three of them (and others) in terms of a shared social identity (as "us footballers")—that allows her to play and enjoy a game of football. The same logic explains why identity-based relationships in the home, in the workplace, and in society at large are critical not only for self-definition but also for meaningful social functioning.

From this example, it can be seen that the SIA is distinguished from other models of social connectedness by its emphasis on the power of social group memberships to restructure a person's self-concept and, through this, their behavioral repertoire. The approach argues that social identification fundamentally affects the way that individuals perceive themselves and their place in the world. Indeed, more starkly, it suggests that it is social identities that *give* people a place in the world, and thereby also furnish them with a sense of purpose and meaning (Dingle, Brander, Ballantyne, & Baker, 2012; S. A. Haslam, Jetten, & Waghorn, 2009; Jones et al., 2011). A social identity is meaningful whenever it has significance or importance to the individual—that is, when he or she identifies with the group. We see this in our example, where it is Jane's sense of herself as a member of a football team that gives meaning to her relationship with Janet and Jill and also gives them a sense of common direction and purpose—by virtue of the fact that this social identity specifies a constellation of shared norms, goals, and aspirations. This is clearly a mundane example, but more generally, it can be seen that in the world at large, social identities (e.g., where "us" encompasses one's family, one's workgroup, one's church, one's neighborhood community, etc.) provide the basis for networks of shared meaning and activity that bind people together and allow for coordinated goal-oriented endeavor.

In light of the above points, it is not surprising that social identities have a profound impact on well-being. Indeed, precisely because they engender a sense of purpose and direction, it generally feels good to identify strongly with a group. This is particularly true, however, to the extent that social-structural features of the world allow people to define in-group identity as positive, distinct, and enduring—something for which social identity theory suggests there is a motivational preference (Tajfel & Turner, 1979; see also Ellemers, De Gilder, & Haslam, 2004). Here, social identification literally entails being part of something bigger and better, and a large body of research confirms that this has positive implications for self-esteem (Bettencourt & Dorr, 1997; S. A. Haslam & Reicher, 2006; Ellemers, Kortekaas, & Ouwerkerk,

Table 1. Depression-Specific Hypotheses Derived From the Social Identity Approach.

H1. Social identification with meaningful groups will predict lower levels of depression.
H2. Social identification with a greater number of meaningful groups will predict lower levels of depression.
H3. The benefit of group membership for depression symptoms will be moderated by relevant normative content.
H4. Subjective indicators of social relationships will be better predictors of depressive symptoms than objective indicators.
H5. Social identification will determine the impact of the various social factors (e.g., social support) that are implicated in depression.
H6. Social interventions for depression will be more effective to the extent that they increase social identification.

1999; Phinney, Cantu, & Kurtz, 1997; Wann & Branscombe, 1990). This, then, is the basis for an initial hypothesis regarding depression:

> **Hypothesis 1 (H1):** Social identification with meaningful groups will predict lower levels of depression.

Yet, although any particular social identity has the capacity to be a valuable psychological resource, it is also the case that such identities are rarely mutually exclusive. For example, as well as being a member of a recreational football team, Jane may be a psychologist, a mother, a churchgoer, and an Australian. Insofar as each of these social identities has the capacity to provide a person with a sense of meaning, purpose, and direction, each can make a unique and potentially additive contribution to mental health (Jetten, Haslam, Haslam, Dingle, & Jones, 2014; Jones & Jetten, 2011; Ysseldyk, Haslam, & Haslam, 2013). This is particularly true if the identities are compatible (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Jetten, Haslam, Iyer, & Haslam, 2009). This therefore leads to a second hypothesis:

> **Hypothesis 2 (H2):** Social identification with a greater number of meaningful groups will predict lower levels of depression.

Other things being equal, the process of seeing oneself as a member of a valued group (or groups) should generally be beneficial to health. However, a fundamental insight of the SIA is that, in the case of groups, other things are often *not* equal (S. Reicher, Spears, & Haslam, 2010; Tajfel & Turner, 1979). Accordingly, it is not the case that all social identities are beneficial as a basis for preventing or treating depression. On the contrary, there is evidence that, at times, groups can be harmful and impede recovery (Crabtree, Haslam, Postmes, & Haslam, 2010; Finfgeld, 2000; Helgeson, Cohen, Schulz, & Yasko, 2000; see also Molero, Fuster, Jetten, & Moriano, 2011). In particular, because social identities are powerful vehicles for self-definition and social influence (Turner, 1991), strong identification with a group that is negatively defined (e.g., stigmatized) or whose identity incorporates damaging norms and practices (e.g., anti-social behavior) has the potential to increase health vulnerability. Examples might be a peer group with norms that encourage drug-taking or self-harm—where the shared behavior on which group membership is based is itself deleterious to mental health (Schofield, Pattison, Hill, & Borland, 2001).

Therefore, in addition to the question of how strongly a person identifies with a group, and how many groups they identify with, to predict the implications of internalized group memberships for a person's mental health, it is also critical to attend to the *content* of those social identities (i.e., the nature and basis of social identification). Accordingly, a third hypothesis is as follows:

> **Hypothesis 3 (H3):** The benefit of group membership for depression symptoms will be moderated by relevant normative content.

Key Premise 2: Individuals' Self-Concept and Social Behavior Are Structured by Perceived *Social Relationships*

A large body of research has shown that, as well as having poor general health, individuals who lack meaningful social relationships are far more prone to depression. The fact that this relationship is robust to differences in researcher perspective, sample population, and observation context increases our confidence that the link is real, important, and causal. What the SIA offers that goes beyond other models is a specification of the way in which the realities of social life (e.g., number of connections, degree of contact, actual support) are represented psychologically and internalized by perceivers. For example, if John were a professional footballer and only playing with his teammates for financial incentive, he might play on his football team without particularly valuing the team or feeling connected to his teammates. However, another player, James, might miss out on a place in the team but attend training every week, avidly supporting the team, and valuing both the football community and his place within it. Sociologically speaking, one might say that John (but not James) is a member of the football team. However, *psychologically* speaking, it is James (but not John) who identifies with the team, and it is this process of identification that is critical in shaping behavior, attitudes, and self-concept. As a result, any mental health outcomes associated with being a member of the team should be more apparent for James than for John, despite the former's lack of official group member status.

The point here, then, is that although objective group membership (e.g., being a formal team member) might increase the likelihood that social identification is present, it is only ever a crude indicator of individual actors' psychological perspective on the social world. To ascertain individuals' social connectedness, the most relevant social

indicator is therefore their perception of shared social identification in important and valued domains (Eggins, O'Brien, Reynolds, Haslam, & Crocker, 2008). The fact that it is the *subjective* experience of belonging to a social category that underpins meaningful group behavior (Turner & Oakes, 1997) leads to our fourth hypothesis:

Hypothesis 4 (H4): Subjective indicators of social relationships will be better predictors of depressive symptoms than objective indicators.

The foregoing claim that objective reality influences human experience and behavior only indirectly through the lens of perception should not be a controversial proposition. On the contrary, the variety of ways in which human perception transforms reality has long been a dominant focus of psychological research (particularly in the cognitive tradition; Kruglanski, 1989). However, it is worth noting that this theme provides a stronger focus for social identity research than for most other models previously used to conceptualize the role of social relationships in depression.

These arguments lead to an assertion that social identification is the "active ingredient" of social connectedness. This does not mean that other aspects of social connectedness (e.g., instrumental or emotional support) cannot be beneficial for health. Nevertheless, it does suggest that social identification (i.e., seeing oneself as a group member) will largely determine the impact of these processes. This means, for example, that whether or not social support is beneficial for health will depend, among other things, on the degree to which the source of that support is *perceived* to be an ingroup member. In other words, the benefits of social relationships for health should be most apparent when individuals feel that the group *matters* to them, and that they matter to the group. Both these points have empirical support in predicting depression, as will be outlined further below.

Hypothesis 5 (H5): Social identification will determine the impact of the various social factors (e.g., social support) that are implicated in depression.

Key Premise 3: Social Identification Is a Dynamic Process That Responds to Meaningful Variation in the Social World

Within the SIA, individuals are understood to define both themselves and others through a process of social comparison. That is, "self" is defined, in part, through contrast to what is "not self." At a group level, this means that who "we" are is defined partly by our understanding of "them" (and what we are not); whereas at a personal level, who "I" am is partly defined by who "you" are (and what I am not). However, as the comparative context within which the self is understood changes, so too will the meaning of self. What it means to be a psychologist depends on whether one compares oneself with physicists or historians (Doosje, Haslam, Spears, Oakes, & Koomen, 1998; Hopkins & Murdoch, 1999); what it means to be compassionate depends on whether one compares oneself with Mother Theresa or Adolf Eichmann (Onorato & Turner, 2004; Reynolds & Oakes, 2000).

In this way, the SIA conceptualizes the self not as a set of stable traits but as a potentially fluid *process*. That said, in many contexts, the self will be experienced as stable because the contexts in which it is located (or studied) are relatively stable (Turner et al., 1994). Indeed, it is worth noting that psychologists and psychological methods often go to great lengths to ensure this stability (e.g., through the standardization of testing regimes; Reynolds et al., 2010).

There are a range of factors that the SIA sees as contributing to personal and social identity formation over the short term and long term (see Blanz, 1999; Oakes, Haslam, & Turner, 1994; Postmes & Jetten, 2006; Postmes, Haslam, & Swaab, 2005). Broadly, though, the salience of particular identities is seen to reflect their *accessibility* (the readiness of perceivers to use them) and *fit* (Oakes, 1987; after Bruner, 1957). This means that people will be inclined to define and understand themselves in terms of categories that have proved to be useful in the past, and that allow them to make sense of their current circumstances. For example, Jane may be more likely to define herself as the supporter of a particular football team if she regularly attends the games of that team (high accessibility) and if she is in a conversation about football with a supporter of a rival team (high fit) rather than working as a psychologist. Moreover, in these two contexts, who she is as a person—and who she sees herself to be—is likely to reflect the norms of the specific group membership that informs her identity: So that at the game, she is loud and emotional, whereas at work, she is reserved and conscientious (Turner, Reynolds, Haslam, & Veenstra, 2006).

One key implication of this analysis for depression is that the ability of an individual to benefit from the social connectedness that flows from internalized group membership (as per H1 and H2) should be conditioned by both the accessibility of a suitable group membership and its contextual fit. So, for example, it should be easier for a man (say) to benefit from the social support that his family can provide if he has a history of strong ties with his family and if his family is seen as relevant to the issue at hand (e.g., dealing with the stress of parenthood rather than with stress of work; Sani, Magrin, Scrignaro, & McCollum, 2010). This point is particularly important for interventions that seek to improve social connectedness in depression, as it allows us to specify *when* such interventions will affect the self-concept and social identities of an individual and thus, be beneficial. More specifically, it leads to the following hypothesis:

Hypothesis 6 (H6): Social interventions for depression will be more effective to the extent that they increase social identification.

In light of this hypothesis, there is a final point to be made about the utility of the SIA for depression. Unlike most clinical models, the approach conceptualizes self-concept and social identity as fundamentally malleable and context-dependent. From the perspective of developing effective interventions, this malleability has considerable potential, because social identification is a more fluid—and hence, potentially treatment-responsive—construct than, say, distorted cognitions or lack of social skills. Although these latter constructs might be altered through extended therapeutic work over months or even years (Kovacs & Beck, 1978; Segrin, 2000), social identity is generally highly responsive to changes in a person's social or environmental context. Therefore, social identity interventions that target an individual's community or environment are likely to have ongoing therapeutic benefits over and above those that can be achieved in brief one-on-one medical or psychological treatment (Helliwell & Barrington-Leigh, 2012). All this suggests that social identification—and the material and psychological factors that feed into it—may be particularly suitable as a target for therapeutic intervention to counteract depression.

Empirical Evidence: Social Identity and Depression

The SIA, on one hand, and the clinical literature on depression, on the other, each represent substantial research disciplines comprising hundreds of researchers and thousands of published works. They are established fields—"pylons" for the bridge that we propose to build between the two. However, the bridge itself between social identity and depression has barely commenced construction.

There is, however, evidence that social identification is a powerful predictor of mental health and well-being more generally. Therefore, although clinical depression has received less attention, an abundance of empirical evidence indicates that social identity is implicated in a range of related health phenomena. For example, along the lines of H2, there is evidence that the number of social identities that people have prior to a stroke is a good predictor of their recovery and well-being 6 months following the event (C. Haslam et al., 2008). Acquiring new group memberships is similarly protective following trauma (Jones et al., 2011; Jones et al., 2012). Among older adults, group interventions that build social identity have been shown to improve well-being, reduce falls, and slow cognitive decline (Gleibs, Haslam, Haslam, & Jones, 2011; Gleibs, Haslam, Jones, et al., 2011; C. Haslam, Haslam et al., 2010; C. Haslam, Haslam, et al., 2012; Knight, Haslam, & Haslam, 2010). Social identification has also been found to buffer individuals from the negative impact of a range of stressors, including illness (S. A. Haslam, Jetten, & Waghorn, 2009), memory loss (Jetten, Haslam, Pugliese, Tonks, & Haslam, 2010), confrontation (S. A. Haslam & Reicher, 2006), and discrimination (Branscombe, Schmitt, & Harvey, 1999). In large, representative community samples social identification has also been found to predict life satisfaction and general well-being (Helliwell & Barrington-Leigh, 2012).

The physical and mental health benefits of social identification are therefore well-established and not specific to depression. However, given the centrality of social relationships to the etiology, symptomatology, and treatment of depression, it seems plausible that social identification is at least as important in this domain. In this section, we review evidence that speaks to this possibility and to each of the six hypotheses proposed in the previous section. From this review, two themes are apparent: First, that current evidence is predominantly supportive of these hypotheses; and second, that much remains to be done to test these hypotheses fully.

Evidence for H1: Social identification with meaningful groups will predict lower levels of depression.

Only a handful of previous studies have included measures or manipulations of social identification along with a dependent measure of depression. For the most part, the literature consists either of studies with crude indicators of social identities (e.g., ethnicity) that have a validated clinical measure of depression, or studies with crude indicators of depression (e.g., negative mood) that have validated social identification measures.

Nevertheless, we identified 16 relevant studies that have directly examined the relationship between degree of social identification with valued groups and depression symptoms, with a total of more than 2,700 participants. More detail of each of the studies is provided in Table 2. All studies report a negative relationship between these variables, such that high social identification with a valued group predicts fewer depression symptoms. This negative correlation persists across diverse populations ranging from Norwegian heart surgery patients (S. A. Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005) to Australian school students (Bizumic, Reynolds, Turner, Bromhead, & Subasic, 2009), and when measuring identification with diverse groups including family (Sani et al., 2010), tertiary institution (Cameron, 1999) and ethnic group (Branscombe et al., 1999). Some of this work also demonstrates that social identification predicts change in depression symptoms over time more strongly than vice versa, although the effect remains significant in both directions (Iyer et al., 2009; Cruwys et al., in press).

Although these studies were correlational and approximately half used non-diagnostic measures of depression, they nevertheless tell a consistent story that speaks to the protective role of group memberships in preventing depressive symptoms. This story is also consistent with evidence

Table 2. The Relationship Between Social Identification and Depression Symptoms, as Reported in 14 Published Studies.

No.	Authors	Year	Journal		*N*	Population	Social group	ID measure	Depression measure	*r*
1	Cruwys, Haslam, Dingle, Jetten, Hornsey, Chong & Oei	in press	*JAffectDisord*		52	Disadvantaged community	Recreational group	4 items Doosje, Ellemers, and Spears (1995)	DASS-21 (21 items)	−0.18*
2					92	Psychotherapy patients with depression or anxiety	Therapy group	11 items Leach et al., (2008)	ZSRDS (20 items)	−0.33*
3	Wakefield, Bickley, and Sani	2013	*JPsychSom*		152	People with MS	MS support group	4 items Doosje, et al. (1995)	HADS (7 item)	−0.31*
4	Sani, Herrera, Wakefield, Boroch, and Gulyas	2012	*BJSP*	Study 1	194	Polish people	Family	4 items Doosje et al. (1995)	CES-D (20 items)	−0.46*
5				Study 2	150	Eastern European Army Unit	Army	14 item Leach et al. (2008)	BDI-II (21 items)	−0.18*
6	Sani, Magrin, Scrignaro, and McCollum	2010	*BJSP*		113	Adult Scottish community	Family	5 items from various scales	BDI-II (21 items)	−0.32*
7	Bizumic, Reynolds, Turner, Bromhead, and Subasic	2009	*APIR*	Study 1	113	Australian school staff	School	4 items Haslam (2001)	Mental Health Inventory (adapted) 5 items	−0.29*
8				Study 2	693	Australian school students (12-17 years)	School	4 items Haslam (2001)	DASS-21 (7 items)	−0.19*
9	Iyer, Jetten, Tsivrikos, Postmes, and Haslam	2009	*BJSP*	Study 1	105	British students starting university	University students	3 items Doosje et al. (1995)	9-item scale Branscombe, Schmitt, and Harvey (1999)	−0.30*
10				Study 2	264	British students starting university	University students	3 items Doosje et al. (1995)	6-item scale Branscombe et al. (1999)	−0.40*
11	S. A. Haslam, O'Brien, Jetten, Vormedal, and Penna	2005	*BJSP*	Study 1	34	Norwegian heart surgery patients	Family and friends	2 items Doosje et al. (1995)	6-item negative emotion scale	−0.12
12				Study 2	40	British workers (20 bomb disposal officers, 20 bar staff)	Work colleagues	2 items Doosje et al. (1995)	4-item negative emotion scale	−0.34*
13	Cameron	1999	*GD: TRP*		167	American university students	Mt Allison University	3 factors (Cameron, 1999)	BDI-II (21 items)	−0.37* −0.11* −0.23*
14	Branscombe et al.	1999	*JPSP*		139	African Americans	Ethnic group	14 item Multi-group Ethnic Identity Measure	6-item negative emotion scale	−0.17*
15	Branscombe and Wann	1991	*JSSI*	Study 1	187	American undergraduates	Sports team	Wann and Branscombe (1990)	1 frequency question	−0.16*
16				Study 3	332	American undergraduates	Sports team	Wann and Branscombe (1990)	1 frequency question	−0.10*

Note. JAffectDisord = Journal of Affective Disorders; JPsychSom = Journal of Psychosomatic Research; MS = multiple sclerosis; *APIR = Applied Psychology: An International Review; BJSP = British Journal of Social Psychology; JPSP = Journal of Personality and Social Psychology; GD: TRP = Group Dynamics: Theory, Research, and Practice; JSSI = Journal of Sport & Social Issues; HADS = Hospital Anxiety and Depression Scale; CES-D = Centre for Epidemiologic Studies – Depression; BDI-II = Beck Depression Inventory 2nd Edition; DASS-21 = Depression, Anxiety Stress Scales (short form); ZSRDS = Zung Self Rated Depression Scale.*

*$p < .05$.

that *anomie*, social fragmentation, and lack of community are associated with the increased prevalence of suicide (Durkheim, 1897/1951; Hawton, Harriss, Hodder, Simkin, & Gunnell, 2001).

More persuasive still are the experimental data showing that manipulations targeting individuals' social identification have consequent effects on depression symptoms. For example, in an immersive study, Reicher and Haslam (2006) randomly assigned 15 well-adjusted men to be either prisoners or guards in a simulated prison (revisiting the paradigm of the Stanford Prison Experiment; Haney, Banks, & Zimbardo, 1973). Over the course of the 9-day experiment, manipulations (in particular, of group boundary permeability; Tajfel & Turner, 1979, see also Ellemers, 1993) served to increase the sense of shared social identity among the prisoners and this led to a gradual reduction in depression symptoms. However, guards' sense of shared social identity declined and this led to a significant increase in depression (corroborated by the observations of on-site clinicians).

In a further example, Gleibs, Haslam, Jones, et al. (2011) invited care home residents to join gender-based social groups (gentlemen's and ladies' clubs) that took part in fortnightly social activities. Compared with baseline, social identification increased and depression symptoms decreased at a 12-week follow-up. A significant improvement was seen among men, who had higher levels of social isolation and depression at baseline.

Importantly, these experimental studies provide initial evidence for the causal role of social identification in shaping mood and clinical outcomes in vulnerable populations. As with most of the correlational studies in this area, depression was not the researchers' primary focus and hence, there are residual questions about the precise clinical implications of the findings. Nevertheless, our confidence in H1 is reinforced by the fact that across both surveys and experimental studies, the negative association between social identification and depression appears not only to be moderately strong but also to be both reliable and robust.

Evidence for H2: Social identification with a greater number of meaningful groups will predict lower levels of depression.

Existing literature provides reliable support for the claim that individuals who have a more complex and varied self-concept (i.e., those who are high in self-complexity; Linville, 1987) are buffered against failure in any one domain and are less likely to become depressed (Koch & Shepperd, 2004; Linville, 1987). Although self-complexity was not originally conceptualized in terms of a person's possession of multiple social identities, several authors have argued that these concepts are compatible (C. Haslam et al., 2008; Iyer et al., 2009). Consistent with this claim, recent studies have found that individuals who report having a greater number of social identities are less likely to develop depression in the context of life events that present severe challenges to well-being, such as starting university (Iyer et al., 2009), having a stroke (C. Haslam et al., 2008), or experiencing brain trauma (Jones et al., 2011).

Speaking further about the importance of the psychological dimensions of group membership for health, evidence shows that individuals' objectively measured resilience is increased by experimental manipulations that make multiple group memberships salient. In one study (Jones & Jetten, 2011), participants who were asked to list five groups to which they belonged (rather than one or three) performed better on a cold-pressor task and recovered more quickly from strenuous exercise.

Finally, Cruwys et al. (2013) report findings from an epidemiological study with a representative sample of more than 4,000 British participants that explored (among other things) the relationship between group memberships and mental health. In this study, the number of social groups to which respondents belonged was a strong predictor of depression symptoms both concurrently and longitudinally (4 years later). Moreover, this effect was more than 3 times as strong among respondents with a history of depression. Depressed respondents with no group memberships who joined one group reduced their risk of depression relapse by 24%; if they joined three groups their risk of relapse reduced by 63%. Such research is part of a growing body of evidence that supports H2 and suggests that social identities are resources that individuals can draw on—and that have protective properties—in times of psychological vulnerability of the form typically associated with depression (C. Haslam, Jetten, & Haslam, 2012). In these contexts, having more identities typically entails having more resources and therefore, conveys greater resilience.

Evidence for H3: The benefit of group membership for depression symptoms will be moderated by relevant normative content.

Social groups communicate a great deal of information to their members about appropriate ways to think, feel, and act. Such information (in the form of "norms"; Cialdini & Trost, 1998; Turner, 1991) has been shown to influence health via at least two routes. First, behavioral conformity can have significant implications for health. For instance, Cruwys et al. (2012) found that women were influenced to eat *either* more or less popcorn than those in a control condition when an ingroup member set a norm for high or low popcorn consumption, respectively. Similar effects have been found for alcohol consumption (Johnston & White, 2003; Reed, Lange, Ketchie, & Clapp, 2007) and smoking (Schofield et al., 2001). Even simply reminding people of a particular social identity that they hold (i.e., making it salient) is enough for them to endorse less healthy behaviors that are in line with

that group's norms (e.g., involving high salt or fat intake; Oyserman, Fryberg, & Yoder, 2007; Tarrant & Butler, 2011). Along these lines, there is some evidence that behaviors implicated in depression are similarly subject to social influence—in particular, social withdrawal and suicidality (Handley et al., 2012). Loneliness itself has also been found to spread through social networks (Cacioppo, Fowler, & Christakis, 2009), and suicide and self-harm are so clearly vulnerable to the influence of others (Motto, 1970; Stack, 2003) that many countries have legal limits on media reporting of these phenomena (Stack, 2005).

The influence of social groups, however, goes beyond mere behavioral conformity. Because identification with a group entails psychologically defining the self as similar to, and part of, the group, the normative content of group identity also influences thoughts, feelings, and even perception itself. Within the health domain, this has been demonstrated in several studies. For instance, St. Claire and He (2009) found that when participants were made to think of themselves as "elderly," they were more likely to describe themselves as having hearing problems. In a study with a similar manipulation, C. Haslam, Morton, et al. (2012) found that 72% of healthy older adults reached threshold for dementia on a diagnostic test when they were randomly assigned to a condition where their older-person identity was made salient and they were told that aging was associated with generalized cognitive deficits. By contrast, only 14% of the participants met the same threshold when their older-person identity was not made salient. More relevant to issues of mental health, R. M. Levine and Reicher (1996) found that female sports science students were more likely to be distressed by a facial scar than a knee injury when their identity as women was made salient but more likely to be distressed by the knee injury when their sports science identity was salient. Although these studies do not speak specifically to depression, they demonstrate that the experience and expression of mental health symptoms are profoundly influenced by the content of salient social identities. It seems highly plausible, for example, that social isolation would prove to be far more likely to engender depression in contexts where it threatened rather than affirmed a contextually meaningful social identity (e.g., as a football fan vs. a mountaineer).

Moreover, as well as shaping thoughts, feelings, and behavior, social groups also communicate information about the relative value or worth of group members. Although social identification generally provides a boost to well-being, identifying with a stigmatized group is more complex, as it encompasses factors that reduce depression risk (via identification; H1) as well as factors that potentially increase depression risk (via normative content; H3). For example, on one hand, identifying with a stigmatized group (e.g., as African American, as a foreign student, or as someone who is HIV-positive) can buffer the stress of experiencing discrimination (Branscombe et al., 1999; Molero et al., 2011; Outten, Schmitt, Garcia, & Branscombe, 2009; Schmitt, Spears, & Branscombe, 2003). Similarly, and directly relevant to depression, Crabtree et al. (2010) found that social identification with a mental health support group was associated with greater perceived social support, rejection of mental illness stereotypes, and resistance to stigma. On the other hand, in and of itself, identifying as a member of a stigmatized group is not necessarily a positive experience, and it can be difficult for individuals to leave these groups, particularly when they are also a source of meaning and support (Howard, 2008; Link et al., 1997). Consistent with this, Crabtree et al. found that those who identified more strongly with a mental health support group had lower self-esteem.

In this way, the *content* of social identities and the specific meaning of groups for their members both have a powerful impact on psychological health. When this content encourages unhealthy behaviors or is stigmatizing, this has the capacity to moderate the capacity of social identification to ameliorate depression. In particular, in the event that a valued social group had normative content encouraging self-criticism and self-harm, the social identity model would predict that group members might be at elevated risk of depression. This is consistent with some empirical work demonstrating that these behaviors are subject to social influence in adolescent peer groups (Dishion, McCord, & Poulin, 1999; Heilbron & Prinstein, 2008). It is not yet clear, however, whether the potential harm associated with these groups is more potent than the various benefits to well-being that result from social identification. Several studies with stigmatized groups have suggested that, at worst, negative normative content can result in a non-significant relationship between identification and well-being (Molero et al., 2011) and an increased desire to leave the group (e.g., Garstka, Schmitt, Branscombe, & Hummert, 2004; Fernández, Branscombe, Gómez, & Morales, 2012).

Evidence for H4: Subjective indicators of social relationships will be superior predictors of depressive symptoms than objective indicators.

Among researchers interested in social determinants of health, in recent years, there has been an emphasis on "objective" indicators of social connectedness, evident particularly in the structure of large-scale population surveys (e.g., the English Longitudinal Study of Ageing; the Housing Income and Labour Dynamics in Australia). However, a SIA to depression would predict that, although indicators such as quality and amount of social contact or access to services might generally be correlated with individuals' actual experience, ultimately, it is the psychological sense of connection to the group that is key to predicting mental health outcomes.

To interrogate this hypothesis, it is possible to rank various measures of social connectedness as a function of how well they approximate social identification and therefore, how well, theoretically, they should predict related health

Table 3. Three Categories of Measures Related to Social Identification.

Category	1 Demographic measures		2 Measures of group-relevant variables		3 Explicit measures of psychological group membership	
Hypothesized strength of relationship to depression	Weak		Moderate		Strong	
	Illustrative measure	*Illustrative reference(s)*	*Illustrative measure*	*Illustrative reference(s)*	*Illustrative measure*	*Illustrative reference(s)*
	Living status	Dean, Kolody, Wood, and Matt (1992)	Social support	Heitzmann and Kaplan (1988)	Social identification	Leach et al. (2008), Postmes, Haslam, and Jans (2013)
	Marital status	Pearlin and Johnson (1977)	Social contact	Peirce, Frone, Russell, Cooper, and Mudar (2000)	Sense of belonging	Hagerty and Patusky (1995)
	Community level measures of social capital or civic engagement (e.g., based on postcode or income)	Hawton, Harriss, Hodder, Simkin, and Gunnell (2001); Kawachi, Kennedy, and Glass (1999), Stafford, De Silva, Stansfeld, and Marmot (2008)	Social networks	Fiore, Becker, and Coppel (1983)	Perceived social isolation (loneliness)	Hughes, Waite, Hawkley, and Cacioppo (2004)
	Social network size	Schaefer, Coyne, and Lazarus (1981)	Social participation	Glass, De Leon, Bassuk, and Berkman (2006)		
			Group membership	C. Haslam et al. (2008), Cruwys et al. (2013)		

outcomes. In this regard, it seems plausible to identify three distinct categories of measure (see Table 3). Category 1 includes the lowest ranking measures and is primarily comprised of *demographic* indicators of social relationships such as living status (alone vs. with others) and community-level measures of social capital and civic engagement (e.g., based on postcode or income). Such measures are typically used by economists, demographers, and epidemiologists (e.g., Banks, Marmot, Oldfield, & Smith, 2006; Helliwell & Barrington-Leigh, 2012; Stafford, De Silva, Stansfeld, & Marmot, 2008). Category 2 includes moderate ranking indicators that take the form of self-reported measures of constructs that are related to group membership, such as social contact and participation, formal group memberships, and social support. These measures are used by most researchers in the field but are particularly popular among psychologists, sociologists, and political scientists (e.g., Cohen & Wills, 1985; Putnam, 2001). Category 3 defines the highest-ranking indicators and includes measures that are explicitly designed to capture a sense of belonging or identification with particular social groups (e.g., as presented and discussed by Jetten et al., 2012, see also Table 4). These measures are favored by many social psychologists (e.g., Baumeister & Leary, 1995; Cacioppo et al., 2010), especially those in the social identity tradition.

Significant evidence now supports the hypothesis that subjective, psychological indicators (particularly, sense of belonging or identification) will most powerfully predict health outcomes. In a major meta-analytic review, Holt-Lunstad et al. (2010) found that risk of death was approximately halved among individuals with stronger social relationships, with the largest effects found for "complex" measures of this construct that incorporated both structural and functional aspects of social relationships (e.g., marital status *plus* perceived social support). Similarly, in a large nationally representative sample, Berry and Welsh (2010) found that individual-level psychological measures of social capital (in particular, sense of belonging) had the strongest relationship with physical and mental health. Specific to depression, Cacioppo and colleagues (2010) found that *perceived* social isolation was the best predictor of depression symptoms, even after controlling for more distal social factors, including social network size (Category 1) and social support (Category 2).

More pertinently still, as part of a program of research that included both a clinical measure of depression and a social identification scale, Sani, Herrera, Wakefield, Boroch, and Gulyas (2012) reported two studies that found evidence of a strong negative relationship between depression and social identification (see Table 1) but only a weak-moderate relationship between depression and social contact (i.e., frequency of interaction with various members of the group; Category 2). Indeed, in a regression model, social contact did

Table 4. Measures of Social Identification.

Scale name	Scale items	Reference
Single-Item Social Identification measure	I identity with [In-group].	Postmes, Haslam and Jans (2013)
Four-Item Social Identification measure	1. I identify with [In-group]. 2. I feel committed to [In-group]. 3. I am glad to be [In-group]. 4. Being [In-group] is an important part of how I see myself.	Adapted from Doosje, Spears and Ellemers (1995). See also Doosje, Haslam, Spears, Oakes, and Koomen. (1998) and Leach et al. (2008)
Multiple Group Memberships Scale	1. I belong to lots of different groups. 2. I am involved in the activities of lots of different groups. 3. I have friends who are in lots of different groups. 4. I have strong ties with lots of different groups.	Adapted from the Exeter Identity Transition Scale, see C. Haslam et al. (2008)

Note. All items are measured on a 7-point Likert-type scale from *strongly disagree* (1) to *strongly agree* (7).

not account for any unique variance after social identification was accounted for.

H4 is also consistent with evidence reported by Cameron (1999), who measured three components of social identification: identity centrality, in-group ties, and in-group affect. All three components were significantly and negatively related to depression. However, the strongest relationship was with the in-group ties component of social identification (as assessed by agreement with items such as "In a group of Mt Allison students, I really feel like I belong"). This adds to the evidence that it is the *perceived belonging* dimension of social connectedness (Category 3) that is most pertinent to health outcomes. Finally, in a study of disadvantaged people who were facilitated to join social groups (Category 2), Cruwys et al. (in press) found that this intervention had the effect of decreasing depression symptoms most among those participants who reported a strong sense of belonging with the social group (Category 3).

Consistent with H4, all the above studies suggest that Category 3 measures of social connectedness are better predictors of depression than Category 1 or 2 measures. In other words, it appears that measures of individuals' own sense of their social connection to others do a rather better job of capturing the psychological substrates of depression than other more objective indicators. Critically too, it also explains why there is a difference between psychological states such as loneliness and the material reality of being alone. Among other things, this is needed to explain why individuals can feel most alone in a crowd, or why, as Sylvia Plath put it more poetically in *The Bell Jar* (written in 1963, the same year that she took her own life), how even when "on the deck of a ship or at a street café in Paris or Bangkok," one can have the experience of "sitting under the same glass bell jar, stewing in my own sour air" (p. 185).

Evidence for H5: Social identification will determine the impact of the various social factors (e.g., social support) that are implicated in depression

As the previous section suggests, the SIA gives primacy to social identification as the key ingredient of social connectedness. However, this is not to say that other aspects of group life, such as social support (instrumental and emotional), trust, and helping are not important—they clearly are. Rather, these are conceptualized as "secondary benefits" of social group membership that arise from, and are facilitated by, a sense of shared social identity.[2]

Consistent with this claim, the social-psychological literature provides copious experimental evidence of these "secondary benefits" flowing from social identification. For example, manipulations that increase perceived shared group membership have been shown to promote trust (Foddy, Platow, & Yamagishi, 2009; Tanis & Postmes, 2005), helping behavior (Levine, Cassidy, Brazier, & Reicher, 2002; M. Levine, Prosser, Evans, & Reicher, 2005; Platow et al., 1999), and social support (emotional, intellectual, and material; S. A. Haslam et al., 2005; S. A. Haslam, Reicher, & Levine, 2012; M. Levine & Thompson, 2004).

Although little, if any, of this work has been focused on issues pertaining directly to depression, in two studies that most closely address H5, social support was found to mediate the negative relationship between social identification and both stress and well-being (S. A. Haslam et al., 2005). Furthermore, experimental studies have shown that it is only when a shared group membership is psychologically salient that potentially supportive actions are *perceived* as supportive. For example, students preparing for a challenging exam were only encouraged to construe this as a challenge rather than a threat when this encouragement came from an in-group member (S. A. Haslam, Reicher, & Levine, 2012).

It is clear that within the health and social-psychological literatures more generally, shared social identity has been shown to foster and provide a foundation for the range of depression-preventative phenomena variously described as social engagement, participation, support, networks, functioning, and connectedness (C. Haslam, Jetten, & Haslam, 2012; Morton, Wright, Peters, Reynolds, & Haslam, 2012). In short, it appears that social identification is the psychological process that makes possible those forms of social connectedness that mitigate against depression.

Evidence for H6: Social interventions for depression will be more effective to the extent that they increase social identification

A crucial indicator of the utility of the SIA for researchers and practitioners working in the field of depression will be its capacity to inform effective prevention and treatment protocols. As depression is an extremely common, chronic, and relapsing condition, interventions need to be effective (and cost-effective) in boosting an individual's capacity to manage future as well as current stressors. There is substantial evidence that social interventions for depression are both effective and boost long-term resilience (Hawkley & Cacioppo, 2010; McWhirter, 1990; Perese & Wolf, 2005). Moreover, in line with H6, interventions that include a component that facilitates social interaction in groups appear to be particularly effective, relative to those whose focus is on skills training, psycho-education, or one-on-one support (Cattan, White, Bond, & Learmouth, 2005).

Evidence of the specific role played by social identification also emerges consistently from a program of small-scale intervention studies designed to examine the effects of attempts to increase social identification on the mental health of care home residents. In various studies, this involved bringing residents together to interact in terms of social identities as members of (a) reminiscence groups (C. Haslam et al., 2008), (b) ladies and gentlemen's clubs (Gleibs, Haslam, Jones, et al., 2011), (c) design teams (C. Haslam, Haslam, et al., 2012; Knight et al., 2010), (d) water clubs (Gleibs, Haslam, Haslam, & Jones, 2011), and (e) religious groups (Ysseldyk et al., 2013). In all these studies, participants who were assigned to group-based treatments that led to the development of meaningful social identities showed improvement on health-related outcomes relative to relevant control groups.

Most pertinent to our present concerns, several of these studies (notably Gleibs, Haslam, Jones, et al., 2011; C. Haslam, Haslam et al., 2010) found that interventions that served to increase social identification led to a marked reduction in residents' depression (typically measured by the Hospital Anxiety and Depression Scale; Zigmond & Snaith, 1983). At the same time (and even where this was not the case; for example, because depression was not directly assessed), all studies found that interventions that increased social identification led to improvement on factors known to counter-indicate depression, including cognitive health (C. Haslam, Haslam et al., 2010), perceived social support (Gleibs, Haslam, Haslam, & Jones, 2011), life satisfaction (Knight et al., 2010), and increased social interaction (C. Haslam, Haslam, et al., 2012; Knight et al., 2010).

Two further intervention studies have been carried out with vulnerable populations who either have depression or are at high risk for developing depression. Social identification with a therapy group or community organisation was found to reduce maladaptive thinking styles associated chronic mental illness (Cruwys et al., 2014). Social identification was also found to increase the effectiveness of CBT group psychotherapy, such that only those patients who identified with the therapy group showed a clinically significant reduction in depression symptoms (Cruwys et al., in press).

This line of research is very much in its infancy, and such studies need to be corroborated in larger clinical trials with other populations. Nevertheless, these studies provide consistent support for H6 and very promising evidence that interventions whose explicit goal is to boost social identification among members of vulnerable groups have a good prospect of counteracting depression.

Why and How Do Social Identities Reduce Depression?

It is clear from the preceding review that social identity processes have a crucial role to play in depression. We have argued that social identification is the mechanism through which social relationships affect depression. More fundamentally, however, one might ask exactly why and how this is the case. Our answer is that social identification provides the psychological basis for multiple processes that are antithetical to depression—all of which have already been touched on in this review. In brief, social identities provide *meaning* to life, encourage the provision and receipt of social *support*, facilitate social *influence*, and engender a sense of *belongingness*. Each of these four processes, we argue, contributes to the power of social identity to protect against depression, as depicted schematically in Figure 1.

This, though, is not intended to be a list of potential mediators. Not least this is because, more generally, we argue that social identity matters not only because of what it *leads to* (e.g., social support; S. A. Haslam et al., 2005) but also, and more crucially, because of what it *is.* This point accords with a redefinition of the concept of social identity in terms of the psychological benefits (or "resources") that it provides (Jetten et al., 2012). Furthermore, we argue that depression can be understood as a state that results from the

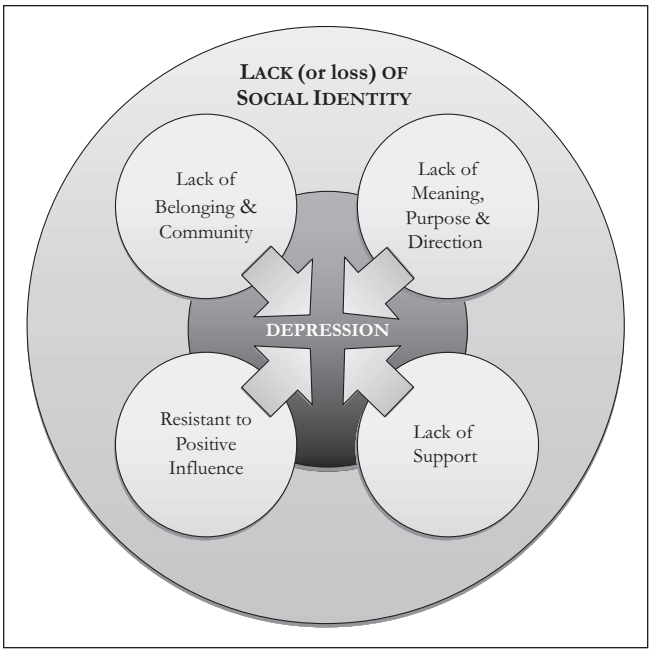

Figure 1. Social identity is a psychological resource that protects against depression in at least four ways.

lack of these crucial resources—meaning, support, influence, and belonging.

The first feature of social identity that speaks to its status as a psychological resource is that it is a basis for *shared* perceptions of ourselves, others, and the world at large. This sense of perceptual connectedness furnishes individuals with a sense of meaning, purpose, and direction, and makes social identities essential for effective (hedonic) social-psychological functioning (e.g., Haslam, Jetten, Postmes, & Haslam, 2009; Jetten et al., 2012). Part of the reason for this is that social identities are a basis for trust (Kramer, Brewer, & Hanna, 1996; S. Reicher & Haslam, 2006) that allows individuals to coordinate their action and thereby achieve collective goals that would otherwise be unattainable and, often, unimaginable (Drury & Reicher, 1999). Shared social identity also underpins a sense of collective values and is a source of motivation and agency (Ellemers et al., 2004). When a person lacks these resources, he or she is thus more likely to feel that life is without meaning, purpose, and direction, and hence, to experience *anhedonia*—a core symptom of depression.

The second resource-related feature of social identities derives from their capacity to facilitate receipt of beneficial forms of social support, whether emotional, intellectual, or material (Haslam, Reicher & Levine, 2012). This means that the psychological and material benefits of social relationships are easier for individuals to access and capitalize on in the context of shared social identity. This mechanism is supported by research related to H5 above and is consistent with a large body of work that speaks to the curative properties of social capital (e.g., Putnam, 2001).

The third mechanism relates to the fact that shared social identity is a basis for social influence (Turner, 1991). This means that when individuals perceive themselves to share identity with other members of a given group, there is a greater likelihood that members of that group will in turn be able to shape their thoughts, feelings, and behavior. The importance of this process is perhaps most obvious in the case of health behaviors such as eating, where individuals model their own eating closely on those of fellow in-group members (Cruwys et al., 2012; Tarrant & Butler, 2011). However, social influence also has a role to play in depression—something that is apparent when one considers the importance of particular cognitions (e.g., those that involve self-criticism) and behaviors (e.g., self-harm). Of course, as H3 suggests, not all groups have normative content that is likely to prevent or ameliorate depression, and in these (arguably rare) groups we do not necessarily expect to see social identification associated with reduced depression. Indeed, this notion that depression (or lack thereof) might "run in groups" is consistent with evidence that supports relational regulation theory (Lakey & Orhek, 2011).

A final feature of social identity that contributes to its status as a psychological resource is the sense of belonging that it engenders. Indeed, evidence suggests that merely thinking about one's group membership(s) has the capacity to reinforce a sense that one has a social place in the world (i.e., that one "belongs"; Baumeister & Leary, 1995; Hawkley & Cacioppo, 2010;), and this is likely to be protective of physical and psychological well-being. As a result, even minimal reminders of social connectedness can increase a person's resilience in stressful situations (Jones & Jetten, 2011) and enhance their immunological resistance to infection (Cohen, Doyle, Turner, Alper, & Skoner, 2003), along lines suggested by the stress-buffering hypothesis (Cohen & Wills, 1985).

Putting these various points together, we contend that, as noted above, at its core, depression is a response to loss. Typically, this is obviously and concretely related to a loss of social connectedness—for example, when precipitated by bereavement or divorce. However, more generally, we would suggest that the precipitant for depression can be understood to be loss (or lack) of *social identity* (e.g., related to loss of health or lack of achievement that can both be conceptualized as social identity losses). More specifically, social identities are the bases for individuals' perception that they have meaningful relationships with others and hence, social identity is the critical mechanism that underpins a person's ability to achieve human sociality through a sense of social connectedness. Indeed, our key analytic point is that social identity transforms "others" into "self," so that whereas the person without social identifications feels psychologically disconnected and dislocated from the social world around him or her, the person who has those identifications is able to properly appreciate and realize his or her social potential. And in so far as a capacity to live out our sociality is central

to our condition as social beings, it follows that an inability to do this should be inimical to a state of psychological equanimity and (if sustained over time) may lead to non-effective functioning of the form implicated in depression onset.

Social identity is the engine of group life and so unsurprisingly, these proposed mechanisms each have some overlap with existing theoretical perspectives on social connectedness and depression. However, the social identity perspective is unique in focusing squarely on a person's internalized sense of group membership (i.e., social identity) as the driving force behind these relationships and in using this to provide a coherent explanation and integration of the various elements that alternative models correctly identify as important.

An Agenda for Research Into Social Identity and Depression

Throughout this review, we have made the argument that the SIA provides a novel and valuable perspective on understanding how and why social connectedness is so critical to the development and treatment of depression. This review has outlined the extensive body of work demonstrating that social connectedness (a) protects against the development of depression, (b) is compromised in depression, and (c) contributes to remission from depression. The literature is approaching consensus on these claims and hence, it seems relatively uncontroversial to suggest that these observations might legitimately be taken as a starting point for future research.

More controversial though, is the precise direction that future research should take, and in the first section of this review, we highlighted three questions of particular contention for the field:

RQ1: How should social connectedness be measured?
RQ2: Why and how does social connectedness affect depression (i.e., what is the mechanism of action)?
RQ3: What types of social connectedness are likely to be the most beneficial in treating (or reducing the likelihood of) depression?

Although ongoing research is needed, we believe that the theoretical contributions and the empirical support of the SIA offer some insights into how these three issues might be usefully addressed and resolved.

With regard to RQ1 and in line with H1, H2, and H4, we suggest that the quality of social relationships might be best assayed using subjective psychological measures that provide insights into the way in which an individual is currently experiencing his or her social world. Social identification is one such variable (see Table 4). Moreover, speaking about RQ2, we believe that social identification might be a particularly useful measure because it captures what we see as a crucial mechanism of action (discussed in detail above). In relation to RQ3, it therefore follows too that attempts to cultivate social connectedness are most likely to be beneficial when they facilitate group formation and social identification (H6) providing those groups do not cohere around maladaptive or stigmatizing normative content (H3).

However, many questions remain unanswered, both theoretically and empirically. In this section, we discuss what we see as the most urgent issues to be addressed in building the bridge between social identity and depression. Broadly, this can be divided into two key areas of research: first, *theoretical* work to clarify conceptual issues and test the propositions of the SIA and, second, *clinically oriented* work to deliver on the promise of the SIA and improve outcomes for people with (or at risk of) depression.

Theoretical Research Questions

Sani and colleagues (2012) have made an important contribution in demonstrating that social identification predicts health outcomes (including depression) better than mere social contact (H4). This is also consistent with work by S. A. Haslam et al. (2005, 2011) demonstrating that social support, trust, and cooperation emerge from, and are dependent on, shared group membership (H5). However, it is essential that these findings be replicated and extended, to examine the specific symptoms of depression. Here, there is also a particular need for experimental studies designed to disentangle the causal contributions of the related constructs of social support, social identification, loneliness, and social capital to depression-related outcomes. Currently, there is something of a stalemate between researchers from different theoretical backgrounds in how to measure and, more crucially, how to conceptualize social connectedness. High quality experimental or prospective research that competitively tests the different conceptualizations as outlined in Table 3 is needed to advance research in this area.

Within the social-psychological literature, the categorization process that enables social identification has been studied extensively and has yielded reliable evidence of the antecedents of both social identification and social identity salience (e.g., see S. A. Haslam, 2001; Oakes et al., 1994). However, few studies have looked at the emergence (or decline) of social identities among specific *clinical* populations. Yet, this avenue of research is promising for several reasons.

First, it seems possible that the social skills deficits often observed in depressed populations correspond to differences in social identification. This raises the interesting question of whether, on one hand, being depressed makes a person less able to self-categorize in terms of social identity and/or whether, on the other hand, being less able to self-categorize in terms of social identity makes a person depressed. Indeed, on the basis of the foregoing evidence, it seems reasonable to propose that this is the bi-directional mechanism through which social disengagement occurs and social relationships

deteriorate, but clearly, this is a proposition that remains to be empirically tested.

Second, conceptualizing deficits in social relationships as identity-driven phenomena, rather than individual deficits, has important implications for treatment. Social identification acts across both individual (clinical) and social/community spheres, and so interventions that explicitly target this may therefore show sustained benefits in terms of mood—particularly relative to pharmaceutical interventions that fail to address the social-structural and psychological dimensions of depression and hence, leave the individual vulnerable to relapse once treatment concludes. As we noted above, in contrast to many other relevant psychological constructs (e.g., cognitive style, personality) social identifications are understood to be highly malleable and contextually dependent (e.g., Doosje, Ellemers, & Spears, 1995; S. A. Haslam & Turner, 1992; van Rijswijk & Ellemers, 2002) and thus seem particularly well suited as targets of intervention. Again, although forays in this direction are encouraging (as noted in relation to H6 above), a clinically robust empirical case for these assertions remains to be made.

Clinically Oriented Research Questions

As we have already noted, although around 20% of people will experience clinical depression in their lifetime (WHO, 2012), only a small minority gain access to best-practice and affordable treatment (Goldman et al., 1999; Simon et al., 2004). A key research priority is therefore to identify cost-effective, evidence-based treatment and to devise ways of making this widely accessible. Interventions that promote social group memberships are extremely promising in this regard (see H6). Social identities make good targets for treatment, particularly if they are conceptualized as concrete resources (e.g., Jones & Jetten, 2011). One way in which this has already been utilized in therapeutic contexts is through social identity mapping—a structured process that takes individuals through the process of reporting and displaying their group memberships in schematic form (Jetten et al., 2010; after Eggins et al., 2008). More specifically, this has been used as a stimulus to uncover a person's key social identities that can then be drawn on therapeutically in the process of identifying ways to use group memberships as resources to help people adjust to significant life change (e.g., stroke, Jetten et al., 2010; recovery from substance abuse, Best et al., in press).

Importantly too, joining social groups is likely to be less resource-intensive, more widely accessible, and less stigmatized than either anti-depressant medication or many individual-based psychological therapies. Furthermore, social group membership has other benefits for health and fewer health risks, making it suitable for a broad-base intervention (C. Haslam, Jetten, & Haslam, 2012). Yet, regardless of whether it is practically plausible to address the epidemic of depression one person at a time, we would argue that there are good theoretical reasons for thinking that this is sub-optimal.

We need to recognize, though, that, as yet, health professionals have been relatively slow to endorse group-based treatment strategies that might deliver a "social cure," and most psychologists are inclined to retain a preference for individual-based interventions. There are a number of reasons for this, including (a) a conviction that group-based treatments (and research) are somehow unscientific, (b) therapist and patient expectations (or prejudices) about appropriate treatment, and (c) the structure of existing clinical training and systems. Applied research is therefore needed to address this impasse and find ways in which social interventions of the form envisioned by the SIA might be effectively promoted *by* and *to* health professionals and institutions.

Several such studies already exist and provide a blueprint for future research to tackle the practical question of how health practitioners and others might effectively facilitate identity formation. Interventions that specifically target loneliness have been developed (for reviews, see Cattan et al., 2005; Perese & Wolf, 2005). Although these have not been designed as treatments for depression per se, they provide evidence of the effectiveness of enhanced social interaction of a form likely to facilitate social identification (Postmes et al., 2005). In addition, much can be learnt from the series of small-scale studies that have effectively improved the quality of life for nursing home residents (as reviewed above). However, as we have already noted, large-scale, randomized control trials are sorely needed to drive home the conclusions of these studies. These and other studies have also revealed several high-risk times for social isolation and group membership loss, such as transition to university (Iyer et al., 2009), entry into residential care (McCloskey, Haslam, Haslam, & Mewse, 2014), or following a significant injury (C. Haslam et al., 2008; Jones et al., 2012). It is at these times that institution-level interventions to promote group membership might be particularly effective.

In line with H3, one important area of research to explore is whether there are any risks to enhancing social identities for people with depression. Although, overall, there is a clear benefit from social group memberships, there are potential exceptions. In particular, as we have noted, the normative content of group memberships exerts a strong influence over individual behavior (Cialdini, Reno, & Kallgren, 1990; Deutsch & Gerard, 1955), and this content does not necessarily support adaptive health behaviors. For example, we might speculate that a group that coheres around essentialized conceptions of depression as biologically determined may resist behavioral treatment, because it is perceived as irrelevant to their condition (see also Crabtree et al., 2010). Therefore, there are circumstances where an intervention that facilitates group membership might potentially have a negative effect on recovery. It will be important for future research to determine whether this risk is non-trivial, and, if so, how it might be circumvented.

Given the demonstrated importance of social identification in preventing and treating depression, future research may also be warranted to examine the social identity processes at work in the therapeutic process itself. That is, how do various evidence-based therapies compare in supporting identity formation and increased social connectedness? The curative benefit of the therapeutic alliance is well-established; however, it has not hitherto been conceptualized as an operationalization or instantiation of identity-based social connectedness. In this regard, we would anticipate that therapeutic efforts would meet with greater success when they are made by a practitioner who is perceived by the patient to be an in-group rather than an out-group member (i.e., understood to be "one of us," and hence "like me," rather than "one of them" and "not like me"). Of course, this shared group membership need not be based on age, gender, and ethnicity, as there are many other ways in which clinicians can and should build a sense of shared identity with their patients. In particular, much of the clinical literature on micro skills and rapport building (e.g., that which encourages empathy, open body language, and inclusive, non-judgmental language) indicates that clinicians' interpersonal style is a key pathway to a sense of similarity, trust, and understanding (Kuntze, van der Molen, & Born, 2009; Sharpley, Halat, Rabinowicz, Weiland, & Stafford, 2001).

A social identity analysis would suggest that therapeutic alliance reflects the emergence of a group-based relationship between the clinician and the patient, where the emergent categorization is based on the perception of identity-affirming features including shared goals (akin to the optimal relationship between the teacher and the learner; for example, Bizumic et al., 2009; Reicher, Haslam, & Smith, 2012). Although the nature of the shared category may be harder to specify and define than one based on demographic characteristics, psychologically, this does not make it any less relevant and potent. It also follows from H6 that fostering a patient's perception that he or she shares group membership with the clinician on valued dimensions will enhance the latter's influence and success. Similarly, although literature suggests that patients report that group processes, including cohesion, are one of the key benefits of group therapy (Hornsey, Dwyer, Oei, & Dingle, 2009), little research has been informed by, or has tested, a theoretical framework in which this is conceptualized or investigated as an exercise in identity formation or maintenance.

Concluding Comment

This review has shown social connectedness to be implicated in the development, progression, and treatment of depression. However, to date, literature has lacked clarity in terms of the nature of this relationship and its cause. This is primarily due to the absence of a coherent, plausible, and empirically substantiated theory of social relationships. Consequently, interventions for depression, both at public health and clinical levels, typically do not address social connectedness in a meaningful way despite the clear promise that this strategy holds for a plethora of positive outcomes (Helliwell & Barrington-Leigh, 2012). We propose that the social identity approach—an influential theory of group processes that is supported by decades of evidence in social and organizational psychology (e.g., S. A. Haslam, 2001; Postmes & Branscombe, 2010)—provides a parsimonious and compelling framework for conceptualizing the role of social connectedness in depression. Furthermore, an abundance of emergent evidence (e.g., as summarized in Table 2) supports this approach.

It is now imperative that we bring this approach to bear directly on the issues at the core of depression. We contend not only that this makes good theoretical sense but also that it is likely to deliver tangible gains in preventing and treating a condition that Kong (2002) described as "the unbearable sadness of being" (p. 195). Indeed, if the best way to avoid depression is to make our being properly social, then it follows that social identification is an essential psychological foundation for the prevention and remediation of this most significant clinical issue.

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Notes

1. As we observe below, many different terms have been used to refer to the social processes involved in depression, and this has been one of the barriers to theoretical integration. Here, we use the umbrella term *social relationships* to refer to the objectively observed presence of a network of supportive connections with others (e.g., involving social contact, social participation, social capital, and social networks). We use the umbrella term *social connectedness* to refer to the subjectively experienced connection to others (e.g., involving social support, belongingness, the absence of loneliness).
2. The determinants of social identification are not the focus of this review, but it would nevertheless be more correct to say that there is a reciprocal relationship between these social phenomena (trust, helping, social support) and social identification. Thus, just as shared social identity is a basis for help, support, and trust (e.g., see Haslam, Reicher & Levine, 2012), so too, help, support, and trust can also promote social identity development (Gleibs, Haslam, Haslam & Jones, 2011). Moreover, providing support to fellow group members is one way in which social identification is enacted and made real in the world. In this way, a virtuous cycle can be created whereby social identification leads individuals to act in identity-maintaining ways that, in turn, strengthen their (and others') identification (S. A. Haslam et al., 2005).

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