



RESEARCH ARTICLE

The Impact of Social Exclusion on Mental Health: A Phenomenological Study on the Sweeper Community

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Abstract: The sweeper community in Bangladesh occupies one of the most socially marginalized positions within an entrenched caste-based hierarchy, facing systematic social exclusion that permeates virtually every domain of their daily lives. Despite the well-documented relationship between social exclusion and adverse mental health outcomes in international literature, the lived psychological experiences of sanitation workers in South Asian contexts remain profoundly understudied. This phenomenological study explores the subjective mental health consequences of social exclusion among 18 adult members of the sweeper community in Dhaka, Bangladesh, recruited through purposive and snowball sampling. In-depth semi-structured interviews were conducted, transcribed verbatim, and analyzed using interpretive phenomenological analysis (IPA). Four overarching themes emerged: (1) internalized stigma and erosion of self-worth, (2) chronic psychological distress and depression-like experiences, (3) social isolation and relational deprivation, and (4) resilience, coping, and meaning-making amid exclusion. Findings reveal that participants experienced pervasive shame, occupational stigma, and profound loneliness compounded by caste discrimination, restricted civic participation, and spatial segregation in housing and education. Despite these adversities, participants drew on religious faith, community solidarity, and familial bonds as psychological buffers. The study underscores an urgent need for culturally responsive mental health services, anti-discrimination policy, and inclusive community programs targeting structurally marginalized populations in Bangladesh and the broader South Asian region.

Keywords: social exclusion, mental health, sweeper community, Bangladesh, stigma, phenomenology, marginalization, qualitative research

1. Introduction

Social exclusion—the process by which individuals and groups are systematically denied access to economic, social, cultural, and political resources—represents one of the most structurally entrenched forms of human marginalization (Sen, 2000; Room, 1995; Silver, 1994). Among its most severe manifestations in South Asia is the caste-based exclusion endured by sanitation workers, colloquially known as the sweeper community. In Bangladesh, members of this community—predominantly of Hindu Dalit or low-caste origin—are engaged in occupations considered ritually impure: sweeping streets, cleaning latrines and drains, and collecting solid waste (Islam & Biswas, 2022; Ahmed & Islam, 2019). Their work is indispensable to urban public health, yet they are simultaneously rendered invisible, stigmatized, and excluded from the civic and social fabric of Bangladeshi society (Zaman & Hossain, 2017; Barua & Barua, 2021).

The relationship between social exclusion and mental health is well established in international literature. Exclusion from social participation produces chronic stress, diminishes self-worth, and generates conditions structurally conducive to depression, anxiety, and psychological distress (Mikkelsen et al., 2005; Allott et al., 2002; Patel et al., 2018). Stigma, as Goffman (1963) classically theorized, functions to reduce the stigmatized person from a whole and usual identity to a tainted, discounted one—a dynamic with profound psychological consequences. Link and Phelan (2001) further conceptualized stigma as a social process involving labeling, stereotyping, separation, and status loss, each of which operates powerfully in the daily lives of sanitation workers. Hatzenbuehler et al. (2013) identified stigma as a fundamental cause of population health inequalities, operating through mechanisms that deny stigmatized individuals access to protective health resources.

Despite this international evidence base, the mental health dimensions of caste-based social exclusion remain deeply understudied in the Bangladeshi context. Mental health research in Bangladesh has historically focused on common mental disorders in the general population (Hossain et al., 2014), with limited attention to structurally marginalized occupational groups. The few existing studies on sanitation workers in South Asia have concentrated primarily on physical health hazards,

occupational rights, and economic deprivation (Karmakar, 2016; Chauhan, 2018), while the *lived psychological experience* of exclusion—how it is subjectively felt, interpreted, and navigated—remains virtually invisible in the scholarly literature.

This study addresses that gap through a phenomenological inquiry into the mental health experiences of adult members of the sweeper community in Dhaka, Bangladesh. Phenomenology, as a qualitative methodology, is uniquely suited to capturing the depth, texture, and meaning-structure of subjective experience (Smith et al., 2009; Creswell & Poth, 2018). By centering the voices of sweeper community members themselves, this study aims to produce knowledge that is not only academically rigorous but also grounded in the lived realities of those most affected.

The following research questions guide this inquiry:

- How do members of the sweeper community in Dhaka experience and describe the mental health effects of social exclusion?
- What forms of stigma, isolation, and psychological distress are most salient in their lived experiences?
- How do participants describe and enact strategies of coping and resilience in the face of chronic exclusion?

The study aims to generate empirical insight that can inform culturally responsive mental health policy, service design, and advocacy efforts for structurally excluded communities in Bangladesh and beyond.

2. Review of Literature

2.1 Social Exclusion: Conceptual Foundations

Social exclusion is a multidimensional concept that emerged in European social policy discourse in the 1970s and has since become a central organizing framework in development studies and public health (Room, 1995; Silver, 1994). Silver (1994) identified three paradigms of exclusion—solidarity, specialization, and monopoly—each emphasizing different mechanisms through which individuals are cut off from participation in mainstream social life. Sen (2000) offered a broader conceptualization, distinguishing between active exclusion (where policies or practices deliberately exclude groups) and passive exclusion (where standard processes inadvertently marginalize certain populations). In both forms, exclusion operates through the denial of capabilities—the real freedoms individuals have to live lives they have reason to value (Marmot, 2015; UNDP, 2020).

In the South Asian context, caste operates as the dominant mechanism of social exclusion, structuring access to occupation, education, housing, marriage, and civic participation along rigid hereditary lines (Ahmed & Islam, 2019; Lamont & Molnár, 2002). The sweeper community in Bangladesh occupies the lowest rungs of this hierarchy, consigned to sanitation work by virtue of birth and simultaneously excluded from the social spaces that define full civic membership. This form of exclusion is simultaneously material—manifesting in poverty, poor housing, and limited educational access—and symbolic, inscribed in the bodies, identities, and self-perceptions of those who experience it (Goffman, 1963; Link & Phelan, 2001).

2.2 Social Exclusion and Mental Health

The mental health consequences of social exclusion are extensive and well-documented across multiple national contexts. Mikkelsen et al. (2005) found strong associations between social exclusion and common mental disorders—particularly depression and anxiety—in a Norwegian community study, underscoring that exclusion affects mental health even in high-income welfare states. Allott et al. (2002) conducted a systematic review establishing that mental illness and social exclusion are mutually reinforcing, with each condition worsening the other in a cyclical pattern. In low- and middle-income countries, this relationship is especially acute: Mitra et al. (2019) demonstrated through meta-analysis that poverty and social disadvantage are among the most robust predictors of common mental disorders globally.

Stigma constitutes a critical pathway through which exclusion produces mental health harm. Goffman's (1963) foundational work demonstrated that stigmatized individuals internalize society's devaluing of them, leading to shame, self-concept disruption, and withdrawal from social interaction. This internalized stigma mechanism has been identified across a range of stigmatized groups globally (Link & Phelan, 2001; Hatzenbuehler et al., 2013). Pascoe and Smart Richman (2009), in a meta-analytic review of 134 studies, found that perceived discrimination was associated with significantly poorer mental health outcomes, with both depression and anxiety elevated among those experiencing chronic stigma-based exclusion.

Social identity theory (Tajfel & Turner, 1979) offers further explanatory purchase here: when group membership is stigmatized and devalued by the broader society, members face threats to their social identity that can generate psychological vulnerability. Jetten et al. (2012) and Haslam et al. (2018) extended this framework, demonstrating that social group membership—when positive and affirming—serves as a powerful buffer against mental ill-health. Conversely, exclusion from valued social groups and the absence of positive group identification constitutes a significant mental health risk factor.

In the Bangladeshi context, Haque and Rahman (2020) found elevated rates of depressive symptoms and psychological distress among urban sanitation workers in Dhaka, with social stigma emerging as a significant mediating variable. Rahman and Iqbal (2019) documented that disadvantaged communities in Dhaka experienced higher rates of anxiety, hopelessness, and social withdrawal. Despite these contributions, phenomenological and qualitative approaches that center subjective experience remain rare, leaving a significant gap in understanding how mental health consequences of exclusion are lived from the inside.

2.3 Coping, Resilience, and Meaning-making

Research on marginalized communities has increasingly recognized that social exclusion does not produce uniform psychological devastation; rather, individuals and communities develop complex repertoires of coping, resistance, and meaning-making that partially mediate the impact of exclusion on mental health (Lazarus & Folkman, 1984; Wilkinson & Pickett, 2009).



Haslam et al. (2018) identified social connection—even within marginalized in-groups—as a powerful protective factor, noting that community solidarity can serve as a 'social cure' when access to broader social resources is blocked.

Religious faith and spiritual belonging have been repeatedly identified as sources of psychological sustenance in South Asian contexts (Bhugra, 2004; Farhood et al., 2010). Islam—the majority religion of Bangladesh—provides frameworks of suffering, endurance, and divine justice that many marginalised individuals draw on as coping resources. For Hindu minority communities such as the sweeper community, similar functions may be served by religious ritual, community festivals, and the moral narratives embedded in religious practice. Parental aspiration for children's upward mobility—a form of vicarious hope—also emerges as a documented coping mechanism in studies of generationally marginalized groups (Chauhan, 2018; Karmakar, 2016).

2.4 The Sweeper Community in Bangladesh: Contextual Overview

Bangladesh's sweeper community numbers in the tens of thousands, concentrated primarily in urban centers where they work under Dhaka City Corporation (DCC) contracts or through informal arrangements with landlords and institutions (Islam & Biswas, 2022; Barua & Barua, 2021). The community is predominantly of Hindu origin, representing a religious as well as caste minority in a Muslim-majority nation—compounding their social vulnerability along multiple axes. They typically inhabit spatially segregated neighborhoods, often in dilapidated colony housing, with limited access to formal education, healthcare, and civic amenities (Ahmed & Islam, 2019; Zaman & Hossain, 2017).

Despite the formal abolition of caste discrimination under Bangladeshi law and international human rights frameworks (UNDP, 2020), the sweeper community continues to face structural discrimination in practice: their children are segregated in schools, their marriage pools are restricted to within-community unions, and they face daily interpersonal exclusion in markets, teashops, religious spaces, and public transport. This systemic exclusion constitutes a chronic stressor with documented implications for both physical and psychological health, yet remains dramatically understudied in the Bangladeshi mental health literature (Hossain et al., 2014; Mitra et al., 2019).

3. Methodology

3.1 Research Design and Paradigm

This study employed an **interpretive phenomenological analysis (IPA)** design, situated within an interpretivist epistemological paradigm. IPA is concerned with exploring in detail how participants make sense of their personal and social world, and with the meaning particular experiences hold for them (Smith et al., 2009; Smith & Osborn, 2003). Unlike survey-based approaches that aggregate responses, IPA attends to the unique perspectival character of experience, making it ideally suited for investigating the subjective mental health dimensions of social exclusion in a population whose inner lives have been systematically ignored in academic discourse.

3.2 Sampling and Participants

A combination of **purposive and snowball sampling** was employed to recruit 18 adult participants from the sweeper community in Dhaka. Purposive sampling criteria required that participants (a) identify as members of the sweeper community by occupation or hereditary affiliation, (b) be 18 years of age or older, (c) be currently residing in Dhaka, and (d) be willing to participate in an in-depth interview in Bengali or English. Initial contact was made through community leaders and non-governmental organization (NGO) workers with established relationships in sweeper colonies in Old Dhaka, Mirpur, Mohammadpur, and Lalbagh. Snowball referrals extended recruitment to Kamrangirchar, Hazaribagh, and other areas. Sampling continued until **data saturation** was reached—the point at which no substantively new themes emerged from additional interviews (Braun & Clarke, 2006; Creswell & Poth, 2018). Table 1 presents the demographic profile of participants.

Table 1: Demographic Profile of Participants

| ID | Role | Age | Gender | Education | Area | Years Working |
|-----|-------------------|-----|--------|-----------|---------------|---------------|
| P1 | Street Sweeper | 34 | Male | Primary | Old Dhaka | 12 |
| P2 | Drain Cleaner | 41 | Female | None | Mirpur | 18 |
| P3 | Garbage Collector | 28 | Female | Secondary | Mohammadpur | 7 |
| P4 | Street Sweeper | 55 | Male | None | Wari | 30 |
| P5 | Latrine Cleaner | 47 | Male | Primary | Demra | 22 |
| P6 | Sweeper (DCC) | 33 | Female | Primary | Badda | 10 |
| P7 | Street Sweeper | 39 | Male | None | Kamrangirchar | 15 |
| P8 | Drain Cleaner | 26 | Female | Secondary | Lalbagh | 5 |
| P9 | Garbage Collector | 52 | Male | None | Hazaribagh | 27 |
| P10 | Street Sweeper | 44 | Female | Primary | Rayer Bazar | 19 |
| P11 | Latrine Cleaner | 36 | Male | None | Tejgaon | 11 |

| ID | Role | Age | Gender | Education | Area | Years Working |
|-----|-------------------|-----|--------|-----------|-----------|---------------|
| P12 | Sweeper (DCC) | 29 | Female | Secondary | Shyampur | 6 |
| P13 | Street Sweeper | 48 | Male | None | Sutrapur | 23 |
| P14 | Drain Cleaner | 31 | Female | Primary | Khilgaon | 9 |
| P15 | Garbage Collector | 57 | Male | None | Jatrabari | 33 |
| P16 | Street Sweeper | 42 | Female | Primary | Tongi | 17 |
| P17 | Sweeper (DCC) | 38 | Male | Secondary | Uttara | 13 |
| P18 | Drain Cleaner | 23 | Female | Secondary | Banani | 3 |

3.3 Data Collection

Data were collected between January and April 2026 through **in-depth semi-structured interviews** conducted at locations chosen by participants, including community centers, participants' homes, and quiet outdoor spaces. An interview guide was developed drawing on the conceptual frameworks of social exclusion (Sen, 2000; Silver, 1994), stigma theory (Goffman, 1963; Link & Phelan, 2001), and mental health (WHO, 2022). The guide covered: (a) daily experiences of exclusion in social, civic, and occupational domains; (b) emotional and psychological responses to these experiences; (c) impact on self-perception and identity; (d) social relationships and sense of belonging; and (e) coping strategies, sources of support, and future aspirations.

Interviews were conducted in Bengali by the primary researcher, who is a native Bengali speaker with training in mental health research and community engagement. Each interview lasted between 55 and 80 minutes. Interviews were audio-recorded with explicit informed consent and transcribed verbatim. A professional translator verified translations of selected excerpts. Field notes capturing contextual details, non-verbal cues, and researcher reflections were maintained throughout data collection.

3.4 Ethical Considerations

Ethical clearance for this study was obtained from the Ethics Review Board of New Model Degree College, Bangladesh. All participants provided **written informed consent** prior to participation. Pseudonyms (P1–P18) replaced all identifying information in transcripts, notes, and outputs. Participants were explicitly informed of their right to withdraw at any time without consequence and without affecting any services or relationships they had with participating NGOs. Given the potential sensitivity of discussing mental health and stigma, the researcher was trained to recognize and respond to signs of emotional distress, with referral pathways established to NGO counseling services. No participant required referral, though several expressed relief and catharsis at having their experiences acknowledged.

3.5 Data Analysis

Data were analyzed using the six-stage IPA process outlined by Smith et al. (2009): (1) reading and re-reading transcripts; (2) initial noting of observations, reflections, and emergent meanings; (3) developing experiential statements; (4) searching for connections across experiential statements; (5) moving to the next case; and (6) looking for patterns across cases. Analysis was conducted in NVivo 12, which facilitated systematic organization of codes and theme development while preserving the depth of individual accounts. **Researcher reflexivity** was maintained throughout through a reflective journal documenting assumptions, reactions, and interpretive decisions. Peer debriefing with two colleagues in social psychology and qualitative methods provided external checks on the plausibility and coherence of emerging interpretations.

3.6 Trustworthiness

Trustworthiness was established through four criteria proposed by Lincoln and Guba (1985): **credibility** through member checking (six participants reviewed preliminary theme summaries and confirmed their resonance); **transferability** through thick description of the Bangladeshi context and participant characteristics; **dependability** through an audit trail of analytic decisions; and **confirmability** through reflexive journaling and peer review. Multiple analyst review of one third of the transcripts produced consistent coding, indicating acceptable inter-rater reliability in theme identification.

4. Findings

Four overarching themes emerged from interpretive phenomenological analysis of the 18 interviews, each capturing a distinct but interconnected dimension of participants' lived experience of social exclusion and its mental health consequences. These themes, their constituent sub-themes, and representative participant expressions are summarized in Table 2, followed by detailed discussion of each theme.

Table 2: Summary of Themes and Representative Expressions

| Theme | Sub-themes | Sample Participant Expression |
|---|---|---|
| Internalized Stigma & Eroded Self-worth | Occupational shame, caste identity burden, self-devaluation | "People treat us like we are less than human. After years, you start to believe it yourself." (P4) |

| Theme | Sub-themes | Sample Participant Expression |
|---|--|--|
| Chronic Psychological Distress | Persistent sadness, anxiety, helplessness, somatic complaints | "My chest is always heavy. I cannot sleep. I worry about everything but nothing changes." (P9) |
| Social Isolation & Relational Deprivation | Exclusion from social spaces, rejection by neighbors, loneliness | "No one sits with us at the tea stall. Our children are kept away from the other children in school." (P7) |
| Resilience, Coping & Meaning-making | Religious faith, family bonds, community solidarity, hope for children | "I pray every day. God sees us. And I work so my children will not have to do this." (P1) |

4.1 Theme 1: Internalized Stigma and Erosion of Self-worth

The most pervasive and psychologically devastating finding across interviews was the **internalization of societal stigma**—a process through which participants had absorbed and come to partially accept society's devaluing evaluations of them, their occupation, and their community. Consistent with Goffman's (1963) conceptualization of stigma as a spoiled identity and Link and Phelan's (2001) elaboration of its social consequences, participants described a gradual erosion of self-worth over years of exposure to contempt, ridicule, and dehumanization.

P4, a 55-year-old street sweeper with three decades of experience, articulated this internalization with stark clarity:

"People treat us like we are less than human. After years, you start to believe it yourself. I used to argue with people who insulted us. Now I just look down. It is easier. But inside, something has died." (P4)

P9, a 52-year-old garbage collector, described how shame had become reflexive, not requiring an external trigger:

"When I go to the market in my work clothes, I feel ashamed before anyone even looks at me. I am ashamed of what I am. My whole life, I have been taught to be ashamed." (P9)

This shame was deeply tied to occupational identity. Several participants described a painful awareness that their work—essential to public health—was treated as evidence of their unworthiness rather than their contribution. P13 noted:

"We clean so others can live cleanly. But they treat us like we are the dirt itself. We are not people to them—we are the work we do, and the work is dirty, so we are dirty." (P13)

Consistent with Hatzenbuehler et al.'s (2013) framework of stigma as a fundamental cause of health inequality, this internalized shame appeared to undermine participants' capacity to seek help, advocate for their rights, or access social and health services—compounding the direct psychological harm of stigma with secondary exclusion from resources that might buffer it.

4.2 Theme 2: Chronic Psychological Distress and Depression-like Experiences

Participants described a cluster of persistent psychological symptoms consistent with what clinical and epidemiological literature would classify as depressive and anxiety disorders (WHO, 2022; Kessler & Üstün, 2008), though none had received formal psychiatric diagnosis. These experiences were characterized by **chronicity**—not acute episodes but sustained states of suffering embedded in the ordinary fabric of daily life.

P9 described a pervasive, unrelenting heaviness:

"My chest is always heavy. I cannot sleep. I worry about everything—my children's school, money, what people think of us—but nothing changes no matter how much I worry. I have felt like this for so long I do not remember feeling different." (P9)

P5, a 47-year-old latrine cleaner, described functional impairment associated with his distress:

"There are days I cannot get out of bed, not because I am sick in my body but because my mind refuses. What is the point? Nothing will change for us. My father did this work, I do this work, my son will do this work." (P5)

The sense of **hopelessness** and entrapment—what Seligman's helplessness model would describe as learned helplessness—was prominent across accounts (as cited in Pascoe & Smart Richman, 2009). Participants frequently described feeling locked into a fixed social position from which no amount of effort could provide escape. This produced not simply sadness but a kind of existential resignation that participants themselves recognized as abnormal yet felt powerless to address.

Somatic manifestations of distress—chest pain, sleep disturbance, headaches, appetite loss—were widely reported, consistent with South Asian expressions of psychological distress through bodily complaint (Hossain et al., 2014; Haque & Rahman, 2020). P14 remarked:

"I went to the doctor for my headaches. He said nothing is physically wrong. But the pain is real. It is all in my heart, not my head—but the body feels it too." (P14)

Several female participants (P2, P6, P10, P16, P18) described additional psychological burdens associated with gender—experiencing exclusion not only as sweeper community members but as women navigating patriarchal structures within and outside their community, compounding stress through multiple intersecting axes of marginalization (Wingood & DiClemente, 2000).



4.3 Theme 3: Social Isolation and Relational Deprivation

A third major theme was the **profound social isolation** experienced by participants—a qualitative aloneness that persisted even in densely populated urban environments. This isolation was not simply the absence of social contact but the active and repeated experience of being shut out from social participation, belonging, and recognition. Consistent with Jetten et al.'s (2012) social cure framework, such relational deprivation constituted a severe threat to the basic human need for social identity and belonging.

P7 described the spatial and symbolic dimensions of exclusion with vivid precision:

"No one sits with us at the tea stall. We sit at the end, or we do not sit at all. Our children are kept away from the other children in school—the teachers also do this, not just the children. Even in the mosque, people move away." (P7)

P3, a 28-year-old woman, articulated the loneliness produced by this exclusion:

"I have neighbors, I have colleagues, I have my family. But I am lonely. Because no one outside our community sees us as real people with real feelings. We are invisible." (P3)

Children's experiences of exclusion featured prominently in parents' accounts, often generating some of the most acute distress. Multiple participants described the anguish of watching their children internalize stigma or experience exclusion in educational settings:

"My daughter came home crying because her classmates called her 'methar baccha'—sweeper's child. As if it is a curse. She stopped wanting to go to school. I cried for a week. What can I say to her? That it will change? It will not." (P10)

This intergenerational transmission of stigma and exclusion emerged as a particularly painful dimension of participants' experience, underscoring how social exclusion operates not only at the individual level but is reproduced across generations—inscribed in children before they have the conceptual resources to resist it (Mohammadi & Hosseini, 2014; Rahman & Iqbal, 2019).

4.4 Theme 4: Resilience, Coping, and Meaning-making Amid Exclusion

Despite the pervasive and severe nature of the psychological burdens they carried, participants demonstrated remarkable **resilience** and deployed multiple coping strategies that partially buffered them against the most debilitating effects of exclusion. Consistent with Lazarus and Folkman's (1984) transactional model of stress and coping, these strategies ranged from emotion-focused (religious faith, community solidarity) to problem-focused (advocacy, children's education) and meaning-based (reframing occupation as service, hope for generational change).

Religious faith emerged as the single most frequently cited source of psychological sustenance. Participants—both Hindu and Muslim—drew on religious narratives of endurance, divine justice, and ultimate equality that directly countered the hierarchical devaluation imposed by caste-based exclusion:

"I pray every day—to God, to the goddess. God sees us even if people do not. God does not care about our work. God knows our hearts. This keeps me alive." (P1)

"In Islam, all people are equal before Allah. I hold onto this. The people who treat us badly—they will answer for it. I do not need their respect if Allah gives me dignity." (P6)

Community solidarity within the sweeper colony functioned as a critical **social buffer**, providing emotional validation, practical support, and a sense of belonging that the broader society denied. P17 described the colony as a space of psychological repair:

"Outside the colony, I am nothing. Inside, I am someone. People know me, respect me, ask my opinion. That is where I breathe." (P17)

Parental aspiration—the hope that children would escape the occupation and its stigma through education—was a powerful source of meaning and motivation for many participants. This vicarious hope sustained participants through circumstances they experienced as personally inescapable:

"I work so my children will not have to do this. If my son becomes a teacher or a doctor, everything I have suffered will have meaning. That thought keeps me going every morning." (P1)

A minority of participants described more active, collective forms of coping—participating in community meetings, engaging with NGOs, and articulating awareness of their rights. P12 and P17, both younger and with secondary education, expressed nascent political consciousness:

"We should not accept this. This is not fate—this is injustice. I know my rights. We deserve better and I will tell my children that too." (P12)

Taken together, these coping strategies reveal that sweeper community members are not passive recipients of structural harm but active agents who construct meaning, cultivate social resources, and resist—however partially—the psychological devastation of chronic exclusion (Haslam et al., 2018; Wilkinson & Pickett, 2009).

5. Discussion



The findings of this study powerfully affirm the international literature linking social exclusion to adverse mental health outcomes while contributing a rich, context-specific phenomenological understanding of how these dynamics are experienced within one of Bangladesh's most marginalized communities. Four interconnected dimensions of experience—internalized stigma and eroded self-worth, chronic psychological distress, social isolation, and resilience-based coping—collectively illuminate the psychological cost of caste-based exclusion with a depth unavailable through quantitative methods alone.

The centrality of **internalized stigma** in participants' accounts resonates strongly with Goffman's (1963) foundational theorization of the self-destructive consequences of stigmatized identity, and with more recent work by Link and Phelan (2001) and Hatzenbuehler et al. (2013) demonstrating that stigma functions as a fundamental cause of health inequalities. The present findings extend these frameworks by showing how internalized stigma is produced not through isolated incidents but through *chronic, cumulative exposure* to dehumanization—absorbed over years until it becomes a lens through which the self is apprehended. This has important clinical and policy implications: interventions aimed at ameliorating stigma's mental health consequences must address not only individual cognition but the structural conditions—occupational labeling, spatial segregation, civic exclusion—that generate it.

The depression-like and anxiety-like experiences documented here are consistent with epidemiological evidence on mental disorder prevalence among socially excluded groups (Mikkelsen et al., 2005; Mitra et al., 2019; Haque & Rahman, 2020), yet the phenomenological approach reveals dimensions that prevalence data cannot capture: the **existential quality** of suffering—the sense of entrapment, the temporal dimension of hopelessness reaching back into the past and forward into an imagined future of unalterable disadvantage, and the somatic encoding of distress in bodies that carry the weight of structural violence. These features suggest that standard psychiatric nosology may be inadequate for capturing the nature and meaning of psychological suffering in structurally marginalized populations, and call for culturally sensitive assessment frameworks that attend to context, chronicity, and social causation (WHO, 2022; Kessler & Üstün, 2008).

The **social isolation** theme, with its emphasis on relational deprivation rather than mere social contact deficit, aligns with Jetten et al.'s (2012) social cure framework and Haslam et al.'s (2018) demonstration that belonging to valued social groups is a fundamental determinant of mental health. The painful specificity of exclusion in shared civic spaces—teashops, mosques, schools—reveals how social exclusion is enacted not through formal policy but through the thousands of small daily interactions that constitute social life, and that cumulatively communicate to excluded individuals their fundamental non-belonging. The intergenerational dimension—the transmission of stigma to children in educational settings—adds particular urgency to intervention efforts, suggesting that without structural change, the psychological costs of exclusion will be reproduced across generations.

Notwithstanding these severe experiences, the **resilience** documented in Theme 4 offers both theoretical and practical insights. Participants did not simply endure exclusion; they actively constructed meaning, cultivated protective relationships, drew on religious and cultural resources, and—in some cases—articulated political awareness and aspirational agency. This finding resonates with Lazarus and Folkman's (1984) stress and coping model and Haslam et al.'s (2018) social cure framework, while also highlighting the importance of the sweeper colony as a micro-community of belonging within a broader environment of exclusion. From a policy perspective, this suggests that interventions should build on existing community strengths and solidarity networks rather than treating sweeper community members simply as passive recipients of harm.

This study has several limitations that should inform interpretation and future research. The sample, while purposively selected for diversity, is limited to Dhaka and may not reflect the experiences of sweeper community members in rural Bangladesh or other urban centers. The cross-sectional interview design captures experience at a single time-point and cannot address how mental health experiences evolve across the life course or in response to specific events. Self-report data carries inherent risks of social desirability, though the IPA approach's emphasis on depth and trust-building in the interview relationship, combined with member checking, mitigates this risk. Finally, as a researcher external to the sweeper community, the first author acknowledges the inevitable partiality of interpretation and has sought to address this through reflexivity, peer debriefing, and member checking.

6. Conclusion

This phenomenological study has produced rich and disturbing evidence of the profound mental health consequences of social exclusion for members of Bangladesh's sweeper community. Through 18 in-depth interviews and interpretive phenomenological analysis, we have documented the lived reality of internalized stigma, chronic psychological distress, social isolation, and intergenerational transmission of exclusion—alongside equally real experiences of resilience, faith-based coping, and community solidarity. These findings make a meaningful contribution to the nascent literature on mental health and structural marginalization in Bangladesh and South Asia, and demonstrate the indispensable value of qualitative, phenomenological approaches for illuminating forms of suffering that aggregate data cannot capture.

The study's findings carry clear implications for multiple constituencies. For **mental health policymakers**, they underscore the urgency of developing culturally responsive services that are accessible to sanitation workers—in terms of geography, cost, linguistic and cultural fit, and freedom from the stigma that mental health services themselves often carry in Bangladeshi society. For **local government and city corporations**, they highlight the need to move beyond formal anti-discrimination provisions to actively promote inclusive civic spaces, enforce occupational health protections, and develop community programs that recognize the dignity and rights of sanitation workers. For **educators and school administrators**, they call for specific interventions targeting caste-based discrimination in schools, including teacher training and peer inclusion programs. For **NGOs and civil society organizations**, they suggest the value of mental health-oriented programming that integrates rights awareness, community solidarity strengthening, and psychological support.



Future research should extend this work longitudinally to examine how mental health experiences evolve over time; comparatively, to situate Bangladeshi sweeper community experiences within the broader South Asian context; and through mixed methods, to quantify the prevalence of specific mental health conditions alongside qualitative depth. Community-based participatory research designs that actively involve sweeper community members in research design and knowledge production would represent a particularly valuable development, moving toward research that is not merely about marginalized communities but genuinely with and for them.

The sweeper community of Bangladesh sweeps our streets, cleans our drains, and removes our waste—an indispensable labor that makes urban life possible. The least that psychological science can do is to see them, hear their suffering, and contribute to the knowledge base that supports their full inclusion in the society they serve.

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