Psychiatry Research 228 (2015) 340–346

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Identification with social groups is associated with mental health in adolescents: Evidence from a Scottish community sample

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ARTICLE INFO

Article history:
Received 17 September 2014
Received in revised form
6 April 2015
Accepted 23 May 2015
Available online 27 June 2015

Keywords:
Social identity
Groups
Mental health
Social determinants of health

ABSTRACT

The promotion and maintenance of mental health is an increasingly important societal issue. Previous research has shown that identification with social groups is positively associated with adult mental wellbeing, with multiple group identifications being particularly beneficial. The aim of the current study was to investigate whether the same is true for adolescents. 1111 Scottish secondary school students aged 13–17 completed a questionnaire investigating mental health symptoms and the extent of their identification with their family, school, and friendship groups. Higher identification with each group predicted better mental health. There was also an additive effect of group identification, with the odds of reporting psychiatric disturbance decreasing for every additional group with which participants identified strongly. These effects held even when age, gender, and group contact were controlled for. Our findings have implications for the prevention and treatment of mental problems, offering an alternative to traditional ways of viewing mental illness in adolescence and beyond.

1. Introduction

Researchers from numerous disciplines agree that membership in social groups (e.g., family, social club, local community, tribe) is a core feature of human existence (Tuomela, 2007; Tomasello, 2014). Group membership typically involves some degree of engagement in group related activities and interaction with in-group members. However, one may also develop feelings of belonging, affiliation and connectedness to a group, coupled with a sense of commonality with fellow group members (Sani et al., 2014). Researchers adopting a *social identity* approach to group processes (Turner et al., 1987) define these positive feelings and cognitions about an in-group as *group identification*. Group identification is distinct from merely being part of a group – it refers to the subjective aspects of group membership, including the sense of identity and self-definition provided by feeling subjectively attached to a group (e.g., Jetten et al., 2012). It is therefore important to make this distinction between contact with/connectedness to groups, and a sense of identification with them.

1.1. Group identification and mental health

The social identity perspective has helped to highlight the important effects that group identification can have on individuals' behavior and mental processes, either among adults (e.g., Haslam, 2004) or children and adolescents (Bennet and Sani, 2008a,b). In particular, researchers have demonstrated that we tend to help, like, and cooperate with people who are members of groups with which we identify. We are also likely to receive such benefits from other group members in return (e.g., Turner et al., 1987; Haslam et al., 2004; Levine and Thompson, 2004; Levine et al., 2005; Platow et al., 2007).

Importantly, the various benefits of group identification also extend to the domain of mental health. For instance, researchers have demonstrated that greater identification with the family (Sani et al., 2010), the work group (Wegge et al., 2006; Haslam et al., 2009; Sani et al., 2012), and the support group (Wakefield et al., 2013) predict higher levels of psychological wellbeing and lower levels of self-reported psychiatric symptoms (particularly depression, anxiety, and stress). Moreover, the relationship between group identification and mental health appears to be highly consistent: systematically reviewing thirteen such studies, Cruwys and colleagues found the typical Pearson's correlation coefficient between group identification and self-reported depression to approximate −0.30 (Cruwys et al., 2014).

1.2. Group identification and adolescent mental health

While such studies have emphasized the important effects that group identification can have on the mental health of adult populations, very few social identity researchers have considered the potential impact of group identification on the mental health of

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http://dx.doi.org/10.1016/j.psychres.2015.05.088
0165-1781/

adolescents. This is a significant oversight, since 75% of mental disorders emerge before the age of 25, and many argue that the mental health of young people is worsening (McGorry, 2013). The presentation of mental health problems in adolescence increases the risk of mental ill-health in adulthood (Birchwood and Singh, 2013); a fact that has prompted calls for adolescent treatment plans to be put in place, and for preventative action to be taken earlier in the life-course of potentially-vulnerable individuals (Wang et al., 2007; Sawyer et al., 2012). These calls are supported by research indicating that early treatment can reduce the social consequences of mental illness (Kessler et al., 1997, 1998), decrease comorbidity with more complex conditions (Kessler and Price, 1993), lessen suicidality (Meltzer et al., 2003), and reduce 'neural kindling', which can cause untreated disorders to worsen (Post and Weiss, 1998).

One of the few social identity-based papers to address the important issue of adolescent mental health is that by Bizumic et al. (2009). The authors found that greater school identification was associated with lower levels of depression, more positive affect, and less destructive behavior in a sample of Australian high school pupils. However, this study neglects an important fact: that school pupils can identify with multiple groups, not just their school.

1.3. Multiple group identifications and mental health

One of the central tenets of social identity theory is that we are all members of multiple social groups, even though we are unlikely to identify with all of these groups (Tajfel and Turner, 1979). The potential health benefits of multiple group memberships have started to receive attention in the social identity literature (e.g., Jones and Jetten, 2011), but, more importantly, so have the potential health benefits of identifying simultaneously with multiple social groups. For instance, in their study assessing well-being after joining university, Iyer et al. (2009) concluded that multiple group identifications can be particularly beneficial for wellbeing, because being a member of a group with which one has a sense of belonging can provide individuals with knowledge and opportunities (Bourdieu, 1979/1984) which, in turn, can provide material and psychological resources. Individuals who identify with multiple groups therefore have more resources and support available to them than those with fewer group identifications (e.g. Haslam et al., 2005; Iyer et al., 2009).

However, to our knowledge, there has been no research conducted in order to investigate the effect of multiple group identifications on the mental health of adolescents. We consider this a significant oversight: to help young people achieve good mental health as they move into adulthood, it is important that they feel safe and supported in multiple group contexts, including the family, the school, and peer/friendship groups (Viner et al., 2012).

1.4. Aims and hypotheses

With these issues in mind, our aim is to investigate the relative impact of each of these groups (family, school, and friends) on adolescent mental wellbeing. Based on Bizumic et al.'s (2009) findings regarding adolescent identification with a single group (as well the findings of studies regarding adult identification with single groups, e.g., Sani et al., 2009; Rosenthal et al., 2014), we suggest that identification with each of the three groups under study will predict better adolescent mental health (Hypothesis 1). In line with Iyer et al.'s (2009) suggestion, we further hypothesize that there will be a cumulative effect of group identifications, with multiple group identifications decreasing mental health symptoms (Hypothesis 2).

2. Methods

2.1. Participants and procedure

Our study is based on Wave 1 of a 2-wave longitudinal research project. The Wave 1 sample included 1111 pupils (553 males, 553 females, Mage=15.07 years, SD=0.97, range: 13–17 years) from four Scottish public (non-fee-paying) secondary (high) schools. Schools were chosen based on their willingness and ability to participate fully in both waves.

Each school obtained parental permission for all pupils to participate in the study. Pupils also gave their personal informed consent before participating, and were reminded of their right to withdraw at any time. Only one individual chose not to participate. Participants completed a questionnaire in class time under exam conditions, either in assembly or in class. The questionnaire was administered either by the researcher or by class teachers. In cases where the researcher was not present, the teachers administering the questionnaire were fully briefed on ethical and procedural considerations. In order to encourage honest responses, participants completed the questionnaire anonymously (although codes were used to allow the linking of Wave 1 and Wave 2 data).

2.2. Questionnaire measures

2.2.1. Group identification

Participants' identification with three distinct social groups was measured: the family, the school, and a friendship group. Concerning 'family', participants were instructed to consider 'your immediate family or the people you live with most of the time, for example, your parents, carers, step-parents, or other family members who live with you in your house'. With regards to 'school', participants were asked to think about it in terms of 'an institution with its history, values and beliefs'. Finally, concerning the group of 'friends', participants were asked to think about "the group of friends that you spend most time with or your 'best' friends".

Group identification was assessed with the widely used four-item global scale devised by Doosje et al. (1995). All items (e.g., 'I feel strong ties with members of [group]') were rated using a 1 ('I strongly disagree') to 7 ('I strongly agree') scale, and participants completed the scale with reference to the family (Cronbach's α=0.92), the school (Cronbach's α=0.89), and a friendship group (Cronbach's α=0.91).

We then created three binary variables to allow us to sum the number of strong identifications students had (for further examples of this method see Sani et al., 2014; Sani et al., under review). One variable was created for each group identification measure (i.e., family, school, and friendship group). We did this by calculating each participant's average identification score for each of the three groups. If a participant's average score was 5 or less for a particular group, they received '0' for that binary variable (indicating the participant did not identify strongly with that particular group), while if their average score was 6 or 7 they received '1' for that binary variable (indicating the participant identified highly with that particular group). We then summed the three binary variables to create a variable indicating each participant's number of high group identifications. This variable ranges from 0 (indicating the participant did not identify highly with any of the three groups) to 3 (indicating the participant identified highly with all three groups).

2.2.2. Mental health

We assessed mental health with the 12-item version of the General Health Questionnaire (GHQ-12; Goldberg, 1972). This is a well-validated and extensively-used screening instrument designed for the detection of mild psychiatric disturbance in both clinical and non-clinical populations. It discriminates well between cases and non-cases of psychiatric disorders (Cano et al., 2001). Although designed for adults, the scale has been used successfully with adolescents (Baksheev et al., 2011; Goldberg and Williams, 1988). Each item assesses the frequency with which the participant has experienced a particular symptom over the past month (e.g., 'Feeling unhappy and depressed'), using a scale ranging from 1 ('never') to 4 ('all the time').

Although there is debate over the optimal method of scoring, the instrument's creator recommends bimodal scoring (0-0-1-1) over Likert-scaled scoring (0-1-2-3) (Goldberg and Williams, 1988). A binary variable was therefore created, where responses of 1 and 2 were assigned scores of '0' (indicating the absence of a symptom), and responses of 3 and 4 were assigned scores of '1' (indicating the presence of a symptom). Each participant's 12 binary scores were then summed to create a GHQ-12 score, which could range between 0 and 12, with higher values indicating poorer mental health (Cronbach's α=0.89). Goldberg et al. (1998) suggested that the optimal cut-off threshold for the GHQ-12 should be between 3 and 4 (with a score of 3 indicating the absence of a mental disorder, and a score of 4 indicating the presence of a mental disorder). Moreover, Hardy et al. (1999) claimed that this threshold gives the best conservative estimate of minor psychiatric morbidity. With this in mind, we created a binary variable called 'psychiatric disturbance', where participants with a GHQ-12 score of 3 or less received '0' (lack of disturbance), and participants with a GHQ-12 score of 4 or more