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Social Group Membership, Social Identities, and Mental Health Experiences in Urban Poor Communities in Ghana: A Critical Social Psychology Inquiry

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Abstract
Social groups and identities significantly influence mental health outcomes, yet their impact in resource-poor communities remains understudied. We explored the role of social group memberships and identities in shaping mental health experiences in two urban poor communities in Ghana. Data from 77 participants were analyzed thematically, revealing widespread engagement in social groups that provide access to both material and symbolic resources. However, these groups also serve as sources of tension and contribute to the stigmatization and marginalization of vulnerable members. Those affected include individuals with severe mental disorders, men experiencing depression, young men involved in substance abuse, family caregivers, migrant and tenant households, and otherwise healthy individuals with recurring psychosocial challenges. The groups exacerbate mental health challenges and restrict access to care among marginalized populations. The findings underscore the need for targeted interventions aimed at enhancing mental health support and reducing stigma in resource-poor settings.

Keywords Social groups · Group membership · Social identities · Mental health · Community

Introduction

The association between where people live and their mental health is well-supported by a vast body of multidisciplinary research (Campbell, 2020; Haslam et al., 2023). Research shows that individuals and groups in resource-poor communities experience poorer mental health outcomes (Burgess, 2023; Campbell, 2020). The burgeoning literature indicates that social identity facilitates connectedness in groups (Cruwys & Gunaseelan, 2016; Haslam et al., 2022; Vella et al., 2023) and mediates and moderates the association between neighborhoods and mental health (Campbell, 2020; Haslam et al., 2023). Membership in and identification with social groups can enhance or undermine mental health (Campbell & Cornish, 2014; Jetten et al., 2017). Social group membership is health-enhancing when it provides a positive sense of identity characterized by support, meaning, and agency, and health-damaging when it challenges a sense of identity (Campbell et al., 2013b; Haslam et al., 2023; Jetten et al., 2017).

The role of social identities in mental health research has increased over the last decade, providing a theoretical and empirical basis for advancing a 'social care' pathway to sustaining optimal mental health and a 'social cure' pathway to ameliorating poor mental health (Cruwys et al., 2015; Haslam et al., 2016; Jetten et al., 2017). Mainstream psychology research has focused on quantitative evidence of how membership in and identification with social groups affect mental health in affluent communities in industrialized and western countries (Grishina et al., 2023; Haslam

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et al., 2023). Such studies report that social groups reduce depression in elderly individuals with chronic illnesses (Cameron et al., 2018), improve recovery from depression (Cruwys et al., 2014), cure existing depression and protect against future depression (Cruwys et al., 2013), reduce general and social anxiety (Cruwys et al., 2014; Haslam et al., 2016), lower paranoia (Greenaway et al., 2019), and promote general and psychological health (Cruwys et al., 2014; Haslam et al., 2016; Lam et al., 2018; McLaren et al., 2022; Ruben & LaPiere, 2023; Vella et al., 2023).

The effect of social identity on mental health depends on the type of social groups. Postmes et al. (2019) in a meta-analysis identified four categories of social groups on two continua: group type (interactive groups and social categories) and group stigma (stigmatized groups and non-stigmatized groups). Interactive and non-stigmatized groups protect against depressive symptoms more than social categories and stigmatized groups (Postmes et al., 2019). The impact of multiple social group membership on mental health is inconsistent. Some studies show that membership in multiple groups reduces psychiatric distress (Miller et al., 2017) and depression (Lam et al., 2018; Sani et al., 2015), while others report that it leads to identity interferences and incompatibility, reducing psychological well-being (Iyer et al., 2009; Settles, 2004), and predicts future depressive symptoms among individuals with a history of depression (Cruwys et al., 2013).

Critical psychology studies, mostly community-based, have used qualitative evidence to understand how material, symbolic, and embodied factors shape identities and structure mental health in resource-poor communities in non-western countries (Burgess, 2023; Campbell, 2020; Campbell & Jovchelovitch, 2000; Campbell & Cornish, 2021). Various forms of material poverty, such as food insecurity, housing problems, and financial difficulties, are associated with higher psychological distress among HIV-positive adults in India (Kang & Bodenhausen 2015), household heads in rural communities in Northern Ghana (Atuoye & Luginaah, 2017), severe mental disorders in rural China (Ran et al., 2018), and poor mental health in migrants in Europe (Awuah et al., 2022; Dreger et al., 2014; Durbin et al., 2017). Understanding how material and symbolic conditions shape identities within communities reveals groups at risk of poor mental health. In Ghana, high mental health risks are reported among groups such as family caregivers (Kyei-Arthur, 2013, 2017), individuals living with chronic physical conditions (de-Graft Aikins et al., 2020), families affected by mental illnesses and self-harm (Cooper, 2016; Asare-Doku et al., 2017; Osafo et al., 2015), teenage girls in mining communities (Doh et al., 2016), migrant squatters in affluent urban communities (de-Graft Aikins & Ofori-Atta, 2007), and migrants in poor urban communities (Asafu-Adjaye, 2015).

Despite increasing research attention, empirical studies on social identities and wellbeing in resource-poor communities are limited. Although the link between social identity and mental health is well-researched, there are limited empirical studies exploring how social identities shape mental health experiences of individuals and groups in communities. Further, there is a gap in understanding the nuanced impacts social identities have on different types of mental health issues. We respond to this gap by exploring social group memberships and how social identities shape mental health experiences in two urban poor communities in Accra, Ghana. First, we explored why individuals actively choose affiliations with personally selected social groups to understand agency in shaping social identities within community contexts. Next, we explored how imbue members with identities that influence their experiences of different mental health conditions. Central to our analysis was the recognition that social groups not only provide a sense of belonging and support but also act as frameworks through which individuals negotiate and construct their identities (Howarth, 2001, 2006). This approach allowed us to explore how different types of social identities, shaped within the context of diverse social groups, mediate and moderate diverse mental health outcomes.

Methods

Study Setting

The study was conducted in two indigenous urban communities - Jamestown and Usshertown, located at the heart of Accra, Ghana's capital city. The two communities were chosen for the study due to their socio-historical significance and the high physical and mental health burden (de-Graft Aikins et al., 2020). They regarded as twin communities and referred to as Ga-Mashie or 'Old Accra' because it is regarded as the oldest communities in Accra, and home to native Ga-Adangbe ethnic group (Boakye & Béland, 2018). The main local language spoken there is *Ga*. However, there are other ethnic groups in the communities such as the Akans who speak *Twi*, the Ewes who speak *Ewe*, the Mole-Dagbani who speak *Dagbani* and the Guans who speak *Guan*.

The major source of livelihood there is fishing for the men and fish mongering for the women. However, other economic activities such as petty trading, food vending, hair dressing, carpentry, butchery, electrician are also popular in the communities (Wrigley-Asante & Mensah, 2017). The communities lack adequate public infrastructures and social

amenities such as playgrounds, parks and gardens (de-Graft Aikins et al., 2020). Sanitation is a major health concern in both communities, with poor management of solid and liquid waste; poor functioning sewage systems because existing drains are always chronically choked (de-Graft Aikins et al., 2020). There is also high prevalence of chronic physical conditions and mental health disorders (de-Graft Aikins et al., 2020; Kushitor et al., 2018).

Study Design and Data Collection

Qualitative data was gathered using key informant interviews, focus group discussions, and situated conversations. The key informants purposively selected were local community leaders, biomedical practitioners (community mental health nurse and over-the-counter medicine seller), faith-based healers (traditional priestess and prophet), herbal and traditional medicine practitioners, and leaders of social groups, individuals with history of mental illness, and family caregivers. The focus groups were held with conveniently selected community members and other identified social groups such as members of self-help group, male-only groups, and female-only groups in each community. The situated conversations were opportunistic engagements with some of the community members during the fieldwork. These conversations were usually impromptu, informal, and unstructured short conversations that was held, as and when the opportunity presented itself, sometimes with one person, and other times with groups of two or three members of the community.

Study Participants

A total of 77 participants were involved in the study (Table 1). Slightly more than half were females (61%), majority were Ga-Adangme (77.9%), and educational levels were low.

Table 1 Demographic profile of participants

Characteristics	Categories	f (%)
Community	Jamestown	44 (57.1)
	Usshertown	33 (42.9)
Gender	Male	30 (39.0)
	Female	47 (61.0)
Ethnicity	Ga-Adangme	60 (77.9)
	Akan	12 (15.6)
	Ewe	5 (6.5)
Age	20–29 years	9 (11.7)
	30–39 years	26 (37.8)
	40–49 years	11 (14.3)
	50–59 years	17 (22.1)
	60 + years	14 (18.2)
Educational level	No education	35 (45.5)
	Basic/Middle School	30 (39.0)
	Secondary/SHS	5 (6.5)
	Tertiary	7 (9.1)

Ethical Consideration

Ethical clearance for the study was obtained from the Ethics Committee for Humanities of the University of Ghana (ECH:010/18–19). Informed consent was obtained from all participants either orally or in writing. Privacy and confidentiality were ensured throughout the process of the study.

Data Analysis

The data was analysed using theory-driven thematic and social group analysis. First, all the transcripts were coded both deductively and inductively. The deductive codes derived from previous studies on mental illness experiences in communities in Ghanaian and global mental health literature (Campbell & Burgess, 2012; de-Graft Aikins, 2015; Mathias et al., 2018). The inductive codes were derived from community-specific issues. The next stage involved developing the codes into themes. Attride-Stirling (2001) identified three kinds of themes in thematic analysis - basic themes, organizing themes, and global themes. She defined basic theme as the lowest-order theme derived from textual data (Attride-Stirling, 2001). In the current study, basic themes were derived by drawing basic similarities and linkages between the codes. From the basic themes, the next stage involved deriving organizing themes. Attride-Stirling (2001) defined organizing themes as the middle-order theme that organizes basic themes into cluster of similar issues. In the current study, the basic themes were defined as groups of basic themes that provide mid-level insight into the study objectives.

In conducting this study, the researchers' positionality played a crucial role in shaping the data collection, analysis, and interpretation processes. The lead author has been part of the second author's decade long longitudinal social psychology project on community health development within the communities. Therefore, we were aware of our own identities, backgrounds, and potential biases, which could influence our engagement with participants and interpretation of the findings. To mitigate these influences, we adopted reflexive practices throughout the research process. This involved continuously reflecting on our positionalities and engaging in discussions between first and second authors to recognize and address any biases that might emerge to ensure that the voices and experiences of participants were represented accurately and respectfully.

Further, to further establish trustworthiness of our data, we employed several strategies to ensure transferability, dependability, and confirmability. We adopted thick

descriptions of context to address transferability by providing rich, participant demographics and context. We used audit trail to address dependability through a transparent and systematic approach to data collection and analysis, documenting each step of the research process, from the initial coding to the development of themes. We triangulated data from key informants, focus groups and situated conversations to address confirmability in validating the findings and minimize personal biases. Additionally, member checking was conducted by sharing preliminary findings with participants to verify the accuracy and resonance of the interpretations. These measures collectively enhance the robustness and trustworthiness of our study.

Findings

We present findings based on global themes, organizing themes, and basic themes (Fig. 1). First, the findings on social group engagement are presented, where two main organizing themes – motivation for group membership and tensions within the groups are presented. Next, the findings on how social groups shapes identities and experiences of spectrum of mental illnesses are presented.

Social Group Engagement – Motivations and Tensions

We found a high level of social group engagement among the participants, highlighting their agency in group memberships as well as importance of these groups in their lives. Eight distinct groups were identified: profession-based groups, religious groups, support groups, civic groups, political groups, ethnic-based groups, social clubs, and 'boys-boys' groups (Table 2). Each group played a unique role in providing a sense of belonging and support to its members. Profession-based groups were often formed around shared occupational interests and goals, while religious groups provided spiritual guidance and community. Support groups offered emotional and practical assistance, especially for those facing specific challenges. Civic groups were focused on community service and engagement, whereas political groups focused on advocacy and political participation. Ethnic-based groups helped migrants maintain cultural ties and heritage, and social clubs facilitated leisure and social interactions. The 'boys-boys' groups were informal social networks often centred on camaraderie and mutual support among young men. Our analysis revealed two key organizing themes regarding social group engagement: the motivations for joining these groups and the tensions experienced within the groups.

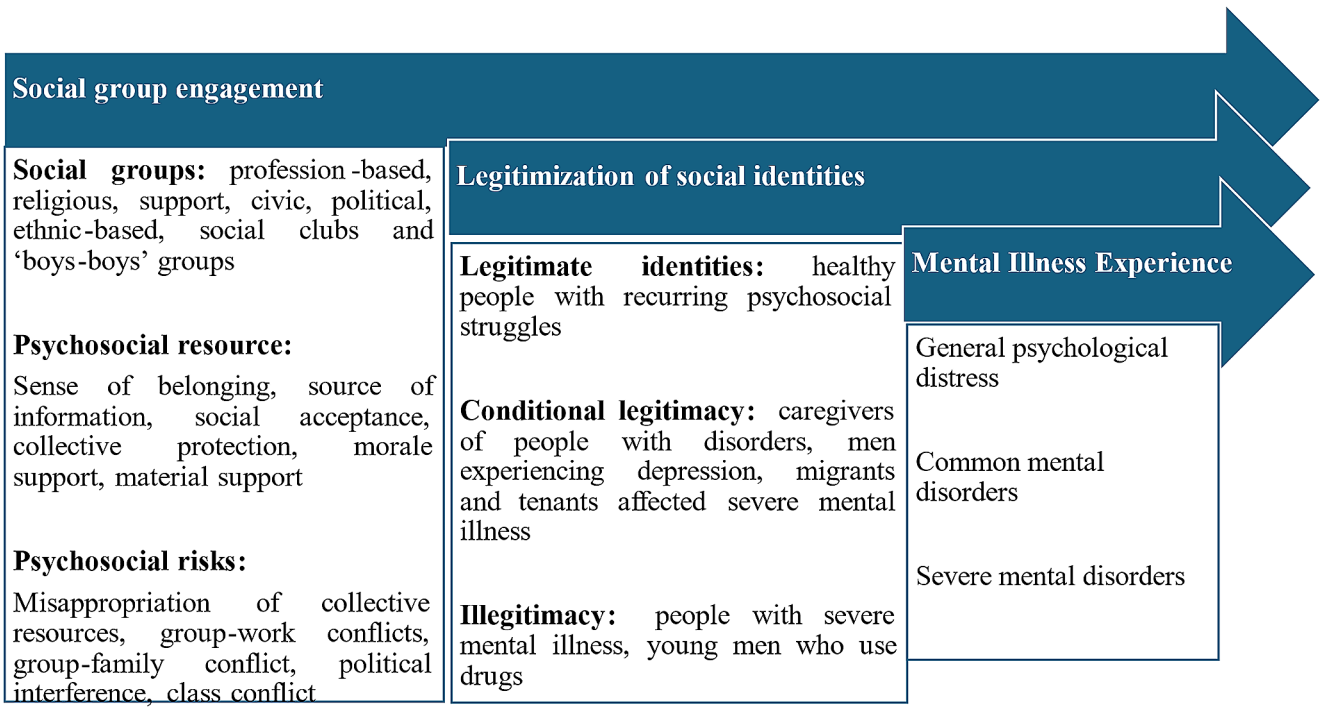

Fig. 1 Social groups influencing identities and mental illness experience

Table 2 Description of types of social groups

Social groups	Organized around;	Sample groups	Composition
Profession-based groups	economic and livelihood activities	Fishermen Association, Butchers Association, Market Women Association, Amateur *Boxers Association*, Young Boxers Movement, Artists' Club	Cuts across men and women of all working ages
Religious groups	religious beliefs, worship and practices	Men's Fellowship, Women's Fellowship, Pentecost Prayer Group, Pentecost Youth, Susanna Wesley	Cuts across men and women of all working ages
Self-help groups	collective health needs	James Town Health Club (JHTC) Basic Needs	Predominantly older women
Civic groups	social and community participation	*Ga-Mashie Youth* for Change, Gumption Social Club, Hope for Humanity, New Generation, Red Cross Society, Great Thinkers	Mainly young men and women
Political groups	political interests and ideologies	NPP Youth, NDC Youth, Young Progressives, Concern Youth	Mainly young men and women interested in political issues
Ethnic groups	migrant ethnic identities	Association of Asantes, Ewes' Group, Northerners' Association	Migrants of all ages
Social clubs	social interests and leisure activities	Drama Fun Club, Dromo Fun Club, Such Is Life Fun Club, Wuutie Fun Club, Rock Fun Club, Atinka Fun Club	Mainly young men and women
Boys-boys' groups	young fraternity for protecting members' safety and group territory	Boko Haram, Roman Boys, Roma Academy, Road Close, Water Boys, Nothing Bhard Boys	Young men between 16–30 years

Motivations for Social Group Membership

Seven basic themes emerged regarding the motivations for joining social groups: sense of belonging, source of information, social acceptance, collective protection, emotional support, social participation, and material support. Each of these basic themes is described next, with illustrative quotes from participants.

- **Sense of belonging**: participants joined groups to fulfil their need for belongingness. One participant noted, "As humans, you cannot say that you won't join any group. At least, as for one or two groups, you must join. That is what makes us human" (Man, 40, Jamestown). Another added, "My reason for joining the groups is because it is good to know that you belong to groups, so you know that you are not alone" (Woman, 43, Usshertown).
- **Source of information**: belonging to groups provided access to valuable information. One participant explained, "I joined groups here because you always get information about what's happening in the community" (Man, 31, Usshertown). Another shared, "I joined because they give us knowledge on how we can control our BP. Every month, we discuss different things. Sometimes we talk about diet, exercise, drugs, and many things" (Woman, 39, Jamestown).
- **Social acceptance**: some participants were drawn to groups that accepted them unconditionally. One participant stated, "Here, everybody says I'm a prostitute. But when I'm with my group, nobody judges me. I am accepted" (Woman, 32, Usshertown). Others joined groups where members had similar health conditions, fostering a sense of acceptance: "When we meet, we all have the BP so when you are there, you don't feel any kind of different" (Woman, 49, Jamestown).
- **Collective protection**: some participants joined groups to protect themselves against violent attacks. One participant explained, "When someone attacks you, the members will attack the person too" (Man, 29, Usshertown). Another shared, "My boyfriend was beating me always, so I went to join them. When he beat me again, they went and gave him a strong warning. We protect ourselves" (Woman, 29, Jamestown).
- **Emotional support**: participants joined groups to gain support during significant life events such as weddings, funerals, and outdooring ceremonies. One participant noted, "When you are bereaved, we all come and mourn with you. We contribute and make donation and we all dress the same way to mourn with the person. When it happens like that, at least you can take heart" (Woman, 42, Usshertown). Another shared, "I joined so that when

I am getting married, I will get people to come and support me" (Woman, 29, Jamestown).

- **Material Support**: Material support included subsistence allowances, renewal of health insurance, supply of drugs, and provision of foodstuffs. One participant stated, "I joined because they do health insurance for us free. Sometimes they asked all those whose health insurance have expired, and they ask us to bring it, then they renew it for us" (Woman, 59, Jamestown). Another added, "For our groups, sometimes the MP comes and gives us something small [money] to share. So, it helps us" (Man, 38, Usshertown).

The motivations for joining social groups collectively contribute to the overall wellbeing of the participants. These groups fulfil fundamental psychological needs by providing a community where individuals feel connected, informed, and accepted, which enhances their individual and collective self-esteem and reduces feelings of isolation. Additionally, the groups offer practical benefits like protection and material support, which can alleviate stress and provide a sense of security and stability. Emotional and social support during significant life events further reinforces community bonds and helps individuals cope with personal challenges. These factors combined, create a supportive environment that fosters mental and emotional wellbeing, and contribute to a more resilient and cohesive community.

Tensions within Social Groups

Notwithstanding the benefits, seven basic thematic tensions were identified to characterize membership of these groups: misappropriation of resources, conflicting group-work demands, conflicting group-family demands, political interference, competing group demands, domestic-to-group conflict, and class conflicts.

- **Misappropriation of group resources**: Group leaders were often accused of misappropriating both material and symbolic resources for personal gain. For instance, one participant remarked, "When the MP brings us money, they [the executives] share without giving us some" (Woman, 43, Usshertown). Another added, "During Christmas and Easter, some people bring us rice and other things. However, the executives will keep all the items and give us only one rice each" (Man, 38, Jamestown). Symbolic resources, such as opportunities and recognition, are also perceived to be misappropriated: "Sometimes, the MP will tell the executives to bring names of members who are unemployed and looking for jobs. Before you know it, the leaders will put in names of their family members" (Man, 28, Jamestown). Another also remarked "When some influential people visit us, we take pictures with them as a group. After that the leaders will also take pictures together with them. Then each of the leaders will also take personal picture with them. But we the members are not allowed to take personal pictures with them" (Man, 39, Usshertown).
- **Conflicting group-work demands**: Job demands often hindered participation in group activities, causing resentment among members. One participant noted, "Some people never come for meetings. When we are going to a funeral, you will never see them. The excuse they keep giving is that because of their work it is difficult for them to come. As if the rest of us don't work" (Man, 38, Jamestown).
- **Conflicting group-family demands**: Family obligations frequently conflicted with group demands, creating tensions. For example, one woman shared, "I have small children, so I must be at home to take care of them. Because of this when we are going for programs or other activities outside this community, I am not able to join them" (Woman, 39, Usshertown). Another participant added, "I am taking care of my mother. She is old and sick too, so I must always be at home to be able to take care of her. Because of that I am not able to work, how much more going to meetings. Some of my group members are always accusing me of not being active in the group but I don't mind them" (Female Caregiver, 42, Usshertown).
- **Political interference**: Political parties often try to annex groups during elections, leading to conflicts. One participant stated, "When elections are coming then there's always conflict because different parties want to use us to do campaign" (Woman, 37, Jamestown). Another noted, "As for our group, it is politics that is killing it. So, many people have stopped the group because the politics has become too much" (Man, 39, Usshertown).
- **Competing group demands**: Membership in multiple groups created difficulties in meeting the demands of all groups. One woman remarked, "I belong to four groups, and they all have meetings and other things every week. If you decide to go to all of them, then you will spend all your week on the groups and not do anything for yourself" (Woman, 35, Jamestown). Another added, "Some of our members for instance, you don't see them at our activities, but you will see them in other groups' activities. If you ask them to leave the group too, then they are angry " (Man, 39, Usshertown).
- **Domestic-to-group conflict**: family conflicts often spilled over into group activities, causing disruptions. One participant noted, "When people have conflicts at home, then they bring it here. It always creates confusion" (Woman, 40, Usshertown). Another shared, "Last

week, two women fought during our meeting. They are sisters-in-law, and they have issue at home, then they carried the issue to the meeting. Such things happen a lot" (Man, 51, Jamestown).

- **Class conflicts and marginalization**: some members looked down on others for various reasons, particularly non-payment of group dues. Others used their social status to marginalize opinions. A market woman stated, "You see, let's say we have gone for meeting today and there is a problem that we are discussing. Those who have been to school always behave as if those who didn't go to school don't have sense in our heads" (Market Woman, Usshertown). Another participant added, "Oh, as for the groups, that is how it is. If you are rich, the way they treat you is different from if you are poor. There is one woman whose children are abroad. For her, everybody respects her but people like me who is poor, even when you are sick, nobody checks on you " (Female Trader, Jamestown).

The identified tensions within social groups constitute significant psychosocial risks for poor mental health. Misappropriation of resources breeds distrust and frustration among members, undermining the sense of community and support that social groups ideally provide. Conflicting demands from work, family, and multiple group memberships create stress and feelings of inadequacy, as individuals struggle to meet the expectations of all these spheres. Political interference and class conflicts exacerbate divisions within the groups, leading to a sense of alienation and marginalization for some members. Domestic-to-group conflicts bring personal issues into the communal space, disrupting group cohesion and causing emotional distress. Together, these tensions erode the potential mental health benefits of social group engagement and potentially contribute to poor mental health outcomes.

Social Groups Influencing Identities: Legitimization of Social Identities

The second global theme explored was how social groups contribute to the construction of identities and influence the experiences of different mental health conditions. As illustrated in Fig. 1, social groups influence legitimization of identities in three organizing themes: legitimate identities, conditional legitimate identities, and illegitimate identities. Each of these identities structure their experiences of different mental illnesses.

Legitimate Identities this encompasses individuals who are generally healthy but experience recurring psychological or social challenges due to structural factors. They are typically viewed as legitimate members of the groups because their struggles are seen as temporary or manageable within the social framework. These include individuals experiencing general psychological distress, such as periodic stress, anxiety, or mild depression due to everyday life pressures. For instance, a single mother of four and a caregiver recounted her struggles.

> Here, people think too much. Me for instance I will not be telling the truth if I tell you I don't think. Every night I am not able to sleep because the pressure on me is too much. I alone am taking care of my four children, my sick mother, and two small siblings. The stress is too much for me (Woman, 40, Jamestown).

Similarly, a fisherman recounted his recurrent psychosocial stress: "In this community, we struggle too much. There are no jobs, no money, nothing. It makes life too difficult. So, there are so many people who are frustrated and hopeless here. Me, every day is frustration for me. Every little thing and I am getting angry" (Man, 38, Usshertown).

Conditional Legitimacy this encompasses individuals whose social legitimacy is contingent upon their circumstances or roles. While they are accepted within the community, their legitimacy is conditional and often tied to the perceived nobility or necessity of their situation. These individuals are more exposed to common mental disorders, such as moderate depression and anxiety, due to their caregiving roles, societal expectations, and stressful living conditions.

- **Caregivers of people with chronic conditions**: Individuals who provide care for family members with health conditions issues are often respected for their caregiving role but may also experience stress and stigma. For example, a 39-year-old caregiver expressed feeling being trapped in her role due to cultural expectations and lack of marriage:

> If you are a woman here and you are not married, it is difficult. The pressure they put on you, it is as if you have decided not to get married. Sometimes I just want to leave the community and go somewhere else where nobody knows me. But because of my mother that I am taking care of, I can't go. Every day is stressful for me because I don't have a husband (Woman, 39, Usshertown).

- **Men experiencing depression**: men who are battling depression may receive some sympathy but also face stigma due to societal expectations about masculinity and mental health. One middle-aged man who attempted

suicide due to depression recounted how he is constantly teased: "We all know that thing [depression] is for women. But for a man to experience it, I was even embarrassed. Some of my friends even till now they tease me. They will ask you, has your depression come?" (Man, 45, Usshertown).

- **Migrants and tenants affected by severe mental illness**: Migrants and tenants managing severe mental illness might be conditionally accepted based on their ability or willingness to remove the care receiver from the house or confine the person. For instance, a migrant woman tenant recounted how she had to send her son to live with her mother in her village because the landlord did not want him in the house: "When his condition started, he became a bit violent. The landlord told us they can't live with him so I should find a place for him to stay. If someone tells you this, you know that he wants you out of the house" (Woman, 42, Jamestown). Another woman described the challenges she faces with co-tenants because of her brother who is addicted to drugs: "The house where we live, they are always fighting with us to leave because my brother is a drug addict" (Woman, 38, Usshertown).

Illegitimacy this encompass individuals who are largely stigmatized and marginalized within the community due to the severity of their mental health conditions or behaviours. They are often perceived as dangerous, deviant or burdensome, leading to their exclusion from social acceptance and support. These individuals experience severe mental disorders, such as schizophrenia, or substance-induced psychosis, and face significant barriers to care and social inclusion.

- **People with severe mental illness**: Individuals with conditions such as schizophrenia or bipolar disorder face significant stigma and are often seen as dangerous and incapable of contributing to society. They do not receive the needed quality of care and treatment due to poverty. For instance, a woman with a daughter with an undiagnosed severe mental disorder recounted how poverty has prevented her family from seeking treatment: "Every time people tell us to take her to the hospital, as if we don't know that she needs the hospital. But where is the money for that? My husband doesn't work. I used to sell things, but now I don't go, so where is the money to take her to the hospital?" (Woman, 50, Jamestown).
- **Young men who use drugs**: Young men who are involved in substance abuse are frequently labelled as troublemakers and are subjected to harsh judgment and exclusion by the groups. They are often associated with 'madness' by adult community members. A middle-aged man indicated: "In this community, I would say drug abuse. The young people here use drugs too much. When you see them, you see that they are mad, but it's the drugs that have made them like that" (Man, 40, Usshertown). A community leader also associated young men who use drugs with madness: "It's through tramadol and some of these hard drugs. When they use the drugs too much, it causes mental illnesses. They are all mad and just roaming about" (Man, 55, Jamestown).

Discussion

We explored social group engagements, identities and mental health experiences among participants. We observe find high level of social group engagements. The extensive engagement in various social groups underscores agency in social group selection. The groups play pivotal role in providing material support, psychosocial reinforcement, and avenues for social participation. These psychosocial benefits of group membership underscore the crucial role that social groups play in meeting both practical and psychological needs within communities. These findings align with existing research highlighting the positive impact of cohesive social networks on mental wellbeing (Campbell et al., 2013a; Crabtree et al., 2010; Cruwys et al., 2014, 2016; Greenaway et al., 2019; Haslam et al., 2014).

However, the influence of social group memberships reveals a complex dynamic. Alongside their benefits, the groups also create sites for substantial tensions. characterized by misappropriation of resources, conflicting demands from work and family roles, political interference, competition among groups, domestic conflicts spilling into group dynamics, and class-based marginalization. These tensions illuminate the complex interplay of individual needs and group demands, highlighting challenges that can undermine the supportive potential of social groups in contexts where material deprivation and cultural intersect. These findings align with few existing studies such as Osborne and colleagues (2009) and Campbell and colleagues (2013a) in challenge simplistic views of social groups as universally beneficial, emphasizing the nuanced role of group dynamics in influencing mental health within marginalized communities.

Through the lens of legitimization processes, our study further elucidated how social identities are constructed and contested within these groups, with implications for understanding the varied experiences of individuals across different spectra of mental health conditions. For individuals coping with severe mental disorders, social groups often amplify social stigma and exclusion, exacerbating challenges in accessing essential care and support. This

underscores persistent issues of stigma documented in mental health literature (de-Graft Aikins, 2015; Thornicroft et al., 2016, 2022). Conversely, those experiencing common mental health problems such as depression and anxiety derive direct benefits from the supportive environments provided by social groups, which can alleviate symptoms and aid recovery, aligning with the social cure framework (Burgess & Mathias, 2017; Burgess et al., 2020; de-Graft Aikins, 2015; Haslam et al., 2016).

Further, our findings highlight the pervasiveness of general psychological distress among community members, particularly pronounced among marginalized groups facing chronic structural stressors such as financial instability and housing insecurity. These structural determinants significantly impact mental health outcomes (Mahr & Campbell, 2016; Mathias et al., 2018), echoing findings from previous studies on community health disparities (Campbell et al., 2013a; de-Graft Aikins et al., 2020; Gibbs et al., 2015). Our research enriches the social identity approach to mental health by illustrating the intricate interplay between social group memberships, identities, and the spectrum of mental health challenges in resource-constrained settings.

The qualitative approach has provided deep insights into the lived experiences of individuals and how that intersects with their social groups and identities within resource-poor communities. Further studies are needed into the mechanisms underlying class conflicts and stigmatization within these communities. Mental health interventions in communities that draw on social groups must acknowledge and address both the supportive functions and stress-inducing dynamics of social group memberships. Practitioners should tailor interventions to foster supportive group environments while mitigating tensions that threaten mental health outcomes. Building mental health competence within such community contexts necessitates comprehensive strategies that account for the diverse social identities and material conditions prevalent in resource-poor communities. Addressing these complexities is vital for advancing mental health equity and enhancing community mental health resilience in the face of ongoing challenges.

Conclusion

Our study underscores both the pivotal and double-edge role of social group memberships in shaping mental health outcomes in urban poor communities. While these memberships provide crucial material and psychosocial support, they also introduce tensions that can exacerbate stress and stigma, particularly for individuals with severe mental disorders. The findings highlight the complex interplay between social identities, structural determinants like poverty and housing insecurity, and the spectrum of mental health challenges experienced by community members. Effective community mental health interventions must navigate these complexities by promoting supportive group environments while addressing underlying tensions and disparities. This approach is essential for fostering resilience, reducing stigma, and enhancing mental health equity within resource-poor settings. Future research should further explore these dynamics across diverse populations and settings to inform targeted interventions that promote holistic wellbeing and social inclusion.

Declarations

Conflict of interest The authors declare that there are no actual or potential conflict of interests regarding research, authorship, and publication of this article.

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