Identification Reduces Stigma of Mental Ill-Health: A Community-Based Study

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Highlights

• Group identification reduces stigma of mental ill-health.
• Multiple identities can interact to enhance social resources crucial for well-being.
• Identification with one social group can lead to gaining another.

Abstract The stigma surrounding mental ill-health is an important issue that affects likelihood of diagnosis and uptake of services, as those affected may work to avoid exposure, judgment, or any perceived loss in status associated with their mental ill-health. In this study, we drew upon social identity theory to examine how social group membership might influence the stigma surrounding mental ill-health. Participants from two urban centers in Ireland (N = 626) completed a survey measuring stigma of mental health, perceived social support as well as identification with two different social groups (community and religion). Mediation analysis showed that subjective identification with religious and community groups led to greater perceived social support and consequently lower perceived stigma of mental ill-health. Furthermore, findings indicated that high identification with more than one social group can lead to enhanced social resources, and that identification with a religious group was associated with greater community identification. This study thus extends the evidence base of group identification by demonstrating its relationship with stigma of mental ill-health, while also reinforcing how multiple identities can interact to enhance social resources crucial for well-being.

Keywords Mental health · Mental illness · Stigma · Community · Social identity · Social support · Groups

Introduction

Our social network and those with whom we associate can massively impact our thoughts, feelings, and behaviors toward a multitude of issues (Jetten, Haslam & Haslam, 2012). This is particularly true for those whom we view as similar others, or share a social identity with (Turner & Oakes, 1986). In the current study, we examine how identification with two different social groups can influence perceived stigma toward mental ill-health in two towns in the Republic of Ireland. Drawing on the social identity approach, we assess whether levels of perceived stigma and social support differ based on the strength of religious and community identification. We further explore how identification with more than one group may impact these measures, allowing us to examine the role of multiple group membership in the stigma of mental ill-health.

Research has shown that where individuals share group membership, help received from members of that group is more welcome and perceived as less threatening to one’s self-esteem than help offered by outgroup members (Reicher, Cassidy, Wolpert, Hopkins & Levine, 2006). The shift toward provision of mental health services from large hospitals or specialized psychiatric centers to local,
community-based mental health services that has been seen in Ireland, and elsewhere (Health Service Executive, 2016), can in this way be viewed as a welcome development. A consequence, however, is that the chances of encountering familiar persons while accessing such services are increased. This is unproblematic if the health service being accessed is not considered taboo within one’s social group. However, if the health issue is one that is stigmatized (e.g., HIV, sexually transmitted infections, suicide, mental ill-health), those in need of services may be less likely to seek help (Lichtenstein, 2003; Mapp, Hickson, Mercer & Wellings, 2016); particularly from sources within their own group (Kearns, Muldoon, Msetfi & Surgenor, 2015). The change in mental health service provision to community settings therefore reinforces the need to understand positive attitudes toward mental health at a local level, as stigma reduction is one of the most effective ways to eliminate negative attitudes surrounding help-seeking (Gulliver, Griffiths, Christensen & Brewer, 2012; Pearson, Claassen & Booth, 2014). In the current study, we explore stigma of mental ill-health in two towns in the Republic of Ireland, where the establishment of local, community-based clinical services for those affected by mental health problems is planned. Resulting from the physical positioning of such services within the community, the stigma perceived among fellow community members, to whom an affected person risks exposing their mental health problems should they choose to engage with this source of help, is likely to predict service usage when these centers are established.

Mental Ill-Health and Related Stigma as a Major Social Issue

In this study, our focus is on the impact of perceived public stigma on help-seeking of those affected by mental ill-health. Perceived public stigma relates to how we think other people perceive mental ill-health or people who experience mental ill-health (Link, 1982). This type of stigma has been shown to inhibit help-seeking behavior (Corrigan, 2004). We use the term “mental ill-health” here to acknowledge that, just like physical health, mental health ranges along a healthy to ill continuum (World Health Organization, 2001). Therefore, this term encompasses a wide range of mental health issues, from stress and anxiety to clinical depression and psychosis. When a person has mental ill-health, they will generally have difficulties in carrying on with everyday life, the extent of which differs based on how serious the mental health problem is (Kinderman, 2014).

Mental ill-health is something that affects large portions of the population. Estimates of the lifetime prevalence of such problems range from 25% to 50% of the global population (Kessler et al., 2005; Moffitt et al., 2010; WHO, 2001). Similar to the rest of the world, 20% of respondents in the 2016 “Healthy Ireland Survey” indicated that they currently, or at one point in their lives, had a mental health problem (Ipsos, 2015), while 28% of Irish participants in a more recent survey indicated that they had previously been treated for mental ill-health (St. Patrick’s Mental Health Service, 2017). Despite such high prevalence, mental ill-health continues to be seen as taboo, and a source of shame and stigma. Those experiencing mental health problems are often viewed as dangerous, unpredictable and untrustworthy by the general public (Angermeyer & Dietrich, 2006; Thornicroft, 2006). In the Irish context, 64% of people believe that being treated for a mental health difficulty is seen as a sign of personal failure, while 73% maintain that those who receive in-patient care for mental health difficulties are treated differently by society (St. Patrick’s Mental Health Services, 2017). Stigma of mental ill-health is acknowledged as one of the strongest barriers to engaging with professional mental health services (Gulliver et al., 2012). Tackling these prevailing attitudes is thus a necessary priority. Failure to do so may negatively impact the uptake of vital professional services (Corrigan, 2004).

Social Identification, Stigma, and Social Support

Stigma is a social phenomenon (Blaine, 2000). It is driven by shared understandings and associated values attached to a given issue, in this case mental ill-health. In this study, we investigate how people’s social groups, the vectors of shared understandings and values, may be influential in the perception of stigma. We posit that group identification can influence perceived stigma of mental ill-health via increased social support. The basis for this argument comes from the social identity approach, a body of work incorporating social identity theory and self-categorization theory (Tajfel & Turner, 1979; Turner, Hogg, Oakes, Reicher & Wetherell, 1987). Previous research using this framework has demonstrated that sharing a social identity with similar others and recognizing them as members of your “ingroup” can lead to positive psychological outcomes, including a feeling of belonging and enhanced social support, with ultimate benefits for health and well-being; an effect called “the social cure” (Jetten et al., 2012). Group identification can fill an important need and alleviates the negative psychological outcomes associated with having a stigmatized identity due to the platform it provides for the giving and receiving of social support necessary to cope with and resist the prejudice or discrimination experienced (Crabtree, Haslam, Postmes & Haslam, 2010; Turner, Oakes, Haslam & McGarty, 1994).

To date, it has been established that group membership can positively or negatively influence help-seeking
behaviors, dependent on levels of stigma among fellow group members (Kearns et al., 2015; Reicher et al., 2006). As yet, the role of identification levels with a given group is less clear. The influence of group membership is likely to have important consequences for the beliefs and expectations that individuals have about other group members. One line of enquiry focusing on ingroup favoritism has outlined how group members have a strong preference for extending prosocial behavior to other members of their group. Thus, reciprocal exchange is expected such that the help and support expected from the ingroup is above and beyond that expected from members of the outgroup (Everett, Faber & Crockett, 2015). Moreover, in what can be considered stereotyping, ingroup members are commonly perceived to be more altruistic and viewed in a more positive light than outgroup members (Yamagishi & Kiyonari, 2000). Therefore, we expect that those with higher group identification are likely to have greater access to the social support associated with group membership, which can lead to increased expectations of care and understanding (Haslam, O’Brien, Jetten, Vormedal & Penna, 2005). Resulting from these increased feelings of social support, we also expect that levels of mental ill-health stigma will differ based on the strength of identification with the group.

Multiple Groups and Potential Amplification Effects?

As outlined above, group membership is associated with many benefits and positive psychological outcomes. Research has also demonstrated that these effects may be augmented when you are a part of more than one group. Individuals usually belong to many different groups at the same time, all of which form part of their social identity (Ashforth & Johnson, 2001). A substantial line of enquiry focusing on multiple group membership shows that the number of groups an individual belongs to is positively associated with psychological well-being, with incremental increases based on the number of group memberships (Walter, Jetten, Dingle, Parsell & Johnstone, 2015), which has important health consequences such as protecting against depression (Cruwys et al., 2013), promoting well-being after a stroke (Haslam et al., 2008), brain injury (Walsh, Muldoon, Gallagher & Fortune, 2015), and adjusting to life transitions (Iyer, Jetten, Tsivrikos, Postmes & Haslam, 2009).

In the current study, we concentrate on benefits resulting from membership of two groups that are particularly relevant in our Irish community-based sample. Advancing on previous research, we examine how the strength of identification with these two groups may influence social support and stigma. This study had particular relevance in Ireland where clinical mental health service provision is being rolled out and offered at a local level. Our data was collected in two communities where community-based mental health service provision for those affected by suicide and self-harm was about to become on stream. Ensuring a lack of stigma at local level for those seeking to access these services is particularly important in a country with a long history of stigmatizing mental health problems not least because of the historically ambivalent attitude of the dominant religious influence in the country, the Catholic Church, to mental illness (Leavey, Loewenthal & King, 2007).

So, in this study, we measure extent of identification with the local community as well as religious identification with preferred religion. Both identities are important elements of the social fabric of everyday life in Ireland. The geographical locality, here and in common parlance in Ireland, is referred to as the community where a person is from. Community identity, embedded in spatial, place, and family identities, represents an important social identity in Irish culture. “Community” encompasses everyone that lives and interacts with others within that locality. For the majority of the community, it is where they attend school or work, make friends and conduct their daily routine, and thus constitutes for most individuals where their social relationships exist. Communities are also key focal points around which local government and sporting identities are built. As a consequence, many people feel a strong sense of loyalty to their community. A second important identity in Irish life is religion. Church organizations are embedded in local communities. Historically, the units of church organization, parishes, have been predominantly Catholic although there is also a much lower density of Protestant parishes. The Catholic Church retains an important position in Irish society and many people continue to identify as Catholic. Many important community resources remain under the auspices of religious groups, such as community meeting places as well as hospital and maternity services and many social care facilities. For this reason, community and religious identities were selected as identities of particular relevance to this study, oriented as it is to the impact of identities on uptake of embedded and local health service provision.

Exploring the impact of two identities is also theoretically interesting. An amplification effect has previously demonstrated that pre-existing group memberships can facilitate the acquisition of additional group memberships. For example, those with more group memberships prior to commencing university found it easier to settle in and were more likely to acquire new group memberships when compared to those with fewer group memberships prior to this transition (Iyer et al., 2009). However, this work also highlights the importance of identity compatibility in facilitating this transition. Past research, for
example, has shown that low-income students report tension between their new and pre-existing group memberships. In these cases, drawing on their previous social group memberships to support their adjustment to university life is less fruitful (Iyer et al., 2009). With the aim of adding to this field of research, the current study will investigate if identification with one group may facilitate identification with a second group, looking to the strength of identification with the first group as a predictor of new group acquisition rather than focusing on memberships of multiple groups as has previously been tested. We further consider how identity compatibility may help or hinder this process.

Current Research

In this study, we want to determine if levels of perceived stigma of mental ill-health and social support differ between those who identify strongly with their community and religion compared to those who have high identification with only one, or neither of these groups. Our first hypothesis (H1), investigates if levels of perceived social support, and perceived stigma of mental ill-health differ based on the strength of identification with our two groups. We expect that strength of identification with both community and religious identities will be related to perceived social support, and perceived stigma of mental ill-health. Furthermore, we expect where our participants strongly identify with one, both, or neither group will affect perceived social support and perceived stigma. Mediation analysis is employed to determine if religious and community identification predicts perceived stigma of mental ill-health via perceptions of social support (H2). The mediation model also tests our amplification hypothesis (H3) that one form of identification, for example, religious identification can facilitate identification with a second identity, for example, community identification.

Method

Participants

The study sample was recruited from the populations of two towns in the Republic of Ireland (population of Town 1 was 51,000; Town 2, 23,000), as these were the focus of a roll-out of provision of community-based mental health services. Participation was voluntary and anonymous in all cases. The inclusion criteria were that participants were currently residing in one of these two areas and were over the age of 18. Given the high prevalence of mental ill-health and likelihood of an individual struggling with a mental health problem over the lifespan, a decision was made to impose no other exclusion criteria. Participants were invited to complete either an online or a paper-based survey that focused on community and religious identity, social support, and mental health stigma. In total, 712 people took part in the study, with 626 of these completing all the survey items relevant to this study, representing 0.85% of the total population of the two towns. There was a higher absolute number of participants from Town 1 (n = 400, representing 0.78% of the population), than from Town 2 (n = 226, representing 0.97% of the population), which is reflective of it having a larger population overall. Participant age ranged from 18 to 90 (M = 37.79, SD = 15.29), of whom 74.5% were women. The mean age of participants in Town 1 (M = 38.25, SD = 14.64) was significantly higher than that in Town 2 (M = 34.70, SD = 14.64, t(624) = 3.13, p = .003); a difference that is reflective of the average age for each town recorded in the most recent national census (Central Statistics Office, 2016). There were no differences in the proportion of male/female participants between the two towns (p = .75). We did not carry out an in-depth assessment of the mental health services in each locality at the time of the research; however, the designation of these two towns as locations for new, community-based mental health services indicates that current services were not considered adequate.

A variety of different sampling methods was used to ensure a representative sample of each town, evident from the extensive age range highlighted above. Participants were recruited to the online survey via advertisements shared on social media platforms including Twitter and Facebook by numerous community-based groups, organizations, and sports clubs from each town. Further recruitment stemmed from study information published in local media outlets and radio interviews conducted on local stations to raise awareness of the study. Those who completed the paper survey did so in person at workplaces and shopping centers local to each area, where efforts were made to recruit participants who may not otherwise have taken part in the study—those who did not have access to or were unable to use the Internet (including an older population), and men, who continually demonstrate low response rates to studies focusing on mental health (Kearns, Muldoon, Msetfi & Surgenor, 2017); something that can also be seen in the current study. Evidence that these sampling methods were successful can be seen in that there was a significant difference in age among those who took part in the survey in person (M = 42.60, SD = 18.42) compared to those who completed the survey online (M = 32.85, SD = 11.56), p < .001. Furthermore, 25% of all males who took part in the study did so in person, while paper responses represented less than 10% of the total number of responses for females. Those who were not resident in the local community were excluded.
by screening questions prior to commencing the questionnaire. The study received full approval from the Faculty of Education and Health Sciences Research Ethics Committee at the University of Limerick.

Measures

**Community Identification**

Community identification was measured using the four-item measure of social identification (FISI). This short measure is adapted from a longer scale (Doosje, Ellemers & Spears, 1995), and is recommended when it is not possible to administer an extensive questionnaire (Postmes, Haslam & Jans, 2013). FISI consists of four items (I identify with [In-group], I feel committed to [In-group], I am glad to be [In-group], Being [In-group] is an important part of how I see myself), and is designed to be adapted to measure identification with any specified group. In this case, participants were asked to respond to each item by stating where they identify with “my community in Town X.” In this way, community was defined as the geographical locality associated with the town. Items were scored on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree) and summed, with higher scores indicating a stronger identification with the community. Based on residency, all participants who took part in the study could be considered part of the “community” group, as those not resident in the area were excluded at the screening stage. Cronbach’s $\alpha$ for this measure was .85.

**Religious Self-Categorization and Identification**

A measure of religious self-categorization was included as while all study participants were automatically part of the “community” group, religion is something that people must claim. This was measured using a single-item measure taken from the Irish census survey (Central Statistics Office, 2016), “What is your Religion?” Responses were recoded into a dichotomous variable for analytic purposes to differentiate between those who subscribed to a religion and those who did not ($1 = religion, 2 = no religion$).

The Duke University Religion Index (DUREL; Koenig & Büssing, 2010), a three-dimensional, five-item measure of religious involvement developed for use in large cross-sectional studies was employed to measure religious identification. Two of these items, taken from the “intrinsic religiosity” dimension of the DUREL, were used as a measure of religious identity centrality yielding a Cronbach’s $\alpha$ of .91 for this study. These were: “My religious beliefs are what really lie behind my whole approach to life” and “I try hard to carry my religion over into all other dealings in life.” These items were scored on a 5-point Likert scale ranging from 1 (definitely not true) to 5 (definitely true for me) and summed. Other dimensions of this measure representing spirituality and connections to co-religionists were not used as the former cannot be considered a measure of identification and the latter is likely to artificially inflate the extent of the relationship between this variable and social support. The reason that these items were used in our analysis rather than the measure of self-categorization with a religion (e.g., Catholic, Protestant, Islam, etc.) was that in the Irish context, many people categorize with a religion despite not holding any religious views, for reasons that have cultural and political underpinnings (see Hanson, 2014). In this study, we wanted to differentiate between such individuals and those who actively engage with their religion and subjectively define it as an important part of who they are.

**Religious Attendance**

This was included as a covariate and measured using a single-item subscale from the DUREL, “How often do you attend church or other religious meetings?” The item was scored on a 5-point Likert scale ranging from 1 (never) to 5 (more than once a week). The rationale for the inclusion of this covariate was to ensure that it was identification with a religion, rather than any affect associated with socializing at religious gatherings that was reflected in our analysis.

**Social Support**

Perceived social support was measured using 15 items from the widely used Medical Outcomes Study Social Support Survey Instrument (Sherbourne & Stewart, 1991), incorporating the emotional/informational support subscale, affective support subscale, and positive social interaction subscale. Due to concerns about the length of the survey and in the hope of maximizing completion rates the tangible support subscale was not included. Wording of the instructions was slightly adapted for the current study, with participants asked to indicate, “How often would the following types of support be available from people in your community if you needed it?” Examples of items include “Someone you can count on to listen to you when you need to talk,” “Someone to love and make you feel wanted,” and “Someone to do things with to help you get your mind off things.” Items were scored using a 5-point Likert scale ranging from 1 (none of the time) to 5 (all of the time) and averaged, with higher scores indicating greater perceived social support. Cronbach’s $\alpha$ for this measure was .97.

**Perceived Stigma of Mental Health**

The 12-item Perceived Devaluation Discrimination Scale (PDDS; Link, 1982; Link, Mirotznik & Cullen, 1991)
measures beliefs that people will devalue or discriminate against someone with mental ill-health. In this study, the 12 items were amended to specifically refer to *people in their community*. For example, “Most people in my community would treat someone who once suffered from mental ill-health just as they would treat anyone.” Items were rated on a 6-point Likert scale, ranging from 1 (strongly agree) to 6 (strongly disagree). Positively worded items were recoded, and item scores were averaged with higher scores reflecting higher perceived stigma of mental health. Cronbach’s α for this measure was .87.

Procedure

Individuals living in Towns 1 and 2 were invited to complete the study measures via an online survey, or in person. The paper-based survey was identical to the online survey but printed in booklet form. In both formats, the first page of the survey outlined the study information and contained screening questions related to the inclusion criteria (being over the age of 18 and currently residing in one of the two towns). The survey took approximately 15 minutes to complete, after which participants were thanked and given information on relevant support services in their area if needed. Participants in the online survey received no compensation; those who were recruited in person were given a voucher for tea/coffee that could be redeemed in an on-site café where they could sit and complete the survey.

Analytic Procedure

In order to examine our hypothesis, H1, and determine if those who identified strongly with multiple social groups have better outcomes in terms of social resources, we used a median split to separate survey respondents into high/low identifiers with the two groups relevant to this study, religion (Mdn = 4), and community (Mdn = 19). A new variable was then created with three categories: (a) those that identified strongly with both groups, (b) those that identified strongly with one group only, and (c) those who did not identify strongly with either group. These three categories were selected for this analysis for theoretical reasons. Following the analytical precedent by Jetten and colleagues (Jetten, Mols & Postmes, 2015), this approach allowed us to establish whether our study measures differed based on the number of groups participants identified strongly with, rather than the main and interaction effects of the particular identity. Univariate analyses of variance (ANOVA) were used to investigate differences in social support and stigma of mental ill-health between these groups; planned comparisons using pairwise comparisons adjusted using the Bonferroni correction for multiple testing were then compared to those who identified strongly with both groups to each of the other two groups.

Our second and third hypotheses (H2 and H3), were examined using serial mediation analysis, computed using PROCESS, Model 2.15 (Hayes, 2012). An estimate of the indirect effect was obtained by running 5,000 iterations of computed samples using the bootstrapping procedure with bias-corrected and accelerated 95% confidence intervals. All analyses were carried out using SPSS v.22. Three additional mediation models were then computed to ensure that our results were accurate and not due to the influence of external variables. First, we wanted to establish if the order of the identification measures were influential—something that would speak to the importance of group compatibility in new group acquisition—so the order of these two variables were reversed, i.e., community identification influencing religious identification. Second, participants who indicated that they had no religion were removed from the dataset. This was because while all participants were automatically part of the community group because of their residence (determined by a screening question prior to participation in the survey), all participants did not self-categorize with a religious group. Therefore, we wanted to ensure that any effects found were not overly influenced by this subpopulation who did not claim membership of both groups, particularly as preliminary analysis revealed high correlations between the dichotomous measure of religious self-categorization and study measures (see Table 1). Third, religious attendance was added as a covariate to ensure that it was religious identification and not simply attendance at formal religious gatherings (where social interaction would also be facilitated), influencing any effects found.

Results

Investigation of H1

An ANOVA revealed a significant difference in perceived stigma of mental health between the three groups (those who identified strongly with both religion and community, those who identified strongly with one group only, and those who did not identify strongly with either group), $F(2, 623) = 7.73$, $p < .001$, $η^2 = .03$. Pairwise comparisons revealed that those who identified strongly with both religion and community ($n = 173$, $M = 3.17$, $SD = .88$) had significantly lower perceived stigma of mental ill-health than those who identified strongly with only one group ($n = 260$, $M = 3.41$, $SD = .90$; $p < .01$), and those who did not identify strongly with either group ($n = 193$, $M = 3.54$, $SD = .97$; $p = .02$). A second univariate ANOVA with perceived social support as the
dependent variable again revealed significant differences between the three groups \( F(2, 623) = 16.51, p < .001, \eta^2 = .05; \) see Fig. 1). Pairwise comparisons adjusted using the Bonferroni correction revealed significantly higher levels of perceived social support among those who identified strongly with both religion and community group (\( M = 4.14, \ SD = .86 \)) than those who identified strongly with only one group (\( M = 3.73, \ SD = .99; p < .001 \)), or those who did not identify strongly with either group (\( M = 3.55, \ SD = 1.08, p < .001 \)). For a depiction of these effects, see Fig. 1.

Investigation of H2 & H3

Serial mediation analysis tested our hypothesis (H2) that community identification (\( m_1 \)) and perceived social support (\( m_2 \)) would explain the relationship between religious identification and perceived stigma of mental ill-health. We predicted that religious identification would increase community identification (H3), which in turn would increase perceived social support from community members and result in lower perceived stigma of mental health among community members.

Our hypothesis, H2, was supported, as the indirect effect of religious identification on stigma of mental health via community identification and social support was significant, \( B = -.01, SE = .002; 95\% CI (-.01, -.003) \). The combination of these variables accounted for 10% of the variance in perceived stigma of mental ill-health (\( F[3, 622] = 22.31, p < .001 \)). The direct effect of religious identification on stigma of mental health was not significant, \( B < -.001 \ SE = .01, 95\% CI (-.03, .03) \). However, religious identification results in increased community identification, \( B = .50, SE = .09, 95\% CI (.32, .67) \), supporting our second hypothesis (H2), which in turn has a positive relationship with perceptions of social support, \( B = .05, SE = .01, 95\% CI (.03, .06) \). Finally, social support has a negative relationship with perceived stigma of mental ill-health, \( B = -.21, SE = .04, 95\% CI (-.28, -.13) \). This means that those with higher levels of religious identification display higher levels of community identification, and thus higher levels of perceived social support from their community. This in turn leads them to perceive there to be lower levels of mental ill-health stigma among community members. Fig. 2 depicts the size and direction of effects.

Additional Analyses

The serially mediated model outlined above remained significant when religious attendance was added as a covariate. Religious attendance was not significantly related to

![Fig. 1](Mean scores for (a) perceived social support, and (b) perceived stigma of mental ill-health based on strength of identification with religious and community groups. LL, low identification with both groups; HL, high identification with one group, low identification with the other; HH, high identification with both groups.)

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**Table 1** Descriptive statistics and Pearson’s correlations for study variables

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<th>M</th>
<th>SD</th>
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<th>7</th>
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<tbody>
<tr>
<td>1. Gender</td>
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<tr>
<td>2. Age</td>
<td>25.97</td>
<td>12.68</td>
<td>–04</td>
<td>.10*</td>
<td>.37**</td>
<td>–</td>
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<td>3. Religious identification</td>
<td>4.83</td>
<td>2.61</td>
<td>.10*</td>
<td>.19**</td>
<td>.22**</td>
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<td>4. Community identification</td>
<td>18.34</td>
<td>5.96</td>
<td>.03</td>
<td>.05</td>
<td>.07</td>
<td>.12**</td>
<td>–29**</td>
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<td>5. Social support</td>
<td>3.79</td>
<td>1.01</td>
<td>–04</td>
<td>.06</td>
<td>.07</td>
<td>.12**</td>
<td>.29**</td>
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<td>6. Stigma of mental ill-health</td>
<td>3.38</td>
<td>.92</td>
<td>–04</td>
<td>.06</td>
<td>.07</td>
<td>.12**</td>
<td>.29**</td>
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<td>7. Religious attendance</td>
<td>–</td>
<td>–</td>
<td>–21**</td>
<td>–13**</td>
<td>–83**</td>
<td>–11**</td>
<td>–04</td>
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Note: *p < .05 **p < .01, two-tailed.
community identity, social support, or stigma of mental ill-health ($p > .07$ for all). A second model whereby the identification measures were reversed (community identification predicting religious identification) was then tested to determine if the ordering of identification measures in our model was important. While the overall model was the same as reported above and thus significant, as was the direct effect of community identity on stigma of mental ill-health ($B = -.03$, $SE = .01$, 95% CI $[-.04, -.02]$), the serially mediated pathway of community identity to mental ill-health stigma via religious identity and social support was not, $B = -.001$, $SE = .001$, 95% CI $(-.001, <.001)$. A further model where participants who indicated that they had no religion ($n = 120$) were removed from the dataset also maintained the serially mediated pathway outlined above in the main analyses (religious identification $\rightarrow$ community identification $\rightarrow$ social support $\rightarrow$ stigma of mental ill-health; $n = 506$, $B = -.01$, $SE = .002$, 95% CI $(-.01, -.002)$).

**Discussion**

**Evidencing the Beneficial Nature of Groups**

Previous research has demonstrated how group memberships and social identity processes can bolster social resources resulting in positive psychological outcomes for group members (Jetten et al., 2012; Muldoon & Lowe, 2012). The current study reinforced this finding and extended evidence of the beneficial nature of multiple group memberships and group identification to a reduction in the perceived stigma of mental ill-health, which is a crucial determinant of help-seeking behavior and diagnosis of mental health problems.

At first glance, these findings may appear to conflict with previous research demonstrating that when study variables are reversed, stigma results in lower social identification, lower perceived social support, with negative outcomes for health and well-being (e.g., Jay et al., under review). However, the important difference here is that the current study sample represents a community cohort without a personally stigmatized identity, thus differing vastly from previous research that focused on felt stigma where the study sample was personally affected. Taken together, these findings lead to an interesting paradox whereby stigma, including the stigma of mental ill-health, can inhibit group identification and lead to individuals who are struggling with such issues turning away from a group for fear of judgment when, in fact, to deal with stigma and experience the acceptance of mental health issues among peers, they need to turn toward the group. By doing so, they gain from their group membership in terms of health and well-being (e.g., Jetten et al., 2012).

Of note in the current study is that participants perceived stigma surrounding mental health problems to be present within their community, yet remained willing to offer social support to group members and reject this stigma. That such stigma rejection was demonstrated within reasonably distal or abstract groups (religion and community) as opposed to tight-knit, well-established groups (e.g., family, work colleagues) is especially promising: it is not just being nice to those personally known to us that is important—it is about being inclusive and understanding to those whom we perceive as being similar by virtue of being in our community or subscribing to the same religion.

**Strength of Identification and Group Content as Influential Factors**

Although a growing body of research points to the beneficial nature of group memberships—including this study—simply being a member of different social groups is not where the story ends. Here, we demonstrated that it is not only membership of multiple groups, but also the strength
of identification with and content of groups that can impact upon social and psychological outcomes. In this study, those who identified strongly with both religious and community groups demonstrated increased social support and lower perceived stigma of mental ill-health when compared with those who claimed membership of these groups, but did not identify strongly with them. This study also showed that the two groups examined were not equal when it came to influencing outcomes, but rather that the content of the group is important. Religious group membership, while having an influential position in Irish community settings, did not significantly impact upon the stigma of mental ill-health, or indeed social support once community identification was included in the model. These findings reinforce the importance of considering the content and strength of identification with groups in study designs; measuring the number of group memberships alone is not sufficient.

Identity Amplification and Group Compatibility

This study further revealed that the content of a group is important not only for predicting social and psychological factors, but also for new group acquisition. We showed that identification with one social group (religion) can lead to the acquisition of an additional group membership (community) which, in turn, was shown to increase perceptions of social support and reduce the perceived stigma of mental ill-health in a serially mediated pathway. Again, this feeds into prior research demonstrating that existing group memberships can facilitate membership of new groups (Iyer et al., 2009). These findings are also novel in that they reiterate the importance of strength of identification with the ingroup(s) rather than solely focusing on the number of group memberships, and provide evidence that one group can be a building block for another—perhaps through enactment of identity giving access to belonging, something that has previously been suggested by Walsh et al. (2015). What is notable is that this finding differed based on the order in which identification variables were entered in the model. The identification amplification pathway demonstrated in the current study was that religious identification facilitated community identification and thus social support; a mediation pathway with these two variables reversed was found not to be significant. This reiterates findings by Iyer et al. (2009) that when it comes to one group identity facilitating another, the type of the original identity matters, with group compatibility needed for new group acquisition.

Religion is a unique type of identity due to expectations around participation in organized, formal activities (Ysseldyk, Matheson & Anisman, 2010), thereby facilitating social interaction with other group members who will likely live in close proximity and therefore represents a key link to the locality in which a person resides. Due to such social interactions with proximal others enabled by religious identification and engagement, we believe that this may have harnessed community ties and consequently aided community identification within our sample. As to why the identification pathway did not work in reverse, it is less likely that a person would affiliate themselves with a religious group simply because of identification with others in their community—subscribing to a religion involves adopting a particular set of beliefs and practices that the individual may not necessarily agree with, and so in reverse these two groups may be incompatible. This finding adds to literature highlighting the powerful nature of religion as an identity (Ysseldyk et al., 2010); indeed, religion may be viewed as a gateway identity leading to new group acquisition due to high levels of compatibility with a wide range of other groups.

Study Limitations and Directions for Future Research

The primary limitations in this study are linked to the study design and inclusion of only specified social group memberships. As we were interested in how the strength of group identification influenced study measures rather than the number of group memberships, we decided to select two groups that we felt had a particular relevance within a local area, and focus on participants’ identification with these groups only. There are, of course, additional groups within communities from which those local to the area derive support and friendship and which may influence attitudes toward social issues; for example, sports, drama, or senior groups. Future studies should consider allowing participants to indicate levels of identification with self-selected and self-defined groups to avoid overlooking their potentially prominent influence. This would also help to alleviate a potential issue in this in that one of the prescribed groups, community, may have a very broad interpretation.

Furthermore, as noted above, the two identity measures included in this study were not equal in their relationship with our study measures, with community identification having the strongest influence on both perceived social support and stigma of mental ill-health. This may be due in part to the content of the identity, as was discussed previously, but also to the measurement of study variables. Religious identification was measured using items from an intrinsic religiosity scale (DUREL; Koenig & Büssing, 2010), that may reflect religious centrality to a greater extent than religious identification. An additional limitation of the current study is that it does not measure past experience with mental ill-health and help-seeking, either from a personal perspective or through familial ties. As past experience with mental ill-health is likely to influence
future perceptions of public stigma, this is something that should be included in future research. Future research could also usefully consider an exploration of specific types of social support (e.g., emotional/informational support, affectionate support, positive social interaction, tangible support, etc.) to assess which subscales may have particular relevance for explaining the relationship with perceived stigma observed in this study. Finally, conclusions from this study are limited by the cross-sectional design. Although the data is part of a larger longitudinal study that is still underway, this study includes measures taken at one time point only. As such, it is impossible to make causal inferences based on present findings, but these findings do pinpoint areas for investigation once the longitudinal study is complete.

Conclusions and Implications for Provision of Mental Health Services

The contribution of this study lies not only in the theoretical domain by adding to the evidence base of social identification and group membership, but also in applied settings, with specific reference to mental health service provision. That group identification was shown to be associated, via social support, with decreased perceptions of mental ill-health stigma is a crucial finding given the localities in which the current research was conducted. The two towns included in the study are sites where community-based mental health services are about to be rolled out, as they are subject to rates of suicide and self-harm above the national average (National Suicide Research Foundation, 2016). Perceived public stigma of mental ill-health has previously been shown to be a significant barrier to help-seeking behavior (Corrigan, 2004), particularly when that stigma is evident among a person’s in-group (Kearns et al., 2015). If group identification can, as this study suggests, reduce this barrier, this may facilitate the uptake of vital support services that are due to be implemented by those who need them the most.

A problem still exists, however, whereby those struggling with issues related to mental health are less likely to feel part of groups in the first place—due in part to stigma (McNamara, Stevenson & Muldoon, 2013). As such those who are stigmatized can miss out on the associated benefits of group membership, including awareness of stigma rejection among group members, as was seen in the current study. Going forward, efforts need to be made to ensure that individuals within communities and social groups that have been personally affected by issues related to mental ill-health and suicide are made aware of the support and lack of judgment among their peers, in the hope of increasing both group identification and help-seeking behavior. This may be achieved through actively and publicly vocalizing support and understanding for individuals struggling with mental health issues. The roll-out of new community-based mental health services offer an ideal opportunity to achieve this, and is something that should be capitalized on by community, religious and other groups local to the area by lending their support to such initiatives.

Acknowledgments This research was funded by the Irish Research Council Enterprise Partnership Scheme in conjunction with Pieta House (EPSPG/2014/74).

Conflict of Interest

The authors declare that there are no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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