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Harnessing shared identities to mobilise resilient responses to the COVID-19 pandemic

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Abstract

Shared social identifications (family, community, nation, humanity) predict normative actions and psychological well-being, and can be invoked discursively by leaders to mobilise their followers. We illustrate the potential for harnessing shared identities to mobilise resilient public responses against COVID-19. Study 1 explored which patterns of social identification predicted protective behaviours (personal hygiene, physical distancing), prosocial actions (helping proximal and distal others), and psychological well-being (mental well-being, depressive symptoms, anxiety), among 560 UK adults surveyed during lockdown. Study 2 contrasted Prime Minister Ardern's use of identity-based rhetoric to mobilise New Zealanders, with Prime Minister Johnson's use of individualistic appeals to the UK public. Our findings suggest how political leaders might beneficially use social identities in communications about extreme events.

Keywords: COVID-19; IDENTITY ENTREPRENEURSHIP; NATIONAL IDENTITY; POLITICAL LEADERSHIP; PUBLIC HEALTH

Harnessing shared identities to mobilise resilient responses to the COVID-19 pandemic

During a global pandemic, a crucial task for political leaders is mobilising the public rapidly to engage in novel collective behaviours (e.g., hand sanitising, mask wearing) and relinquish existing potentially harmful behaviours (e.g., face-to-face meetings, physical greetings). Achieving large-scale behaviour change is difficult because it requires appealing simultaneously to individuals with very different values, concerns, and interests. To bridge these differences, behavioural scientists propose that leaders must cultivate and harness a sense of shared identity among the public (Van Bavel, Baicker et al., 2020). Here, we report findings of two studies illustrating how social identification can predict resilient public responses to COVID-19 (Study 1) and how political leaders can rhetorically facilitate these social identity processes among their followers (Study 2).

Shared Identities and Resilience

Shared identities offer at least three potential benefits for societal resilience in a pandemic: motivating action, fostering well-being, and enabling leadership.

Motivating Action

When a social group/category is contextually salient, people tend to see themselves as group members and act according to group norms (Abrams et al., 1990; Hogg & Turner, 1987). Thus, a sense of shared identity with others—*social identification*—is an important basis for collective action on behalf of one's group (van Zomeren, 2013), including mutual helping in emergencies (Drury et al., 2019). Individuals may underestimate their personal susceptibility to COVID-19 infection, and most infected individuals have mild or no symptoms, but infecting others could be fatal (Kuper-Smith et al., 2020). Evidence suggests people who are overconfident about their personal immunity engage in better hand hygiene when reminded of consequences for others (Grant & Hofmann, 2011). Hence, protective measures such as handwashing and physical distancing can be viewed as collective acts of

solidarity. Social identification may motivate compliance with these measures, as well as prosocial actions such as shopping for others or donations.

Fostering Well-Being

Social identification with a positively valued group can provide feelings of belonging and support, boosting health and well-being (Haslam et al., 2009; Jetten et al., 2017) and reducing negative psychological states such as depression (Cruwys et al., 2013) or low self-esteem (Schmitt et al., 2003). During the 2015 MERS-CoV outbreak, dialysis patients experienced significantly higher stress after two weeks' isolation (Kim et al., 2019). Health care professionals and medical staff risk developing psychiatric disorders (such as anxiety disorders and PTSD) following infectious disease outbreaks (Park et al., 2018). Yet, group identification can reduce stress linked to severe illnesses as well as occupational strain (Haslam et al., 2005). Thus, shared identities may function as a *social cure* (Jetten et al., 2017), helping people cope with the uncertainty and strains of a pandemic.

Enabling Leadership

Persuading the public to act collectively against a global pandemic requires effective leadership. Recent advances view effective leadership as a relational process between leaders and their followers based on shared social identity (Haslam et al., 2020). Language plays a key role in identity-based leadership, reflected in analyses focusing on the rhetorical and interactional nature of social categories in talk (Housley & Fitzgerald, 2015). *Identity entrepreneurs* rhetorically construct their audiences by invoking particular social categories and defining their boundaries, norms and interests (Reicher & Hopkins, 2001), sometimes with major societal consequences (Reicher et al., 2006). Leaders establish the collective social subject to be mobilised (Fladerer et al., 2020) and define the nature of particular events (e.g. the COVID-19 pandemic) and of the desired collective responses (Reicher & Hopkins, 1996). They also construct and position themselves as prototypical group members (Haslam

et al., 2020), representing and embodying the values of their socially diverse audiences (Augoustinos & De Garis, 2012). Constructing a shared social identity with one's audience facilitates trust in one's leadership and secures compliance with norms defined by the leader—identity-based followership (Steffens, 2020). Thus, identity-based leadership can facilitate social identification, motivate group-based action and foster well-being, which may be crucial for promoting resilient collective responses to COVID-19.

Current Studies

We report two studies investigating how these benefits of shared identities might be harnessed to mobilise resilient responses to the COVID-19 pandemic. Study 1, an online survey, explored the role of social identification with family, local community, nation, and all humanity in predicting compliance with protective measures, prosocial actions, and psychological well-being among UK adults during the first phase of lockdown. Study 2, a discursive analysis, explored the use of identity-based rhetoric by two contrasting political leaders—UK Prime Minister Boris Johnson and New Zealand Prime Minister Jacinda Ardern—seeking to mobilise public responses to COVID-19.

Study 1

For Study 1, we examined which patterns of social identification predicted individual differences in protective behaviours, prosocial actions, and psychological well-being among UK adults during the 4th to 7th weeks of lockdown. We focused on four identity categories that might be salient in the context of COVID-19: humanity (because the pandemic is global), the nation (because protective measures were decided and promoted nationally), local community (because geographical proximity enables transmission and helping), and family (because families often connect members of lower-risk and higher-risk age-groups).

Method

Between 17th April and 9th May 2020, 560 adults (458 female, 95 male, 3 non-binary/queer, 4 unspecified) aged 18 to 85 (mean = 43.36, SD = 14.67), residing across the four UK nations, completed our online survey. The survey comprised demographic questions (including impacts of lockdown on work), brief measures of well-being (mental well-being, depression, anxiety), perceived severity of the pandemic, own and close others' suspected coronavirus symptoms, social identification with family, community, nation and humanity, and self-reported protective and prosocial actions (personal hygiene, physical distancing, helping proximal and distal others). Participants, procedure, measures, and analyses are described fully in the Online Appendix and Supplementary Tables S1-S5.

Results and Discussion

Social identification measures were associated with protective and prosocial actions, well-being, and greater perceived severity (Table S3). Controlling for age, gender, nation of residence, and experiences of COVID-19 (own and close others' symptoms, impact on work, days into lockdown), social identification measures predicted significant and substantial additional variance (ΔR^2) in all outcomes except personal hygiene (Tables S4-S5). Thus, social identification can predict desired outcomes during a global pandemic.

Crucially, each social identification measure uniquely predicted different outcomes. Figure 1 summarises regression paths involving social identification that reached statistical significance. These findings are culturally and historically contingent and may differ where the content and norms of identity categories are constructed differently. Family identification predicted physical distancing (and perceived severity). This is striking, as compliance with physical distancing was extremely high at that time, leaving little room for variation (Table S2). Community identification predicted helping proximal and distal others (and lower depressive symptoms) (for converging findings, see Stevenson et al., 2020). Humanity

identification predicted mental well-being, and lower anxiety and depressive symptoms, unlike pre-pandemic findings where less inclusive identities better predicted well-being (Hodges & Gore, 2019). Thus, in the early-lockdown UK, family and community identities respectively showed strongest links to protective and prosocial actions, whereas humanity identity showed strongest evidence of social cure effects.

National identification did not significantly predict protective actions. It predicted somewhat higher mental well-being and showed complex relations with prosocial actions—predicting more actions helping proximal others, but *fewer* actions helping distal others. We explored the latter finding in follow-up analyses separating three facets of social identification (see Online Appendix). Participants higher on national *satisfaction* (i.e., proud to be British)—rather than national *solidarity* (i.e., committed to British people) or national *centrality* (i.e., British is an important part of identity)—reported lower distal helping. Unwillingness to help distal others might be linked to national hubris, rather than national identification per se. Still, the failure of British national identification to predict desired actions is striking, raising questions about how the content and norms of British national identity were constructed at the time.

Study 2

Hence, in Study 2, we compared the use of identity-based rhetoric by UK Prime Minister Boris Johnson and New Zealand Prime Minister Jacinda Ardern at the onset of the pandemic. Although affluent and culturally similar island nations, the UK and New Zealand showed diverging early trajectories for the pandemic. Up to 29th May, 2020, England had the highest cumulative excess mortality rate of 23 European countries, with Scotland 3rd, Wales 5th, and Northern Ireland 8th (Office for National Statistics, 2020), whereas New Zealand almost entirely eliminated the virus during the same period (Baker et al., 2020). Johnson and Ardern have been extensively compared by political commentators on COVID-19 (e.g., The

National, 2020). Ardern's leadership has been hailed as exemplary, but not yet analysed from a social identity perspective (Wilson, 2020). We analysed the first 10 speeches/briefings regarding COVID-19 by each leader. We explored how each invoked specific social categories, and how they rhetorically constructed themselves and their audiences, when requesting adherence to protection measures.

Method

Official transcripts were sourced from the respective governments' websites (see Online Appendix). We adopted a discursive thematic analysis (Clarke et al., 2015), informed by the rhetorical shift in the social identity approach (Reicher & Hopkins, 2001) and the ethnomethodological approach to category use (Housley & Fitzgerald, 2015). Thus, we treated identity as accomplished through rhetorical practices, exploring variability in category use and content, positioning of the self and of the respective audiences, and the social action performed by invoking particular categories. We used an iterative approach cycling from data to theory, back to data, identifying theoretical codes, and progressively forming wider themes. Three authors worked on the analysis (see Online Appendix). Verbatim quotations illustrate our analysis (see also Online Appendix: Table S6).

Findings

We identified two subthemes illustrating how the leaders positioned themselves and their audience in requests for action, and two subthemes highlighting how they rhetorically constructed their audiences, by invoking social identities and associated norms. To respond to Study 1 findings, we pay special attention to the interactional work accomplished in uses and constructions of national categories.

Leader Self-Positioning in Requests for Action

Positioning Self and Audience. We found striking differences in how the leaders positioned themselves in relation to their audiences when requesting protective actions:

Johnson: I want to repeat that everyone – everyone – must follow the advice to protect themselves and their families, but also – more importantly – to protect the wider public.

Ardern: That means we need friends, family and neighbours to support our older New Zealanders and people who may be in this group by doing simple things like keeping in contact and dropping off food or other supplies.

Here and in further quotes (Table S6), Johnson constructs his audience in generic terms ('everyone', 'wider public', 'people'), whereas Ardern positions her audience as an inclusive national category ('we as a nation', 'our older New Zealanders') while simultaneously invoking further commonplace categories associated the provision of social support ('friends', 'family', 'neighbours'). Ardern uses the first-person plural to position herself and her government within the national category, framing her requests as representing the collective interest ('we want to make sure', 'we need to'). In contrast, Johnson's use of diverging pronouns creates distance between himself as the leader of the government ('I want', 'I know') and his audience ('you', 'them', 'themselves').

Framing Government Decisions. The two leaders also differently portrayed governmental decisions. Ardern frames her decisions as *moral imperatives* ('New Zealanders' public health comes first', 'The worst-case scenario is simply intolerable': Table S6), in which she has a personal stake:

Ardern: For those of you who are parents or caregivers, you will have questions about schools and education facilities. [...] I can assure you we are constantly monitoring

these settings to keep children safe. As a mum, I can assure you that is my key consideration.

Whilst positioning herself as both maker and recipient of government decisions through employing commonplace categories that can facilitate rapport with a diverse national audience ('as a mum'), Ardern also attributes agency to her listeners ('you will have questions').

Johnson frames his decisions as *technical requirements* ('we need to keep people apart', 'we need health workers who are also parents to continue to go to work': Table S6). His language seemingly locates agency with the government rather than the public:

Johnson: And even if you don't have symptoms and if no one in your household has symptoms, there is more that we need you to do now.

By separating "we" (decision-makers) from "you" (recipients of instructions), it is unclear whether the decision-makers are also expected to follow their own instructions.

Constructing the National Group and Defining its Content, Norms and Interests

Invoking Collective Resilience. Both leaders constructed the pandemic as a national problem that could be overcome through collective agency (Johnson: 'We will beat the coronavirus and we will beat it together'; Ardern: 'let's finish what we started'). Typical of national mobilisation rhetoric (see Reicher & Hopkins, 2001), both invoked explicit or implicit wartime references to characterise the nation as resilient to adversity (Ardern: 'ANZAC weekend', 'the amazing sacrifice of our forebears', 'a very different battle'; Johnson: 'every one of us is directly enlisted', 'as they have in the past so many times': Table S6).

Framing Protective Actions. However, the two leaders constructed very different rationales for adopting protective measures:

Johnson: Some people may of course be tempted to go out tonight. But please don't. You may think you are invincible, but there is no guarantee you will get mild symptoms, and you can still be a carrier of the disease and pass it on to others. So that's why, as far as possible, we want you to stay at home, that's how we can protect our NHS and save lives.

Ardern: In the face of the greatest threat to human health we have seen in over a century, Kiwis have quietly and collectively implemented a nationwide wall of defence. You are breaking the chain of transmission. And you did it for each other. As a Government, we may have had pandemic notices. We may have had powers that come with being in a national emergency. But you held the greatest power of all. You made the decision that together, we could protect one other. And you have.

Johnson appeals to listeners primarily as individuals and asks them to protect *others* and generically “save lives”, whereas Ardern stresses the importance of protecting *each other*, emphasising the *mutuality* of protective actions. Referring only obliquely to national identity by invoking the National Health Service (“protect our NHS”), Johnson emphasises the frustration that collective compliance might cause (‘You might be tempted to go out tonight’), attributes limited agency to the public (‘You may think you are invincible, but ...’) , and invokes modest collective goals (‘slow the spread’). In contrast, Ardern specifies a shared national mentality (‘how we must all collectively think’), links the national category to smaller commonplace social categories consonant with her audience (family, friends,

neighbours), and defines mutual helping as a central characteristic of national identity ('putting each other first [...] is what we as a nation do so well.': Table S6). Moreover, Ardern attributes progress to collective national agency ('Kiwis have quietly and collectively implemented a nationwide wall of defence', 'you held the greatest power of all') and aspires to 'breaking the chain of transmission'.

Discussion

We found notable differences in the leaders' uses of identity-based rhetoric. Although both made some use of national wartime references, Johnson mainly positioned himself as an individual, constituted a generic audience of 'people', emphasised the benefits of adherence for protecting 'others' and national assets (NHS), and portrayed an agentic government separate from a hopefully compliant public. Ardern positioned her audience simultaneously as a national group and as members of the same smaller communities that were associated with protective and prosocial actions in Study 1 (family, neighbours), imbuing this national group with collective agency and effectively construing group norms of mutual helping and solidarity. Ardern's rhetoric matches recommendations for facilitating adherence to health protection measures, including clear guidance, behavioural norms that emphasise collective well-being and protection, and a sense of togetherness (Drury et al., 2019). Novel insights regarding identity-based leadership (Haslam et al., 2020) concern how Ardern positioned herself as having a *shared stake* with her audience in the decisions made, constructed her decisions as *moral imperatives*, and attributed *collective agency* to the nation to address the pandemic through *mutual solidarity*.

General Discussion

These studies illustrate the potential of shared social identities for translating political decisions into public action during a global pandemic. The design of these studies does not permit strong causal inferences, but the findings suggest a pathway from political rhetoric to

public action via social identification, consistent with research into identity-based leadership (Haslam et al., 2020). During March 2020, Boris Johnson invoked British national resilience in speeches about COVID-19 but emphasised the disadvantage for *individuals* in adopting protective measures, avoiding discourses of moral necessity, collective agency and *mutual* solidarity, as emphasised by Jacinda Ardern. During April-May 2020 in the UK, family identification predicted protective action, community identification predicted helping, and humanity identification predicted well-being; but national identification did not predict protective actions and showed ambivalent associations with helping. Intriguingly, initial results from a 67-country survey suggest that national identification predicted public health engagement and support very weakly in the UK, but more strongly in New Zealand (van Bavel, Cichocka et al., 2020).

Meanings of national identities are shaped partly by political discourse (Reicher & Hopkins, 2001). Thus, differences in how leaders construct identity categories may help explain why British national identification was not more strongly associated with protective actions, perhaps contributing to understanding why the UK and New Zealand had such different early trajectories during the pandemic. Had Johnson linked British national identity rhetorically to family and community solidarity and to moral imperatives of mutual helping and protection, we might have expected British national identification to motivate and thus predict desired outcomes. The Practice Highlights summarise our recommendations for identity-based political leadership during COVID-19.

Practice Highlights

- Political leaders seeking to mobilise cooperative, resilient public responses to the COVID-19 pandemic should portray themselves and their followers as sharing multiple group identities.

- They should attribute collective agency and norms of solidarity to these groups.
- They should portray desired public behaviours as morally necessary acts of mutual helping, stemming from the ‘character’ of the invoked group identities.
- They should show they have a personal stake in the political choices they make, as members of the groups affected.

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Figure 1. Statistically significant paths from social identification to outcomes. Numbers are standardised regression weights (β) controlling for age, gender, nation of residence, and experiences of pandemic. See Tables S4-S5 for full results with unstandardised weights and bootstrapped confidence intervals. *** $p < .001$, ** $p < .01$, * $p < .05$

Online Appendices for

Harnessing shared identities to mobilise resilient responses to the COVID-19 pandemic

Study 1: Supplementary Information

Historical Timeline and Procedure

The UK government put lockdown restrictions in place on 23rd March 2020, introducing a three-point message: “Stay at home. Protect the NHS. Save lives”. On 10th May, after seven weeks of lockdown, the UK Prime Minister announced partial easing of restrictions in England and introduced a revised three-point message: “Stay alert. Control the virus. Save lives.” Devolved governments in Scotland, Wales and Northern Ireland did not make parallel changes, nor did they adopt the new three-point message. We launched our online questionnaire on 17th April 2020, four weeks into the initial lockdown period. The questionnaire was finally closed on 20th May 2020, but we decided to use a cut-off data of 9th May for inclusion in our analyses, given the change in government messaging from 10th May and that only 9 participants had completed the study from 10th May onwards.

Study 1 was conducted by FT and VV, with additional input to the selection of measures by EN. Ethical approval was granted by the School of Psychology, University of Sussex (reference: ER/FT83/2). The study was created online using the Qualtrics survey platform. Participants across the UK were recruited using a snowball sampling technique beginning with Facebook posts (including local community and COVID-related pages), Instagram posts, and group e-mails. After reading an information page and confirming their informed consent and that they were over 18 years of age, participants completed six questionnaire sections: (1) demographic questions, (2) well-being measures, (3) experiences of COVID-19 (e.g., own and others’ symptoms), (4) social identification scales, (5) protective and prosocial behaviours, and (6) additional questions on buying groceries and medicines (which were for another project). The debriefing page explained the goals of the

study and provided an e-mail address to contact the researchers, as well as links to the NHS coronavirus information page and recommended mental health apps.

Participants

Between 17th April and 9th May, 738 individuals consented to participate, of whom 560 (75.9%) provided sufficient data for inclusion in our analyses. Participants were aged 18 to 85 years (mean = 43.36, SD = 14.67). A majority ($n = 458$; 81.8%) identified as female, 95 (17.0%) as male, 3 as non-binary/queer, and 4 preferred not to say. Thus, women were overrepresented compared to the UK population (51.1% of UK adults over 18 years in mid-2019 were female: Office for National Statistics, 2020), as is often the case for online surveys (e.g., Busby & Yoshida, 2013; Whitaker et al., 2017). Most (92.9%) reported their ethnicity as White, and most (90.9%) freely described their nationality as British (including UK, English, Scottish, Welsh, Irish, or some combination of these terms); 87.3% reported their ethnicity as White AND their nationality as British, which closely matches an estimated 87.2% of the UK population who were classified as White British in 2014 (Institute of Race Relations, 2020). Although women were overrepresented, the sample was diverse in terms of geographical dispersion, (impact on) work, and experiences of the virus.

Geographical dispersion. Participants resided in at least 69 counties across the UK; 492 participants (89.6%) resided in England (across 46 out of 48 English counties), 35 (6.4%) in Scotland (across at least 13 out of 32 Scottish council areas), 16 (2.9%) in Wales (across 6 out of 8 preserved counties of Wales), and 6 (1.1%) in Northern Ireland (across 4 out of 8 Northern Irish counties and county boroughs). Although residents of Scotland, Wales and especially Northern Ireland were underrepresented compared to the latest available UK population statistics (England 84.3%; Scotland 8.2%; Wales 4.7%; Northern Ireland 2.8%; Office for National Statistics, 2020), the sample was geographically dispersed both across and within the four nations of the UK.

Work and lockdown impacts. Most participants (77.2%) worked across a wide range of sectors, including education, health and social care, retail and catering, accounting and finance, administration, transport, arts and media, business management, social and youth work, cleaning/housekeeping, and various other roles; a further 8.6% were retired, 8.2% were students, 3.4% described themselves as homemakers or full-time parents, and 2.3% reported their occupation as unemployed, sick or disabled. Participants reported a range of impacts of lockdown on their work: 101 (18.0%) were still mostly working as normal; 166 (29.6%) were working remotely; 78 (13.9%) were temporarily not working (with furlough pay); 9 (1.6%) had lost their jobs; 105 (18.8%) reported “other” impacts on their working life (e.g., reduced hours, changed shift patterns, mixed remote and on-site working); and 101 (18.0%) reported that the question was not applicable (e.g., if they were retired or full-time students).

Own and other’s symptoms. We asked participants about their own and close others’ symptoms that “might be due to the coronavirus” (see below for item wordings). Regarding participants’ own symptoms: 347 (62.0%) reported having experienced no symptoms, 133 (23.8%) had experienced mild symptoms (e.g., headache, conjunctivitis, blocked or runny nose, sore throat, diarrhoea), 76 (13.6%) had experienced moderate symptoms (e.g., persistent cough, fever, exhaustion), and 4 (0.7%) had experienced severe symptoms (e.g. pneumonia, oxygen deficiency, symptoms requiring hospitalisation). Regarding close others: 289 (51.7%) knew at least one person who had experienced moderate symptoms, 123 (22%) knew at least one person who had required hospitalisation, and 66 (11.8%) knew at least one person who had died as a result of suspected coronavirus.

Materials and Measures

Well-being Measures

Mental well-being. Participants completed the Short Warwick Edinburgh Mental Well-being Scale (Tennant et al., 2007). This scale has been shown to be a valid and reliable

tool for measuring well-being (Stewart-Brown et al., 2011). Participants responded to seven items (e.g., “I’ve been feeling optimistic about the future”) rating their experiences over the last two weeks, using a 5-point response scale (1 = None of the Time; 5 = All of the Time). The scale showed good internal consistency ($\alpha = .82$).

Anxiety and depression. Participants completed the Patient Health Questionnaire-4 (PHQ-4; Kroenke et al., 2009), an ultra-brief but reliable screening measure for symptoms of depression and anxiety. Participants responded to two depression items (e.g., “Little interest or pleasure in doing things”) and two anxiety items (e.g., “Feeling nervous, anxious, or on edge”) rating their experiences over the last two weeks on a 4-point response scale (0 = Not at all; 3 = Nearly every day). Spearman-Brown split-half reliability coefficients (Eisinga et al., 2013) showed good internal consistency for anxiety ($\rho_{S-B} = .87$) and depression ($\rho_{S-B} = .81$).

Experiences of the Virus.

Perceived severity. Participants responded to a single item, “How serious do you believe this pandemic to be?” on a scale from 0 to 10 (0 = “not at all”; 10 = “extremely”).¹

Personal symptoms. Since COVID-19 testing was not widely available in the UK at that time, we asked participants “Have you personally experienced symptoms that you suspect are due to the coronavirus?”. Response options were “I have experienced no symptoms that might be due to the coronavirus” (coded 1), “I have experienced mild symptoms (e.g. headache, conjunctivitis, blocked or runny nose, sore throat, diarrhoea) that might be due to the coronavirus” (coded 2), “I have experienced moderate symptoms (e.g.

¹ Another single-item rating, “How much have you altered your lifestyle because of the pandemic?”, was not used in our analyses, because the protective and prosocial behaviours measures gave a more detailed picture of lifestyle alterations.

persistent cough, fever, exhaustion) that might be due to the coronavirus” (coded 3) or “I have experienced severe symptoms (e.g., pneumonia, oxygen deficiency, symptoms requiring hospitalisation) that might be due to the coronavirus” (coded 4).

Others’ symptoms. We asked participants three questions about the symptoms of close others: “Has anyone in your close social circle (e.g., family, friends, colleagues) [experienced moderate symptoms of suspected coronavirus? /severe symptoms of suspected coronavirus that required hospitalisation? /died as a result of suspected coronavirus?/]” Participants answered yes or no, with a box to report the number of people they knew who had been affected in each way. We did not ask about mild symptoms, as we expected that participants might not be aware if people they knew had experienced mild symptoms. For analyses, we computed a single index, coded 1 if they knew nobody who had experienced moderate symptoms or worse, 2 if they knew at least one person who had experienced moderate symptoms (but none with severe symptoms or who had died), 3 if they knew at least one person who had experienced severe symptoms (but none who had died), and 4 if they knew at least one person who had died as a result of suspected coronavirus.

Social Identification Measures

Social identification with family, local community, British people and all humanity were measured using parallel versions of Koc’s (2017) 12-item social identification scale. This measure is closely derived from well-used measures of social identification (e.g., Becker & Tausch, 2014; Leach et al., 2008), was validated in a non-student non-Western cultural sample to reduce cultural biases in item selection, and includes three subscales: solidarity, centrality and satisfaction (4 items each). Unlike previous measures, each subscale includes a balance of forward and reverse-coded items, to avoid a potential confound between social identification and acquiescent response style that might otherwise lead to spurious positive correlations with other measures (Podsakoff et al., 2012).

Participants rated items on a 7-point scale (1 = strongly disagree; 7 = strongly agree). Examples are “The fact that I am part of my family is an important part of my identity” (family centrality); “I feel committed to my local community” (local community solidarity); “I am unhappy about being British” (national satisfaction reversed). All four social identification scales showed excellent reliability: *family identification* ($\alpha = .90$), *community identification* ($\alpha = .92$), *national identification* ($\alpha = .93$), *humanity identification* ($\alpha = .90$). Solidarity, centrality and satisfaction subscales of each measure all showed acceptable reliabilities (all $\alpha > .74$).

Protective and Prosocial Actions

An initial pool of 33 items² measuring protective and prosocial actions was adapted and extended from Rubin and colleagues’ (2014) measure of behaviours during an influenza pandemic. To measure *protective behaviours*, we supplemented items from Rubin et al. (e.g., “Cleaned or disinfected things you might touch (doorknobs, surfaces) more often than usual”), with additional items reflecting the UK government guidance for reducing the spread of COVID-19 (e.g., “Stayed at least 2 metres at all times from people who are not part of your household”). Moreover, we added items on *prosocial actions*, such as “Donated money to charity or NHS” and “Offered to shop for vulnerable people”. Participants reported whether they had performed each action during the past 7 days due to the COVID-19 pandemic. Possible responses were yes (coded 1), no (coded 0), not sure (coded 0.5) or N/A (treated as missing data).

² Two further items asked whether participants had “bought more [groceries / medicines] than you normally would”. The final section explored reasons for doing so among those who responded yes. These actions are not straightforwardly protective or pro-/anti-social. We plan to write about them elsewhere, and we did not include them in the current analyses.

Note that these items would not be expected to follow classic psychometric principles. Some actions were only applicable to a minority of participants (e.g., those who had children, or used public transport), and some might also be used in substitution for each other (e.g., donating money or donating food). Hence, we did not expect to find internal consistency, nor that the items would necessarily show a ‘clean’ factor structure. We therefore prioritised conceptual coherence over statistical properties when creating our action measures. To gain insight into dimensionality, we ran Categorical Principal Components Analyses treating items as ordinal and using oblimin rotation. We found four interpretable factors, which we named (I) personal hygiene, (II) proximal helping, (III) physical distancing, and (IV) distal helping. Item-level descriptive statistics and rotated component loadings are shown in Table S1. Of the 33 initial items, 20 loaded cleanly ($>.4$) on their respective components, 12 cross-loading items were attributed to subscales based on conceptual fit (which usually, but not always, coincided with their highest factor loading), and one item was excluded from further analyses (“followed a healthy diet or took vitamin supplements”).

We created four behavioural indices for use in our main analyses, expressed as the percentage of applicable actions in each category that participants reported having taken (or not taken) in the past week. One physical distancing item (“met with people outside your household for non-essential reasons”) was reverse coded. Because these were behavioural composite scores, rather than psychometric measures, internal consistency was expected to be mediocre: personal hygiene (8 items; $\alpha = .69$), physical distancing (13 items; $\alpha = .61$), proximal helping (5 items; $\alpha = .69$), distal helping (6 items; $\alpha = .50$).

Main Analyses

Table S2 reports descriptive statistics and bivariate correlations for our main measures. To allow for non-normal distributions, we conducted bootstrapped analyses with

10000 resamples. Correlations between the four social identification measures and eight outcome measures are shown in Table S3.

For our main analyses, we conducted bootstrapped hierarchical regression analyses. For each outcome, Model 1 included age, gender, nation of residence, and experiences of COVID-19 (own and close others' symptoms, impact on work, and days into lockdown); Model 2 added social identification measures. Full results of these models are shown in Tables S4 and S5. Significant standardised paths are summarised in Figure 1.

Supplementary Results

An unexpected finding was that national identification negatively predicted helping distal others. To explore this finding further, we re-ran our analyses replacing the national identification scale with its three subscales: solidarity, centrality and satisfaction. Distal helping showed a significant negative correlation with national satisfaction ($r = -.09, p = .04$, 95% CI: $-.17, -.004$), whereas correlations with national solidarity ($r = -.02, p = .58$, 95% CI: $-.10, .06$), and national centrality ($r = -.08, p = .07$, 95% CI: $-.15, .003$) did not reach significance. In our weighted bootstrapped regression model, national satisfaction was a marginally significant negative predictor of distal helping ($\beta = -.15$; $B = -2.29, p = .05$, 95% CI: $-4.62, 0.02$). However, distal helping was not significantly predicted by national solidarity ($\beta = .06$; $B = 1.02, p = .44$, 95% CI: $-1.48, 3.37$) nor by national centrality ($\beta = -.04$; $B = -0.52, p = .54$, 95% CI: $-2.21, 1.19$).

We also considered the possibility that associations with British national identity might be attenuated or confounded by the complexities of national identities among people in Scotland, Wales and Northern Ireland. Hence, we ran an alternative set of analyses focusing exclusively on participants residing in England. In these analyses, the association of national identity with mental well-being was reduced to marginal significance ($p = .067$) and the association with proximal helping was reduced to non-significance ($p = .116$), but the

negative association with distal helping remained significant ($p < .001$). Thus, we found no evidence to suggest that the poorer outcomes associated with British national identification, compared to other identity categories, were attributable to anomalous results in Scotland, Wales or Northern Ireland.

Study 2: Supplementary Information

Historical Timeline and Data Corpus

In the UK and New Zealand, the first confirmed cases of COVID-19 were reported respectively on January 29th and February 28th, the first cases of local transmission were confirmed respectively on February 28th and March 5th, and the first COVID-related deaths were reported respectively on March 5th and March 29th. We analysed the first 10 speeches and briefings regarding COVID-19 given by each country's Prime Minister—Boris Johnson (UK) and Jacinda Ardern (New Zealand)—at the outset of the pandemic. These were given between March 9th and 27th for Johnson and between March 14th and April 20th for Ardern. At this initial stage of the crisis, both leaders urgently needed to mobilise their followers from no action to unprecedented action (e.g., lockdown measures). We also found that Boris Johnson became sick with COVID-19 after his first 10 speeches, providing a natural break in the historical sequence. Official transcripts, sourced from the respective governments' websites, were of similar length (Ardern: ~10,500 words; Johnson: ~8,500 words).

Qualitative Data Analysis

The qualitative analysis for Study 2 was conducted in four phases. Prior to beginning the analyses, the data and research questions were agreed between VV and ZJ. The main analysis was conducted by ZJ and EN, with additional input from VV.

Phase 1. ZJ independently analysed the two leaders' rhetoric by iteratively appraising abductively the data (Locke et al., 2008). This author identified some theoretically relevant themes and discussed and refined these with EN.

Phase 2. After EN reviewed the speeches, the two authors settled on two very broad themes: *Leader Self-Positioning in Requests to Public*, and *Constructing the Group and Defining its Content, Norms and Interests*. Together the two authors started developing some NVivo codes within each theme, by iteratively exploring the leaders' rhetoric vis-à-vis existing theories (Corbin & Strauss, 1990), which have now been captured in the literature review.

Phase 3. ZJ and EN independently coded the leaders' speeches in NVivo and compared codes, iteratively, until they reached consensus around two second-order concepts per theme. For Theme I, the second-order concepts were: *Positioning Self and Audience* and *Framing Government Decisions*; for Theme II, they were: *Invoking Collective Resilience* and *Framing Protective Actions*. To illustrate these analytical concepts, ZJ and EN identified three representative quotes per second order concept and co-wrote an initial draft of the analysis. These quotes are reported partly in text (in the paper) and partly in Table S6, below.

Phase 4. The process of coding was explained to VV. This author checked the second-order concepts and quotes for consistency, discussing some possible refinements to the analysis with the initial two authors. All three authors worked collaboratively on a final draft of the analysis.

A final note is important: Of the four second-order concepts, we found that one subtheme—Invoking Collective Resilience by appealing to nationalistic and wartime rhetoric—was less novel (cf., Billig, 1995; Reicher & Hopkins, 2001). Due to restrictions on the word limit, we report this subtheme very succinctly in the paper, omitting to include one of the three quotes in text. This subtheme therefore appears with three quotes in Table S6.

Theoretical Forestructure, Groundedness and Reflexive Validity

The goal of an in-depth qualitative analysis such as this is to generate novel insights through the researchers' intensive engagement with the data. The analysis reported here was

informed by the researchers' prior expertise in leadership (e.g., Jaser, in press), social identity processes in extreme events (e.g., Ntontis et al., 2019), and identity construction (e.g., Vignoles, 2019). In the process of coding, we mitigated interpreters' bias, and increased validity, by constantly comparing results between authors, and with theory (Stiles, 1993). Similar to previous studies of identity-based leadership, our first-order themes explore how leaders constructed themselves and their audiences (e.g., Haslam et al., 2020; Reicher et al., 2006). However, the deeper analysis of second-order concepts generated novel insights about the leaders' framing of decisions as moral imperatives (in which they have a personal stake) versus technical requirements (in which they may not), and their constructions of protective actions as mutual helping or helping others. Thus, our theoretical forestructure was changed by the data, confirming that the analysis has reflexive validity (Stiles, 1993). Moreover, we illustrate our analysis with verbatim quotes from the two leaders' speeches, with further quotations in Table S6, allowing readers to evaluate independently the grounding and persuasiveness of our interpretations (Levitt et al., 2017).

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Table S1. *Descriptive statistics and rotated component loadings for items measuring protective and prosocial actions.*

Items	N	% applicability	% likelihood	Rotated component loadings			
				I	II	III	IV
<i>Personal hygiene</i>							
Carried hand sanitising gel when you're out and about	536	96%	67%	0.998	0.170	0.100	-0.107
Cleaned or disinfected things you might touch (doorknobs, surfaces) more often than usual	559	100%	74%	0.994	0.055	-0.039	-0.173
Used hand sanitising gel to clean your hands, more often than usual	551	98%	75%	0.961	0.213	0.116	-0.339
Reduced the amount that you touched your eyes, nose, or mouth	559	100%	69%	0.959	0.092	-0.088	0.097
Usually carried tissues with you when out and about	534	95%	60%	0.922	-0.083	0.005	0.307
Usually used tissues when coughing or sneezing	498	89%	74%	0.894	0.012	-0.041	0.346
Sneezed or coughed on your elbow	524	94%	76%	0.711	0.019	-0.067	0.614
Washed your hands more frequently or thoroughly than usual	559	100%	96%	0.571	0.046	-0.671	-0.442
<i>Proximal helping</i>							
Shopped for other households	548	98%	55%	0.010	0.991	-0.126	-0.074
Collected medication for someone on their behalf	537	96%	29%	0.250	0.962	0.023	0.003
Offered to shop for vulnerable people	524	94%	67%	0.018	0.953	-0.226	0.081
Offered to help people with their computers to set up Skype, Facetime, etc. with their loved ones	500	89%	42%	0.025	0.887	-0.218	0.305
Given up supplies to let someone vulnerable have them	485	87%	48%	0.325	0.793	0.037	0.418

Items	N	% applicability	% likelihood	Rotated component loadings			
				I	II	III	IV
<i>Physical distancing</i>							
Stayed away from loved ones (family, partner, friends) to adhere to the rules of the lockdown	551	98%	96%	0.009	0.050	-0.987	-0.227
Tried to avoid people who have the virus	489	87%	93%	0.073	0.080	-0.982	-0.139
Used video calls to talk to loved ones (e.g. Skype, Facetime, etc.) instead of meeting in person	552	99%	91%	-0.308	0.273	-0.955	-0.107
Kept away from crowded places generally	553	99%	98%	0.169	-0.032	-0.944	-0.280
Reduced the amount that you go into shops	552	99%	95%	0.319	-0.059	-0.904	-0.085
Cancelled or postponed a social event such as meeting friends, eating out or going to a sports event	528	94%	94%	-0.001	0.343	-0.903	0.140
Reduced or changed the way you use public transport	367	66%	90%	-0.128	-0.066	-0.895	0.423
Stayed at home at all times unless you were buying essentials, doing essential work, or exercising	559	100%	94%	0.437	-0.226	-0.801	0.088
Kept one of your children out of school or nursery	187	33%	80%	-0.304	0.580	-0.792	-0.015
Reduced the amount you go to school, college, university or work	452	81%	83%	-0.449	-0.093	-0.792	0.523
Stayed at least 2 metres at all times from people who are not part of your household	553	99%	88%	0.440	-0.060	-0.765	0.256
Met with people outside your household for non- essential reasons	559	100%	12%	-0.748	0.238	0.475	-0.178
Self-isolated	548	98%	60%	0.062	-0.607	-0.457	0.667

Items	N	% applicability	% likelihood	Rotated component loadings			
				I	II	III	IV
<i>Distal helping</i>							
Signed a petition for housing rights during the pandemic	538	96%	22%	-0.113	-0.103	-0.173	0.984
Donated to food banks	549	98%	24%	0.217	0.264	0.236	0.893
Given blood	534	95%	3%	-0.087	0.085	0.508	0.887
Donated supplies/money to a homeless person	533	95%	25%	0.125	0.342	0.310	0.869
Offered to volunteer for the NHS	522	93%	11%	-0.260	0.418	0.054	0.867
Donated money to charity or NHS	555	99%	55%	0.285	0.254	-0.291	0.788
<i>Excluded item</i>							
Followed a healthy diet or took vitamin supplements	555	99%	63%	0.412	-0.423	-0.171	0.765

Note. Total $N = 560$. % applicability is the percentage of participants who answered yes, no or not sure (rather than N/A) to an item. % likelihood is the estimated percentage of participants who had performed the behaviour (counting “not sure” as indicating 50% likelihood to have performed the behaviour).

Rotated component loadings $> .4$ are shown in bold.

Table S2. Means, standard deviations and zero-order correlations of main Study 2 measures.

Measure	N	Mean	(SD)	1	2	3	4	5	6	7	8	9	10	11	12
1. Personal hygiene	560	73.87%	(23.20)	-											
2. Physical distancing	560	88.96%	(11.87)	.28	-										
3. Helping proximal others	557	48.27%	(32.82)	.21	.12	-									
4. Helping distal others	560	23.64%	(21.50)	.17	.15	.29	-								
5. Mental well-being	560	3.24	(0.66)	-.06	-.02	.07	-.02	-							
6. Anxiety	560	2.13	(0.93)	.16	.06	.02	.02	-.61	-						
7. Depression	560	2.02	(0.85)	.07	.02	-.05	.01	-.71	.69	-					
8. Perceived severity	559	9.68	(1.83)	.27	.38	.12	.07	-.04	.09	-.01	-				
9. Family identification	560	5.44	(1.13)	.14	.14	.16	.05	.20	-.18	-.22	.25	-			
10. Local community identification	560	4.51	(1.11)	.10	.10	.17	.18	.20	-.15	-.24	.16	.33	-		
11. National identification	557	4.73	(1.21)	.08	.04	.14	-.07	.15	-.10	-.10	.13	.23	.08	-	
12. Humanity identification	557	5.16	(0.99)	.04	.10	.10	.14	.26	-.22	-.32	.17	.34	.41	.09	-

Table S3. *Bivariate correlations with 95% bias-corrected accelerated confidence intervals (CI; 10000 requested bootstrap resamples) testing the associations between social identification and outcome measures.*

Predictors	Behavioural outcomes				Psychological outcomes			
	Personal hygiene	Physical distancing	Proximal helping	Distal helping	Mental well-being	Anxiety	Depressive symptoms	Perceived severity
Family identification <i>r</i> [95% CI]	.14*** [.06, .23]	.14** [.04, .23]	.16*** [.08, .24]	.05 [-.03, .13]	.21*** [.13, .30]	-.18*** [-.26, -.09]	-.22*** [-.31, -.14]	.25*** [.17, .33]
Community identification <i>r</i> [95% CI]	.11* [.02, .19]	.10* [.02, .18]	.17*** [.08, .25]	.17*** [.09, .25]	.19*** [.10, .27]	-.14*** [-.23, -.05]	-.23*** [-.32, -.15]	.16*** [.09, .24]
National identification <i>r</i> [95% CI]	.07† [-.01, .16]	.04 [-.05, .12]	.14*** [.06, .22]	-.07† [-.15, .01]	.15*** [.06, .24]	-.10* [-.19, -.02]	-.10* [-.19, -.02]	.13** [.04, .22]
Humanity identification <i>r</i> [95% CI]	.04 [-.04, .12]	.10* [.01, .19]	.10* [.01, .18]	.14** [.06, .22]	.25*** [.17, .34]	-.22*** [-.30, -.13]	-.32*** [-.39, -.24]	.17*** [.08, .25]

Note. Significant correlations are in bold.

*** $p < .001$, ** $p < .01$, * $p < .05$, † $p < .10$

Table S4. Multiple regression parameters with 95% bias-corrected accelerated confidence intervals (CI; 10000 requested bootstrap resamples) testing the associations between social identification and behavioural outcome measures.

Predictors				Behavioural outcomes															
				Personal hygiene				Physical distancing				Proximal helping				Distal helping			
				B		[95% CI]		B		[95% CI]		B		[95% CI]		B		[95% CI]	
<i>Model 1 [control]</i>																			
Intercept	54.25	***	36.43	73.51	92.03	***	81.38	103.62	40.16	**	16.38	63.97	14.44	†	-2.21	31.43			
Age	0.30	***	0.16	0.44	0.05		-0.03	0.14	0.07		-0.12	0.26	0.17	*	0.04	0.30			
Gender (male)	-8.51	**	-14.13	-2.90	-5.08	***	-8.00	-2.17	-11.98	**	-19.30	-4.45	-7.54	**	-12.17	-2.45			
Residence (Scotland)	1.70		-7.04	9.58	-2.29		-6.37	1.45	4.17		-7.57	15.84	-3.68		-12.02	3.94			
Residence (Wales)	0.59		-12.13	12.05	2.37		-1.29	5.63	11.28		-3.37	25.35	-1.67		-11.12	6.80			
Residence (N. Ireland)	-1.20		-21.33	23.57	0.06		-7.22	8.52	-16.61		-34.93	1.16	8.82		-5.07	27.77			
Working as normal	2.16		-2.57	7.19	-6.55	***	-8.97	-4.06	4.09		-3.07	11.50	-4.00	†	-8.56	0.47			
Working remotely	-2.78		-6.98	1.28	1.73	†	-0.15	3.59	4.26		-2.08	10.40	2.69		-1.51	6.77			
Furloughed	2.60		-2.21	7.27	3.88	***	1.73	6.05	3.65		-3.92	10.98	3.04		-1.93	7.88			
Lost job	5.13		-9.24	17.84	0.14		-5.75	5.68	0.98		-18.61	21.74	-2.09		-15.03	12.42			
Other work impact	-1.52		-6.26	3.17	2.03	†	-0.11	4.14	-3.79		-11.07	3.28	1.86		-3.19	6.98			
Personal symptoms	2.09		-0.35	4.37	0.28		-1.14	1.60	-0.32		-4.12	3.61	3.14	*	0.74	5.71			
Others' symptoms	1.42		-0.43	3.40	0.11		-0.95	1.10	3.00	*	0.26	5.51	0.89		-0.74	2.55			
Days into lockdown	0.13		-0.34	0.56	-0.15		-0.46	0.16	0.00		-0.67	0.67	-0.02		-0.46	0.43			
Model 1 R^2	8.1%***				11.9%***				6.5%***				6.1%**						
<i>Model 2 [identification]</i>																			
Intercept	45.53	***	23.54	69.45	81.81	***	70.27	93.70	3.71		-26.48	33.08	3.74		-16.22	23.44			
Age	0.26	**	0.11	0.41	0.01		-0.07	0.09	-0.09		-0.28	0.11	0.13	*	0.00	0.27			

Predictors	Behavioural outcomes															
	Personal hygiene				Physical distancing				Proximal helping				Distal helping			
	B		[95% CI]		B		[95% CI]		B		[95% CI]		B		[95% CI]	
Gender (male)	-7.97	**	-13.57	-2.51	-4.72	**	-7.68	-1.68	-10.09	**	-17.52	-2.58	-8.35	***	-12.98	-3.28
Residence (Scotland)	1.42		-7.71	9.54	-2.21		-6.37	1.54	4.88		-6.30	16.06	-4.90		-13.32	2.81
Residence (Wales)	-0.18		-12.29	11.20	1.92		-1.76	5.31	7.16		-5.91	20.59	-0.26		-9.77	8.70
Residence (N. Ireland)	-0.16		-20.42	23.61	0.51		-6.52	8.68	-11.83		-30.42	4.32	7.51		-7.89	26.60
Working as normal	2.05		-2.74	7.14	-6.81	***	-9.15	-4.40	3.12		-4.03	10.40	-2.82		-7.25	1.60
Working remotely	-2.95		-7.22	1.16	1.60	†	-0.23	3.40	3.73		-2.64	9.94	1.31		-2.73	5.37
Furloughed	2.85		-1.90	7.60	4.05	***	1.91	6.16	4.75		-2.72	11.89	4.21	†	-0.55	8.81
Lost job	4.80		-9.80	17.47	0.43		-5.21	5.51	1.38		-17.86	21.80	-3.19		-15.86	10.51
Other work impact	-1.33		-6.14	3.53	1.91	†	-0.17	4.02	-3.73		-10.99	3.42	2.08		-2.73	6.96
Personal symptoms	2.14	†	-0.30	4.48	0.32		-1.08	1.64	-0.17		-3.84	3.72	3.21	**	0.86	5.77
Others' symptoms	1.29		-0.55	3.26	0.02		-1.02	0.96	2.42	†	-0.31	4.92	0.85		-0.78	2.51
Days into lockdown	0.14		-0.33	0.60	-0.16		-0.48	0.15	-0.06		-0.72	0.63	0.06		-0.38	0.51
Family identification	1.52		-0.51	3.43	1.15	*	0.12	2.25	2.33		-0.54	5.05	-0.66		-2.30	0.93
Community identification	1.40		-0.52	3.45	0.33		-0.62	1.32	3.50	*	0.68	6.19	2.83	**	1.18	4.44
National identification	0.03		-1.66	1.67	0.27		-0.52	1.06	2.76	*	0.37	5.13	-2.04	**	-3.44	-0.72
Humanity identification	-0.88		-3.00	1.18	0.70		-0.49	1.84	1.14		-2.04	4.38	1.81	†	-0.21	3.79
Model 2 ΔR^2	1.0%				2.3%**				4.2%***				4.1%***			

Note. Significant parameters are in bold. Gender was coded (0 = female; 0.5 = non-binary/unspecified; 1 = male). Nation of residence was contrast coded (-1 = England; 1 = target nation; 0 otherwise). Working impacts were contrast coded (-1 = not applicable; 1 = target category; 0 = otherwise).

*** $p < .001$, ** $p < .01$, * $p < .05$, † $p < .10$

Table S5. Multiple regression parameters with 95% bias-corrected accelerated confidence intervals (CI; 10000 requested bootstrap resamples) testing the associations between social identification and psychological outcome measures.

Predictors		Psychological outcomes															
		Mental well-being				Anxiety				Depressive symptoms				Perceived severity			
		B		[95% CI]		B		[95% CI]		B		[95% CI]		B		[95% CI]	
<i>Model 1 [control]</i>																	
Intercept	2.91	***	2.41	3.43	2.48	***	1.75	3.16	2.44	***	1.83	3.02	8.94	***	7.43	10.49	
Age	0.01	***	0.01	0.01	-0.01	***	-0.02	-0.01	-0.01	***	-0.02	-0.01	0.03	***	0.02	0.04	
Gender (male)	0.02		-0.11	0.15	-0.23	*	-0.43	-0.02	-0.07		-0.25	0.12	-0.72	**	-1.17	-0.28	
Residence (Scotland)	-0.06		-0.33	0.19	-0.05		-0.36	0.28	0.08		-0.19	0.37	-0.06		-0.66	0.53	
Residence (Wales)	0.09		-0.21	0.38	-0.20		-0.57	0.20	-0.21		-0.51	0.12	0.22		-0.57	0.98	
Residence (N. Ireland)	0.09		-0.40	0.66	0.17		-0.40	0.68	-0.02		-0.55	0.46	-0.26		-1.66	1.10	
Working as normal	0.27	***	0.13	0.41	-0.18	*	-0.36	0.00	-0.24	**	-0.42	-0.07	0.26		-0.14	0.66	
Working remotely	0.14	*	0.02	0.27	-0.12		-0.29	0.03	-0.20	*	-0.36	-0.05	0.16		-0.16	0.50	
Furloughed	-0.08		-0.24	0.09	-0.18	†	-0.38	0.02	0.08		-0.13	0.28	0.29		-0.13	0.71	
Lost job	-0.30		-0.75	0.12	0.63	**	0.13	1.11	0.45	†	-0.12	1.01	-0.83		-2.09	0.32	
Other work impact	0.01		-0.12	0.15	-0.02		-0.21	0.17	-0.12		-0.31	0.07	0.30	†	-0.06	0.65	
Personal symptoms	-0.04		-0.12	0.03	0.12	*	0.01	0.23	0.08	†	-0.02	0.19	-0.22	*	-0.44	0.00	
Others' symptoms	-0.01		-0.06	0.04	0.07	†	0.00	0.14	0.02		-0.04	0.09	0.20	**	0.06	0.32	
Days into lockdown	0.00		-0.01	0.01	0.00		-0.02	0.02	0.00		-0.02	0.01	-0.02		-0.06	0.02	
Model 1 R ²	9.0%***				8.3%***				8.6%***				10.8%***				
<i>Model 2 [identification]</i>																	
Intercept	1.99	***	1.42	2.56	3.60	***	2.76	4.39	3.83	***	3.13	4.51	6.95	***	5.25	8.79	
Age	0.01	**	0.00	0.01	-0.01	**	-0.01	0.00	-0.01	**	-0.01	0.00	0.02	***	0.01	0.03	

Predictors	Psychological outcomes													
	Mental well-being				Anxiety				Depressive symptoms				Perceived severity	
	B	[95% CI]			B	[95% CI]			B	[95% CI]			B	[95% CI]
Gender (male)	0.05	-0.08	0.18		-0.26	**	-0.45	-0.06	-0.09	-0.26	0.10		-0.65	** -1.10 -0.20
Residence (Scotland)	-0.04	-0.32	0.22		-0.07		-0.39	0.27	0.07	-0.21	0.37		-0.05	-0.64 0.52
Residence (Wales)	0.03	-0.28	0.32		-0.14		-0.53	0.27	-0.16	-0.46	0.17		0.14	-0.60 0.87
Residence (N. Ireland)	0.15	-0.38	0.78		0.11		-0.52	0.67	-0.06	-0.68	0.49		-0.18	-1.56 1.14
Working as normal	0.25	***	0.11	0.38	-0.16	†	-0.34	0.03	-0.23	**	-0.40	-0.05	0.21	-0.16 0.59
Working remotely	0.12	*	0.00	0.25	-0.10		-0.26	0.05	-0.16	*	-0.31	-0.01	0.14	-0.17 0.46
Furloughed	-0.06		-0.21	0.10	-0.20	†	-0.41	0.00	0.04	-0.16	0.23		0.33	-0.08 0.72
Lost job	-0.26		-0.69	0.15	0.58	**	0.09	1.06	0.40	-0.15	0.94		-0.78	-1.96 0.28
Other work impact	0.00		-0.13	0.13	-0.01		-0.19	0.18	-0.10	-0.28	0.09		0.27	-0.06 0.60
Personal symptoms	-0.04		-0.11	0.03	0.12	*	0.01	0.22	0.08	-0.02	0.18		-0.21	* -0.42 0.00
Others' symptoms	-0.02		-0.07	0.03	0.08	*	0.01	0.15	0.04	-0.03	0.10		0.18	* 0.04 0.30
Days into lockdown	0.00		-0.01	0.01	0.00		-0.02	0.02	0.00	-0.02	0.01		-0.02	-0.06 0.02
Family identification	0.04		-0.02	0.10	-0.06		-0.15	0.02	-0.06	-0.13	0.02		0.25	** 0.10 0.39
Community identification	0.04		-0.02	0.10	-0.04		-0.12	0.05	-0.07	†	-0.14	0.00	0.07	-0.06 0.21
National identification	0.05	*	0.00	0.10	-0.05		-0.12	0.02	-0.03		-0.09	0.03	0.04	-0.09 0.17
Humanity identification	0.10	**	0.04	0.17	-0.13	**	-0.22	-0.04	-0.18	***	-0.26	-0.10	0.11	-0.06 0.27
Model 2 ΔR^2	5.9%***				4.3%***				8.5%***				3.9%***	

Note. Significant parameters are in bold. Gender was coded (0 = female; 0.5 = non-binary/unspecified; 1 = male). Nation of residence was contrast coded (-1 = England; 1 = target nation; 0 otherwise). Working impacts were contrast coded (-1 = not applicable; 1 = target category; 0 = otherwise).

*** $p < .001$, ** $p < .01$, * $p < .05$, † $p < .10$

Table S6. *Additional quotations illustrating each discursive theme.*

Theme 1: Leader Self-Positioning in Requests for Action	
Ardern	Johnson
Positioning Self and Audience	
We need as a nation to prepare and manage the spread of COVID-19.	But I want to stress something that is very important in the wake of what we're saying this afternoon – I urge people, who think in view of what we're saying about their potential symptoms that they should stay at home.
If we want to make sure that we are a health success story and ensure our economy can start to operate again without the virus taking off, we need to get the next phase right.	I also want at this stage to speak directly to older people. Because this disease is particularly dangerous for you, for older people, even though the vast majority this will be a mild to moderate illness, I know that many people will be very worried.
Framing Government Decisions	
We have two choices as a nation. One is to let COVID-19 roll on, and brace. The second is to go hard on measures to keep it out and stamp it out - not because we can stop a global pandemic from reaching us, but because it is in our power to slow it down. I make no apology for choosing the second path. New Zealanders public health comes first.	And even if you don't have symptoms and if no one in your household has symptoms, there is more that we need you to do now.
I do not underestimate what I am asking New Zealanders to do. It's huge. And I know it will feel daunting. But I wanted to share with you the stark choice we face. [...] The worst-case scenario is simply intolerable. It would represent the greatest loss of New Zealanders' lives in our country's history.	But the sad thing is that today for now, at least physically, we need to keep people apart.

Theme II: Constructing the National Group and Defining its Content, Norms and Interests

Ardern

Johnson

Invoking Collective Resilience

And so, this weekend, ANZAC weekend, enjoy the company of your bubble, stay local, and reflect on the amazing sacrifice of our forebears. Decades ago, they came together in the most testing of circumstances half a world away and helped forge who we are today. It was a very different battle than the one we are in now, but the character of who we are as a country remains exactly the same. So please, stay strong, stay home, be kind. And let's finish what we started.

For now, I ask that New Zealand does what we do so well. We are a country that is creative, practical, and community minded. We may not have experienced anything like this in our lifetimes, but we know how to rally and we know how to look after one another, and right now what could be more important than that. So thank you for all that you're about to do.

These measures, while disruptive, are needed to make the space we need as a nation to prepare and manage the spread of COVID-19.

But in this fight we can be in no doubt that each and every one of us is directly enlisted. Each and every one of us is now obliged to join together. To halt the spread of this disease. To protect our NHS and to save many many thousands of lives. And I know that as they have in the past so many times. The people of this country will rise to that challenge. And we will come through it stronger than ever.

There is no hiding from the fact that the coronavirus outbreak will present significant challenges for the UK, just as it does in other countries. But if we continue to look out for one another, to pull together in a united and national effort, I have no doubt that we can and will rise to that challenge.

We will get through this, this country will get through this epidemic, just as it has got through many tougher experiences before if we look out for each other and commit wholeheartedly to a full national effort.

Framing Protective Actions

If you have any questions about what you can or can't do, apply a simple principle. Act like you have COVID-19. Every move you then make is a risk to someone else. That is how we must all collectively think. That's why the joy

From tomorrow, if you have coronavirus symptoms, however mild – either a new continuous cough or a high temperature – then you should stay at home for at least 7 days to protect others and help slow the spread of the disease.

of physically visiting other family, children, grandchildren, friends, neighbours is on hold. Because we're all now putting each other first. And that is what we as a nation do so well.

Finally, we are a tough resilient people. We have been here before. But our journey will depend on how we work together. We are taking every measure we need as a government, and we ask that you do to. We all have a role to play. Look out for your neighbour, look out for your family. Look out for your friends

So, to relieve the pressure on the London health system and to slow the spread in London, it's important that Londoners now pay special attention to what we are saying about avoiding non-essential contact, and to take particularly seriously the advice about working from home, and avoiding confined spaces such as pubs and restaurants