

Healthy and Unhealthy Wars: The Effects of Ingroup-Committed Violence on Physical and Mental Health

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Intergroup violence can profoundly affect the health of involved parties. Complementing existing research on ingroup-suffered violence and health, this paper proposes an integrative framework explicating how and why ingroup-committed violence can positively or negatively affect the health of ingroup members. Based on different models of social identity and health, we argue that ingroup identification (i.e., attachment and glorification) determines how people cope with ingroup-committed violence. We lay out different nondefensive strategies critically identified group members are likely to engage in, and defensive strategies uncritically identified members are likely to engage in. We further posit that nondefensive strategies are less adaptive for maintaining and/or improving health in the short (but not long) term than defensive strategies, and that ingroup identification can act as both moderator and mediator of the effects of ingroup-committed violence on health. Thus, harming outgroup members can hurt or help ingroup members.

Keywords: intergroup violence, perpetrator group, health, stress and coping, identification

War takes a toll on those who fight or suffer it, with many negative consequences. These consequences even extend to those who do not fight nor suffer the war directly, for instance civilians at the “home front” far away from the battlefield. Among perpetrator groups, research to date has primarily investigated such consequences in terms of indirect societal costs (e.g.,

economy, wages, unemployment rates, education; for a review, see Pedersen, 2002). Healthcare costs, for instance, dramatically increase when a country perpetrates violence against another country, as veterans and wounded need increased healthcare upon returning home. We suggest that perpetrator groups do not only suffer indirect negative consequences from having to provide for their veterans and wounded. Perpetrator groups might also suffer more direct negative consequences, as most of their members, while not involved in direct violence themselves, are aware of the violence committed by their fellow group members in the name of the group. They are usually exposed to media coverage of such *ingroup-committed violence*, which can harbor health stressors. Americans, for instance, pay particular attention, and react very strongly, to U.S. military action overseas, especially war crimes such as the My Lai massacre during the Vietnam War or the more recent “Abu Ghraib scandal” of torture perpetrated by American soldiers against detainees in Iraq. As much as we would expect a parent’s health to be affected by the offspring’s questionable actions, the health of members of larger social groups should be affected by questionable actions of fellow group members. In line with research showing that chronic and/or re-

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peated exposure to even lower-level, nontraumatic stressors diminishes people's coping capacity and erodes physical and mental health (Christopher, 2004; Gunnar & Quevedo, 2007; Kubiak, 2005; Sapolsky, 2004), the intensity and frequency of ingroup-committed violence and the oftentimes visceral reactions to it should have pervasive effects on health.

Yet, the wealth of research on the effects of intergroup violence on health in the context of direct or indirect victimization (e.g., among victims/survivors, former prisoners of war, post-war generations; Al-Krenawi et al., 2011; Aoun et al., 2013; Bonanno, Field, Kovacevic, & Kaltman, 2002; Bonanno, Rennie, & Dekel 2005; Dekel, Mandl, & Solomon, 2011; Lykes, 2013; Okello, Nakimuli-Mpungu, Musisi, Broekaert, & Derluyn, 2013; Palosaari, Punamäki, Qouta, & Diab, 2013; Schick, Morina, Klaghofer, Schnyder, & Muller, 2013; Shemyakina & Plagnol, 2013; Sledge, Boydstun, & Rabe, 1980; Solomon et al., 1999; Vollhardt, 2012; Wohl & Branscombe, 2008) and bystander situations (e.g., among third parties; Lopes Cardozo et al., 2013) is not matched by research on the effects of intergroup violence on health in the context of direct or indirect *perpetration* of violence. Research in this context has been confined to direct perpetration of intergroup violence, almost exclusively focused on posttraumatic stress (Danish & Antonides, 2013; Hasanović & Pajević, 2013; McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013; Schok, Kleber, & Lensvelt-Mulders, 2010; for a review, see Schok, Kleber, Elands, & Weerts, 2008; see also Christie & Montiel, 2013). It is absent, however, in the context of interest here: *indirect* perpetration of intergroup violence—that is, violence not perpetrated by a person him- or herself, but by others in the person's group, who are therefore psychologically related to the person via shared group membership (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) and shared social identity (Tajfel & Turner, 1979). We will refer to this form of violence as *ingroup-committed violence*.

This contribution draws on scholarship on the links between social identity and health, and between ingroup-suffered violence (i.e., ingroup victimization) and health, in order to develop a conceptualization of the links between ingroup-committed violence and health. In doing so, we review and discuss different models

of the link between social identity and health, and apply them to the context of ingroup-committed violence. As such, this paper (a) strengthens the links between the literatures on social identity and violence on the one side and health on the other; (b) expands research on these links to the context of ingroup-committed violence, effectively integrating the literatures on ingroup-committed violence and health; (c) highlights and addresses challenges for research on these links, such as the often made but never substantiated claim that coping strategies in response to ingroup-committed violence (e.g., moral disengagement) have positive effects on health; and (d) hopes to inspire research whose findings will be of great importance to public health, and public and foreign policy. As our goals here are to focus on integration and synthesis of literatures, naturally we will not be able to give the detailed attention to the complexities and multitudes that any one literature or topic truly deserves. While an in-depth investigation of direct perpetration of violence and its relationship with indirect perpetration of violence is beyond the scope of this contribution, for instance, we will point to, touch and draw on research on direct perpetration (or suffering) of violence where pertinent. In the following, we review the research relevant to understanding the health-related consequences of ingroup-committed violence. Then we present a typology of possible strategic responses to such consequences and show that—in line with both the transactional and the integrated social identity model of stress—social identification can both moderate and mediate these processes.

Health in the Group Context

In the past decades, research has started to investigate psychological factors and mechanisms to explain stress, mental and physical health. As a consequence, new disciplines have been established (e.g., health psychology) and new models generated, from purely psychological to biopsychosocial models. The vast majority of this research has conceptualized health as a phenomenon that occurs at the level of the individual (Folkman & Moskowitz, 2004), exploring how factors situated within the individual or within the individual's environment relate to the individual's health (e.g., Lester, Smart, & Baum, 1994; McCrae, 1984; McCrae

& Costa, 1986). Going beyond the individual, some research has begun to examine how relationships, interactions, and/or dynamics between dyads or larger networks of individuals affect the health of the individuals involved (Pietromonaco, Uchino, & Dunkel Schetter, 2013; Christakis & Fowler, 2007; Wilkinson, 2001). Following calls to pay more attention to the role that group life plays in health (Aspinwall & Taylor, 1997; Cooper, Dewe, & O'Driscoll, 2001; Haslam, 2004), only recently has research explored how health affects, and is affected by, the psychology of groups. That is, how health is linked to social identity/identification.

Health and Social Identification

A new social identity framework of health in general, and stress in particular, has argued that social identity plays a key role in how people experience and react to stressors (Branscombe, Schmitt, & Harvey, 1999; Haslam, 2004; Haslam, Jetten, Postmes, & Haslam, 2009; Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; Haslam & Reicher, 2006; Nikitin & Freund, 2008; Peterson, Park, & Sweeney, 2008; Terry, Carey, & Callan, 2001). According to this framework, social identity, if salient, should predict people's appraisals of stressors through people's attitudes toward, evaluations of, and connections to their ingroup. Research has investigated social identity as (a) a determinant of symptom appraisals and responses (e.g., St. Claire & He, 2009), (b) a determinant of health-related norms and behavior (e.g., Falomir-Pichastor, Toscani, & Despointes, 2009; Oyserman, Fryberg, & Yoder, 2007), (c) a basis for social support (e.g., Haslam et al., 2005; Wegge, Van Dick, Fisher, Wecking, & Moltzen, 2006), (d) a coping resource (e.g., Matheson & Cole, 2004), and (e) a determinant of clinical outcomes (Cole, Kemeny, & Taylor, 1997; Bizumic, Reynolds, Turner, Bromhead, & Subasic, 2009; for an overview see Haslam, Jetten, Postmes, & Haslam, 2009).

In support of this framework, research has found that groups such as professional groups or families have important consequences for well-being and health of their members (Elliott & Umberson, 2004), and that higher ingroup identification predicts better wellbeing and mental health (Jetten, Haslam, Haslam, & Branscombe,

2009). The reason behind this link is that ingroup identification helps people to cope with stress by providing people with a sense of meaning and facilitating trust, social support, and cooperation within the group (Barreto & Ellemers, 2002; Lincoln & Chae, 2012; Worchel, Rothgerber, Day, Hart, & Butemeyer, 1998; for a recent review, see Jetten, Haslam, & Haslam, 2012). Residents of a care home, for example, had greater life satisfaction when making decisions about the home as a group (Knight, Haslam, & Haslam, 2010), and people who have dementia can overcome a sense of loss by creating self-help groups (Clare, Rowlands, & Quin, 2008). Similarly, the seemingly paradoxical finding that among people with traumatic brain injury, severity of traumatic brain injury is positively associated with life satisfaction, has been explained by the fact that traumatic brain injury increased people's sense of identity strength and their closeness to family and other social support networks (Jones, Williams, Haslam, Jetten, & Morris, 2008). As such, ingroup identification has been shown to lead to less depression and physiological stress (Reicher & Haslam, 2006), less emotional exhaustion in the workplace (Wegge et al., 2006), and less anxiety (Bizumic et al., 2009). Comparing its predictive power with that of social contact, ingroup identification has been shown to predict mental health and stress better (Sani, Herrera, Wakefield, Boroch, & Gulyas, 2012).

Social identities are also related to experiences, appraisals, and responses to stress. Stressors are perceived as less threatening when a "protective" social identity is salient (e.g., student rather than gender identity in the case of facial scarring among women; Levine, 1999; see also Haslam, Jetten, O'Brien, & Jacobs, 2004; Levine & Reicher, 1996; St. Claire & He, 2009). Stress appraisals have also been shown to vary consistently across time in relation to salience of social identities (Muldoon, 2004; Muldoon, Trew, & McWhirter, 1998). Further, social identity is involved in behavioral reactions to health problems of self and others. For instance, social identity enables people to engage in more problem-focused coping and lowers stress markers such as cortisol (Matheson & Cole, 2004). Similarly, group esteem—commonly associated with perceived control over one's own fate—has been identified as a major protective factor against chronic illness (Bailis,

Chipperfield, & Helgason, 2008; Chandler & Lalonde, 1998; Michinov, Fouquereau, & Fernandez, 2008). Beyond these effects of social identity on group members' health, social identification has also been shown to improve the wellbeing and sustainability of institutions and societies which group members are part of. Teachers' and students' identification with their school, for example, is a strong predictor of their ability to control their emotions and disruptive behavior, leading to better institutional climates (Bizumic et al., 2009; see also Reicher & Haslam, 2006). Last, but not least, social identification can increase the likelihood that disadvantage or deprivation are perceived as collective/group-based (rather than personal), triggering collective action as an approach-based coping strategy (van Zomeren, Spears, Fischer, & Leach 2004; van Zomeren, Leach, & Spears, 2012).

The research on the link between social identity and health reviewed above follows and/or falls in line with one of two models that have proved to be very influential in psychological research on health: Lazarus' transactional model of stress (Lazarus & Folkman, 1984) and Haslam's integrated social identity model of stress (Haslam, 2004).

Transactional model of stress (TMS).

The TMS posits that coping is a result of cognitive appraisal, which itself is a result of resources such as social support (Lazarus & Folkman, 1984). In other words, resources affect coping, which in turn generates adaptive, health-related outcomes. Cardiac patients, for example, choose approach-oriented coping strategies, which lead to less depression, to the extent that they feel supported (Luszczynska, Mohamed, & Schwarzer, 2005). While the TMS has originally been conceptualized from an interpersonal perspective, it is not incompatible with a social identity perspective. From a social identity perspective, social identity itself can be seen as a resource affecting appraisal and coping (cf. Haslam & Reicher, 2006). When group membership is salient, the group's norms, expectations and values influence appraisal. Whether flu is perceived as dangerous (St. Claire, Clift, & Dumbelton 2008), smoking (Kobus, 2003) or unprotected sex (Campbell, 1997) as risky, the appraisal depends on whether, and which, group membership is highlighted. From the perspective of the TMS, social

identity should thus moderate the effects of stressors on appraisals, coping and stress.

Integrated social identity model of stress (ISIS). The ISIS (Haslam, 2004; Haslam & Reicher, 2006) differs from individualistic approaches to health that see within-individual variables (e.g., personality, coping styles) as universal determinants of stress outcomes. In line with social identity theory (Tajfel & Turner, 1979), the ISIS conceptualizes stressors as aversive social structural conditions and attempts to account for variation in responses to them. Specifically, the model claims that people choose individual or social identity-based coping strategies depending on whether or not they see opportunities to escape a stressor. When they do, they will try to individually avoid the stressor. When they do not, however, they will turn to the group (i.e., to their social identity) in order to find alternative coping strategies such as collective denial or resistance. Through social identification, negative experiences of a stressor can be transformed into positive and/or productive ones. Evidence for this model comes most strongly from the BBC Prison Study, where identity-based processes affected participants' experience of stress (Haslam & Reicher, 2006). In the BBC Prison Study, participants in the role of prisoners were more supportive of each other and resisted stressors better through increased shared identity. In contrast, participants in the role of guards were less supportive of each other and resisted stressors less through decreased shared identity (Haslam & Reicher, 2006). From the perspective of the ISIS, social identification should thus mediate (rather than moderate) the effects of stressors on appraisals, coping, and stress (cf. Muldoon, Schmid, & Downes, 2009).

Although building on the TMS, the ISIS differs fundamentally from the TMS. The TMS conceptualizes social identity at the individual level; social identity only matters as far as it affects individual coping. Therefore, social identity in the TMS is best conceptualized as a moderating factor of the relationship between life events and health (cf. Folkman & Moskowitz, 2007). The ISIS, on the other hand, places social identity front and center of the stress process. Here, social identity does not simply moderate coping, but it is directly linked to stress in that variations in stress experiences are related to group membership and the level of

identification with the group. In other words, in the view of the ISIS group experiences affect coping, stress, and health of the individual *as a group member*. People choose (individual- or group-level) coping strategies *because* they responded to a given stressor by increasing or decreasing their social identification. That is why in the ISIS social identity is best conceptualized as a mediating factor of the relationship between life events and health. Thus, the crucial difference between these models is that the TMS does not treat social identity as a causal variable, whereas the ISIS does. Despite this difference, the views of social identity as mediator or moderator are not mutually exclusive. In fact, we will argue that in the context of ingroup-committed violence, social identity is best understood as both a mediating *and* a moderating variable.

Health in the Context of Intergroup Violence

In the context of intergroup violence, research has distinguished between direct and indirect violence, and between victim and perpetrator experiences. While from an individual health perspective direct experiences of violence are more important, from a group as well as public health perspective indirect experiences are at least equally important. Given the traditionally more individual focus of psychology in general, it is not surprising that most research on health and intergroup violence has focused on direct rather than indirect violence. Although some argue that indirect (as opposed to direct) experiences of violence have not only equal but greater influence on identity (Hayes & McAllister, 2001) and health (Miller & Rasmussen, 2010), research on indirect violence and health is still in its infancy. Further, given that victims are reasonably considered to be more adversely affected by violence than perpetrators (cf. Cairns, 1996; Muldoon, 2004), research on indirect violence and health has so far exclusively focused on victim experiences. Yet, from a public health perspective, effects of indirect violence on health in the context of perpetrator experiences should be equally impactful. While such research is nonexistent, existing research on indirect violence and health in the context of victim experiences can inform our understanding of the potential effects of

indirect violence on health in the context of perpetrator experiences.¹

The Case of Ingroup Victimization

One of the many adverse effects of intergroup violence is that on victims' health. In Northern Ireland, for instance, the likelihood of ill health increases with increasing victimhood, even when controlling for associated demographic factors (O'Reilly & Stevenson, 2003). The reason for this effect on health is that ingroup victimization poses an existential threat to the group, which can lead to many health problems (Bar-Tal & Antebi, 1992; Wohl, Branscombe, & Reysen, 2010). However, the role that identification with the victim group plays in this regard has been contested (cf. Van IJzendoorn, Bakermans-Kranenburg, & Sagi-Schwartz, 2003). While some have found that identification with the victim group amplifies stress (e.g., Wayment, 2004), others have found that it buffers against stressors (e.g., Punamäki & Suleiman, 1990). Like the "buffering hypothesis," the rejection-identification model (Schmitt & Branscombe, 2002) also predicts positive effects of group identification on wellbeing. This model applies specifically to minority group members and, most importantly, postulates that the group members' belief that they are illegitimately targeted by others' prejudice increases ingroup identification, which, in turn, increases wellbeing. In other words, group identification mediates the effect of the minority group members' rejection of the prejudice targeting them on wellbeing (Blaine & Crocker, 1995; Branscombe et al., 1999; Postmes & Branscombe, 2002). This way, social identification can help sustain the

¹ While there is also research on direct perpetration of violence and health (e.g., posttraumatic stress disorder [PTSD] among soldiers; for a review, see Schok et al., 2008), this research is less pertinent to ingroup-committed violence because it focuses predominantly on PTSD (Miller & Rasmussen, 2010; Summerfield, 2000), an outcome that is rather unlikely and therefore less relevant in the context of indirect perpetration of violence. Further, the context of direct as compared to indirect violence differs not only in its intensity or adversity, but substantially in its quality. Stressors investigated among direct perpetrators are, if anything, based on personal identity (Miller & Rasmussen, 2010), whereas in the context of indirect perpetrators important stressors should be based on social identity.

health of vulnerable populations. As such, identification with the ingroup and self-stereotyping as an ingroup member facilitate Southern Italians' resistance to discrimination (Latrofa, Vaes, Pastore, & Cadinu, 2009) and predict Black Americans' perceived efficacy of different strategies to cope with discrimination (Outten, Schmitt, Garcia, & Branscombe, 2009). In the context of intergroup violence, it has been shown that intergroup violence increases ideological commitment and identification with the victim group (Dawes, 1990; Punamäki, 1987; Ziv, Kruglanski, & Shulman, 1974), which can buffer the otherwise negative effects of victimization on health. Palestinian women adapted better and were more resilient to negative consequences of political violence, the higher their ideological commitment (cf. Cairns & Dawes, 1996; Punamäki & Suleiman, 1990). In Israel, political violence was related to anxiety, insecurity, and depression only among adolescents with weak ideological commitment (Punamäki, 1996). The same was true in Northern Ireland (Muldoon & Downes, 2007; Muldoon et al., 2009; Muldoon & Wilson, 2001).

Addressing the open question of whether, or when, victim group identification amplifies or buffers against stress, recent research has found that victim group identification buffers posttraumatic stress disorder (PTSD) symptoms for people with indirect victim experiences but worsens PTSD symptoms for people with relatively more direct victim experiences (Kellezi & Reicher, 2012; Wohl & Van Bavel, 2011). Further, national identification appears to have only a buffering effect on health when the identity is conflict-relevant, as it mediated the effect between victimization experiences and health for British and Irish in Northern Ireland, but not for Northern Irish (whose identity is less relevant to the conflict; Muldoon et al., 2009). Similarly, victim group membership positively predicted mental health for Kosovans who supported the 1999 Kosovo conflict but not for Kosovans who did not, indicating that the link between victim group identification and health is positive when intergroup violence is seen as identity-affirming but negative when it is seen as identity-negating (Kellezi, Reicher, & Cassidy, 2009).

The Case of Ingroup-Committed Violence

Groups rarely see themselves as perpetrators, both during and after conflict—especially since WWII. Ingroup-committed violence is usually portrayed as a response to violence or injustice suffered at the hands of the adversarial group (e.g., Noor, Shnabel, Halabi, & Nadler, 2012; Sullivan, Landau, Branscombe, & Rothschild, 2012), or even as “pre-emptive self-defense” (Krauthammer, 2008). When the ingroup is (seen as) the victim, the group's status/power is in question, but its morality is intact (Nadler & Shnabel, 2008; Shnabel & Nadler, 2008). Yet, groups are at the very least aware when they are seen primarily as the perpetrator of a conflict by third-party groups (e.g., Serbia in the Balkan wars). When the group is (seen as) the perpetrator, the group's status/power is usually intact but its morality is in question. Thus, whereas ingroup victimization poses a threat to the group's security and existence, ingroup perpetration of violence poses a threat to the group's moral standing. Like ingroup victimization, ingroup perpetration should therefore affect group members' health, even if they have not engaged in violence directly. Unlike in the case of ingroup victimization, however, we argue that in the case of ingroup perpetration of violence, ingroup identity cannot only heighten the threat to moral identity and therefore pose a risk to health, but also provide strategies to cope with this risk. When coping is successful, it can even improve health through reaffirmation of or increase in perceived power/status of the ingroup without a simultaneous loss in moral standing. Thus, intergroup violence should affect the health of members of the perpetrator group through identity threat appraisal and coping (see Figure 1); whether these effects turn out negative or positive depends on social identification and coping. Importantly, while in the majority of health research a health problem is the source of stress, here social identity is partially the source of stress (in addition to the ingroup-

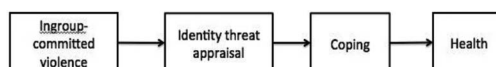


Figure 1. Effects of ingroup-committed violence on the health of members of the perpetrator group through identity threat appraisal and coping.

committed violence)—without social identity, ingroup-committed violence alone would not pose a health risk.

Due to the lack of research on indirect perpetration of intergroup violence and health, we will not make specific predictions as to which health indicators different coping strategies should affect. Rather, we will make general predictions regarding the direction of such effects. Yet, it is useful to briefly explain how such effects on health might look like specifically. Recent research has demonstrated that social relationships in general have strong effects on mortality, chronic illness, or pain (Holt-Lunstad, Smith, & Layton, 2010; Sani et al., 2012), and shed light on the biopsychological processes that suggest how a damaged ingroup image specifically can affect health. At the individual level, social-evaluative threat comes with increased cortisol response (Dickerson & Kemeny, 2004; Gruenewald, Kemeny, Aziz, & Fahey, 2004), a finding similar to findings among other mammals about the relationship between social threat and cortisol level (Sapolsky, 1993; Shively, Laber-Laird, & Anton, 1997). Social threat and shame—a common reaction to ingroup identity threat (Lickel, Schmader, & Barquissau, 2004; Lickel, Schmader, Curtis, Scarnier, & Ames, 2005; Lickel, Steele, & Schmader, 2011)—also increases inflammatory reactions such as proinflammatory cytokine activity (Dickerson, Gable, Irwin, Aziz, & Kemeny, 2009; Dickerson, Kemeny, Aziz, Kim, & Fahey, 2004). Shame- and guilt-related reactions for experiencing social threat can lead to successful coping reactions in the short term, but when such threat is sustained, the reactions can seriously and negatively affect mental (Scheff, 2001; Gilbert & Trower, 1990) and physical health, including negative effects on the immune system

(Segerstrom et al., 1996; Munck, Guyre, & Holbrook, 1984), cardiovascular disease (Black & Garbutt, 2002), and mortality (Harris et al., 1999; for a review, see Dickerson, 2008, 2012). While these health consequences have not yet been investigated in the context of vicarious shame and guilt induced by ingroup-committed violence, as we will argue in the following section, such research is theoretically warranted and will be of great practical importance. It is with these health consequences in mind that we predict how coping strategies in response to ingroup-committed violence should affect health, and how they are determined by social identification as a moderating and mediating influence.

Coping Strategies and Health

Despite the above mentioned commonality of ingroup suffering and ingroup perpetration of violence triggering threat, they should lead to different coping strategies. The different kinds of threat inherent in perpetration rather than suffering of violence (existential vs. moral identity threat) should lead to distinct coping strategies related to the threat. In the context of ingroup-committed violence, people can choose not to defend their psychological equanimity and rather face the group's demons, or they can defend their psychological equanimity and shy away from the demons. Further, they can engage in strategies to do so either at the individual or at the group level (see Table 1).

Defensive coping strategies at the individual level. A wealth of research has investigated psychological defense mechanisms that allow people to maintain a positive self and group image even in the face of norm-violating ingroup behavior. Several such mechanisms have been summed up under the label “moral

Table 1
Defensive and Nondefensive Coping Strategies at the Individual or Group Level

	Individual level	Group level
Defensive	Disidentification Moral disengagement Morality shifting Demonization	Ingroup-uncritical collective communication Ingroup-defending collective action
Nondefensive	Black sheep Ingroup dissent	Ingroup-critical collective action Ingroup-critical institutionalized action

disengagement,” as they allow people to disengage from the (im-)morality of an action or event, thus avoiding condemnation of their own, or their own group’s, behavior as immoral (Bandura, 1999, 2002). Focusing on the (out-group) victims, people can blame them for their suffering (e.g., Campbell & Raja, 1999; Ryan, 1976), or dehumanize them in order to diminish the magnitude of the suffering (Kelman, 1973). With respect to ingroup-committed violence, it has been demonstrated that Americans and British dehumanized Native Americans when the ingroup was portrayed as being responsible for the suffering of Native Americans (Castano & Giner-Sorolla, 2006). Focusing on the (ingroup) perpetrators, people can displace their responsibility, or diffuse the responsibility by pointing to many different “cogs in the machine.” When ingroup-committed violence is morally disengaged from through these and other strategies, people’s self and group image stays intact and aversive self-focused emotions such as guilt or shame are alleviated (Aquino, Reed, Thau, & Freeman, 2007, Study 2). Thus, we expect that these strategies will also buffer the stressor of ingroup-committed violence and thereby protect people’s health, for instance in terms of inflammatory reactions that aversive threat-induced emotions like shame can cause otherwise (cf. Dickerson et al., 2004, 2009). Yet, there might be negative side effects, as moral disengagement strategies deplete cognitive resources and cause ego depletion (e.g., Hagger, Wood, Stiff, & Chatzisarantis, 2010), which, in the long run, can be costly for people’s coping and health (Hagger, Wood, Stiff, & Chatzisarantis, 2009).

To the extent that people are aware of moral disengagement, some situations may render it less feasible, for example, in cases of extreme violence that are hard(er) to disengage from. Yet, people can still opt to psychologically leave the ingroup (disidentification). A wealth of social identity research has suggested that social categorization is inherently variable and fluid, varying systematically with changes in social context (e.g., Turner, Oakes, Haslam, & McGarty, 1994). In other words, whether others are categorized as similar to or different from the self varies with “the perceiver’s changing relationship to reality” (Turner et al., 1994, p. 458). One important aspect of this “reality” is the image of the relevant social group. The

basic assumption of social identity theory is that people strive for a positive self-concept derived from membership in social groups (Tajfel & Turner, 1979). This implies that perceived immorality of a group can motivate members of the group to distance themselves from—or even leave—the group, if possible. Research on group permeability lends support to this possibility by showing that when the ingroup is described as having low (rather than high) status, identification decreases, especially when group boundaries are permeable (Ellemers, van Knippenberg, de Vries, & Wilke, 1988; Ellemers, van Knippenberg, & Wilke, 1990). Even if leaving the group is not an option—in case of citizenship, the majority cannot give back their passport and move to another country—reducing psychological connectedness with the group is still possible. When the group’s reputation drops and identity threat looms large, members often distance themselves from the group, hiding their group membership in intergroup situations (cutting off reflected failure; Snyder, Lassegard, & Ford, 1986). Ellemers and colleagues (1997, Study 1) further demonstrated that low identifiers were more likely than high identifiers to feel less committed to their group and exhibit more individualistic rather than group-oriented behavior when the ingroup had low rather than high status. Similarly, as a reaction to identity threat, low identifiers distance themselves from the group whereas high identifiers pull closer and show loyalty (Branscombe et al., 1999; Spears, Doosje, & Ellemers, 1997). These findings are consistent with the proposition that ingroup-committed immoral acts can lead people, especially low identifiers, to disengage from their group as a self-protective strategy. By severing the ties between the ingroup and themselves, the immoral behavior does not threaten people’s social identity anymore because people are not invested in the group and its image anymore. Thus, people’s health should no longer suffer from the violence committed by the (former) ingroup. Yet, people’s health might suffer in the long term if people’s need to belong (Baumeister & Leary, 1995) is not satisfied by membership in other groups (e.g., Baumeister, Brewer, Tice, & Twenge, 2007; Brown, Silvia, Myin-Germeys, & Kwapi, 2007).

The individual-level defense strategies discussed thus far buffer health, but they do not

necessarily increase health. Strategies that allow people not only to demoralize but to actively moralize ingroup-committed violence might be able to do just that. Rather than disengage from the violence as a moral issue, people can shift the moral principles they use to evaluate whether or not the violence was (im-)moral. Americans confronted with violence against Iraqis, for instance, shifted their morals from violence-condemning harm- and fairness-based to violence-legitimizing or even violence-demanding loyalty- and authority-based morals when the violence was committed by U.S. rather than Australian soldiers (Leidner & Castano, 2012). Similarly, demonization of outgroups as perpetually evil does not only allow for outgroup members to be harmed (like dehumanization), but it *requires* them to be harmed (Giner-Sorolla, Leidner, & Castano, 2011). For instance, the rhetoric of “good versus evil” was commonly employed to justify and even moralize post-9/11 wars waged by the United States and others. The U.S. government has repeatedly used the term “axis of evil” to gain public support for its military endeavors. Recent research supports the link between demonization and violence. In a series of studies, Campbell and Vollhardt (2014) found that belief in evil predicted enhanced support for various violent policies, and this effect was mediated by endorsement of redemptive violence—the notion that violence can be used to save the world from evil. What strategies like morality shifting and demonization have in common is that they imbue ingroup-committed violence with meaning and turn it into a moral mandate (Skitka, 2002; Skitka & Mullen, 2002). As a consequence, violence should be experienced as rewarding and transform the potential distress of ingroup-committed violence into eustress, resulting in better health (Simmons & Nelson, 2001). This possible outcome of violence is mirrored in a host of studies on soldiers’ and combatants’ cognitive appraisals of (direct perpetration of) violence, finding that war veterans generally report more positive than negative effects from their war experiences (e.g., Dohrenwend et al., 2004; Elder & Clipp, 1989; Fontana & Rosenheck 1998; Mehlum, 1995; for a review, see Schok et al., 2008)—even more so with increasing levels of combat intensity (Aldwin, Levenson, & Spiro, 1994; Spiro, Schnurr, & Aldwin, 1999; for similar results among prison-

ers of war, see Sledge et al., 1980; Solomon et al., 1999). These effects are driven by veterans’ ability to find meaning in war and predict lower posttraumatic stress responses and higher quality of life (Schok, Kleber, Lensvelt-Mulders, Elands, & Weerts, 2011).

Nondefensive coping strategies at the individual level. Instead of engaging in defensive coping strategies, individuals have also been shown to be able to cope in nondefensive ways. They can either call out the individual ingroup members who perpetrated violence, or they can call out the ingroup as a whole on its perpetration of violence. When people have the opportunity to blame specific deviant ingroup members who are believed to be responsible for the ingroup’s immoral behavior, people remain identified with the ingroup (Cameira & Ribeiro, 2014) but expel the deviant members from the group (black sheep effect; Marques, Yzerbyt, & Leyens, 1988; Marques, Abrams, Páez, & Hogg, 2001; Castano, Paladino, Coull, & Yzerbyt, 2002). People are harsher in judging failing ingroup (compared to failing outgroup) members precisely because the failing ingroup members’ behavior can reflect back to the entire ingroup and threaten the related identity (Marques et al., 1988). The harsh judgments thus serve to protect people’s social identity (Marques & Páez, 1994; Marques et al., 2001). This protective function could therefore also extend to people’s health. Yet, as performing the black sheep strategy is a demanding cognitive task (Coull, Yzerbyt, Castano, Paladino, & Leemans, 2001) and leads to ego depletion, it can also be negative for health in the long term (cf. Hagger et al., 2009).

Rather than confronting particular group members, people can also confront the group as a whole. While nonconformity to group norms has traditionally been viewed as negatively associated with identification with a particular social group (e.g., Terry & Hogg, 1996), more recent theorization of social identity suggests that identification with a group does not necessarily imply blind attachment to group values or uncritical compliance with group decisions (Hornsey, 2006; Roccas, Klar, & Liviatan, 2006). The normative conflict model (Packer, 2008) proposes two distinct forms of nonconformity, one motivated by the desire to challenge the group in order to improve it, and one by disengagement, or the desire to distance one-

self from the group (see individual-level defense strategies above). These two forms of nonconformity are closely linked to group identification. Whereas strongly identified group members are willing to dissent when confronted with group-related, but not individual-related, problems (Packer, 2009; Packer & Chasteen, 2010), weakly identified members are more willing to dissent when the problem harms individuals within the group (Packer & Miners, 2012). Therefore, instead of engaging in defensive strategies, individuals also engage in nondefensive strategies in response to perceived harmful group norms or behavior. Yet, such dissent goes counter strong norms to consent with the ingroup (Abrams, Wetherell, Cochrane, Hogg, & Turner, 1990) and bears risks, for instance, to be ostracized by fellow group members. These potential consequences of ingroup dissent are associated with ill health (Smart Richman & Leary, 2009). Further, dissent with ingroup-committed violence should lead to ill health in and by itself, as it amounts to acknowledgment of ingroup-committed immoral behavior, and corresponding negative self-conscious emotions (e.g., guilt, shame). Such emotions, again, have been associated with ill health (Myers, Hewstone, & Cairns, 2009).

In sum, nondefensive coping strategies at the individual might lead to poorer health through a failure to protect people's social identity in the face of ingroup-committed violence. Interestingly, however, these strategies might at the same time have a self-affirming effect, possibly bolstering people's individual moral identity, especially those who are not strongly attached to their ingroup and ingroup norms. Support for this possibility comes from studies showing that people who put high self-importance on their moral identity tend to shape up rather than ship out (Aquino et al., 2007). Moreover, the normative conflict model suggests that strong identifiers express dissent with the goal of protecting the collective moral identity, which may also buffer the negative effects of ostracism on the dissenter's wellbeing (Packer & Miners, 2012). Thus, whereas defensive strategies at the individual should clearly bolster health, for nondefensive strategies at the individual level, it is unclear whether they will bolster or undermine health.

Defensive coping strategies at the group level. People can also cope with ingroup-committed violence by engaging with fellow ingroup members by shaping a collective

memory or narrative of "just violence." While it is commonly said that history is written by the victors, it is more accurate to say that every group writes its own history. Even groups on the losing side of war develop their own narratives of what happened, as has been demonstrated by the narrative of WWI in Weimar Germany, the Palestinian narrative of "nakba," and many others (Hammack, 2008; Hammack & Pilecki, 2012). Recent research has shown that in discussions of atrocities with fellow ingroup (rather than outgroup) members, people covertly recall justifications for the atrocities that have not even been mentioned in the discussion (Coman, Stone, Castano, & Hirst, 2014). This way, immoral events in the ingroup's history can be cleansed through ingroup-uncritical communication between ingroup members. Going one step further, people can also justify and even facilitate ingroup-committed violence through ingroup-defending collective action. Just as specific groups or movements can be created and actively formed with prosocial motives, they can also be formed with hostile (Thomas, Smith, McGarty, & Postmes, 2010) or even violent (Staub, 1989; Zimbardo, 2007) motives. Social problems and political agendas often contribute to the development of specific opinion-based groups to address the issues that elicited them (McGarty, Bliuc, Thomas, & Bongiorno, 2009). Identification with such action-based groups is the key in effective social movements (Thomas, Mavor, & McGarty, 2012; Thomas, McGarty, & Mavor, 2009b). Through adopting social identities based on injunctive social norms that legitimize ingroup-committed violence (Smith, Thomas, & McGarty, 2014), people can form movements that defend and even promulgate the use of violence by the ingroup (e.g., Nazism, White Power, Hutu Power in Rwanda). Such collective justification is further facilitated by the phenomenon that people show increased and often uncritical support for the ingroup in times of crisis (rallying around the flag, Lambert et al., 2010; Lambert, Schott, & Scherer, 2011; terror management theory, Greenberg, Solomon, & Pyszczynski, 1997; Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989).

Both coping strategies, ingroup-uncritical collective communication and ingroup-defend-

ing collective action, should lead to better health, but at the same time to other group-level costs due to lack of self-correction of the group (e.g., more future conflict and its corresponding societal burdens). Also, the just war narrative might be less effective in buffering stress and identity threat when other groups question the narrative. In the second Balkan war, for instance, Serbs were convinced that they were historically and morally justified to start a war. This view was maintained even after the North Atlantic Treaty Organization mounted its intervention, leading to Serbia's political isolation and further international decisions disadvantageous to Serbia. In addition to the violence inherent in humanitarian (i.e., military) interventions, their (side) effect of ostracizing the target of the intervention at group level (i.e., Serbia's isolation in the international community) might affect the health of the ostracized group's members negatively in the long run.

Nondefensive coping strategies at the group level. Nondefensive strategies at the group level can essentially take one of two forms: ingroup-critical collective action or ingroup-critical institutionalized action. As alluded to earlier, when people are confronted with ingroup wrongdoings, they cannot only cope as individuals but also as group members (van Zomeren, Postmes, & Spears, 2008; van Zomeren et al., 2004, 2012). When people develop a critical rather than condoning opinion of an episode of ingroup-committed violence, they may form a prosocial opinion-based group (Thomas et al., 2010), engaging in collective action to right the ingroup-committed wrong. The likelihood for such action is enhanced when people believe that the ingroup's behavior was unjust (van Zomeren et al., 2008), react with emotions such as ingroup-directed anger (Mackie, Devos, & Smith, 2000; Iyer, Schmader, & Lickel, 2007; Stürmer & Simon, 2009), and/or believe that ingroup-critical collective action is worthwhile and can succeed (Bandura, 1997, 2000; Klandermans, 1997). Social identification shapes such reactions to injustice but is also affected by these reactions (Thomas, Mavor & McGarty, 2012).

The possible health consequences of forming or joining a social movement criticizing ingroup-committed injustice are complex. On the one hand, people who join such movements are usually the ones plagued most intensely by col-

lective guilt and shame in response to the ingroup wrongdoing (Iyer et al., 2007; see also Doosje et al., 1998). Additionally, even in societies where it is legally and existentially safe to question the group, the psychological costs can be high. Ingroup-critical social movements often create a new conflict—within the ingroup—that has to be fought with opponents of the social movement, often the group's authorities. Ingroup-critical movements and their members can be blamed, punished, or treated as a herd of black sheep by the majority (Marques et al., 2001; Jost & Burgess, 2000). Thus, ingroup-critical collective action can increase rather than decrease health risks.

On the other hand, people who join ingroup-critical movements may be relieved from the vicariously felt responsibility for the ingroup's behavior because they are trying to use their group membership to prevent or correct the behavior. They can also benefit psychologically from the emotional social support from fellow protesters (van Zomeren et al., 2004) and channel self-directed anger and negative self-conscious emotions into anger toward those who they hold responsible for the ingroup wrongdoing (Leach, Iyer, & Pedersen, 2006). Similarly, according to the normative alignment model (Thomas, McGarty, & Mavor, 2009a), people may subtype themselves and identify with the specific part of the ingroup that opposes the immoral action and is therefore less responsible for it. Indeed, identifying with social movements leads to disidentification with the superordinate ingroup (Becker, Tausch, Spears, & Christ, 2011). These effects should alleviate the negative health consequences of acknowledgment of the ingroup wrongdoing and of repercussions for challenging the broader ingroup.

While ingroup-critical collective action usually focuses on the cessation of unjust behavior, ingroup-critical institutionalized action usually focuses on addressing the effects such behavior has already had. In the context of ingroup-committed violence, institutional mechanisms such as international criminal tribunals or truth commissions work to redress past injustices. Based on the logics of retributive and restorative justice, respectively, international criminal courts aim to improve intergroup relations through holding perpetrators accountable, whereas truth commissions aim to improve in-

tergroup relations through truth telling and bilateral dialogue between victims and perpetrators. Evidence for the efficacy of such institutional mechanisms comes from studies that show positive effects on postconflict states' human rights records (Olsen, Payne, Reiter, & Wiebelhaus-Brahm, 2010; Sikkink & Walling, 2007) and less revenge motivation and more willingness to reconcile among victims (Li, Leidner, Petrovic, Orazani, & Rad, 2014). These mechanisms should also help clean the stain on the ingroup's image that was left by ingroup-committed violence, at least in the eyes of ingroup-critical group members. Support for or participation in such institutionalized action should thus protect the health of members of the perpetrator group by rehabilitating the group and its image. Similar to ingroup-critical collective action, there are also potential health risks. For instance, while transitional justice mechanisms can decrease shame among victims, improve intergroup relationships, and reinforce respect for human rights (e.g., Martín-Beristain, Paez, Rimé, & Kanyangara, 2010; Rimé, Kanyangara, Yzerbyt, & Paez, 2011), they can also increase negative emotions at the individual (Kanyangara, Rimé, Philippot, & Yzerbyt, 2007) or societal level (Martín-Beristain et al., 2010). Yet, unlike nondefensive strategies at the individual level, nondefensive strategies at the group level should be relatively less likely to have such risks, as risks like ostracism or unsatisfied need to belong are counteracted and possibly balanced by membership in the subgroup that supports or engages in collective or institutionalized action.

Coping Strategies and Social Identification

Whether the identity threat induced by ingroup perpetration of violence will trigger defensive or nondefensive coping strategies should depend on the quality and strength of social identification. Past research has shown that in situations characterized by ingroup-committed violence, but not in other situations, social identification usually triggers ingroup defensiveness (e.g., Leidner, Castano, Zaiser, & Giner-Sorolla, 2010). It has been found, for example, that Dutch who strongly identify with The Netherlands felt less group-based guilt for their country's colonial history than Dutch who weakly identify with The Netherlands (Doosje

et al., 1998). This group-based guilt has further been associated with motivation to repair the wrongs committed by one's country (Doosje, Branscombe, Spears, & Manstead, 2006). These findings have since been refined in that it is a particular aspect of identification that triggers psychological defense mechanisms, resulting in less group image threatening emotions like guilt, more outgroup derogation, and less reparation motivation and behavior (Roccas et al., 2006; Leidner & Castano, 2012; Leidner et al., 2010). As recent research has shown, national identification is better conceptualized through multiple, related dimensions, for instance patriotism and nationalism (Kosterman & Feshbach, 1989), constructive and blind patriotism (Staub et al., 1997), or national attachment and glorification (Roccas et al., 2006). In general, national identification consists of an aspect that can be characterized as importance of and commitment to the ingroup (ingroup attachment), and another aspect that can be characterized as perceived superiority of the ingroup over other groups, and unconditional submission to ingroup norms and authorities (ingroup glorification; see also Roccas et al., 2006). These components serve very different psychological functions with distinct consequences: Glorification, but not attachment, has been demonstrated to increase ingroup defensiveness (Leidner & Castano, 2012; Roccas et al., 2006), often at the expense of outgroup derogation and victimization (Leidner et al., 2010; Li et al., 2014)—but only when the ingroup's morality is at stake (Leidner & Castano, 2012, Study 3). Attachment, on the other hand, has been demonstrated to serve an ingroup-critical and conciliatory function (Leidner & Castano, 2012; Roccas et al., 2006). Thus, when confronted with ingroup-committed violence, people's ingroup identification can protect their health or subvert it, depending on the levels of attachment and glorification.

Glorification and coping. Glorification should positively predict the use of defensive strategies at both the individual and the group level. Support for this hypothesis comes from research showing that glorification predicts Jewish Israelis' exonerating cognitions in response to "hot" conflict with Palestinians (Roccas et al., 2006), Americans' and Britons' dehumanization of Native Americans when their ingroup has been portrayed as being responsible

for Native American deaths (Castano & Giner-Sorolla, 2006), Americans' dehumanization and emotional minimization of Iraqis in response to ingroup- rather than outgroup-committed torture of Iraqi detainees (Leidner et al., 2010), and shifting from violence-prohibiting harm- and fairness-based morals to violence-permitting loyalty and authority morals in response to ingroup- rather than outgroup-committed torture (Leidner & Castano, 2012). Similarly, in response to ingroup-committed harm, beliefs in ingroup superiority predicted Americans' increased justification for wrongdoings, decreased anger toward perpetrators, and decreased sympathy toward victims (Bilali, Tropp, & Dasgupta 2012).

Further, glorification should negatively predict nondefensive coping strategies at both the individual and the group level. Because one core aspect of glorification is deference and loyalty to the ingroup, it should inhibit strategies that require ingroup dissent or confrontation. Because another core aspect of glorification is belief in the superiority of the ingroup over outgroups, it should inhibit strategies that aim at cessation of ongoing ingroup-committed violence (ingroup-critical collective action) or addressing past ingroup-committed violence (ingroup-critical institutionalized action). Support for this hypothesis comes from research showing that in response to ingroup-committed violence, glorification leads to less demands for punishment of ingroup perpetrators and compensation of outgroup victims (Leidner et al., 2010), and less support for nonviolent conflict resolution and less willingness to reconcile among Americans and Serbs (Li et al., 2014).

Attachment and coping. Attachment should have the opposite relationships with in-

group-focused coping strategies that glorification has. As attachment allows for ingroup criticism, it should allow for strategies that require ingroup dissent or confrontation (e.g., ingroup-critical collective action), and inhibit defensive strategies inasmuch they focus on the ingroup (e.g., victim blaming, dehumanization). It should not, however, inhibit outgroup-focused defense strategies. Support from this hypothesis comes from research showing that attachment is negatively related to cognitions exonerating ingroup perpetrators (Roccas et al., 2006), whereas it is unrelated to dehumanization or emotional minimization of outgroup members victimized by the ingroup (Leidner et al., 2010).

Joint effects of attachment and glorification.

Attachment and glorification should not only have the general relationships with coping strategies described above. They should also *jointly* affect coping strategies (see Table 2). When attachment and glorification are both low, disidentification should be most likely (individual-level defensive coping), as there are no strong ties with the ingroup and therefore the costs of "losing the group" are low. When attachment is low but glorification high, disidentification would be more costly to the individual, as the individual is more invested in the group. Because this investment is characterized by low levels of attachment, individual-level strategies should be more readily available than group-level strategies. And because the investment is further characterized by high levels of glorification, defensive strategies should be more likely than nondefensive strategies. Thus individual-level defensive strategies other than disidentification, allowing for maintenance of identification with the group, should be most likely (moral disengagement, morality shifting, demonization). When attachment is high but

Table 2

Joint Effects of Attachment and Glorification on Coping Strategies

	Low glorification	High glorification
Low attachment	Individual-level defensive coping via disidentification	Individual-level defensive coping via moral disengagement, morality shifting, demonization
High attachment	Individual-level non-defensive coping via black sheep, ingroup dissent Group-level nondefensive coping via ingroup-critical collective or institutionalized action	Group-level defensive coping via ingroup-uncritical collective communication, ingroup-defending collective action

glorification low, individual- (ingroup dissent, black sheep) or group-level (ingroup-critical collective or institutionalized action) nondefensive strategies should be most likely, as attachment allows for or even motivates ingroup criticism to improve the ingroup. When attachment and glorification are both high, group-level defensive strategies should be most likely, as attachment should facilitate a focus on the ingroup and collective behavior, while glorification facilitates ingroup-defense strategies and outgroup derogation. As such, people should be more likely to engage in collective communication or action that aims at justifying or moralizing ingroup-committed violence.

The role of social identification: Moderator and mediator. As mentioned earlier, from the perspective of the TMS social identification is seen as a resource moderating appraisal of and coping with stressors. From the perspective of the ISIS, social identification is seen as a cause of appraisal of and coping with stressors. In the case of the stressor of ingroup-committed violence, we believe that social identification (ingroup attachment and glorification) acts as both moderator and mediator (see Figure 2).

In line with the TMS, preexisting levels of attachment and glorification (before people are confronted with ingroup-committed violence) should moderate the effect of ingroup-committed violence on identity threat (appraisal) and coping strategies (as outlined above). At the same time, and in line with the ISIS, attachment and glorification can also be affected by ingroup-committed violence (the stressor). While it may seem counterintuitive to conceptualize social identification as both moderator and me-

diator, research has found that social identification can play multiple and dynamic roles in psychological processes (Swaab, Postmes, van Beest, & Spears, 2007). Further, in the collective action literature, the social identity model of collective action (van Zomeren et al., 2008) treats social identification as a moderator of the effects of appraised injustice and efficacy on collective action, whereas the encapsulated model of social identity in collective action treats social identification as a mediator of these effects (Thomas et al., 2009a, 2009b; Thomas & McGarty, 2009). Testing both models, Thomas et al. (2012) showed that social identification shapes affective and cognitive reactions to injustice but is also affected by these reactions. Similarly, we believe that the different roles attributed to social identification by the TMS and the ISIS are not mutually exclusive, and that they should both be accounted for to properly reflect the effects of ingroup-committed violence on health.

Summary

Taken together, individuals respond to stressors caused by ingroup-committed violence with a variety of individual- and group-level coping strategies, which can lead to negative or positive health outcomes. Perpetrator group members either engage in nondefensive coping strategies and actively deal with the immoral acts committed by the ingroup, or in defensive coping strategies and avoid confronting the ingroup's immoral acts. Whereas the former response is more likely to occur when individuals are critically identified with their ingroup, the latter is more likely when individuals are uncritically identified with their ingroup. Moreover, identification can determine the choice of different coping strategies by people's predispositions of ingroup attachment and glorification, or by changes in itself due to ingroup-committed violence. Defensive strategies should be adaptive in the short term in that they protect and/or improve health, but less adaptive in the long term because they do not inhibit future health risks due to future ingroup-committed violence. Nondefensive strategies, on the other hand, should be relatively less adaptive in the short term but more adaptive in the long term, as they should inhibit future ingroup-committed violence and therefore fu-

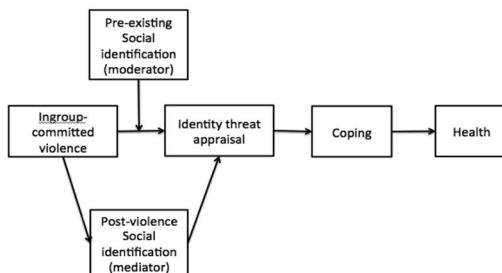


Figure 2. Ingroup identification (attachment and glorification) moderates and mediates the effects of ingroup-committed violence on health through identity threat appraisal and coping.

ture health risks. Further, group-level strategies should be more adaptive than individual-level strategies of the same kind (i.e., defensive or nondefensive strategies, respectively).

Needless to say, by integrating vast literatures on health, social identity, and intergroup conflict and violence, naturally, we sometimes simplified or generalized, and rarely could we give any one topic or literature the detailed attention it truly deserves. For instance, we neglected the important distinction between effects that derive from group *membership* as opposed to those that derive from group *identification*. Effects such as ostracism can occur for all members of a perpetrator group, regardless of whether the group member identifies strongly or weakly with the group. Effects such as collective guilt, on the other hand, occur only for those who weakly identify with their group (e.g., Doosje et al., 1998). Thus, some effects and health consequences may not depend on social identification. Yet, how group members cope with these consequences should still depend on social identification; for instance, weakly and strongly identified group members likely cope with ostracism differently. Another topic we neglected is that of the consequences of people's needs and emotions in response to ingroup-committed violence, and how they themselves affect health. Perpetrator group members' need for acceptance, for example, can lead to increased willingness to reconcile, and their collective guilt can motivate reparations (Baumeister, Stillwell, & Heatherton, 1994; Brown & Cehajic, 2008; Doosje et al., 2006). Although we are not aware of any research linking motivations to reconcile or repair to health, it is likely that they affect health. Last but not least, while we discussed ingroup dissent and criticism as a nondefensive strategy of coping with ingroup-committed violence, we did not explicitly tie this strategy to norms, nor did we elaborate on how different descriptive or injunctive norms can render ingroup dissent/criticism more or less likely. While we regret these omissions, the fact that many links and topics can be omitted in a nevertheless extensive discussion of ingroup-committed violence and health underlines how underdeveloped but fruitful this area of research is. We see our contribution as a starting point for this research and hope that our framework can inspire empirical tests and theoretical refinements of the

novel pathways and hypotheses we laid out as this research progresses.

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Correction to Abrams et al. (2015)

In the article “Equality Hypocrisy, Inconsistency, and Prejudice: The Unequal Application of the Universal Human Right to Equality,” by Dominic Abrams, Diane M. Houston, Julie Van de Vyver, and Milica Vasiljevic (*Peace and Conflict: Journal of Peace Psychology*, Vol. 21, No. 1, pp. 28–46. <http://dx.doi.org/10.1037/pac0000084>), the copyright should have been “© 2015 The Author(s)”. The author note also should have included the following license statement, “This article has been published under the terms of the Creative Commons Attribution License (CC-BY, <http://creativecommons.org/licenses/by/3.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. Copyright for this article is retained by the author(s). Author(s) grant(s) the American Psychological Association the exclusive right to publish the article and identify itself as the original publisher.” The online version of this article has been corrected.

<http://dx.doi.org/10.1037/pac0000115>