A qualitative study on factors affecting mental well being among low income working mothers in Chennai-India

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INTRODUCTION:

Mental health disorders contribute significantly to the global burden of non-communicable chronic disease: the World Health Organization has estimated that mental and behavioral disorders account for 12% of the global burden of disease, while community-based epidemiological studies in different settings have recorded a lifetime prevalence of mental disorders ranging from 12.2–48.

Low-income urban working mothers face a range of challenges in their domestic, environmental, and working conditions that may affect their mental health. In India, the second most populous country in the world, approximately 31% of the total population lives in urban areas and almost a quarter of urban residents live in slums.

To meet financial needs, the majority of women work, but they commonly have limited job choices and frequently cite heavy workload challenges [. Research suggests that life stressors associated with poverty increase the risk of mental health disorders and that women are more vulnerable than men to mental health problems such as unipolar depressive disorders, schizophrenia, unipolar affective disorders and self-inflicted injuries.

A few small-scale initiatives to provide community-based mental health services in India have been successful, but the need for well-designed and appropriately targeted services for a range of different population groups remains great. Filling this need will require evidence on both the triggers of poor mental health and the potential mitigators.

Various studies in urban India have identified risk factors for depression and suicide among people living in slums: an ethnographic study set in Mumbai slums con- ducted amongst a small sample of men and women found that poverty, poor living and working conditions, alcoholic husbands and intimate partner violence were factors that increased risk for depression , while another rural study identified husband's alcohol consumption, intimate partner violence and financial difficulties as increasing risk for attempted suicide among women .

Methods:

Study design:

Mothers of children between the ages of 0-5 years old who were currently working (and had been working for a mini- mum of a year) as construction workers, domestic workers, garment factory workers, or fruit/vegetable/flower street vendors were eligible to participate in the study.
The four occupation groups were selected on the basis of being the most common low-income occupations amongst mothers of young children living in slums in Chennai, and were initially identified through discussions with key informants (women's group leaders in slums; representatives of NGOs working on labour issues, community development, women's rights and child rights; government day care centre workers in slums; and, representatives of trade unions for low income workers).

These occupations also represented a range of working conditions, such as variable work hours and multiple employers for domestic workers; daily wage labour for construction workers and some street vendors; self-employment and flexible working hours for some street vendors; and, unionization and industrial labour regulation for garment factory workers. Amongst the selected occupation groups, monthly income for a full day's work ranged from INR4,000-INR8,000 .

A qualitative researcher visited multiple worksites (4 fruit and vegetable markets, 3 garment factories) and low-income residential areas (22 medium to large slums across Chennai) to recruit study participants who would represent a range of working and living conditions. Forty-eight women (12 from each occupation group) who met the inclusion criteria were recruited.

Data collection and analysis:

Interviews were conducted by a qualitative researcher in the local language, Tamil, at a time and place of the participant's choice. The data was collected in 2 phases between August 2021 and Nov 2021 .

All participants (n = 48) were administered a short closed-ended questionnaire.
It included questions on participant age, marital status, participant and spouse highest education level, years of experience in current occupation, house ownership, number and age of children, monthly household income, household assets (mobile phone, bicycle, motorbike, car/auto rickshaw, television, refrigerator), and workplace benefits (Provident Fund, paid leave, maternity leave, health insurance).

The participants were then interviewed with in-depth open ended questions for about an hour about their working conditions, child care and spousal support, child and maternal health and wellbeing, and family, community and other types of support available to them.

Following a preliminary analysis of the first phase of interviews, more de- tailed questions were added in the second phase on mental health status, the relationships between work, caring for family, spousal support and mental health, the availability of emotional support, and stress mitigators. The Kessler psychological distress questionnaire was also administered to the second phase participants.

This 10- item scale, validated for use in India, yields a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the past four weeks
Participants who were experiencing substantial mental distress were given the name, location and contact details of local NGOs that provided counseling and other support services for women.

After completion of data collection, all participants were assigned aliases to maintain anonymity in the reporting of results. Interviews were simultaneously translated and transcribed in English by bi-lingual research assistants. The transcripts were reviewed by the interviewer, who listened to the audio recording while reading through the transcripts to check for accurate and consistent translation.
Transcripts were subsequently language edited to en- sure contextual translation. The transcripts were then analyzed thematically, using NVivo 9.2 qualitative data analysis software.
Transcripts were coded for descriptions of state of mental health, factors that affected mental health positively or negatively, manifestations and consequences of stress and depression, and stress mitigators. Mental health concerns were qualitatively identified when respondents spoke about life events or their general state of being in terms of feelings of severe stress, anxiety, sadness and despair, uncontrollable crying, persistent frustration, feelings of worthlessness, no desire to live and suicide attempts.
The socio-economic and Kessler scale data were entered and analyzed in Statistical Package for the Social Sciences
A variable was created to assess if the participants were below poverty line, based on a new methodology pro- posed by the Planning Commission, which takes into ac- count residential, occupational and social vulnerability of families.
Although we did not have all the information necessary to create a vulnerability score for participants, we were able to categorize families

living below the poverty line based on automatic inclusion criteria related to occupation of participants and their spouses.

Study participants were aged between 19 to 40 years, and had between 1 and 5 children. Socio-demographic and economic characteristic of the participants are detailed in Table 1. The participants were characterized by low education levels. Out of 48 participants, 40 were married, 5 were widowed and 3 were divorced or separated. The monthly household income ranged from INR 2,000-12,000

Table 1 Socio-demographic and economic characteristics of the participants

	Construction worker (12)	Domestic worker (12)	Factory worker (12)	Street vendor (12)	Total n = 48
Age in years (median, range)	25, 20-35	28, 21-36	25, 21-31	21, 19-40	25, 19-40
Marital status					
Married	11	11	10	8	40
Widowed	-	1	2	2	5
Divorced/separated	1	-	-	2	3
Number of children (median, range)	3, 2-5	3, 1-5	2, 1-4	2, 1-5	3, 1-5
Respondent higher education level					
No education	7	4	3	5	19
Primary	4	7	6	7	24
Secondary	1	1	2	0	4
Tertiary	0	0	1	0	1
Spouse highest education level					
No education	6	2	2	2	12
Primary	3	7	5	4	19
Secondary	2	2	1	2	7
Tertiary	1	0	2	0	3
Number of years in current occupation (median, range)	12, 2-20	8, 1-22	6, 2-14	8, 3-20	8, 1-22
Monthly household income in INR (range)	2,000 10,000	-2,800 11,000	–2,000 12,000	–3,000 10,000	–2,000 12,000
Below poverty line	12	12	6	12	42

These included households where any member is a domestic worker (12), where all earning adults are daily wagers or irregular wagers (24), women headed house- holds (2), and households where the main bread-winner is a head-loader, security guard, driver or painter (4). Most women had been working in their current occupations for several years (median 8 years, range 1-22 years).

Mental health status

Out of the 24 respondents who were administered the Kessler 10 test, nearly half (11) were diagnosed as likely to have a moderate to severe mental disorder. One third (8) were likely to have a mild mental disorder, and only a fifth(5) were diagnosed as likely to be well. In the qualitative interviews with all 48 participants, about two thirds of women (32) mentioned that their mental health was not good. Less than one fifth of the participants (9) mentioned that they felt peaceful or happy with the current situation in their life. Amongst Phase 2 participants, 17 of the 21 women who spoke about their mental health concerns in interviews were found likely to have a mild to severe men- tal disorder as per the Kessler scale. This indicates a correspondence of over 80% between qualitative assessment and the Kessler assessment.

Some women had experienced sustained states of de- pression and hopelessness, while others spoke about experiencing a poor state of mental health which had passed when circumstances changed. The mothers in this study described a range of symptoms commonly associ- ated with manifestations of poor mental health (detailed in Table 2). At the extreme end were attempts at suicide (2), suicidal ideation (5) and uncontrollable crying (14). A large number of respondents also mentioned feelings of anxiety, stress, frustration, disappointment, despair and re- duced desire to live. Consequences of this stress reported

Table 2 Symptoms and consequences of poor mental health amongst study participants, as mentioned during in-depth interviews

	n = 48	%
Symptoms of poor mental health		
Uncontrollable crying	14	29.2
Suicidal ideation	5	10.4
Attempted suicide	2	4.2
Consequences of poor mental health		
Inability to care properly for family	21	43.8

Hitting children	18	37.5
Poor performance at work or missing work altogether	8	16.7
Picking fights with spouse and family member	6	12.5
Lack of desire to interact with others	4	8.3
Chewing tobacco	2	4.2

by respondents included inability to care properly for fam- ily (21), hitting children (18), poor performance at work or missing work altogether (8), picking fights with spouse and family members (6), lack of desire to interact with others (4) and chewing tobacco (2). None of the par- ticipants mentioned seeking professional help for anxiety or depression. The major causes of poor mental health and stress mitigating factors identified by respondents are discussed below.

Factors contributing to mental distress

The most frequently cited factors that affected mental health negatively were an alcoholic spouse, intimate part- ner violence, poor working conditions, and barriers to caring for children. While most women in the study reported experiencing these factors at one time or another, long- term prevalence of mental distress appeared to be greatest amongst those facing sustained difficult circumstances such as having an alcoholic spouse, on-going intimate partner violence, the need to care for special needs children, or lack of support for providing quality routine care for children.

Alcoholic spouses and intimate partner violence

More than half the women (25) in the study reported that their husbands drank alcohol regularly and heavily. Most of the women whose husbands drank regularly also reported experiencing intimate partner violence which pro- foundly affected their mental health. Most of the respondents who spoke about attempted suicide or suicidal ideation were victims of intimate partner violence. In some families, children were also victims of abuse by an alcoholic father. None of the women mentioned seeking help in deal- ing with an alcoholic spouse or intimate partner violence.

Challenges providing for children's health needs

Mothers with special needs children are particularly susceptible to chronic stress and depression. Most respon- dents also reported that they faced barriers in providing adequate care when their children fall sick, including not having enough money for treatment and not having time to care for the sick child due to work commitments.

Challenges providing for routine child care

Amongst working mothers, routine child care concerns could also be a cause of anxiety and stress. Respondents expressed a number of concerns about their children's well-being, including abusive childcare, children's safety in the absence of supervised child care, financial and time constraints to providing adequate nutrition and supervision for children, and lack of physical and emotional sup- port to care for their children.

Work conditions

The women in our study expressed how negative working conditions also affect their mental health. Domestic workers had no formal leave from work. This was a source of anxiety when women had to take long leaves because of their own or children's health problems, and they worried about losing their job as a consequence.

Selvi was denied leave when she was having a high fever and feeling too weak to stand, she narrated an instance when she had an injury at work and her employer refused to give her leave:

Mitigators of stress

Supportive spouse

Having a supportive spouse who contributes to household expenses, participates in childcare and helps in household tasks was a significant mitigator of life stressors. A few respondents mentioned that their husband helped them with household chores when they were unwell. Many respondents also mentioned that their husband contributed money to meet the household expenses, although in most cases, insufficiently or irregularly.

Supportive work environment

While a few women spoke about work as being a stressor, empathetic employers and friendly colleagues were commonly mentioned as factors that helped to relieve stress caused by problems at home. More than a quarter of the respondents (14) mentioned that work had a positive im- pact on their

mental health. These women discussed problems related to children, spouse, work or their general state of mind with their employers or colleagues, and found the sharing to be very effective in relieving stress and alleviating depression. The respondents who reported that work had a positive impact on their mental health all spoke about experiences of sharing their feelings, especially when they are facing difficult times at home.

Discussion

This qualitative study raises concerns that low-income working mothers in urban areas in India are at a high risk for depression. Women who have an alcoholic and/or abu- sive husband, face intimate partner violence or are raising children with special needs appear to be more susceptible to severe and prolonged periods of depression and suicide attempts. At the same time, when a range of more temporal life stressors (such as illness in the family especially among children, financial problems, and lack of support from family members) strike at the same time, this could push women into spells of severe depression. Even within our small study sample, extreme consequences of depression were evident: several women spoke of instances of attempted suicide and suicidal ideation.

None of the women in the study, including those who attempted suicide, mentioned seeking professional support for anxiety or depression. There were a number of mitigating factors that could help women to battle, anxiety and depression, such as social and financial support from family, friends and col- leagues and the distraction or fulfillment of work. Given the need to address mental health issues amongst women in India, these findings suggest potential directions for mental health interventions among low-income working mothers in urban India.

Our study examined the role of supportive work environment particularly in relation to psychological benefits of emotional support offered by colleagues. In India, data on the effects of work on the mental health of mothers is virtually non-existent. In our study, many of the mothers who had school-aged children spoke about the psycho-logical benefits of their work: these included support when their employers were sympathetic and helpful, the chance not be exposed to and focus on the problems at home for some hours of the day, and, most of all, the emotional sup- port and encouragement they received from their colleagues when they spoke about their problems, including depression and suicidal ideation. These findings suggest that, apart from economic benefits, working outside the home can promote the mental health of mothers with children who are school-age, and pre-school age when care is available.

A strength of our study is that we examined women's perspectives on factors that have impacted their mental health across their family and work roles. Previous re- search in India has not detailed the role of work in women's mental health and how this interplays with women's family responsibilities. Our study thus provides

Conclusion:

India was one of the low-income countries to recognize the need to address mental health with its Na- ti Mental Health Programme (NMHP) which was launched in 1982. Unfortunately, its goals remain largely unattained . One of the reasons is the ignorance about mental health between the women.

India has now resolved to frame a mental health policy that takes into account the specific local context of mental illness.

The development of this policy and subsequent implementation should draw on existing research documenting factors associated with negative mental health amongst specific population groups, in order to ensure greater effectiveness and impact.

Indeed, the Millennium Development Goals to improve maternal health, reduce child mortal- ity, promote gender equality and empower women and eradicate extreme poverty cannot be attained without a specific focus on women's mental health.

References

Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, Rahman A:

No health without mental health. Lancet 2007, 370:859–877.

World Health Organization: Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in low-Resource Settings. Geneva: WHO; 2010.

Patel V, Boyce N, Collins PY, Saxena S, Horton R: A renewed agenda for global mental health. Lancet 2011, 378(9801):1441–1442.
Patel V: Mental health in low- and middle-income countries. Br Med Bull
2007, 81 and 82:81–96.
Registrar General and Census Commissioner: Census of India 2011. In Rural Urban Distribution of Population (Provisional Population Totals). New Delhi: Government of India; 2011.
Make cities liveable and safe places for millions of children. [http://www.unicef.org/india/media_7541.htm.](http://www.unicef.org/india/media_7541.htm)
Kotwal N, Gupta N, Manhas S: Impact of work and environment on women living in Urban Slums of Jammu city. Stud Home Community Sci 2008, 2(2):93–97.
Patel V, Araya R, de Lima M, Ludermir A, Todd C: Women, poverty and common mental disorders in four restructuring societies. Soc Sci Med 1999, 49(11):1461–1471.
Parkar SR, Fernandes J, Weiss MG: Contextualizing mental health: gendered experiences in a Mumbai slum. Anthropol Med 2003, 10(3):291–308.
Patel V, Kleinman A: Poverty and common mental disorders in developing countries. Bull World Health Organ 2003, 81(8):609–615.
Gruebner O, Khan MM, Lautenbach S, Muller D, Kramer A, Lakes T, Hostert P:
Mental health in the slums of Dhaka - a geoepidemiological study.
BMC Public Health 2013, 12:177.
Patel V, Ramasundarahettige C, Vijayakumar L, Thakur JS, Gajalakshmi V, Gururaj G, Suraweera W, Jha P: Suicide mortality in India: a nationally representative survey. Lancet 2012, 379(9834):2343–2351.
Poongothai S, Pradeepa R, Ganesan A, Mohan V: Prevalence of depression in a large urban South Indian population–the Chennai Urban Rural Epidemiology Study (CURES-70). PLoS One 2009, 4(9):e7185.
Balaji M, Chatterjee S, Koschorke M, Rangaswamy T, Chavan A, Dabholkar H, Dakshin L, Kumar P, John S, Thornicroft G, et al: The development of a lay health worker delivered collaborative community based intervention for people with schizophrenia in India. BMC Health Serv Res 2012, 12:42.
Patel V, Weiss HA, Chowdhary N, Naik S, Pednekar S, Chatterjee S, De Silva MJ, Bhat B, Araya R, King M, et al: Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. Lancet 2010, 376(9758):2086–2095.
Kermode M, Herrman H, Arole R, White J, Premkumar R, Patel V: Empowerment of women and mental health promotion: a qualitative study in rural Maharashtra, India. BMC Public Health 2007, 7:225.
Parkar SR, Nagarsekar BB, Weiss MG: Explaining suicide: identifying common themes and diverse perspectives in an urban Mumbai slum. Soc Sci Med 2012, 75(11):2037–2046.
Silvanus V, Subramanian P: Epidemiological study of mental morbidity in an urban slum community in India for the development of a community mental health programme. Nepal Med Coll J 2012, 14(1):13–17.

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