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The Relationship Between Discrimination, Emotional Dysregulation And Psychological Distress Among University Students

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ABSTRACT

The present study aim was to examine the correlation between Discrimination, Psychological distress and Difficulty in Emotion Regulation among universities student. The objective of study is to investigate the correlation between discrimination, psychological distress and emotional dysregulation. The population of this study was comprised of all enrolled students in HEC recognized universities in KPK. The sample size was selected 324 students, which contain both male and female. In order to measure the variables, we used Everyday Discrimination scale (EDS), Psychological Distress (PDS) and Difficulty in Emotion regulation scale (DERS). Quantitative survey methodology was used to collect the data by adopting convenient sampling technique. A valid standardization scales used in Google form then online questionnaire sent to the student through contacts and QR code. Data were analyzed through SPSS. The result revealed that there was positively significant relationship of Everyday Discrimination with the DERS sub scales Strategies, Non- acceptance, Impulse, Goal, and Clarity (r =.36, .34, .41, .20, .29) except Awareness which is negatively non-significant (r=.11).Furthermore, according to our hypothesis there is positively Significant relationship of Psychological Distress with sub-scales of Difficulty in Emotion Regulation Strategies, non-acceptance, impulse, goal, and clarity (r=.53, .43, .47, .38, .46) except Awareness which is negatively non-significant (r=.14).

Keywords: *Discrimination, Emotional Dysregulation, Psychological Distress, University Students, Mental Health*

Chapter-I
INTRODUCTION

Psychological problems are influenced by the individual differences in emotional processes, as the way individuals approach or control their emotions can have both immediate and long-term effects on their emotional state. Studies have shown the importance of emotional reactivity in psychological problems, with depression being associated with low and high levels of negative emotional response. Socially anxious individuals exhibit greater negativity towards social threats, while those with compulsions experience an increase in emotional behavior related to their emotions.

Several recent studies have examined the indirect influence of emotional reactivity on dysregulation, and their significance in understanding how these emotions are affected. Additionally, there is growing evidence that suggests deeper psychological processes may be necessary for understanding this phenomenon within individuals. By examining differences in emotional response, along with problems within the organization and control of emotions, one could gain insight into how psychopaths interact to explain symptoms associated with each emotion.

The impact of trait emotional reactivity on adolescents' ability to regulate depression symptoms can be explored more extensively in the future, as demonstrated by Fitzpatrick and Koo (2016) and others (2016). This study aimed to address this research gap by investigating the links between positive and negative emotional reactivity, as well as emotion dysregulation (the stimulus for feeling) and psychological distress. The research also examined the possible mediator effects of issues with emotion regulation in relating emotional response to psychological disturbance.[A]. The prediction was made that in a fully latent structural equation model, negative emotional reactivity dimensions of activation, intensity, and duration (along with multiple emotion regulation difficulties (e.g, non-acceptance, impulsivity)) would collectively indicate general dysregulation, while symptoms of depression, anxiety, or stress would indicate overall psychological distress. In order to mitigate difficulties in interpreting mediation results, an alternative model was also tested, which involved changing the emotional reactivity and emotion dysregulation positions. This model posited that, in the alternative one, negative emotional reactivity would either not account for the link between emotion dysregulation and psychological distress or had a less significant role in mediating than does this approach.

The mental health status of individuals is assessed by various constructs such as psychological distress, life satisfaction, depressive symptoms (Williams et al.). Multiple studies have demonstrated a correlation between being discriminated against and lower mental health outcomes and greater psychological distress (Araujo and Borrell 2006). In cases where individuals are not receiving clinical care, psychological distress has been effective in identifying potentially serious mental illnesses (Kesson 2002). Furthermore, Sellers (2003) has suggested that the perceived discrimination was positively associated with higher levels of distress. (A) This study aimed to investigate a model that suggests that negative emotional response can cause psychological harm (such as depression, anxiety, and stress) by altering the way emotions are controlled. Emotion regulation may be compromised by the experience of discrimination.

Chapter-II
LIRERATURE REVIEW

2.1 Discrimination and Psychological Distress

According to Williams and Collins (1995), racism has three major impacts on health: changing socioeconomic status among different racial/ethnic groups, restricting access to health-promoting services and goods, elevating psychological distress, which in turn negatively affects physical and mental health as well as health behaviors. The mental health status of individuals in this setting can be assessed

by a range of indicators such as psychological distress, life satisfaction levels, depressive symptoms and major depression, anxiety, and happiness levels (Williams et al, 2003). Research consistently indicates that discrimination experiences have a correlation with worse mental health outcomes and increased psychological distress (Araujo and Borrell, 2006). The health effects of discrimination against Puerto Rican children and adolescents in the Boston area were a major focus in (2003). Those who experience discrimination in areas other than race, such as gender and religion, were 23% more likely to report worse mental health outcomes according to Stuber et al. (2003). An initial study of the correlation between discrimination, coping, and health among Arab Americans found a significant link between self-reported discriminatory conduct and psychological harm caused by personal control (Moradi & Hasan, 2004).

Significant negative psychological effects, including depressive and anxiety symptoms, have been associated with perceived discrimination (Gamarel et al, 2012; Wu). Those who are discriminated against due to their economic status frequently exhibit greater levels of psychological distress. Evidence suggests that community workers' psychological symptoms are influenced by their perceived status as a minority (Hermanto et al, 2020). A different research indicates that minority populations experiencing racial discrimination are more likely to experience suicidal ideation (Wang et al, 2021).

Various factors that explain the ongoing health disparities have been examined, with racial discrimination (RD) being identified as one of the primary drivers of elevated levels of risk for various detrimental health effects, including physical and mental health issues. See also: Rosenthal et al. (2014); Probability analysis in 2014; Earlier studies have revealed that African-American pre-adolescents are the most susceptible to race-related discrimination, with 91% having experienced at least one such incident within their lifetime (Gibbons et al, 2004). Several cross-sectional studies have demonstrated that experiences of RD can lead to lower self-esteem, heightened anger and increased anxiety and depressive symptoms in the general population. Studies conducted on African-American youth have also revealed a correlation between racial discrimination and lower self-esteem, conduct issues, and depressive symptoms in both groups. Estrada Marinez et al. (2012, 2012).

According to Copeland-Linder et al. (2011), African-American adolescents are more susceptible to chronic, contextual or environmental stressors, such as racial discrimination (Gaylord-Harden and Cunningham, 2009), than their non-minority peers. Among African-American young women, interpersonal stress, RD, and other chronic psychosocial and environmental stressors are believed to be significant factors that increase the likelihood of depressive disorders and elevated depressive symptoms. There is a lack of research on factors that could potentially moderate the relationship between increased depressive symptoms in African-American female adolescents (Seaton et al, 2014).

Multiple studies have revealed that perceived discrimination is connected to a range of chronic conditions, including hypertension, cardiovascular diseases, and cognitive impairment, as well as mental health issues like anxiety, depression, or loneliness (White et al, 2020). Perceived discrimination is not only a significant issue for individuals' health but also contributes to disproportionately high disease burdens for families and society, as it is linked to all-cause mortality. There is a strong correlation between perceived discrimination and depression or depressive symptoms, which has been supported by numerous studies conducted in England and other countries.

When emotions are suppressed or avoided, ERD can lead to persistent worry and an unhealthy fixation on emotional stimuli, which can result in the development of generalized anxiety disorder. Despite taking into account factors such as worry, trait anxiety, and depressive symptoms, studies indicate that ERD is directly related to anxiety diagnosis [Mennin, Heimberg, Turk, Fresco 2005]. According to Golestaneh and Sarvghad, (2013), undergraduate students who engage in rumination (or "reflection analysis")

struggle more with worry, anxiety, and depression. Furthermore, self-blaming, rumination, and catastrophizing are frequently employed cognitive emotion regulation strategies that are problematic for depressed adults, as observed in Garnefski and Kraaij's (2006) study.

This transdiagnostic approach to understanding emotional dysregulation highlights its role in psychological instability and argues that targeted interventions can address emotion regulation skills in all types of disorders. The evidence points to a significant correlation between emotion regulation and subthreshold forms of PTSD, emphasizing the intricate connections that underlie trauma-related disorders. Through this connection, it is evident that interventions aimed at improving emotional regulation skills can also impact the underlying symptoms of PTSD, making treatment and management more likely. Studies have revealed a distinct link between emotional dysregulation (ED) and post-traumatic stress disorder (PTSS), but the exact relationship is not yet fully understood.

This study may help to delve deeper into the mechanisms that link emotional dysregulation with post-traumatic stress, potentially leading to more effective interventions for individuals in this age group. Based on the results, interventions designed to enhance emotional regulation could require consideration of the impact of traumatic early life experiences. The correlation demonstrates that managing affect and emotional regulation difficulties is an essential aspect of therapeutic interventions for BPD, particularly in individuals with a history of early trauma. These results support the idea that early negative experiences can lead to severe psychopathological conditions, and highlight the need for targeted therapeutic interventions that address these fundamental emotional regulation difficulties.

In a study of military individuals, it was found that the ability to handle psychological pain is linked with suicidal ideation (Shelef et al, 2015). However, other studies have shown otherwise. Consequently, it can be the case that certain individuals cannot tolerate psychological pain and, as a means of managing this, may resort to suicidal thoughts as an attempt to avoid experiencing this discomfort due to their difficulty in controlling emotions. Emotional dysregulation is likely linked to suicidal ideation, as suggested by the "cry of pain" and "three-step theories", which may lead to actual suicide if the individual has the capacity for it.

The developmental model of suicide proposed by Adam (1994) suggests that emotions are dysregulated due to both personal and internal working models. Both suicidal behaviors and BPD can be interpreted as disorders of emotion regulation, which is the basis for DBT's biosocial model. The aim of the DBT program is to teach skills that improve emotional management so people feel more at peace with themselves – and therefore, less often than others – and reduce suicidal ideation. The use of DBT to regulate emotions has been shown to significantly reduce the risk of suicidal behavior in individuals with BPD. The effective management of emotions can potentially decrease the occurrence of suicidal thoughts and behaviors, particularly in individuals with psychiatric disorders like borderline personality disorder.

The severity of PTSS was found to be positively linked to self-reported challenges in emotional acceptance, impulse control, and accessing effective emotion-regulation strategies, even after accounting for the general level of negative affect. This was not observed in studies published in 2007. Those with PTSD report an increased negative emotional reaction and decreased positive emotional responses to emotionally charged stimuli. Discussions by van der Kolk (1996) and others, which focus on marked difficulties in regulating emotions among those who have experienced chronic interpersonal trauma. The relationship between emotions and an individual's health has been a significant area of psychological research for decades, with reviews by Pandey and Choubey (2010) recently highlighting the renewed interest in this topic.

Health can be negatively affected by the suppression of emotions, alexithymia in understanding and communicating emotions (Pandey and Choubey (2009)), while positive emotional experiences or

emotional intelligence are often associated with mental health. Psychological and clinical trials (Gross and Munoz, 1995; Taylor & 2004) have shown that mental health and subjective well-being can be negatively affected by various affect-related deficiencies, such as difficulty in comprehending, communicating, and controlling emotions.

Initially, Alexithymia was associated with psychosomatic disorders but it has since been linked to a wider range of mental health issues such as depression and anxiety disorders. This includes eating disorders and interpersonal problems (Taylor, 2004; Bamonti et al, 2010; Lundh and Broman, 2006; Speranza & Vanheule (2007), 2003). The lack of empathy has been connected to a range of mental health issues, including depression, anxiety disorders, and PTSD. An individual's ability to understand and communicate emotions and regulate them is strongly correlated with good mental health and higher levels of subjective well-being.

2.2 Discrimination and Emotional Dysregulation

Moreover, depressed adults tend to use more problematic strategies for managing cognitive emotions, such as self-blame, reflection, and catastrophe, than control subjects without depression (Garnefski and Kraaij, 2006). Additionally, adults with PTSD (Tull et al, 2007), eating disorders (Whiteside e.g.; Whitestone and Associates, 2007), generalized anxiety disorder (Salters-Pedneault & 2006), and depression (Ehring d.e.m.) are among the populations included. This transdiagnostic approach to understanding emotional dysregulation highlights its role in psychological instability and argues that targeted interventions can address emotion regulation skills in all types of disorders.

The study concludes. This interdependence indicates that interventions aimed at improving emotion regulation skills could also impact the core symptoms of PTSD, providing a promising avenue for treating and managing this condition. Evidence suggests that emotional dysregulation (ED) and post-traumatic stress symptoms (PTSS) are strongly associated, but the exact relationship is uncertain. These findings suggest the impact of traumatic early life experiences may need to be considered in intervention for better emotional regulation. These discoveries emphasize the need for devising and utilizing therapeutic approaches that enhance emotional regulation and adaptive cognitive processing to manage and potentially prevent the progression of PTSD symptoms.

The correlation demonstrates that managing affect and emotional regulation difficulties is an essential aspect of therapeutic interventions for BPD, particularly in individuals with a history of early trauma. The outcomes demonstrate the intricate link between early negative experiences and severe psychopathological conditions, highlighting the necessity of targeted therapeutic interventions that address these fundamental emotional regulation difficulties.

The developmental model of suicide proposed by Adam (1994) suggests that emotions are dysregulated due to both personal and internal working models. This model emphasizes the importance of empathy in self-determination. The biosocial model is the basis of DBT, which suggests that both suicidal behaviors and BPD can be interpreted as disorders of emotion control.

Despite accounting for the overall negative affect of the program, self-reported difficulties in emotional acceptance, impulse control, and accessing effective emotion-regulation strategies were positively associated with the severity of PTSS (Sherman et al, 2007). This implies that individuals with PTSS, which may be indicative of PTSD, frequently encounter significant difficulties in managing their emotions.

As per the study (2000, 2000:02), PTSD is an emotional disorder in which one experiences more negative emotions and less positive emotions when exposed to emotionally charged stimuli. The research highlights the crucial role that dysregulation of emotions may play, not only in the presence of PTSS but also in how people emotionally react to events associated with trauma. It is important to conduct longitudinal research on the cause of emotion dysregulation, which may be influenced by PTSS in order

to determine appropriate therapeutic approaches for PTSD. The literature suggests that trauma exposure can have a direct impact on an individual's emotional control.

In their discussions, van der Kolk (1996) and others have also highlighted the occurrence of marked difficulties in controlling emotions among those who have experienced chronic interpersonal trauma. These findings suggest that the degree to which emotions are controlled may not be influenced by the type of trauma, but rather by how severe the PTSD symptoms are. Initially, Alexithymia was associated with psychosomatic disorders but it has since been linked to a wider range of mental health issues such as depression and anxiety disorders. Emotional difficulties have been associated with various mental health issues, such as depression, anxiety disorders, and PTSD.

Strong mental health and higher levels of subjective well-being are closely tied to an individual's ability to comprehend and communicate emotions and regulate them. This is a significant observation.

CHAPTER-III

RESEARCH METHODOLOGY

3.1 Research Design

In the present study, we used cross-sectional survey which is quantitative study. It consists of two stages. First, we did pivot study to check the reliability of our scale. Secondly, after checking the reliability of our pivot study through SPSS we continued data gathering.

3.2 Population and Sample

The population of this study was comprised of all enrolled students in KPK universities of Pakistan. The convenience sampling method was used for sample recruitment. The study comprises total 324 responses from which 182 girls (56.2%) and 132 boys (40.7%) and 10 missing (3.1%) participated. Our sample comprised of 248 Undergraduate (76.5%) Students 67 graduate students (20.7%) and 9 students (2.8%) didn't mention their Study Program.

3.3 Instruments

Everyday Discrimination Scale. People\Students everyday discrimination experience was measure with 9 items everyday discrimination questionnaire (Williams, D.R., Yu, Y., Jackson, J.S., and Anderson, N.B. "Racial Differences in Physical and Mental Health: Socioeconomic Status, Stress, and Discrimination." Journal of Health Psychology. 1997; 2(3):335-351). Items are rated on a 6-point scale ranging from (1=Almost every day,2=At least once a week,3=A few times a month,4=A few times a year,5=Less than once a year,6=Never). The Cronbach's alphas value of this scale is .77. In the present study, Cronbach's alpha value is .80 respectively.

Difficulty in Emotion Dysregulation. The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer 2004) is one of the most widely used self-report measures of emotion regulation deficits. The DERS was developed to capture clinically relevant problems (i.e., those * Sheila E. Crowell sheila.crowell@psych.utah.edu 1 Department of Psychology, University of Utah, 380 S. 1530 E. BEHS 502, Salt Lake City, UT 84112, USA 2 Human Development and Family Studies) However, it has also been used to examine normative developmental processes and experiences because they are associated with emotion regulation functioning as assessed by the DERS (Jankowski 2013; Jankowski and Rękosiewicz 2013; Mirzaei et al. 2014).

The DERS consists of 18 items that load onto 6 subscales (Strategies, Non-acceptance, Impulse, Goals, Awareness, Clarity). In order to assess difficulties regulating emotions during times of distress, many items begin with "When I'm upset", Respondents are asked to indicate how often the items apply to themselves, with responses ranging from 1 to 5, where (1=almost never, 2=sometimes, 3=about half the time, 4=most of the time, and 5=almost always). The DERS has high internal consistency (α=.93),

good test-retest reliability (ρ=.88, p<.01), and adequate construct and predictive validity (Gratz and Roemer 2004). The internal reliability for the current sample was.65 to .78.

Kessler Psychological Distress Scale (K10). The Kessler psychological distress scale (K10) (Kessler 1996) is a widely used, simple self-report measure of psychological distress which can be used to identify those in need of further assessment for anxiety and depression (Kessler, R.C., Andrews, G., Colpe, .et al (2002) Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine, 32, 959-956). This measure was designed for use in the general population; however, it may also serve as a useful clinical tool. The K10 comprises 10 questions that are answered using a five- point scale (where 5 = all of the time, and 1 = none of the time). For all questions, the client circles the answer truest for them in the past four weeks. Scores are then summed with the maximum score of 50 indicating severe distress, and the minimum score of 10 indicating no distress. The Cronbach's alpha value of this scale is .88. In the present study, the Cronbach's value is .84 respectively.

3.4 Data Collection Methods

Data was obtained through a set of questionnaires and informed consent was attached in which we explain the purpose of study. Participant's right to decline to participate and to withdraw from the research. We collected data from enrolled students in KPK universities. Data were collected from above 300 students. We filled 224 questionnaires through Google form to give QR code to every student and told them to scan this code by Google lens and filled with honesty and told them to kindly share this linked with other students and class fellows.

CHAPTER-IV
DATA ANALYSIS

4.1 Overview

In this chapter, results of descriptive analysis and rating scale functioning are presented earlier. Next, results of correlation analyses are presented. All analyses were conducted in IBM SPSS version 29.

4.2 Descriptive Analysis

Table 4.1

Study Participants Demographics Characteristics (N = 324)

Characteristics	Frequency	Percentage
Age		
≤ 20	76	23.5
≥ 21	212	65.4
Missing	36	11.1
Gender		
Female	182	56.2
Male	132	40.7
Missing	10	3.1
Marital Status		
Single	283	87.3
Married	32	9.9
Missing	9	2.8
Monthly Income		
< Rs.50,000	104	32.1

≥ Rs.50,000	210	64.8
Missing	10	3.1
Father Education		
≤ 10 Years	108	33.3
≥ 12 Years	208	64.2
Missing	8	2.5
Mother Education		
≤ 10 Years	211	65.1
≥ 12 Years	103	31.8
Missing	10	3.1
Education Program		
Undergraduate	248	76.5
Graduate	67	20.7
Missing	9	2.8

Table 4.1 shows Participant's Demographics Characteristics... The percentage of participants having age 20 was (23.5%) and the participants having age 21 was also (65.4%) and (11.1%) participants did not indicate their age. Participants were having age 21 or above are in majority than participants having age 20 or less. The percentage of Female participant were (56.2%) and male participant were (40.7%) and (3.1%) participant did mention their gender. Similarly, female participants were in majority than male participants. The percentage of marital status of a single participant are (87.3%) and married participants are (9.9%) and (2.8%) participants did not mention their marital status. Furthermore, single participants were in majority than married participants. The undergraduate participants were (76.5%) and graduate were (20.7%) and (2.8%) participant did not mention their education program. Undergraduate participants were in majority than graduate participants.

Table 4.2

Frequency Distributions for the Everyday Discrimination Scale (EDS) (N = 324)

	Never %	Less Than Once A Year %	A Few Times A Year %	A Few Times A Month %	At Least Once A Week %	Almost Everyday %
EDS1	30.2%	18.2%	23.3%	12.6%	5.0%	10.7%
EDS2	33.3%	17.6%	23.3%	10.4%	6.9%	8.5%
EDS3	27.2%	20.6%	22.2%	14.2%	9.8%	6.0%
EDS4	28.8%	19.4%	19.1%	14.4%	5.9%	12.5%
EDS5	41.5%	14.6%	15.8%	11.4%	8.2%	8.5%
EDS6	43.3%	16.9%	13.2%	12.2%	6.9%	7.5%
EDS7	14.5%	18.2%	24.5%	14.5%	8.5%	19.8%
EDS8	41.4%	16.0%	12.9%	13.5%	8.2%	8.2%
EDS9	51.1%	16.6%	15.4%	6.0%	6.0%	5.0%

Table 4.2 shows responses by percentage scale of Everyday Discrimination scale (EDS). The

study participant responses on EDS items have mostly endorsed “Never” and “a few times a year” except for EDS4, EDS6, EDS7, EDS8, EDS9.

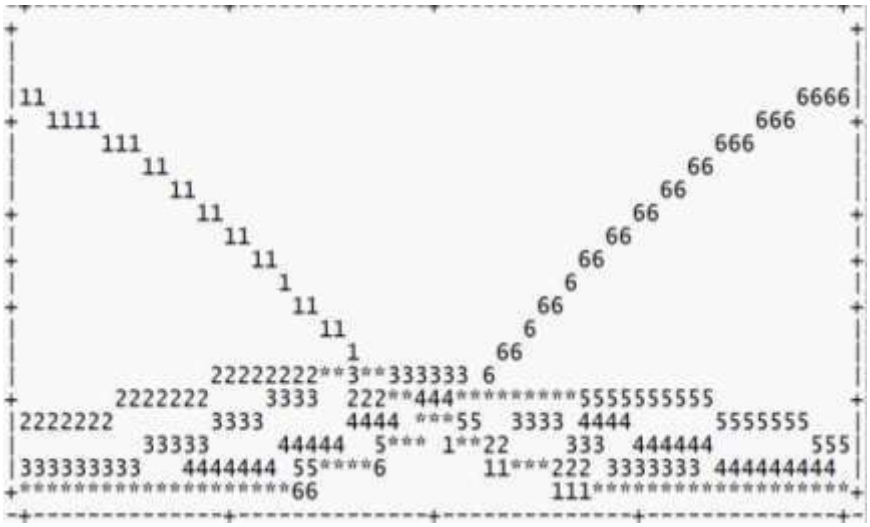

Figure 4.1 Probability curve for the Everyday Discrimination Scale

Figure 4.1 shows good curve for category 1 and 6 but 2, 3, 4, 5 are overlapping so if we collapse 2 with 3 and 4 with 5 categories. So, the scale can become valid and useful and hence the categories will be (1=never), (2=often in year), (3=some often in month), (4=almost every day).Table 4.3

Frequency Distributions for the Kessler Psychological Distress Scale (K10) (N = 324)

	None of the Time %	A Little of the Time %	Some of the Time %	Most of the Time %	All of the Time %
PDS1	18.5%	37.3%	25.7%	13.8%	4.7%
PDS2	14.2%	35.3%	33.8%	12.9%	3.8%
PDS3	29.0%	29.3%	23.7%	13.9%	4.1%
PDS4	24.1%	26.7%	27.3%	15.2%	6.7%
PDS5	14.3%	27.4%	30.3%	20.1%	8.0%
PDS6	19.9%	28.1%	28.1%	18.0%	6.0%
PDS7	20.3%	30.7%	25.9%	16.1%	7.0%
PDS8	12.0%	26.5%	30.6%	21.8%	9.1%
PDS9	19.4%	26.4%	29.0%	17.8%	7.3%
PDS10	29.0%	26.5%	21.1%	16.4%	6.9%

Table 4.3 shows the study participant responses on items have mostly endorsed “a little of the time” and “some of the time” except (PDS3, PDS10).

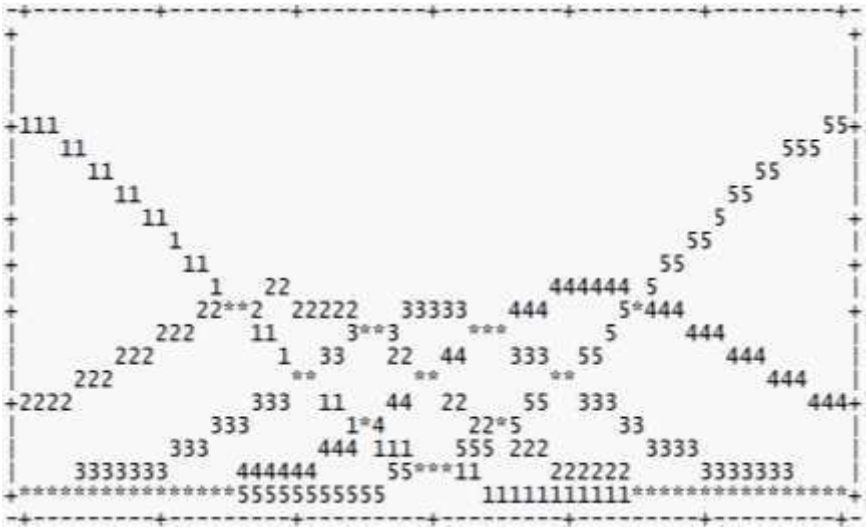

Figure 4.2 Probability curve for the Psychological Distress Scale

Figure 4.2 shows good curve for category 1 and 5 but the 2, 3, 4 are overlapping so if we collapse the 2 with 3category and 4category as it is so the scale can become valid and useful for further research studies. Hence the categories will be (1=none of the time), (2=often), (3=most of the time), (4=All of the time).

Table 4.4

Frequency Distributions for the Difficulties in Emotion Regulation Scale Short Form (DERS- SF) (N = 324)

	Almost Never True %	Sometimes True %	About Half the Time True %	Most of the Time True %	Almost Always True %
DERS1	19.0%	43.6%	13.4%	12.8%	11.2%
DERS2	23.3%	33.3%	18.2%	15.7%	9.4%
DERS3	23.9%	31.4%	17.0%	15.1%	12.6%
DERS4	21.8%	38.5%	19.2%	11.7%	8.8%
DERS5	19.4%	37.6%	17.2%	15.4%	10.3%
DERS6	18.2%	33.3%	19.2%	16.7%	12.6%
DERS7	30.4%	27.0%	17.9%	14.4%	10.3%
DERS8	33.4%	31.9%	14.8%	12.0%	7.9%
DERS9	29.7%	34.7%	16.7%	12.3%	6.6%
DERS10	13.9%	34.4%	18.6%	17.4%	15.8%
DERS11	14.2%	30.6%	18.3%	20.2%	16.7%
DERS12	14.2%	33.4%	19.9%	17.7%	14.8%
DERS13	8.8%	25.4%	19.4%	22.9%	23.5%
DERS14	11.4%	31.9%	18.3%	20.8%	17.7%

DERS15	13.1%	29.6%	19.1%	20.4%	17.8%
DERS16	21.1%	30.6%	18.9%	18.3%	11.0%
DERS17	22.2%	31.3%	20.9%	17.1%	8.5%
DERS18	27.8%	30.3%	15.0%	15.0%	11.9%

The study participant responses on strategies (DERS1 to DERS3) have mostly endorsed "Sometimes true" and "Almost never true". Furthermore, the study participant responses on Non-acceptance (DERS4 to DERS6) have mostly endorsed "Sometimes true" and "Almost never true" except DERS6 which secondly endorsed "About half of the time true". Similarly, the participant responses on impulse (DERS7 to DERS9) have mostly endorsed "Almost never true" and "Sometimes true". Furthermore, the participant responses on Goals (DERS10 to DERS12) have mostly endorsed "Sometimes true" and "About half of the time true" except DERS11 which secondly endorsed "Most of the times true". Similarly, the participant responses on Awareness (DERS13 to DERS15) have mostly endorsed "Sometimes true" and "Most of the time true" or "Almost always true (13)". Furthermore, the participant responses on relatedness Clarity (DERS16 to DERS18) have mostly endorsed" "Almost never true" and "sometimes true". The item total correlation for DERS of this scale have all item total correlation above (.3), therefore these items all measure same thing.

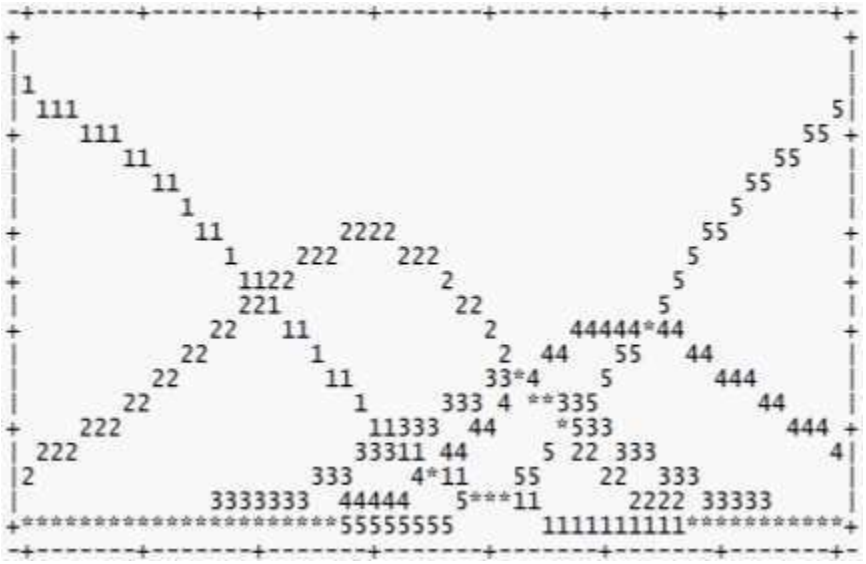

Figure 4.3 Probability curve for the strategies subscale

Figure 4.3 shows good curve for category 1, 2 and 5 but the category 3 and 4 are overlapping. If we collapse 3 with 4 categories so the scale can become valid and useful. Hence the categories will be (1=almost never true), (2=sometimes true), (3=most of the times true), (4=almost always true).

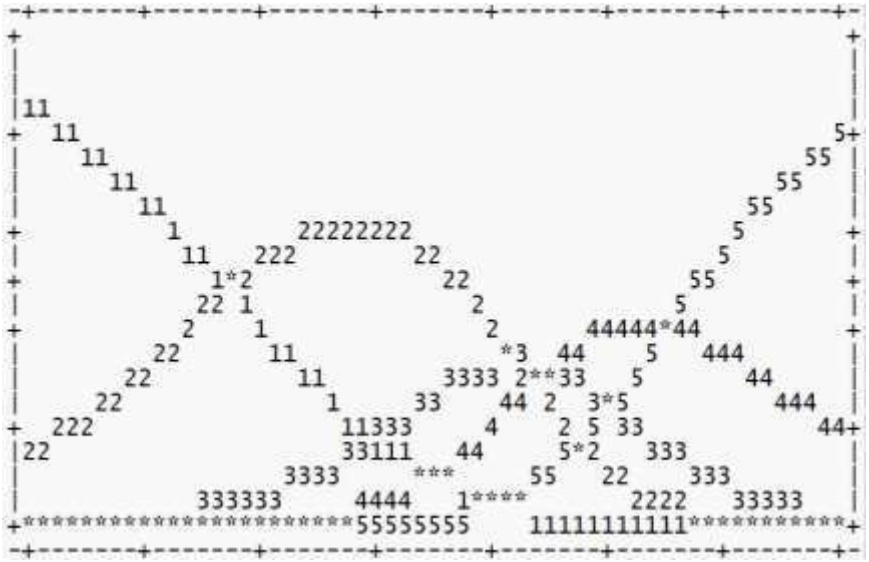

Figure 4.4 Probability curve for the non-acceptance subscale

Figure 4.4 shows good curve for category 1,2,4 and 5 but the category 3 is overlapping. If we collapse 3 with 4 categories so the scale can become valid and useful. Hence the categories will be (1=almost never true), (2=sometimes true), (3=most of the times true), (4=almost always true).

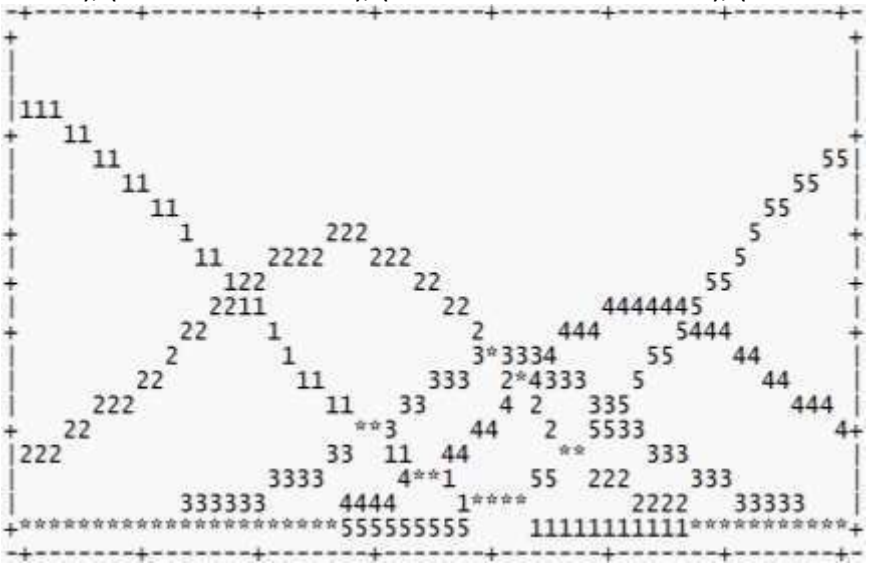

Figure 4.5 Probability curve for the impulse subscale

Figure 4.5 shows good curve for category 1, 2, 4 and 5 but the category 3 is overlapping. If we collapse 3 with 4 categories so the scale can become valid and useful. Hence the categories will be (1=almost never true), (2=sometimes true), (3=most of the times true), (4=almost always true).

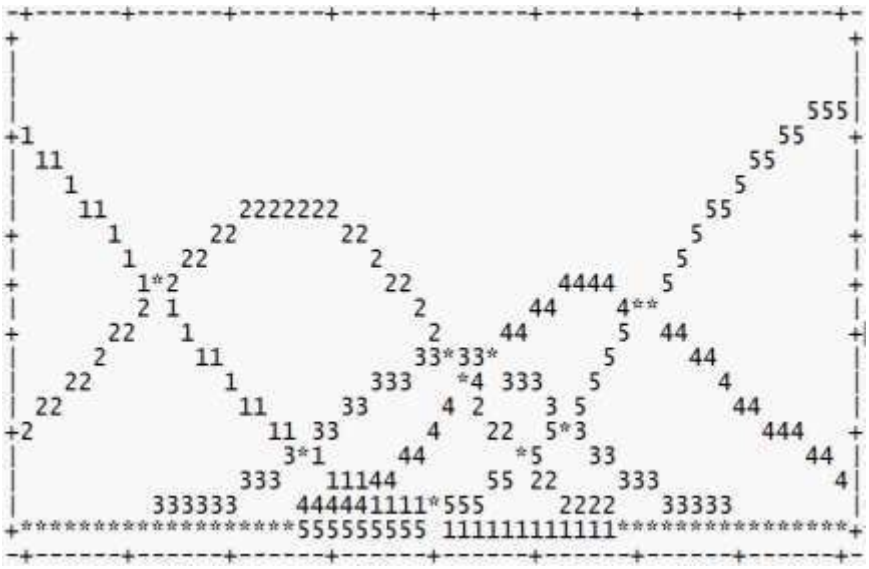

Figure 4.6 Probability curve for the goals subscale

Figure 4.6 shows good curve for category 1, 2, 4 and 5 but the category 3 is overlapping. If we collapse 3 with 4 categories so the scale can become valid and useful. Hence the categories will be (1=almost never true), (2=sometimes true), (3=most of the times true), (4=almost always true).

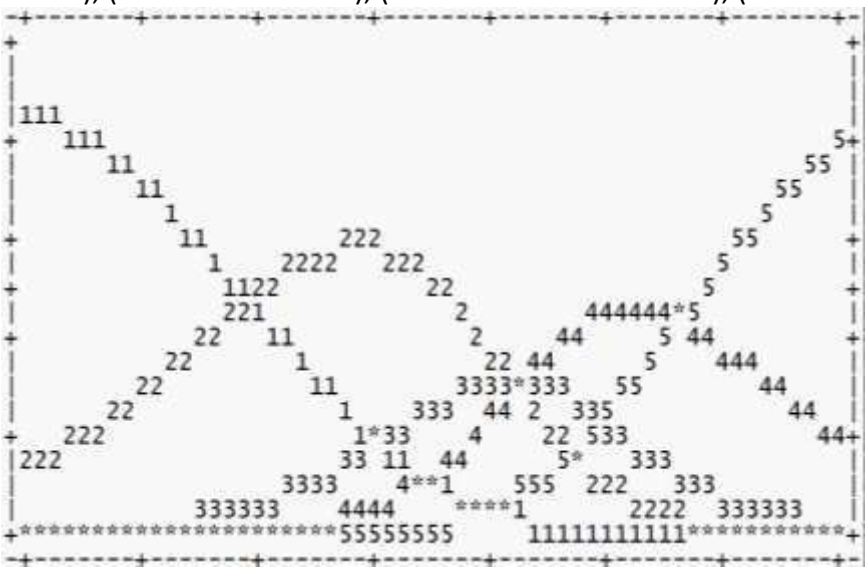

Figure 4.7 Probability curve for the awareness subscale

Figure 4.7 shows good curve for category 1, 2, 4 and 5 but the category 3 is overlapping. If we collapse 3 with 4category so the scale can become valid and useful. Hence the categories will be (1=almost never true), (2=sometimes true), (3=most of the times true), (4=almost always true).

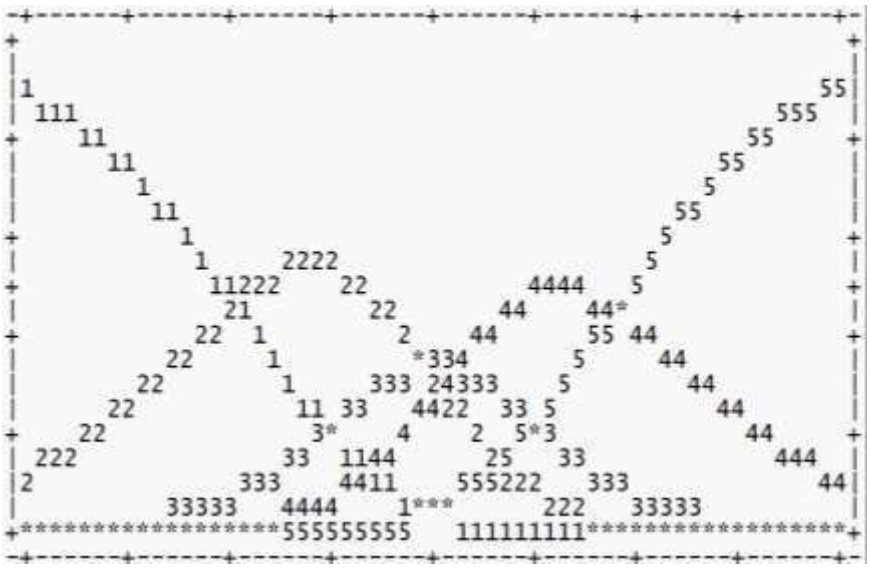

Figure 4.8 Probability curve for the clarity subscale

Above the figure shows good loops of category 1, 2, 4 and 5 but the category 3 is overlapping. If we collapse 3 with 4 categories so the scale can become valid and useful. Hence the categories will be (1=almost never true), (2=sometimes true), (3=most of the times true), (4=almost always true).

Table 4.5

Descriptive Statistics and Reliability Coefficients of Instruments Used in the Study (N = 324)

Measure	Items	*M*	*SD*	*α*	Skewness	Kurtosis	Range	
							Actual	Potential
EDS	9	24.19	9.02	.80	.62	.30	9-54	9-54
PDS	10	26.00	7.40	.84	.38	.33	10-50	10-50
DERS	18							
ST	3	7.66	2.94	.65	.60	-.13	3-15	3-15
NA	3	7.78	2.93	.68	.54	-.24	3-15	3-15
IP	3	7.08	3.12	.76	.60	-.28	3-15	3-15
GL	3	8.67	3.25	.78	.32	-.77	3-15	3-15
AN	3	9.29	3.07	.68	.18	-.79	3-15	3-15
CY	3	7.79	3.10	.72	.49	-.47	3-15	3-15

Note. EDS = Everyday Discrimination Scale; PDS = Psychological Distress Scale; DERS = Difficulties in Emotion Regulation Scale; ST = Strategies; NA = Non-acceptance; IP = Impulse; GL = Goals; AN = Awareness; CY = Clarity.

Table 4.5 shows Descriptive Statistics and Reliability Coefficients of Instruments Used in the Study. In Everyday Discrimination Scale (EDS) Reliability coefficients ranged is .80. In Psychological distress scale (PDS) Reliability coefficients ranged is .84. In Difficulty in emotion regulation Scale (DERS) which consists of 6 subscales Reliability coefficients ranged from .65 to .78. Departure from normality is not problematic according to rule of thumb

|Skewness| > 3.0 and |Kurtosis| > 10.0 (Kline, 2016)

4.3 Correlation Analysis

Table 4.6

Correlations among Scores on Study Variables (N = 324)

Variable	1	2	3	4	5	6	7	8	9
1.EDS	--								
2.PDS	.39**	--							
3.DERS	.41**	.60**	--						
4.ST	.36**	.53**	.74**	--					
5.NA	.34**	.43**	.65**	.44**	--				
6.IP	.41**	.47**	.73**	.46**	.39**	--			
7.GL	.20**	.38**	.73**	.49**	.33**	.47**	--		
8.AN	0.11	.14*	.49**	.19**	.13*	.13*	.29**	--	
9.CY	.29**	.46**	.69**	.38**	.34**	.48**	.33**	.24**	--

Note. EDS = Everyday Discrimination Scale; PDS = Psychological Distress Scale; DERS = Difficulties in Emotion Regulation Scale; ST = Strategies; NA = Non-acceptance; IP = Impulse; GL = Goals; AN = Awareness; CY = Clarity.

*p < .05, **p < .01.

Table 4.6 shows correlations among scores on study variables.

Hypothesis 1 (Supported). There was positively significant relationship of Everyday Discrimination with the DERS sub scales Strategies, Non-acceptance, Impulse, Goal, and Clarity (r =.36, .34, .41, .20, .29) except Awareness which is negatively non-significant (r=.11). Hypothesis 2 (Supported). Furthermore, according to our hypothesis there is positively Significant relationship of Psychological Distress with sub-scales of Difficulty in Emotion Regulation Strategies, non-acceptance, impulse, goal, and clarity (r=.53, .43, .47, .38, .46) except Awareness which is non-significant and against of our study (r=.14).

4.4 Mediation Analysis

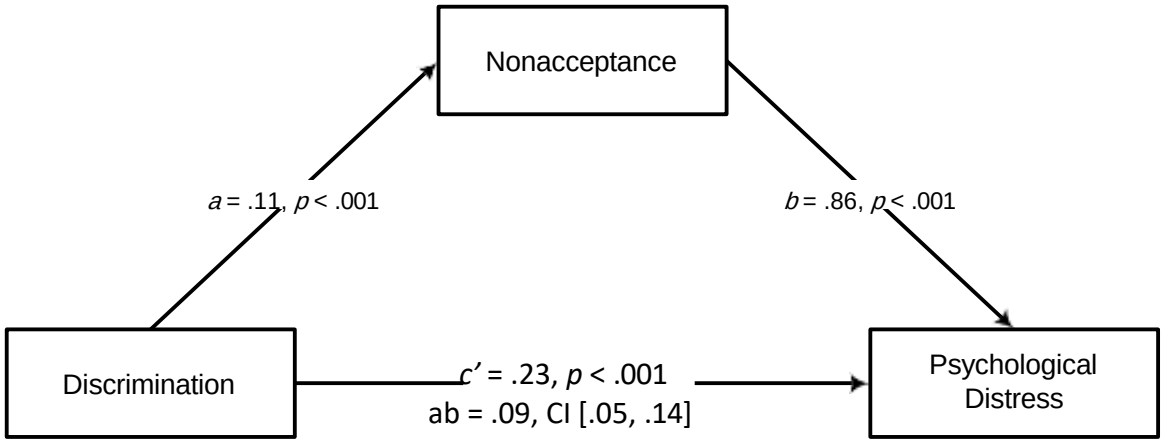

Figure 4.9 Non-acceptance as mediator between the relation of discrimination and psychological distress.

Figure 4.9 shows the results of the mediation path analysis. The model shows that discrimination indirectly influences psychological distress through its effect on non-acceptance (ab =.09, CI [.05, .14]). In essence, high level of discrimination led to high level of non- acceptance (a = .11, p < .001) and high level of non-acceptance led to high level of psychological distress (b = .86, p < .001). There is also evidence that discrimination influenced psychological distress independently (c' = .23, p < .001).

CHAPTER-V
CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

We collected data from 324 participants (182male, 132females and 10 people didn't mention their gender) through convenient sampling. Everyday Discrimination scale, Difficulty in emotion regulation scale and psychological distress scales was used for data collection. The primary goal of this study was to examine relationship between everyday discrimination (ED), psychological distress (PD), and emotional dysregulation (EDR) and testing the potentially mediating role of psychological distress (PS) in the association between racial discrimination and emotional dysregulation in our sample of age 20 and above 21. This study is the first in our region to show that racial discrimination is linked to psychological distress through emotion dysregulation among university students. Previous research showing that perceived discrimination is associated with a variety of negative physical and mental health consequences, including increased psychological distress and increased symptoms of depression (T. Brown et al., 2000; D. R. Williams & Mohammed, 2009), and can be conceptualized as a specific form of stress. These results are particularly valuable as they highlight modifiable emotion regulation processes that can be targeted to improve the psychological and social well-being of students experiencing discrimination. Our findings suggest that it may be beneficial to ask clients

about their experiences of perceived discrimination in their daily lives. The implications of our study are significant for teachers, parents, educators, researchers, and policy makers. It is important for these stakeholders to consider the negative effects of discrimination when developing policies. However, there are several limitations to our study. First, being a cross-sectional study, it does not allow for determination of causality. Therefore, it is crucial to replicate these findings using longitudinal and experimental methods to determine if racial discrimination directly causes emotional dysregulation. Second, the study's sample size is specific and does not take into account cultural influences on these constructs. Future research should include diverse samples to address this limitation. Additionally, future studies should examine emotional dysregulation as an independent variable to identify any systematic differences. Our findings indicate that both, everyday discrimination (ED) and psychological distress (PD) are significant and positively correlated with emotional dysregulation (EDR) and their subscales, strategies (ST), non- acceptance (NA), impulse (IP), goal (GL), and clarity (CY) except awareness subscale (AN). which is non-significant and against of our study.

5.2 Conclusion

The current study explored the connections between everyday discrimination, psychological distress, and emotional dysregulation among university students. The results largely confirmed our hypotheses, revealing a significant relationship between everyday discrimination, psychological distress, and emotional dysregulation. Consequently, it can be concluded that everyday discrimination contributes to the psychological distress (including stress, anxiety, and depression) and emotional disturbances of university students. It is crucial to recognize that students are likely to experience increased psychological and emotional disturbances when they encounter discrimination from individuals such as parents, teachers, and friends. A deeper understanding of these issues could aid in developing environmental and psychological resources to mitigate the effects of discrimination.

5.3 Recommendations

1. Since this study is cross-sectional, future research should consider employing longitudinal or experimental designs to better establish the direction of causality between the variables.
2. Future studies should aim to include a larger and more diverse sample size to enhance the generalizability of the findings. Researchers should also extend data collection to include participants from universities outside KPK in Pakistan, and potentially from different regions and countries.
3. To explore potential cultural variations in the level of discrimination, future research should include participants from various regions and cultural backgrounds. This broader scope will provide a more comprehensive understanding of the issue.
4. Future researchers should consider using a combination of online and face-to-face data collection methods. This approach will help mitigate any biases or inaccuracies that might arise from participants' responses and ensure more reliable and valid data.

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