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THE IMPACT OF PREJUDICE ON MENTAL HEALTH OF YOUNG ADULTS

[1] Ms. Nihareeka Ranka, [2] Dr. Arpita Kackar

[1]Research scholar, [2] Assistant professor
[1]Department of psychology,
[1]Jai Narain Vyas University, Jodhpur, India

Abstract : Prejudice inevitably has effect on mental health. The present study aims to understand the impact of prejudice on mental health of young adults. The objective of this investigation is to highlight the negative beliefs and attitudes of people toward caste that lead to prejudice, which in turn have devastating effect on their own mental health. This study intends to understand the aspects of caste prejudice that lead to very strong negative consequences on mental health. An empirical investigation was conducted on sample of twenty-five young individuals to assess the effect of caste prejudice on overall mental health. Wherein, six dimensions such as Positive self-evolution, Perception of reality, Integration of personality, Autonomy, Group oriented attitudes and Environmental Competence were analyzed to understand the overall mental health of people with prejudice. The findings indicated that there was no significant difference between both the scales suggesting prejudice have no effect on mental health. However, scores also indicated notable gap between the mean score of both the scales suggesting individuals with believe in caste system experiences average to poor mental health as consequences of stigma and lack of seeking help from out group.

IndexTerms - Mental health, Prejudice, Caste, Group, Attitude.

I.INTRODUCTION

The word prejudice is of Latin origin, pre meaning "before" and prejudice stemming from "judged." Prejudice is a negative attitude about members of a group. Prejudice translated into behavior is called discrimination, behaving differently, usually unfairly, toward group members. Prejudice often develops through stereotypes, fixed, simplistic (usually wrong) conceptions of traits, behaviors, and attitudes of a particular group of people. "Prejudiced attitudes are irrational, unjust, or intolerant dispositions towards other groups. They are often accompanied by stereotyping. This is the attribution of supposed characteristics of the whole group to all its individual members" Milner. (1973).

Allport, G. W. (1954) In his work, The Nature of Prejudice, explains that as early as five years old we realize that we are a part of certain groups. These groups (i.e., gender, race, religion, class) are not of our choosing at this point but are assigned to us. We also assume that they are good. Until we are a little older (age nine or so) we won't be able to compare ourselves to other groups on a conscious level, but we will have already developed loyalty to our categories by then. We have also judged others and put them in boxes as well. This is the way our brains make sense of things. Dozo,N.(2015) from their study suggested that gendered prejudice is a complex phenomenon and the underlying motivations are not easily understood from any one particular theory or method of study. Ekehammar, Bo. (2003) In their study “Gender differences in implicit prejudice. Personality and Individual Differences.” Found that men scored higher on explicit prejudice than women. Hoxter, A. & Lester, David.(1994) Stated that women showed less ethnic prejudice than men on a social-distance measure for greater social distance (friendship and living in the neighbourhood) but not for less social distance (marriage). According to Mange J.& Lepastourel N.(2013) Men generally express more negative attitudes than women toward homosexuals. Their study exhibit that stimulating an anti-prejudice norm hinders their attitudes toward homosexuals while, stimulating a prejudiced norm eases expression of male’s negative attitudes toward homosexuals.

Gilbert, G. M. (1951) On the basis of his research stated that the present generation of college students is disinclined to make stereotyped generalizations about the trait of ethnic groups, especially those with whom they have had little contact." Generalizations made tend to be based more on cultural and historical realities and less on fictitious caricatures or parent’s prejudices.

Causes of prejudice: While the causes of prejudice are complex, the following have been suggested as methods of acquiring prejudiced beliefs.

- *Social learning*: Children learn prejudice by watching parents and friends.
- *Motivational theory*: People motivated to achieve success develop negative views about competitors and generalize those views to all members of the competitors' group.
- *Personality theory*: People develop prejudices because of experiences during their development. For example, a person reared by a red-haired authoritarian woman who uses physical punishment may develop a prejudice against all women with red hair.
- *Cognitive theory*: People conceptualize their world by using mental shortcuts to organize it, for example, by thinking such things as “all homeless people are alike.”

People frequently define health as the absence of subjective symptoms of illness or injuries, like pain or nausea, or of objective warning indications that the body isn't functioning properly, such measured high blood pressure (Birren &Zarit, 1985; Thoresen, 1984). However, disease and wellbeing are not wholly distinct ideas; rather, they overlap, with differing degrees of illness and wellness existing along a continuum with a state of neutrality in the middle. Optimal health and death are at either end (Sarafino, 2002). Health is the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain (Park,2011). As a result, the term "health" refers to a range of positive states of physiological, psychological, and social wellness as instead of simply the absence of injury or disease. Thus, it is characterised by variances in healthful symptoms and behaviours.

Dimensions of Health

Social, physical, emotional, mental, and spiritual are the five factors that comprise the dimensions of health. All five of these health-related factors work together to create a complete picture of health, and any change in one of them will have an impact on the others either directly or indirectly.

Physical: A physical dimension of health is nothing more than a physical aspect or biological aspect of health. This points to the increasingly conventional definition of health as the absence of illness, injury, or disease like diabetes, cancer, hypertension, or cardiovascular disease. Since a decline in physical health can lead to reduction in all forms of health, physical health can affect various aspects of health. An individual who suddenly get cold, usually isolated socially in order to avoid contaminate others, may feel troubled as a result of one's isolation.

Social: When we discuss the social dimensions of health, we are referring to an individual's ability to sustain and form important life relationships. High-quality social health involves not only forming relationships, but also sustaining and behaving properly, as well as preserving socially acceptable criteria. The family is the most fundamental social entity of interaction that has a direct impact on a person's life. Social networks, close friends, youth leaders, and teachers are all part of a fundamental interaction that affects anyone's social life. The Social Dimension has an impact on the other dimensions as well. For example, if a person has a poor social life, it might lead to an issue of being lonely and unsatisfied with one's life's purpose.

Spiritual: Spiritual health refers to an understanding of life's overall goal. Individuals used to find their life's purpose through faith or belief systems, while others created their own. A person with a purpose in life is believed to have a better and healthier life than those who do not.

Emotional: The emotional dimension of health refers to an individual's emotional state and mood. When a person is in a good emotional state and in a good mood, we refer to that as having excellent emotional health. It is strongly linked to our self-esteem and our ability to control and manage our emotions in order to maintain a realistic perspective of the situation.

Other dimensions of health are significantly influenced and are related to mental health because a person with good dignity is much more positive in a social context, delivers significantly in physical activity, and makes friends easily.

Mental health

Mental health refers to our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also impacts in what way we deal with stress, interact with others, and make decisions. It is a state in which each individual can act effectively towards himself or herself and in their specific group; in general, it is the absence of mental illness. Mental health is about enhancing abilities and helping Individuals and communities to attain their self-determined goals throughout life, from childhood and adolescence to adulthood as mental health has a direct or indirect impact on other aspects of health. World Health Organization (WHO) defines "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community".

In recent years, a new definition of mental health was proposed by Galderisi et al. (2015), who defined mental health as: "a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium."

Jahoda,M. (1958), devised a list of characteristics that are present in the majority of people who are regarded as normal. Known as Ideal Mental Health, these were: Efficient self-perception, Realistic self-esteem and acceptance, Voluntary control of behaviour, True perception of the world, sustaining relationships and giving affection, Self-direction and productivity.

The impact of poor mental health is often overlooked or ignored. Common issues such as stress, problems at home, feeling anxious or sad, a problem in interpersonal relationships, too much worry, trauma, the loss of a loved one, biological factors, life events, and a family history can have a great impact on one's mental health. Suicide is considered one of the leading causes of death, and which is ranked third in the global burden of disease and is projected to be the major cause for morbidity by 2030. People with mental health issues represent a significant proportion of the world's population. Millions of people worldwide have mental health problems, as it is estimated that one in four people globally will experience a mental illness in their lifetime. F., & Hasin, D. S. (2012). revealed gender differences in prevalence were systematic such that women showed higher rates of mood and anxiety disorders, and men showed higher rates of antisocial personality and substance use disorders.

According to "National Institute of Mental Health", women are more prone to experience severe mental illness than men. Those ages 18 to 25 are most likely to experience a severe mental illness. People with a multi-ethnic background are also possibly experience more serious mental illness than people of other ethnicities. Malhotra, S., & Shah, R. (2015). suggested that differences between genders have been reported in the age of onset of symptoms, clinical features, frequency of psychotic symptoms, course, social adjustment, and long-term outcome of severe mental disorders. Women who abuse alcohol or drugs are more likely to attribute their drinking to a traumatic event or a stressor and are more likely to have been sexually or physically abused than other women. Girls from nuclear families and women married at a very young age are at a higher risk for attempted suicide and self-harm. Social factors and gender specific factors determine the prevalence and course of mental disorders in female sufferers. Droogenbroeck, F., Spruyt, B. & Keppens, G.(2018). Revealed that girls and young people with poor social support experience mental health problems such as psychological distress, anxiety and depression more frequently than boys and those with strong social support.

(Eaton, N. R., et al., 2009). In their meta-analytic review stated that perceived discrimination has a considerable negative consequence on both mental and physical health. Perceived discrimination also yield notable heightened stress responses and is related to participation in unhealthy and nonparticipation in healthy behaviours. Williams, D. R., & Mohammed, S. A. (2009). Suggested Perceived discrimination has also been linked to specific types of physical health problems, such as hypertension, self-reported poor health, and

breast cancer, as well as potential risk factors for disease, such as obesity, high blood pressure, and substance use. Wilson, E. C., Chen, Y. H., Arayasirikul, S., Raymond, H. F., & McFarland, W. (2016).

In there study reported that high transgender-based discrimination was significantly associated with greater odds of PTSD, depression and stress related to suicidal thoughts. High racial discrimination was significantly associated with greater odds of psychological stress, PTSD and stress related to suicidal thoughts. David R. Williams, MPH Jourdyn A. Lawrence MPH Brigette A. (2019) in their study concluded that racial discrimination is an emerging risk factor for disease and a contributor to racial disparities in health and also suggests that discrimination can affect the health of children and adolescents. D.J.A. Edwards (1984) in his study found that blacks were most Cynical about the white group and rated them lower than blacks or coloureds on Trustworthiness and on Altruism. Unexpectedly, white respondents had a relatively unfavourable perception of their own group, rating it lower than other groups on Trustworthiness, Altruism (female respondents only) and Conventional Goodness and having the highest Cynicism scores for their own group. Whites perceived Indians particularly favourably, rating them high on Trustworthiness, Altruism, Conventional Goodness, Independence and Strength of Will/Rationality, and being least Cynical about them. Whites rated blacks low on Strength of Will/Rationality which was interpreted to mean that blacks were perceived to have low internal locus of control.

Dunbar, E. (1997). In his investigation associated Primary DSM-IV diagnosis, General Adaptive Functioning scores, personality disorder criteria, and Minnesota Multiphasic Personality Inventory scale scores were examined in relationship to Prejudice Scale scores and client outgroup attributions. Results of Multivariate analysis of variance indicated that clinician ratings of outgroup bias were significantly related with the Axis II criteria for Paranoid, Borderline, and Antisocial disorders. Both Prejudice Scale scores and clinician ratings of client outgroup bias were significantly related to greater psychopathology, as reflected by lower General Adaptive Functioning scores assigned at the initiation of treatment. Pachter, L. M., Caldwell, C. H., Jackson, J. S., & Bernstein, B. A. (2018). Analysed 90% of African American and 87% of Afro Caribbean youth experienced discrimination. Discrimination was significantly associated with lifetime and twelve-month major depression, and lifetime and twelve-month anxiety.

II.OBJECTIVES OF THE STUDY

- To study the relationship between caste prejudice and mental health.
- To highlight the negative beliefs and attitudes of people toward caste that lead to prejudice, which in turn have devastating effect on their own mental health.
- To understand the aspects of caste prejudice that lead to very strong negative consequences on mental health.

III.HYPOTHESIS OF THE STUDY

H_1: There would be significant difference between Caste Prejudice and Mental Health.

H_2: Subjects of prejudice group will score high on mental health problems.

IV.RESEARCH METHODOLOGY

2.1. Population and Sample

Sample consisted of 20 young adults ranging from 18-30 years.

2.2. Research design

Random purposive research design was use to collect the data.

2.3. Tool used

The Indian Caste Prejudice Scale by Dr. Sheo Nath Singh and Dr. Ram Naresh Prasad: This caste prejudice scale consists of 44 items which are divided into four areas namely Political, Social and Economic Gain (PSEG); Marriage and Interpersonal Relation (MIR); Personal Qualities (PQ); and Education, Employment and Inhabitation (EEI). This scale intends to measure high and low caste prejudice, based on the assumption that high scorers on the scale will be more caste prejudiced whereas low scorers will be less caste prejudice.

Mental Health Inventory by Dr. Jagdish and Dr. AK Srivastava: The Mental Health Inventory consist of 56 statements measuring 6 dimensions namely positive self-evolution, perception of reality, integration of personality, autonomy, group-oriented attitudes, environmental competence. It is based on 4-point Likert scale ranging from “always” to “never”. It is design to measure mental health of normal individuals where low scores indicate poor mental health and high scores indicate good mental health.

2.4. Procedure

In this study subjects were asked to fill mental health and caste prejudice questionnaire with informed consent. They were completely acknowledged about the purpose of the study and were instructed well to fill the questionnaire as per the manual. Data was collected by using The Indian Caste Prejudice scale and Mental Health Inventory. The Indian caste prejudice scale was applied to large population out of which twenty subjects including male and females with high caste prejudice were selected, they were further asked to fill Mental health Inventory. There after scores were computed and data was arranged for statistical analyses. The statistical analyses of scores were carried out with the help of MS Excel to investigate the relationship between both the variables.

V.RESULTS AND DISCUSSION

5.1 Results of Statistical analysis of Study Variables

Table 5.1: Mean and Standard deviation of Mental Health and Caste Prejudice Scores.

Variables	N	Mean	SD	t
Caste Prejudice	20	135.55	26.30	0.074
Mental Health	20	147.7	18.00	

As per the table 5.1 shown, findings of the present study suggest that there is no significant difference between the caste prejudice and mental health as calculated “t” (0.074) value is smaller than the table value at both the level (0.05 and 0.01). Although the mean score of prejudice scale (M=135.55) is lower than the mental health score (M= 147.7) yet mental health is not influenced by prejudice. Jadhav

S., Mosse D., & Dostale, N. (2016) In their study suggested that caste is at once silenced and yet noisier than ever, and views on caste and caste-based discrimination are both diverse and socially dividing. In the contemporary moment caste is simultaneously weakened and strengthened. Predictably, the view of caste as benign or threatening, opportunity or constraint, an orientalist abuse of Indian culture or an abuse of human rights needing the attention of the United Nations, depends upon people's social position and the freedoms they relish.

Today's era is an era of globalization where individuals are coming out of their home early in life and get to interact with people of different beliefs and caste. The assumptions and stereotypes which were made early in life by the primary group easily get shelved in individuals' life as they interact with people. The belief regarding caste is becoming meaningless. As far as mental health is concerned there are various factors influencing it such as family environment, personal abilities, expectation toward life, life challenges, achievement of life goal, interpersonal relationships, and frustration are some of the determinant factors. So, it becomes difficult to say that prejudice is the sole determinant effecting mental health. Gupta, A., & Coffey, D. (2020) In their self-reported mental health survey between the dominant social group (higher caste Hindus) and two marginalized social groups (Scheduled Castes and Muslims) found that differences in socioeconomic status cannot fully explain the large disparities in mental health, especially for Muslims. Findings emphasized the necessity for research to understand the causes and consequences of mental health problems in India, and for policies to move beyond redistribution and address discrimination towards Scheduled Castes and Muslims. Husain, N., & Naqvi, T.F. (2019) also revealed that there is no link between perceived discrimination and mental health. However, it was discovered that students perceived discrimination based on their caste and identity. According to the findings, 4% of scheduled caste students experienced extreme depression, while 69% of SC, ST, and OBC students experienced moderate to severe depression. It was discovered that 64% of marginalized students experienced high to moderate levels of anxiety. It is possible to conclude that there is a significant relationship between Caste Types and Depression Levels.

VI.CONCLUSION

In the present study it was inferred that there was link no between the caste prejudice and mental health of young adults. Therefore, both the hypothesis was rejected. Finding also portray that mean scores of caste prejudice and mental health had substantial difference.

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