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Mental Health among Below Poverty Line, Above Poverty Line Males and Migrant Labours of Haryana

Rakesh Kumar Behmani* Promila** Suman Behmani***

Abstract

Relationships between social status and various aspects of mental disorder have long been of interest to both clinicians and researchers, and a large body of research exists showing the importance of poverty in understanding psychiatric illness and disability. Present study is an effort to study the mental health among males belonging from different strata of society economically. Sample (540 males) was collected from villages of Haryana. The sample is further divided between three categories of migrant labours, below poverty line people and people who earn moderately of above poverty line persons (180 each). Mental health questionnaire prepared by Srivastava and Bhatt was used in this study as instrument. Results show that participants below poverty line and migrant labours scored markedly higher on free floating anxiety, somatic anxiety, and phobic anxiety in comparison to participants above poverty line. Participants below poverty line and migrant labours scored markedly higher on neurotic depression in comparison to participants above poverty line. Participants below poverty line and migrant labours scored markedly higher on hysterical personality traits in comparison to participants above poverty line.

About Author

**Associate Professor, Department of Applied Psychology*

***Research Scholar, Department of Applied Psychology*

****Research Scholar, Haryana School of Business*

Guru Jambheshwar University of Science and Technology, Hisar

Introduction

The complex nature of poverty has long been recognized and studied by psychologists and other professionals from different angles. In Britain, Rowntree (1901), following Mayhew (1851), and Booth (1892), grappled with the complexity of poverty, distinguishing between different categories of poverty and noting the need to take account of social conditions, diet, and health as well as income in assessing living standards. Much later, Townsend (1979) argue that poverty was not the lack of income necessary to purchase a basket of goods but rather the lack of resources to participate fully in society that resulted, through a process he termed 'structuration', from a variety of resource allocation systems operating in society. The measures created by Townsend (1979) have since been critically developed, assessed, examined and refined by various scholars such as Piachaud (1981), and Gordon et al. (2000). An overwhelming majority, however, agrees that income is merely an indirect measure of poverty that is truly experienced as the unavoidable low consumption that denies people access to a normal effective way of life.

Poverty and social inequality have direct and indirect effects on the social, mental, and physical well-being of an individual. It is equally important to note that poverty and inequality are closely linked. In Bridging the gaps, the World Health Organization states, "the World's most ruthless killer and the greatest cause of suffering on earth is extreme poverty".

This statement emphasizes the importance of poverty as a variable adversely influencing health. Poverty can be intrinsically alienating and distressing, and of particular concern are the direct and indirect effects of poverty on the development and maintenance of emotional, behavioural and psychiatric problems.

Categorization of groups of people into upper and lower strata, into superior and inferior, is done by those who require such categorization or division to maintain their superiority and power, prevent others from obtaining an equal share of assets and resources, and thereby propagate and sustain the myth of superiority (Williams, 1993). Thus, classism results from unequal "class privilege (i.e., unearned advantage and conferred dominance) and power" (Moon &Rolison, 1998). Power defined as access to resources, enables the group with greatest access to set the rules, frame the discourse, and name and describe those with less power. Members of high-power groups will be more able than those in low-power groups to maintain their power as they receive its benefits and increase their ability to maneuver within society the control. As Unger (2000) has noted, "those who have the power to define the acceptable qualities of others benefit from their ability to label others" (p.166). Likewise, Sidanius and Pratto (1999) presented data and a convincing argument to support the conclusion that "it is power_ _ _ that enables one to discriminate" (p.19).

Poverty and Mental Health

The complexity in inter-relatedness of factors such as poverty, health and employment make it interesting to look at the relationship that prevails between them. Relationships between social status and various aspects of mental disorder have long been of interest to both clinicians and researchers, and a large body of research exists showing the importance of poverty in understanding psychiatric illness and disability. Epidemiological studies throughout the world have demonstrated an inverse relationship between mental illness and social class. Psychiatric disorders have been consistently shown to be more common among people in lower social class.

Poverty has been associated with numerous psychological variables such as depression, anxiety, self-esteem, strategies for coping with stress, achievement motivation, perception of social support, and locus of control, among others. Reviews by Dohrenwend and Dohrenwend (1974) and Haring, Stock, and Okun (1984) indicate that low SES is associated with high rates of depression, mental illness, and lowered psychological well-being.

In a review of 61 studies, Ortega and Corzine (1990) report that 46 find the highest rates of mental health problems in the poorest social class. Part of the association between poverty and severe forms of psychopathology, such as schizophrenia, is probably due to downward drift; that is, mental illness is likely to be a cause of low SES. But it seems reasonable to conclude that the stressful conditions associated with poverty, and the lack of resources for coping with these stresses, are factors that contribute to the low level of general psychological well-being among the poor. Adler, Epel, Castellazzo and Ickovics (2000) have found that physical and psychological health variables, such as certain styles for coping with stress, levels of stress, physical health and pessimism, are more related to the perceived socioeconomic level than to the objective socioeconomic level.

A review of the literature further reveals that the relationship between detrimental mental health and the experience of poverty and deprivation has been well studied and an association between the two factors has been established. Although no group is immune to mental disorders, the risk is higher among the

poor, homeless, the unemployed, persons with low education (Kuruvilla& Jacob, 2007). The link is however, complex and is influenced by numerous factors. Poverty, acting through economic stressors such as unemployment, inadequate income and resources, and lack of affordable houses, is more likely to precede mental illnesses such as depression and anxiety, thus making it an important risk factor for mental illness (Patel &Kleinman, 2003; Robert, 2003). In the recent past, research has focused on multi-factorial explanations which accept the possibility of some drift, whilst also acknowledging that, particularly at the lower levels of symptomatology, drift is less likely to occur (Payne, 2000).

In the context of the definition of health proposed by World Health Organization, psychological health and social well-being are equally important as physical health. Health is not a static process. It is actually a dynamic process throughout man's life which can be influenced upon by involvement in individual, social, local, regional, and political endeavors. It is largely the outcome of the subjective feeling of well-being, life optimism, social inclusion, and satisfaction with life. One of the unavoidable components included in the definition of health is the subjective well-being, which is a potent predictor of mental health.

Mental health has been under intensive scrutiny in the past few decades, with regard to the important role which it plays in the health of an individual and the nation as a whole. According to Ottawa Chapter for Health Promotion, the basic preconditions for health are peace, a roof above one's head, education, food, income, stable eco-system, sustainable resources, social justice and equality in health (WHO, 1986). According to WHO strategy "Health for all 2020" it is defined that inequalities in health are the consequences of desperate living possibilities. "Health for all 2020" defines justice and solidarity as a basis of a healthy population. The strategy stresses that the greatest attention must be devoted to those who have the greatest needs. Researchers have shown that life-style is a key factor in the development of disease in as much as 50% of cases, whereas genetic factors are responsible for 20%, an additional 20% are attributable to the environment which includes the complex of social and cultural conditions and physical environment, while the remaining 10% cover the factor of health care (Frank &Musard, 1994).

The association between poverty and mental health has been explored from different perspectives:

a) Distress as a result of poverty
b) Mental illness as a result of poverty
c) Psychiatric diagnosis leading to poverty

Social inequality in health has been studied for a number of years and social deprivation is one of the predictors of inequality. However, in the socially deprived population too, not everyone has equal chances for the manifestation or prevention of a disease. Although personal responsibility in the context of adequate and proper nutrition, exercise involving sufficient physical activity, non-smoking, responsible indulgence in sexual behaviour is indispensable for health, the vast literature shows that social determinants of health are necessary for making the right decisions and right choices in life, and, consequently they are the best determinants of health. Studies (Gwatkin et al., 2007) show that population that is low on the social ladder has twice the risk of decease and premature death. Likewise, Poortinga (2006) found that feelings like permanent anxiety, insecurity, low self-esteem, social isolation loss of control over work and life, long-term stress have a base in deprivation.

A recent study (Bilajec, Marchesi, Tesic, &Rukavina, 2014) aimed at determining the relationship of dimensions of personality (optimism, control over life), social involvement (social capital) and socio-economic status with health and inequalities in health. The study was performed on 1017 respondents who were chosen according to the set criteria: middle age, working capability, and, according to the documentation of the centers for social welfare, the recipients of financial welfare from the state. A questionnaire was created from several existing questionnaires with validated indicators. The study revealed that the population was mainly unemployed with insufficient resources for living. More burdened and higher risk for future development of the disease was found within this population. Optimism, social inclusion and life satisfaction played a large role as protective factors in health. The authors concluded that the interventions demand a multidisciplinary approach, and, with regard to the sensitivity of the population, the best solution is in their own empowerment, as a protective factor for mental health.

Another recent study (Herbig, Dragano, &Angerer, 2013) found that impact on health is not only the consequence of material impoverishment, but also of social and psychological problems caused by life in poverty. Unemployment and job insecurity carries and even greater health risk, mental as well as physical. Likewise, Manoranjitham, Abraham, & Jacob (2005), Prasad et al. (2006) and Vijayakumar, John, Pirkis, and Whiteford (2005) emphasized that although mental illness is a significant risk factor underlying suicide, researches in the developing countries including India note that often it is the individual's psychosocial context and stress which are the most common correlates of suicide. The most commonly reported stressors refer to financial hardship, lower education and unfulfilled expectations in a broader perspective: the common denominators of poverty. the high rates of suicide in the unemployed, marginalized and those subject to rapid and significant social change (Vijayakumar, John, Pirkis, and Whiteford, 2005) is explained by the fact that suicide has been interpreted not only as a gesture of the despair but also a means by which to express a deeply felt sense of having been wrong. Self-harm is more than 3 times as common in men and 2.5 times as common in women from the lowest 20% of income compared with those from the highest 20%. Deprivation causes physical health problems which greatly increase the risk of mental illness, particularly depression. Although there is elaborate evidence for the relevance of psychological dimensions to the prevalence of suicide, the evidence for socio-economic dimensions is equally compelling.

Recent reviews of the literature continue to demonstrate that economic hardship and poverty can have devastating consequences for the lives of parents, the effective functioning of families, and the physical, behavioral, emotional, and cognitive development of children (Magnusson & Duncan, 2002; McLoyd, 1998).

In sum, it can be emphasized that people living in poverty are more likely to experience mental health problems because of the following parameters:

a) Worklessness, the lack of opportunities that benefit-dependency affords and the propensity to get into the debt.

b) Poor educational attainment.

c) Family breakdown which leads to social isolation and exclusion.

d) Addiction to drugs and alcohol (self-medication with drugs and alcohol).

e) Many obstacles, deficits, and threats to health are inherent in poverty.

Method

Sample

Sample of the present study consists 540 persons from villages of Haryana. The sample is further divided between three categories of migrant labours, below poverty line people and people who earn moderately of above poverty line persons (180 each). Age range of the whole sample is between 22 to 45 years. In this way a total data of 540 subjects is collected for this study, out of which there are 180 males of migrant families, 180 males of BPL families, 180 males from above poverty line families.

	Below poverty lin e male	Above poverty line male	Migrant labours
Males	180	180	180

Measure/ Instrument:

Mental health questionnaire (Srivastava and Bhatt, 1973):

The mental health questionnaire consist of 48 items to and it cover the following six dimension of sound mental health and psychological well being It include free floating anxiety, obsessional traits and symptoms, phobic anxiety, somatic concomitants of anxiety, neurotic depression, hysterical personality traits to measure mental ill health of the individual. The tester should distribute the questionnaire and ask the subject to give the personal details on the first page. The subject may give their usual details only. The tester should then start reading the instruction printed on the front cover while the subject read them silently. If there are any queries the same could be answered without referring to any item. Usually it takes about 15 to 20 minutes to answer but some subject may take a little longer.

Results and Discussion

Mental health has been under intensive scrutiny in the past several decades, with regard to the important role which it plays in the health of an individual and the nation as a whole. It is a major part of young people's general well being, and is also closely bound up with their physical health. Mental health problems have important implications for every aspect of people's life including their ability to engage with education, make and keep friends, engage in constructive family relationships, and find their own way in the world. Mental health problems are also a major contributor to the global burden of disease (Fink, Patalay, & Sharp, 2015; Fombonne, Quirke, & Hagen, 2011; Whiteford, Degenhardt, & Rehgm, 2013) and untreated problems are likely to be very expensive for health services as young people grow into adulthood.

Health is actually a dynamic process throughout men's life which can be influenced upon through individual, social, local, regional, and national political involvement. Apart from the already mentioned variables, health is largely the outcome of the subjective feeling of wellbeing, optimism, social inclusion and satisfaction with life. Although personal responsibility which includes nutrition, physical activity, non-smoking, responsible sexual behaviour is indispensible for health, literature shows that social determinants of health are necessary for making the right decisions and right choices in life, and consequently they are the determinants of health.

In the context of the significance of mental health, the current study compared three different groups referring to participants below poverty line, above poverty line and migrant labors on six different dimensions of mental health as measured by mental health

questionnaire. The six different dimensions pertains to free floating anxiety, phobic anxiety, obsessional traits and symptoms, somatic concomitants of anxiety, neurotic depression and hysterical personality traits. The groups were compared on these six different dimensions by making use of one way analysis of variance.

Table 1: Mean Scores of Different Groups on Different Dimensions of Mental Health

Code	BPL		APL		ML	
Free Floating Anxiety	Mean	SD	Mean	SD	Mean	SD
Obsessional Traits and Symptoms	7.42	3.74	5.90	3.51	7.45	2.89
Phobic Anxiety	8.78	3.02	8.03	3.12	8.14	2.95
Somatic Concomitants of Anxiety	6.37	3.11	4.82	2.46	6.85	3.03
Neurotic Depression	7.44	3.42	5.45	3.19	7.39	2.96
Hysterical Personality Traits	7.90	3.37	5.60	3.21	7.42	2.93
Free Floating Anxiety	6.92	4.01	5.73	3.30	7.70	3.19

Table 2: ANOVA results for FreeFloating Anxiety

Sources of Variation	Sum of Squares	D.F	Mean Square	F
Between groups	281.24	2	140.62	12.15**
Within groups	6213.79	537	11.57	
Total	6495.03	539		

**P<.01

Table 1 and 2 reveal significant F-value [F (2,537) =12.15, p<.01] for free floating anxiety. The significant F-value implies that there are significant differences between three groups on free floating anxiety. In the context of significant F-value, mean of free floating anxiety scores were computed. The mean scores for three groups referring to below poverty line, above poverty line and migrant labours were found to be 7.42, 5.90 and 7.45 respectively. It is clear from the mean scores that participants below poverty line and migrant labours scored markedly higher on free floating anxiety in comparison to participants above poverty line.

Table 3: ANOVA results for Obsessional Traits and Symptoms

Sources of Variation	Sum of Squares	D.F	Mean Square	F
Between groups	58.63	2	29.31	3.17
Within groups	4954.21	537	9.22	
Total	5012.86	539		

Table 4: ANOVA results for Phobic Anxiety

Sources of Variation	Sum of Squares	D.F	Mean Square	F
Between groups	406.23	2	203.11	24.40**
Within groups	4469.70	537	8.32	
Total	4875.93	539		

**P<.01

Table 5 : ANOVA results for Somatic Concomitants of Anxiety

Sources of Variation	Sum of Squares	D.F	Mean Square	F
Between groups	461.70	2	230.84	22.53**
Within groups	5499.97	537	10.24	
Total	5961.66	539		

**P<.01

Table 6 : ANOVA results for Neurotic Depression

Sources of Variation	Sum of Squares	D.F	Mean Square	F
Between groups	530.32	2	265.16	26.20**
Within groups	5433.31	537	10.11	
Total	5963.63	539		

**P<.01

Table 7: ANOVA results for Hysterical Personality Traits

Sources of Variation	Sum of Squares	D.F	Mean Square	F
Between groups	357.11	2	178.55	14.36**
Within groups	6675.97	537	12.43	
Total	7033.08	539		

**P<.01

Table 3 reveals non-significant F-value [F (2,537) =3.17, NS] for obsessional traits. The non-significant F-value implies that there are no differences between three different groups from the viewpoint of obsessional traits and symptoms. It implies that the different parameters of poverty as used in the current study did not influence the presence/experience of obsessional traits and symptoms.

Table 4 reveals significant F-value [F (2,537) =24.40, p<.01] for phobic anxiety. The significant F-value implies that there are significant differences between three groups on phobic anxiety. In the context of significant F-value, mean of phobic anxiety scores were computed. The mean scores for three groups referring to below poverty line, above poverty line and migrant labours were found to be 6.37, 4.82, and 6.85 respectively.

It is clear from the mean scores that participants below poverty line and migrant labours scored markedly higher on free floating anxiety in comparison to participants above poverty line.

Table 5 reveals significant F-value [F (2,537) =22.53, p<.01] for somatic concomitants of anxiety. The significant F-value implies that there are significant differences between three groups on somatic concomitants of anxiety. In the context of significant F-value, mean of somatic concomitants of anxiety scores were computed. The mean scores for three groups referring to below poverty line, above poverty line and migrant labours were found to be 7.44, 5.45, and 7.39 respectively. The mean scores have also been presented graphically in Figure: 4.24. It is clear from the mean scores that participants below poverty line and migrant labours scored markedly higher on somatic concomitants of anxiety in comparison to participants above poverty line.

Table 6 reveals significant F-value [F (2,537) =26.20, p<.01] for neurotic depression. The significant F-value implies that there are significant differences between three groups on neurotic depression. In the context of significant F-value, mean of neurotic depression scores were computed. The mean scores for three groups referring to below poverty line, above poverty line and migrant labours were found to be 7.90, 5.60, and 7.42, respectively. It is clear from the mean scores that participants below poverty line and migrant labours scored markedly higher on neurotic depression in comparison to participants above poverty line.

Table 7 reveals significant F-value [F (2,537) =14.36, p<.01] for hysterical personality traits. The significant F-value implies that there are significant differences between three groups on hysterical personality. In the context of significant F-value, mean of hysterical personality scores were computed. The mean scores for three groups referring to below poverty line, above poverty line and migrant labours were found to be 6.92, 5.73, and 7.70 respectively. It is clear from the mean scores that participants below poverty line and migrant labours scored markedly higher on hysterical personality in comparison to participants above poverty line.

These presentations of results regarding different indices of mental health in the context of different groups reveal that participants below poverty line and migrant labours scored markedly higher on free floating anxiety, somatic anxiety, and phobic anxiety in comparison to participants above poverty line.Participants below poverty line and migrant labours scored markedly higher on neurotic depression in comparison to participants above poverty line.Participants below poverty line and migrant labours scored markedly higher on hysterical personality traits in comparison to participants above poverty line.The mean scores of participants below poverty line and migrant labours on free floating anxiety, somatic anxiety, phobic anxiety, neurotic depression and hysterical personality traits were more or less same.

For the above results concerning poverty and mental health, earlier observations seem to be in order like Study byGwatkin et al. (2007) show that population that is low on the social ladder has twice the risk of disease and premature death. In the dame manner Poortinga (2006) found that poor mental health is often causes feelings like permanent anxiety, depression, insecurity, low self-esteem, social isolation, loss of control over life and work, and long term stress.

The impact on mental health is not only the consequence of material impoverishment, but also of social and psychological problems caused by life suffering from poverty. Researchers have shown that unemployment

and job insecurity carries even greater health risk, mental as well as physical (Herbig, Dragano, &Angerer, 2013).

Poverty has far-reaching negative consequences for quality of life, an important component of mental health. The poor are more likely than others to be exposed to stressful life events, such as unemployment, crime victimization, and illness; they also live with chronic strains such as economic hardship, job dissatisfaction, and frustrated aspirations (Ross & Huber, 1985; Williams, 1990). Besides being stressful in their own right, these experiences are likely to lower people's self-esteem and diminish their sense of control over life (Mirowsky& Ross, 1990). The poor also appear to have relatively few social resources to draw on, compared with individuals at high income levels; the poor have smaller social networks, less organizational involvement, and less frequent contact with friends and family (Cochran, Larner, Riley, Gunnarsson, & Henderson, 1990). These parameters are a reflection of lower mental health.

Reviews by Dohrenwend and Dohrenwend (1974) and Haring, Stock, and Okun (1984) indicate that low SES is associated with high rates of depression, mental illness, and lowered psychological well-being. In a review of 61 studies, Ortega and Corzine (1990) report that 46 find the highest rates of mental health problems in poorest social class.

The present results in the context of poor mental health of participants belonging to below poverty line and migrant labours need careful attention of all concerned persons in the helping profession.

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