Volume 3, Issue 1, 2025

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

PREDICTING ROLE AND PREVALENCE OF PREJUDICE, DISCRIMINATION AND SOCIAL INCLUSION AMONG HEALTHY POPULATION

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DOI: https://doi.org/10.5281/zenodo.15081441

Keywords

prejudice, Discrimination, Social Inclusion.

Article History

Received on 16 February 2025
Accepted on 16 March 2025
Published on 25 March 2025

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Abstract

Mental health disorders/illnesses are a significant cause of public health worry. They are being projected to affect up to 450 million people around the globe (World Health Organization, 2003). Consequently, the identification of prominent facets that can enhance or aggravate an individual's mental health is essential therefore this study endeavored to investigate the prevalence of stigma, prejudice, and discrimination towards people with mental illness and to the relationship among them. The sample comprised of participant (N = 191; Males n = 36, Females n = 155) age ranges from 18 to 59 years (M = 24.76, SD = 5.44) belonged to both nuclear and joint families of Karachi, Pakistan. To measure their stigma, prejudice, and discrimination, Prejudice Towards People with Mental Illness Kenny, Bizumic, & Griffiths, 2018), Devaluation-Discrimination Measure (Link, et al., 1991), and a self-developed social inclusion Scale (Bogardus format) were used, respectively. The findings revealed that the prejudicial attitude of the general population towards the people who are suffering from mental health illness/disorders is of moderate level i.e., most participants lie at a moderate level of prejudice, discrimination also lies at a moderate level where 33% of the participants are willing to include the people who suffer from mental illness as their partner and 31.4 % are ready to accept them in their family-depicting that people are being socially inclusive towards people with mental illness. Further the results also illustrate a significant negative relationship between prejudice and social inclusion, however, no significant relationship was observed with discrimination. The results support the notion of social inclusion and will aid future researchers to explore the factors that influence prejudicial beliefs, discriminatory behavior, and inclusive attitude in society.

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ISSN: (e) 3007-1607 (p) 3007-1593

INTRODUCTION

People suffering from mental illnesses are often subject to discrimination and stigmatization by the society and this has been going on from centuries in our culture. And because of these social consequences people don't often seek out for help (Schomerus & Angermeyer, 2008). There is always a negative connotation attached with the word 'mental illnesses'. According to WHO's report in 2001 around 25% of the population suffered from any mental disorder at some point in their lives, this percentage is believed to be increased 15 percent by the year 2020 (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003). Considering the high prevalence rate there are various treatment programs which are proven to be effective in reducing the problem and improving the functionality level of individuals who suffers with mental illness (Corrigan, 2004). Still, it has been reported that people do not seek out for help and even if they do, they often do not complete the treatment plan (Corrigan, 2004).

The reason behind this lack of help seeking attitude is the stigmatization, discrimination, and prejudice among other people regarding mental illnesses. According to labelling theory if we label the individual psychiatrically the negative stereotyping which is very common in society will be triggered and it will result in extreme discrimination against the people suffering from mental illnesses (Angermeyer & Matschinger, 2003). Hence the fear of public and apprehensions of being negatively labeled is a significant obstacle in a way of effective treatment and social inclusion of people with mental illness (Schulze & Angermeyer, 2003). Therefore, the current study aims to explore the current trend of the prejudice, discrimination, and attitude of social inclusion towards the people suffering with mental illness in the recent era of advancement and further to investigate their relationship to help the future researchers to formulate the strategies to enhance the attitude of inclusion in the society, to accommodate those who already goes through a lot instead of stigmatizing or labeling them.

Beneath the concept of stigma there are various other components such as stereotypes, prejudice, and discrimination (Corrigan, P. W., Shapiro, J. R., 2010). The process of stigmatization and discrimination develops in four stages: labeling, negative stereotyping, separation (Us and Them) and the loss of status and discrimination (Link & Phelan, 2001). Political, social, and economic status are the factors which shapes the prejudicial views and discrimination against mentally ill people. Among all these components the concept of prejudice has rarely been a focus of study with respect to mental illness and many scales which measures stigma either do not focus on prejudice or completely exclude it from measuring items (Fox, A. B., Earnshaw, V.A., Taverna, E. C., & Vogt, D., 2017).

Recently, Phelan et al. wrote: "the strong congeniality and large degree of overlap we found between models of stigma and prejudice should encourage scholars to reach across stigma/prejudice lines when searching for theory, methods, and empirical findings to guide their new endeavors" (Phelan, J. C., Link, B. G., & Dovidio, J. F., 2008). To investigate this phenomenon, we will use a definition of prejudice as a negative outgroup attitude. Stereotypes are different from prejudice and discrimination, people who agree with stereotypes and develop emotional reaction shows prejudice whereas people who acts on these prejudice shows discrimination.

Researchers believe that it is prejudice which creates discrimination and not the stereotypes against mentally ill people, it has been seen that stereotypes and discrimination has a poor correlation and prejudice is poorly correlated with stereotypes as well (Crocker, et al.,1998). Previous studies show two different clusters that reflect the prejudice of people with mental illness, first is authoritarianism (a belief that mentally ill people are inferior from other people) and benevolence i.e., kindness to unfortunate (Cohen and Struening, 1962).

The result of meta-analysis of 23 different studies showed that discrimination has a very little correlation with stereotypes (r =0.16) while with prejudice it has a significant correlation (r = 0.32), whereas prejudice and stereotypes are poorly correlated with each other as well (Dovidio and Gaertner, 1996). Along with the emerging trend of prejudice, discrimination and social inclusion, this study also focuses on the relationship of prejudice and discrimination against mentally ill people and social inclusion. A major factor that can plays a

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ISSN: (e) 3007-1607 (p) 3007-1593

significant role in reducing the stigma is social inclusion, it is person's willingness to engage the mentally ill people in activities such as hiring them as babysitter, dating them and renting them a room in a house with an aim to make them feel indifferent from others (Link, et al., 1987; Perm, et al., 1994; 1999).

It has been seen that many people who left the mental institutions after treatment were excluded from society. People with mental illness are often not given place in organizations (economic exclusion), denied their rights to vote, to marry and own land (political exclusion) and sociocultural exclusion as well (Corrigan, Markowitz, & Watson, 2004; Stuart, 2006), mental illness and social isolation both are linked with the early death (Holt-Lunstad et al., 2015; Whiteford, H. A. et al., 2013). However, a lot of psychologists who studied the motivational and cognitive thought processes behind the prejudice, discrimination and stereotypes against different groups has made a lot different methodological approaches for the study of mental health stigma (Crocker, et al., 1998; Fiske, 1998). But this study specifically aimed to check the relationship of prejudice and discrimination with the social inclusion of mentally ill people in society.

Significance and Rationale of The Study:

Since 2017, the prevalence of at least one psychological disorder has increased from 20.20 to 29.63 (Winkler, et al., 2020) this shows that the graph of the pervasiveness of mental illnesses keeps on changing throughout the years, it has been clear from the statistics that during the recent pandemic there has been a significant increase in mental illness, therefore this study aims to explore the trends of prejudice, discrimination and the social inclusion with the rise of mental illnesses amidst pandemic as the circumstances of physical isolation of people reflect their feeling of as being psychologically isolated as well (Kantar, kuczynski, 2020).

Throughout the era of advancement of social sciences, the stigma of mental illness has often been explained in terms of the cognitive and behavioral constructs of prejudice and discrimination, but they have never been examined as separate entities affecting the social acceptance or inclusion of people suffering from mental illnesses. Thus, along with their trends, this study also endeavors to evaluate the relationship among them so that the future researcher can benefit from it and can use it for devising effective strategies to elevate prejudice and discrimination to promote social inclusion. Prejudice is negative emotions towards any form of stereotype (Crocker et al., 1998) whereas discrimination is when people act on prejudices (Corrigan, Bink, 2016). This research mainly will focus on inspecting the trends of prejudice and discrimination respectively along with social inclusion from the perspective of the healthy population of the society.

Hypotheses:

1. There is a significant relationship of Social Inclusion, Prejudice and Discrimination towards people with mental health issue/illness.

Methodology

Research Design:

By conducting an exploratory study, the current research utilized quantitative correlational survey design to investigate the relationship among the pre-existing dependent and independent variables of Social Inclusion, Prejudice and Discrimination towards people with mental health issue/illness.

Participants:

The quantitative data was collected using purposive-convenient sampling method. The sample comprised (N = 191; Males n = 36, Females n = 155) with an age range of 18-59 years (M = 24.76, SD = 5.44). Participants were approached from nuclear and joint family system (f = 130, 68.1%) and joint (f = 61, 31.9%) families of Karachi, Pakistan (Table 1).

Inclusion/ Exclusion Criteria:

Participants were required to be citizen of Pakistan and should be older than 17-years. Whereas the Students of Psychology or any other mental health field were not included in the study to avoid the biasness of the previous knowledge.

Through the descriptive statistical analysis, Mean, Standard Deviation, Skewness, Kurtosis, Minimum and Maximum ranges of the continuous demographic variable (age) and Percentage and Frequency of participants' categorical demographic variables (gender, marital status, family structure,

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ISSN: (e) 3007-1607 (p) 3007-1593

family monthly income, education, employment, designation, medical illness, mental health illness, knowing, living or working with anyone with mental health illness, having neighbor or close friend with mental health illness and willingness to discusses own mental health with colleagues or family) were calculated which are mentioned in Table 1.

Table 1: *Frequency, Percentage, Mean, and Standard Deviation of the Demographic Variables (N = 191)*

Variable	*f*	%	M	*SD*
Age			24.76	5.44
Gender				
Male	36	18.8		
Female	155	81.2		
Marital Status				
Single	132	69.1		
Engaged	19	9.9		
Married	35	18.3		
Family Structure				
Nuclear	130	68.1		
Joint Family	61	31.9		
Family Monthly Income				
<15000	7	3.7		
16000-30000	16	8.4		
31000-50000	28	14.7		
51000-70000	44	23.0		
>71000	96	50.3		
Variable	f	%	M	SD
Education				
Matric	3	1.6		
Intermediate/ A/O level	16	8.4		
Undergraduate	109	57.1		
Postgraduate	63	33.0		
Employment				
Employed (including Volunteer)	54	28.3		
Unemployed	36	18.8		
Student	101	52.9		
Designation				
Student	71	37.2		
Owner	9	4.7		
Doctor	11	5.8		
Staff	25	13.1		
Manager	20	10.5		
Teacher	10	5.2		
Officer	5	2.6		
Not Applicable	40	20.9		
Suffered with any medical illness				
Yes	56	29.3		
No	129	67.5		

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Maybe	6	3.1		
Suffered with any mental illness				
Yes	102	53.4		
No	68	35.6		
Maybe	21	11.0		
Know anyone with any mental illness				
Yes	148	77.5		
No	43	22.5		
Lived with someone who suffers from mental illnesses				
Yes	93	48.7		
No	98	51.3		
Worked with someone who suffers from mental illnesses				
Yes	72	37.7		
No	119	62.3		
Have you had any neighbors that suffer from mental illnesses				
Yes	69	36.1		
No	122	63.9		
Have you or had a close friend who suffers from mental illnesses				
Yes	89	46.6		
No	102	53.4		
Comfortable discussing your mental health issues with your colleague				
Yes	107	56.0		
No	84	44.0		
Comfortable discussing your mental health issues with your family or friends				
Yes	128	67.0		
No	63	33.0		
Consult a mental health practitioner				
Yes	146	76.8		
No	45	23.5		
People suffering from mental illness are stigmatized currently?				
Yes	152	79.6		
No	39	20.4		

Note: f = frequency, % = percentage, M= mean, SD= Standard Deviation

The table shows that the participants belonged to nuclear and joint family system, but most of them live in nuclear family (f = 130, 68.1%). The participants' marital status was either single (f = 132, 69.1%), engaged (f = 19, 9.9%) or married (f = 35, 18.3%), their age ranged from 18 to 59 with the mean of 24.76 (SD = 5.44). However, their educational level was matric, intermediate/ A/O level, undergraduate and post-graduate where most of them studies at undergraduate level (f = 109, 57.1%).

The family monthly income was categorized as below 15000, 16000-30000, 31000-50000, 51000-70000, and above 71000, among which majority of the students had family income >70000 (f = 96, 50.3%) while only 7 students had family income <15000 (3.7%). Employment status was divided into employed, unemployed, and student among which most of the participants were students (f = 101, 52.9%). Majority of the participant never suffered with any medical illness (f = 129, 67.5%), but did suffered with mental illness (f = 102, 53.4%) and 21 participants were uncertain of having any mental illness (11.0%).

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Most of the participant knew someone suffering with mental illness (f = 148, 77.5%) while almost equal number of participants have either lived or no with someone having mental illness (f = 93, 48.7%), not lived (f = 98, 51.3%). Majority of the participant never worked or had neighbors or close friends suffering with mental illness (f = 119, 62.3%), (f = 122, 63.9%) & (f = 102, 53.4%) respectively. 107 participants were comfortable discussing their mental health issues with colleague (56%), 128 were comfortable discussing with family (67%) and 146 should willingness to consult a mental health practitioner if have any mental health issue (76.8). Majority of the participants believe that people with mental illness are stigmatized currently (f = 152, 79.6%).

Measures:

Informed Consent: The experimenter secured permission from participants to conduct the study. They were given a brief informed consent form which provided them the comprehensive details about the probable risk and benefits of the study. They were informed that all the information gathered during the research will be kept confidential. Their right to refuse to participate or withdraw at any time during the study without any consequences was mentioned clearly. It was made sure that their participation is completely voluntary, and they are not forced to be a part of the research. It was discussed that it is the sole duty of the researcher to address any concerns of participants before and after the beginning of the study (refer to Appendix A).

Demographic Information Sheet: A demographic form was generated which comprised of question related to personal information of the participants, including their name (optional), age, gender (male, female), residence (city/country/state), marital status (single, married, engaged), family structure (nuclear, joint), family monthly income (<15000, 16000-30000, 31000-50000, 51000-70000, >71000), education (matric, intermediate/ A/O level, undergraduate, post-graduate), employment (employed, unemployed, student), designation, suffered with medical illness, suffered with mental illness, knowing, living or working with anyone with mental health illness, having neighbor or close friend with mental health illness and willingness to discusses own mental health with colleagues or family, believe on are people with mental illness are currently stigmatized or not.

The following questionnaires were used: The Prejudice towards People with Mental Illness (PPMI) Scale (Kenny, Bizumic, & Griffiths, 2018), Devaluation-Discrimination Measure (Link, et al., 1991), and Social Inclusion Scale (Bogardus format).

Prejudice Towards People with Mental Illness: The Prejudice towards People with Mental Illness Scale (Kenny, Bizumic, & Griffiths, 2018) was used to measure the prejudice. It's a recently developed 28-item scale with the reliability of (a = .93). It consists of four subscales: fear/avoidance is an 8-item scale with (a = .89) reliability, 8 item's malevolence subscale with the reliability (a = .76), 6 item's authoritarianism subscale with (a = .76) reliability and 6 item's unpredictability scale with (a = .87) reliability. Scoring of the items was on a 9-point scale which starts from -4 (very strongly agree) through 0 (neutral) to 4 (very strongly agree). Scoring of the scale was calculated in a way that higher score indicated more negative attitude.

Devaluation-Discrimination Measure: To check how other people, discriminate individuals with mental illnesses 12-item Perceived Devaluation Discrimination Scale (Link et al., 1991) was used. The scoring of this scale was on a 6-point Likert scale which ranges from 1 (strongly agree) to 6 (strongly disagree) and the results were calculated by summing the items and then dividing it to 12. The high score indicates more stigma. The scale's overall reliability is (a = .78) whereas the untreated community cases has (a = .73) reliability and well members of the community has (a = .73) reliability. The statements indicate that people devalue clinically diagnosed people with mental illnesses and consider them inferior, intelligently incapable and someone whose opinions and thoughts are considered negligible. This scale is a revised version with items revised from "having had depression" rather than "having been treated for a mental illness."

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Ethical Consideration:

The researcher, while conducting this study, maintained a high level of objectivity and honesty in the whole process of collecting, analyzing data, and communicating findings. Collected data was processed without any sort of manipulation and all possible measures were also taken to eliminate bias from the analysis and interpretation of the findings. All-important procedures were carried out to guarantee participants' privacy, confidentiality, and consent. In particular, the participants were informed about the purpose and aim of the study, could make decision regarding participation and response selection. The participants were given a complete right to withdraw at any time without having to give an explanation.

Results

Results were computed by conducting a series of statistical analysis using the Statistical Package for Social Sciences (SPSS 21.0).

The statistical analysis of scales (Prejudice towards People with Mental Illness, 2018; Devaluation-Discrimination Measure, 2015), their Mean, S.D, Cronbach's Alpha Reliability Coefficient, Skewness, Kurtosis, Potential and Actual Ranges of the scales have been reported in Table 2. The potential range implies the minimum and maximum scores that can be achieved as per the scales' response set, whereas the actual range replicates the minimum and maximum scores of the present participants of the research on the respective scales. According to Bulmer (1979), the scale lies in the acceptable criteria for data to be considered normally distributed both Skewness and Kurtosis (Table 2).

Afterwards, descriptive statistics of frequency and percentages was run for the scales. Next the results of correlation and regression analysis are presented.

Table 2: Descriptive statistics and Cronbach's Alpha Reliability Coefficients, Bivariate Normality of the study variables (N = 191)

Variable	Items	a	M	*SD*	K	SK	Range	
							Actual	Potential
PPMI	28	.804	-1.20	2.56	.342	-.710	-	-
Fear/Avoidance	8	.770	-1.20	1.21	-.530	.143	-3.7-1.6	-4- 4
Unpredictability	6	.673	.574	1.02	-.025	.015	-2.3-3.6	-4- 4
Authoritarianism	6	.621	-.527	1.19	.484	-.571	-4-2.6	-4- 4
Malevolence	8	.604	-1.29	.982	-1.85	.170	-3.5-2.1	-4- 4
DD	12	.541	3.72	.640	1.13	.384	2-6	1-6
Social Inclusion	1	-	6.45	3.14	-.538	-1.04	0-9	0-9

Note: PPMI= Prejudice towards People with Mental Illness, DD= Devaluation -Discrimination, a = Cronbach's Alpha, M = Mean, SD = Standard Deviation, SK = Skewness, K = Kurtosis

The Cronbach's Alpha reliabilities of Prejudice towards People with Mental Illness (PPMI), Fear/Avoidance, Unpredictability, Authoritarianism, Malevolence and Devaluation-Discrimination scales mentioned in Table 3 are: a = 0.804, a = 0.770, a = 0.673, a = 0.621, a = 0.604, and a = 0.541, respectively. According to George and Malley (2003), PPMI scale lies in good range. Whereas Devaluation-Discrimination lies in questionable range.

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Table 3: ***Frequency, Percentage, of Prejudice towards people with mental illness, Devaluation-Discrimination and Social Inclusion (N = 191)***

	f	%
PPMI		
Low	16	8.4
Moderate	151	79.1
High	24	12.6
Devaluation-Discrimination		
Low	2	1.0
Moderate	137	71.7
High	52	27.2
Social Inclusion		
0	16	8.4
1	8	4.2
2	17	8.9
3	4	2.1
4	4	2.1
5	6	3.1
6	5	2.6
7	8	4.2
8	60	31.4
9	63	33.0

Note: PPMI= Prejudice towards People with Mental Illness, f = frequency

Above mentioned table shows brief summary of Prejudice, discrimination and social inclusion of the participants of the study.

Table 4: Pearson Correlation of Perceived Prejudice, Discrimination, and Social Inclusion (N = 191)

	1	2	3
1. PPMI	-	.087	-.336**
2. Devaluation-Discrimination	-	-	-.050
3. Social Inclusion	-	-	-

**p < .01

The above table explains that the prejudice towards people with mental illness has a negative correlation with social inclusion i.e., r = -.336.

Table 5:Regression Analysis with Prejudice towards People with Mental Illness as predictor and Social Inclusion as criterion (N = 191)

						95% CI	
Criterion	B	Sig	R	R^2	ΔR^2	LL	UL
Social Inclusion	-.336	.00	.336	.113	.108	-.577	-.246

Note: p < .01, β = Standardized regression coefficient, Sig = Significance, R^2 = R square, ΔR^2 = R^2 change, CI = Confidence interval, LL = Lower limit, UL = Upper limit.

Discussion

The prevalence of mental illness has tremendously increased throughout the globe, it is estimated that at least one psychological disorder soared from a baseline of 20.20 from 2017 to 29.63 in 2020 amidst of pandemic (Winkler, et al., 2020), the

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ISSN: (e) 3007-1607 (p) 3007-1593

pervasiveness of mental health issues throughout the cultures has been recognized (Lauber & Rosseler, 2007). Widespread mental health disorder such as, depression, anxiety, and substance abuse are a major contributor of the global stress of disease (Barber, et al., 2015), and according to WHO social exclusion is a major precursor of this hyped increment in mental disorder which is facilitated by stigma (WHO Social Exclusion Knowledge Network, 2008). Cultural experience plays a major role in determining mental health issues in respect to the perception, recognition, appreciations, determination of symptoms, and classification and discernment and labeling along with the treatment methodologies (Kleinman, 1977a; Kleinman, 1977b; Ng, 1997).

Stigma is a communal subjective process that incorporates prejudicial believes, discriminatory behavior, and inadequate knowledge of mental health issues/disorders (Thornicroft, Rose, Kassam, & Sartorius, 2007; Link, Yang, Phelan, & Collins, 2004). Therefore, this study aims to evaluate the current trend of prejudice, discrimination, and social inclusion of people suffering from mental illness to encourage the new researchers to work out new intervention to lessen the graph of mental health disorder by exploring these factors in our culture and devise more efficient techniques to help those suffering from mental health issues.

The current finding shows that the prejudicial attitude of the general population towards the people who are suffering from mental health illness/disorders is of moderate level i.e., most participants lie at a moderate level of prejudice. It illustrates that majority of the participant lies on the mid-point of the continuum and the prejudicial believes are neither at peak nor they are being eliminated from the society, this moderation may have occurred because of the current pandemic, it can be assumed that the pandemic has influenced the prejudicial beliefs of people regarding mental illness. As in the current circumstance, people are being more socially connected as compared to physical interactions, and the pandemic has provided us with more opportunities to interact with those we have not interacted with because of personal commitments and goals. Similarly, Thornicroft et al., (2009) in their study claim that social contact plays a vital role in improving and expanding the knowledge and attitude of people concerning the stigma of mental health.

This moderate level of prejudicial belief can be because of the increased psychological awareness campaign on mass media in the pandemic as it is evident from the literature that the intensified use of mass media can have prolific effects on reducing prejudice on short or medium terms (Clement, et al., 2013). Subsequently, it is preferred to continue the use of mass media campaigns on mental health issues as a strategy to nadir the stigma related to mental health problems. Moreover, as mass media campaigns can connect with a substantial number of audiences, even minor advantages will have an impact on the population level (Clement, et al., 2013).

Discrimination is often defined as the behavioral response to prejudicial believes (Crocker, Major, & Steele, 1998). Fullenwider, 1980 reports that the connotations attached with the distinction people do in support or against of any individual were always being extremely deprecatory, such as discrimination is often explained as the adverse, negative behavior or practices of majority groups towards the minorities i.e., people suffering from mental illness (e.g., Allport, 1954; Feagin & Eckberg, 1980). These behaviors and practices could be either observable or hidden actions deemed to exclude or distance oneself from minorities (Hecht, 1998). The present study shows similar evidence for discrimination i.e., most of the participants lie on a moderate level of discrimination. Morgan, (2007) in his study claim that poor mental health is also associated with social exclusion.

Often people with mental illnesses are exempted from jobs (economic exclusion), deprived of their rights to vote, to get married, or own any property (political exclusion), and treated as outcasts i.e., sociocultural exclusion. On the other hand, inclusion lifts the recovery processes of the people who suffer from any mental illness. Results of this study reflect that 33% of the participants are willing to include the people who suffer from mental illness as their partner and 31.4 % are ready to accept them in their family. This exemplifies that people are being socially inclusive towards people suffering from mental illnesses and this can significantly facilitate their recovery. Social inclusion has profuse effects on

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ISSN: (e) 3007-1607 (p) 3007-1593

accelerating mental health and abbreviating mental illness, it aids in encouraging recovery, and facilitates mental as well as physical health benefits (e.g., Boardman, 2003; Waddell & Burton, 2006; Whiteford, Cullen & Baingana, 2005). According to Global mental health, enhanced social inclusion is often highlighted as a key factor for augmenting individuals surviving with mental illness (Collins, Patel, & Joestl, et al., 2011; Carter, Satcher, & Coelho, 2013; Maj, 2011).

Conclusion

Overall, the present study justifies the main aim of the study and depicts that there is a moderate level of prevalence of prejudice and discrimination towards the people suffering from mental illness, whereas a significant number of participants are open to including them in their personal lives as well.

The second aim of the study endorses evaluating the relationship between these variables and the result partially supports the hypothesis that there is a significant relationship between prejudice towards people with mental illness and social inclusion whereas no significant relationship has been observed with the discrimination. The results represent a significant negative relation of prejudice with social inclusion that suggests that if social inclusion increases the prejudice will decrease or vice versa. As Esther (2007) postulate that inadequate knowledge of the causes, triggers, indicator, and appropriate treatment plans of mental illness along with insufficient contact with individuals who suffer from mental illness can result in prejudicial believes and derogatory attitude towards them which can consequently lead to social exclusion. Whereas, growing acknowledgment regarding different mental illnesses, additional media exposure and proper depiction of mental illnesses, and the paradigm shift from institutional to community treatment programs can promote social inclusion subsequently decreasing prejudice (Corrigan, 1998; Henry, Keys, Balcazar, & Jopp, 1996; Ineland et al., 2008).

Stigma often increases the negative repercussion of mental disorders which in turn can slow down the process of recovery. Those patients suffer from many inevitable complications for example discrimination, not getting proper rights, and not being hired for jobs. They also face difficulties in finding houses, getting enrolled in educational institutes, taking insurances, and accessing the basic rights of law as well as proper health facilities (Yamaguchi, Mino, & Uddin, 2011). Therefore, it is important to promote social inclusion that can reduce that prejudice subsequently will increase mental health. This study will aid in promoting future researchers to investigate the factors that affect prejudice, discrimination, and social inclusion. Thus, this study can serve as a baseline for the studies in this domain in our culture.

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