Scaffolding a stronger society

Catherine Haslam on moving beyond social prescribing, by applying Groups 4 Health to unlock the social cure

In January the UK government decided to appoint the first minister for loneliness in the UK. For the party who gave us 'there's no such thing as society', this represents a major, overdue shift in thinking. It forces us to look closely at the social processes and structures that are integral to the wellbeing of societies and to apply ourselves to the challenging task of working to do something meaningful to tackle what is widely recognised as a 'wicked' social problem.

Social isolation touches all our lives and knows no bounds. It affects the young and old, the rich and poor, and those who are in good and ill health. It also places huge pressures on health services – estimates suggest that around 10 per cent of adults suffer from its debilitating consequences, and that GPs spend around 20 per cent of their time dealing with non-health problems with two thirds of their clients raising issues of social isolation (Caper & Plunkett, 2015).

With its new policy focus, the UK government has said it aims to 'develop a wider strategy on the issue, gather more evidence, and provide funding for community groups to start activities to connect people'. A strategy of this form is clearly welcome, but it needs to do more than recognise the value of the various social activities (e.g. arts, sporting and voluntary groups) that are already supported by a large number of charities as part of a wider social prescribing movement. These activities are important, and they have a very positive impact; but, on its own, social prescribing is unlikely to solve the problem of social isolation. A key reason for this is that while social prescribing rightly recognises a lack of social connection as the cause of a great many physical and mental health complaints, merely telling people to go out and make more social connections is unlikely to help them do so. Indeed, many (perhaps most) people who are socially isolated do not wish to be, and they already understand that it is a problem. What they lack is the *social scaffolding* that supports and empowers them to (re)build sustainable and meaningful connections with others independently (Williams et al., in press).

What form, then, might this social scaffolding take, and how can psychologists best act as social scaffolders? On the basis of a large body of research that has been conducted over the course of the last decade, our answer to these questions has recently culminated in the development of a new programme, Groups 4 Health (G4H). This is a structured intervention that puts insights from the social identity approach to health into practice in ways that help to unlock 'the social cure'.

Groups 4 Health

The experience of social isolation and disconnection is common across a range of health conditions and contexts. It is a consequence, for example, of social disadvantage, mental health difficulties, addiction, pain, brain injury, trauma and ageing. At a time when people need them the most, social isolation robs them of the resources that flow from belonging to *social groups*. This is because social group belonging – and the sense of internalised *social identity* that this provides – has been shown to be a key source of self-esteem, feelings of control, access to social support, and a sense of purpose and meaning. As we see it then, *social identity capital* is

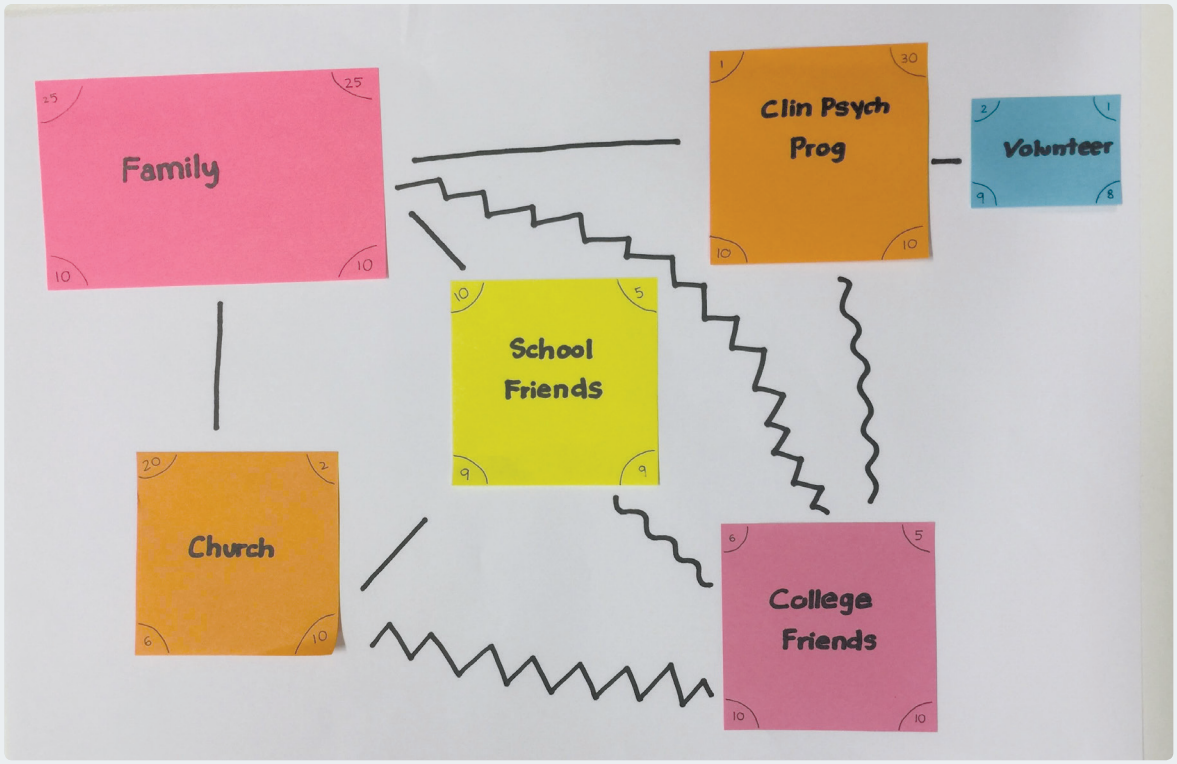

Figure 1. Example of a paper-and-pencil social identity map (from Haslam et al., 2018)

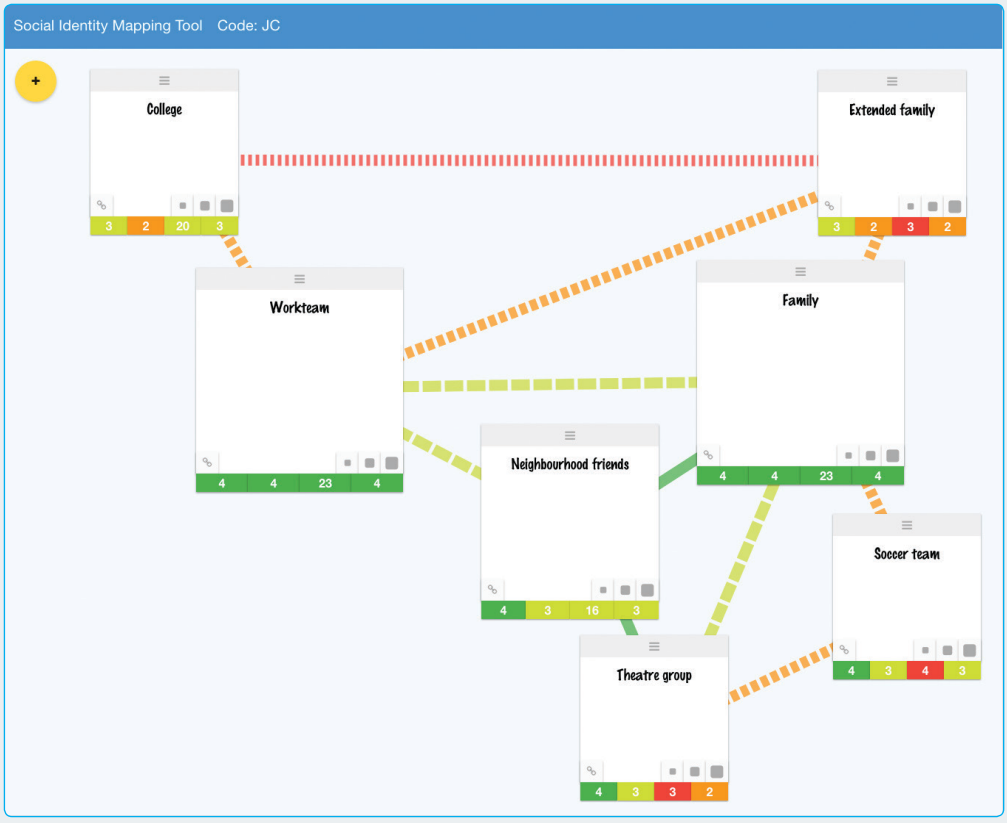

Figure 2. Example of an electronic social identity map (from Haslam et al., 2018)

the key outcome that interventions to tackle social isolation need to deliver.

With this in mind, Groups 4 Health aims to increase such capital by building group-based social ties in the context of an in-vivo group experience, so that the programme itself serves as a classroom through which to tackle the issues it seeks to address (Haslam et al., 2016). The programme is informed by the social identity model of identity change (SIMIC) and works on two pathways that are implicated in positive health outcomes following major life changes associated with such things as illness, trauma or retirement. One of these pathways centres on the process of social identity *continuity* (i.e. maintaining pre-existing group memberships) and the other on the process of social identity *gain* (acquiring new group memberships). The key point here is that when life throws up challenges, a sense of social identification with others is one of the main things that helps us to weather them. Sometimes this identification is associated with groups that we have been members of for a long time (e.g. our family), but sometimes it is associated with groups that we have only just joined (in particular, as a consequence of our shared experience, e.g. as trauma survivors). In all of this, the more groups a person has, the more likely they will weather the storm.

'I first began to recognise the importance of groups for people's health when I was working as a neuropsychologist in a hospital rehabilitation department. What became very clear to me was that, regardless of their specific condition, people who had more fulfilling group lives tended to have far better recovery trajectories.'

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The G4H programme is structured around five modules:

- *Schooling*: Raising awareness of the value of groups for health and of ways to harness this.
- *Scoping*: Developing social maps to identify existing connections and areas for social growth.
- *Sourcing*: Training skills to maintain and utilise existing networks and reconnect with valued groups.
- *Scaffolding*: Using the group as a platform for new social connections and to train effective engagement.
- *Sustaining*: Reinforcing key messages and troubleshooting (held one month later as a booster session).

Each of these modules centres on group tasks and activities that are supported by a facilitator and also by a participant resource book. Among these activities, one that provides the foundation for much of the work is *social identity mapping*. This activity is the focus of the Scoping session and its purpose is to help people create a visual representation of the social groups in their lives. Examples of these maps are provided in Figures 1 and 2. These reveal the number and types of groups that a person belongs to, the groups that are important to them (denoted by larger boxes), their experience of these groups (e.g. how much support they offer and how positive people feel about them, indicated with numbers), and also the relationships between these groups (with the lines between groups indicating how compatible they are).

In our previous research these various features of the maps have been found to be powerful predictors of health and wellbeing (Cruwys et al., 2016). In particular, people who are healthier and more resilient tend to have maps in which there are (a) more important groups, (b) more groups associated with positive experience, and (c) more compatible groups. As well as allowing people to reflect on their social world in the present, these maps provide a useful platform for thinking about how this world might change over time and be enriched in the future. In particular, in the Sourcing and Scaffolding sessions participants are helped to identify groups that they would like to make more important, and groups that they would like to add to their maps. These goals are then the focus of skill and strategy development within the modules, and in the final (Sustaining) module participants recreate their maps to see how successful they have been.

> "when life throws up challenges, a sense of social identification with others is one of the main things that helps us to weather them"

At present, there are around a dozen intervention studies that provide support for individual elements of the G4H programme. Amongst other things, these speak to the importance of helping people to hold on to their membership of groups that matter to them, and, if they can't, of helping them build new ones. Moreover, these benefits have been observed in the context of a range of life transitions including starting university, recovering from injury, having a child and retiring. They have also been observed under conditions of challenge and adversity that might present when a person is living with depression or coping with stress.

There is also growing evidence of the effectiveness of G4H as an integrated package. In particular, this comes from two studies involving adults experiencing social isolation and psychological distress. The first recruited 81 adults and found that G4H was associated

with marked improvement in depression, social anxiety, and loneliness both after the programme and then six months later (Haslam et al., 2016). In the second, 82 adults either received G4H or were placed on a wait list based on random assignment. This found that feelings of loneliness and depression declined in both conditions, but that this drop was greater among those who received G4H. For those receiving the programme, 83 per cent showed an improvement in loneliness and 71 per cent an improvement in depression. Interestingly too, GP visits increased significantly for those in the control group but not for those who took part in G4H (Haslam et al., 2018). This has particular relevance given that one of the key goals of the new minister for loneliness is to reduce the burden that loneliness places on health services, including GPs.

More research is needed, not least to compare the effectiveness of G4H with that of other active treatments, such as cognitive behavioural therapy and social prescribing (involving referral to community case workers and navigators to link people with non-clinical local services). Nevertheless, findings to date provide grounds to be optimistic about the programme's value as a means of building social identity capital among those who are suffering from social disconnection.

Why do we need Groups 4 Health?

Given the number of approaches and interventions that have been used to treat social disconnection, one might reasonably ask why we need another. The answer is that despite the weight of evidence showing that social groups have a disproportionate bearing on health outcomes, existing programmes do not prioritise these as active ingredients in treatment (see Haslam et al., 2018; Jetten et al., 2012). This shortcoming cannot be addressed simply by delivering interventions in groups, or by tacking a group component on to what are primarily individual-focused therapies. To target the group as a core ingredient of intervention we need a framework that speaks directly to the ways in which social groups determine health outcomes and to the role that social identification plays in this. In addition, any applied framework needs to recognise the capacity for groups to function both as a cure and, if inappropriately managed, a curse.

In this regard, there are two key features that differentiate the social identity approach from other approaches to managing health and social disconnection. First, its emphasis on the importance of groups and, second, its emphasis on the importance of a person's identification with those groups. The combined upshot of these means that, as a cure for social isolation, it is not the case that any old group will do. Social prescribing that is oblivious to this point may not succeed and may even backfire. This is because it is only those groups that give our lives meaning, purpose and value that have the power to support and sustain social connectedness. These are the groups that matter to us, that we identify with, and that become central to who we are (e.g. 'we Australians', 'we psychologists', 'we Leicester City supporters'). These two features thus provide the basis for the two fundamental predictions that the social identity approach makes about the role that groups play in health and wellbeing: 1) Because it is the basis for meaningful group life, social identity is central to both good and ill health; and 2) A person will generally experience the health-related benefits or costs of a given group only to the extent that they identify with that group.

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Understanding which groups are a source of social cure – those that promote a sense of belonging, positive health behaviours, and boost self-esteem – and how they might be harnessed to support health and wellbeing is therefore the key starting point for the G4H programme. This knowledge is then backed up with strategies and skills designed to help people (re)build strong group-based ties with others. By providing the means for those who are socially disconnected to (re)gain control of their social lives through the (re)discovery of group-based agency, this framework has the capacity to take social prescribing to the next level.

Seize the opportunity

The appointment of a minister for loneliness is a critical step in the process of prioritising the large-scale problems posed by social isolation. But, as psychologists, we need to seize this opportunity to ensure that people reap the full benefit of social prescribing. In particular, we need to ensure that efforts to promote social participation provide a scaffold that ultimately helps people to manage their own social worlds independently. In this regard, the chief benefit of G4H is that it is a *democratising intervention*, seeking to unlock the curative power of social groups and associated social identities in accessible and effective ways.

Key sources

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