

PSYCHIATRIC MORBIDITY AMONG HOUSEMAIDS IN KUWAIT: THE PRECIPITATING FACTORS

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Research shows that generally, the mental health condition of immigrants differ from those of the host population.^{1,2} High rates of mental morbidity among immigrants are common but not universal.³ Some studies show high morbidity rates for immigrants,⁴⁻⁶ while in others, the rates are lower than those of the host population.⁷⁻⁹ Immigration has been conceptualized as a complex and multifactorial phenomenon involving motives behind or the factors leading to migration, hardships and anxieties surrounding the act of migration, and the psychosocial adversities encountered during settlement into a new environment.^{10,11} Since some groups have high rates of mental morbidity but not others, the question arises as to which subgroup or category of immigrants do have higher rates and under what conditions.³ The aim of this study was to determine the possible role of post-immigration stressful factors in the development of psychiatric disorders among housemaids, a relatively defined sub-group of immigrants, in Kuwait. Housemaids can be regarded as a relatively homogenous immigrant sub-group in terms of their gender, ethnic origin, socioeconomic status, and the somewhat defined and structured nature of their occupation.

Due to the dearth of indigenous manual labor coupled with the boom in the energy sector during the 1970s, the Gulf Cooperation Council countries in general and Kuwait in particular, attracted large numbers of housemaids, principally from Sri Lanka, India, and the Philippines. The foreign housemaids in Kuwait usually get to Kuwait through recruiting agencies in their own countries and in Kuwait. They usually come from a low socioeconomic background, and are normally recruited on two-year contracts which are renewable upon agreement by both parties.

The average monthly salary of a housemaid varies from US\$120 to US\$150 for about 64 hours of work a week in a

household with an average of about 2.8 children. In addition to the salary, the employer is also required to provide airfare and board and lodging facilities. In a survey of complaints usually made by housemaids, irregular payment of agreed wages, inadequate amounts of food, unduly long working hours, and maltreatment by the employers, were the most common problems encountered by them.¹²

The prevalence of psychiatric morbidity among housemaids has been discussed in previous reports. It was reported that psychiatric morbidity was 1.86 times higher in immigrant housemaids than Kuwaiti females, and that severe reaction to stress (49.2%), manic episodes (16.2%), depressive episodes (15.2%), and acute and transient psychotic disorders (13.7%), were the most common disorders (Zahid et al., 2001; personal communication). This paper describes the stressors most commonly reported by housemaids, and discusses the possible relationship with the various psychiatric disorders suffered by them. Our study was done in the Hospital for Psychological Medicine, the only facility of its kind in Kuwait. The 400-bed hospital established in 1958, runs a 24-hour emergency service and operates an outpatient clinic five days a week. The aim of the study was to determine the nature of psychosocial stresses, as perceived by the hospitalized group of housemaids, and evaluate the possible contribution of the psychosocial stresses in the development of various psychiatric disorders found in the housemaids.

Patients and Methods

The study sample consisted of all the hospitalized housemaids during the two-year study period from January 1997 to December 1998. All patients were examined by the co-authors who are all trained psychiatrists. The psychiatric assessment was based on semi-structured interview employed routinely during normal hospital practice. The diagnoses were assigned according to the International Classification of Diseases, 10th revision,¹³ the standard diagnostic system adopted at the hospital. The hospital admission rates and the nature of the psychiatric disorders among housemaids have been discussed elsewhere (Zahid et al., 2001; personal communication).

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TABLE 1. *Demographic characteristics of hospitalized housemaids.*

Age range (15-50)	Mean (29-92) ±SD (6.99)
Nationality	
Sri Lankan	105 (53.3%)
Indian	46 (23.4%)
Filipino	32 (16.2%)
Others	13 (6.4%)
Marital status	
Single	65 (33%)
Married	125 (63.5%)
Widowed	4 (2%)
Divorced	2 (1%)
Education	
Illiterate	52 (26.4%)
1-4 years	79 (40.1%)
5-9 years	51 (25.9%)
10<years	14 (7.1%)
Religion	
Muslim	41 (20.8%)
Non-Muslim	154 (78.2%)

TABLE 2. *Distribution of stressors among the hospitalized housemaids.*

	Non-payment	Less than expected	Satisfactory
Wages	12 (6.1%)	75 (38.1%)	110 (55.8%)
Contact with family (times/past 6 months)	None	1-3 times	3<times
	113 (57.4%)	56 (28.4%)	28 (14.2%)
Household size	1-3	4-6	7<
	21 (10.7%)	118 (59.8%)	52 (26.4%)
Worried about employer's treatment	Yes	No	
	45 (22.8%)	152 (59.8%)	
Harassment	Yes	No	
	30 (15.2%)	167 (84.8%)	
Long working hours (60<hours/week)	Yes	No	
	18 (9.1%)	179 (91.9%)	
Decision to migrate	Right	Wrong	
	146 (74.1%)	51 (25.9%)	

Psychosocial Stressors Scale

Fifty case-notes of housemaids previously hospitalized in the psychiatric hospital were reviewed. Based on the psychosocial stressors most frequently reported by them, three main stressful areas were identified. These related to 1) wages; 2) working conditions; and 3) contact with families in originating countries. A 12-item questionnaire with a yes/no format relating to these areas and covering 95% of the most frequently complained stressful factors was devised and administered to each of the patients (Table 2). In addition, information was recorded on age, ethnicity, years of education, marital and religious status of the patients.

The items of the scale referring to wages included "non-payment" (wages not received for 3 months or more), and "less than agreed wages" (wages received less than originally agreed). The stress concerning working conditions included "long working hours" (more than 64 hours/week); "size of household" (containing 4 or more children under the age of 15); "worries about employer's treatment" (inadequate food/clothing provision or verbal/physical abuse); and "harassment/psychosexual abuse" from fellow employees, recruiting agency, or employer/employer's relatives. Contact (through telephone or mail) with the family back home during the previous six months or since arrival was regarded as "frequent" if it had

been done 4 or more times; "infrequent" 1-3 times; and "none" if no contact had been made.

Categorization of Psychiatric Diagnoses

In order to determine the potential contributory role of the demographic characteristics and psychosocial stressors in the development of psychiatric disorders, the hospital diagnoses were broadly grouped into: 1) stress-related disorders (49.2%); including acute stress reaction (n=26) and adjustment disorder (n=71); and 2) other psychiatric disorders (50.8%) comprising all the remaining diagnostic categories.

The data was analyzed on Windows SPSS, version 8.0. Z-test was used to compare the proportions of diagnostic categories against each of the stressful factors. In order to determine the overall effects of individual demographic variables and psychosocial stressors, logistic regression analysis was carried out. The diagnostic categories were regarded as dependent variables comprising "other diagnoses," coded as "O" and "stress-related diagnoses" coded as "1." A total of 15 items (independent variables) were included in the model. The results showed that the model was significant (chi-square=44.318; $P=.0003$).

Results

Table 1 shows the demographic characteristics of the hospitalized group of housemaids. Their ages ranged from 15-50 years (mean=29.92, SD=6.99). About one-third (n=65) were single and just under two-thirds (n=125) were married. Just over one-fourth of our patients were illiterate, and about one-fifth were Muslims.

Distribution of Stressors among the Patients:

As many as 179 (75.8%) of the patients had had little or no contact with their families back home (Table 2). The mean number of children below the age of 15 in their household was 5.45 (SD=2.28). Forty-five of our patients (22.8%) were worried about their employers' treatment. Of the number, 12 reported inadequate food/clothing provision, and 33 complained about verbal/physical abuse. Another 30 patients reported sexual abuse from fellow employees (n=14), agency personnel (n=11), and employer/employers' relatives (n=5).

Effect of Stressors on Disorders

Patients reporting harassment (4.5 times); those with little or no contact with their families back home (4 times); and those regarding their decision to migrate as wrong (3 times) were more likely to suffer from stress-related than other disorders (Table 3). On the other hand, patients receiving "less than expected wages" were three times more likely to suffer from "other" disorders than "stress-related" disorders. Filipino housemaids were over-represented ($Z=0.570$; $P<.05$) among those suffering from "stress-related" disorders.

TABLE 3. *Logistics regression analysis: effect of individual stressors on "stress-related" and "other" psychiatric diagnoses.*

Characteristics	Co-efficient	S.E	P-value	Odds ratio
Household size	-0.0817	0.0795	0.3046	0.9216
Nationality				
Indian	0.596	0.8041	0.4586	1.8148
Filipino	1.5257	0.8951	0.0883	4.5983
Sri Lankan	0.7249	0.7949	0.3618	2.0645
Religion	0.0678	0.4593	0.8827	1.0701
Marital status	-0.4003	0.3513	0.2545	0.6701
Contact with family (times/6 months)				
None	1.3786	0.6328	0.0294	3.9695
1-3 times	1.4601	0.6454	0.0237	4.3064
Wages				
less than expected	-1.1666	0.6005	0.052	0.3114
non-payment	1.4902	0.7948	0.0608	4.4381
Decision to migrate				
Wrong	-1.051	0.4764	0.0274	0.3496
Harassment	1.4932	0.5308	0.0049	4.4511
Long working hours (64 hours<week)	0.3506	0.5769	0.5434	1.4199
Worried about employer's treatment	-0.0643	0.4008	0.8725	0.9377
Education				
Less than 1 year	0.737	0.4653	0.8742	1.0765
More than 1 year	0.395	0.4126	0.3383	1.4844

Mode chi-square=44.318 ($P=0.0003$); Nagelkerke $R^2=0.271$.

Discussion

We found that a substantial number of our patients suffered from stress-related disorders and that a number of factors including ethnicity, lack of contact with families back home and harassment as reported by the housemaids, were mainly responsible for this excess in stress-related morbidity.

The authors would like to mention some methodological limitations of this study. First, the assessment procedure did not include standardized psychiatric interview. Reliability of the hospital-based psychiatric diagnoses is, therefore, subject to assessor bias. Second, the categorization of the diagnoses into "stress-related" and "other" disorders is arbitrary and does not necessarily imply a definite causative role of the stressors in the development of stress-related disorders. It may be argued that the stressors associated with migration, such as continuing unpleasant circumstances or incidents involving harassment may as well precipitate "other" disorders rather than those confined to stress-related disorders, but their etiological role in the causation of "other" disorders is not always clear. Moreover, their presence is neither necessary nor sufficient to explain the varied nature of the disorders grouped together as "other" disorders. The grouping of the diagnoses into "stress-related" and "others" was based on the clinical manifestations, circumscribed course, and temporal relationship to the stressors; the assumption used in the ICD-10 categorization of the stress-related disorders.¹³

Another interesting finding of the study was that housemaids who received "less than expected" wages and those who believed their decision to migrate was wrong,

were found to suffer from "other" rather than "stress-related" disorders. This, of course, does not mean that receiving less wages did not lead to stress-related disorders and that those suffering from stress-related disorders were happy with their decision to migrate. The finding is difficult to understand. The categorization of hospital diagnoses into "stress-related" and "others" as mentioned earlier, remains arbitrary and it should have been equally possible for stressors like "receiving less wages" to cause any of the stress-related disorders. However, in terms of relative significance among the stressors studied, "harassment" and "lack of contact with families back home" were more likely to cause stress-related disorders, while "receiving less wages" was associated with "other" disorders.

A number of workers have pointed out the deleterious effects of the separation from families and disruption of social networks that all new immigrants have to cope with.^{14,15} The housemaids in Kuwait mainly come from India, Sri Lanka, Bangladesh, and Philippines. Most of them cannot communicate in the local Arabic language and the command of spoken English (second language in Kuwait), with few exceptions, is usually poor. The linguistic barrier, coupled with lack of contact with their families back home, enhances the sense of isolation and intensifies their feelings of homesickness.

"Harassment" of housemaids is a sensitive issue, however, in most of the reported incidents involving harassment, fellow employees rather than the employer or employer's relatives were reported to have been responsible for the incidents. More than 50% of Kuwaiti households, employ male employees including drivers, cooks, cleaners, etc., in addition to the housemaids. It is possible that the sense of marginality in the newly arrived housemaids increases the risk of harassment among them.

Filipino housemaids were over-represented among those suffering from stress-related disorders. It can partly be explained by the fact that the rest of the Filipino female workers in Kuwait are fairly distributed in varied interactive industries like marketing, catering, hotel and tourism, paramedical (nursing), etc. They have well-organized community gatherings, and in so doing, have managed to establish their own ethnic support network that allows them to live relatively independently. The housemaids, however, by the very nature of their occupation, have limited access to their own ethnic social network. Immigrants who maintain their own ethnic culture while adopting the culture and network of the host society tend to exhibit better mental health.¹⁷ Although Indian female workers in Kuwait are also fairly distributed in diverse trades with substantial ethnic support system, they feel less marginalized because of their adeptness at learning Arabic, which is close to Urdu and Hindi, the languages spoken by many Indians.

It is clear from our findings that housemaids constitute a relatively defined and homogenous subgroup of immigrants in terms of their ethnic origin, gender, and more or less

similar educational, socioeconomic, and occupational status. They are exposed to relatively well-defined psychosocial stressors. In addition, the spectrum of psychiatric disorders among the hospitalized group of housemaids seems to follow a particular pattern, with stress-related disorders accounting for almost half of their overall psychiatric morbidity. Outwardly, it might appear as if the psychosocial stressors exert specific effects resulting in mental ill-health, attributable to these stressors. The relationship between psychosocial stressors and their consequences, however, is not simply a cause-effect phenomenon. Recent research has addressed the question of how coping resources interact to mediate or buffer the potentially harmful impact of psychosocial stressors.^{21,22} It may as well be that, as suggested by Odegaard,⁴ the psychological well-being of the housemaids was suspected even before the migration, compromising their resourcefulness needed to cope with the demands of settlement into the host society.

Housemaids constitute a unique group of immigrants who experience well-defined psychosocial stressors after their arrival in the host community. Lack of contact with family back home, harassment, and limited access to social support network were identified as important precipitants of "stress-related" disorders among the housemaids. Since a significant number of housemaids break down within the first few weeks of their arrival, further studies aimed at identifying possible risk factors for this important subgroup of immigrants are needed.

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References

1. Garza-Guerrero AC. Culture shock: its mourning and the vicissitudes of identity. *J Am Psychoanal Assoc* 1974;22:408-29.
2. Cochrane R. Mental illness in immigrants to England and Wales: an analysis of mental hospital admissions. *Soc Psychol* 1971;112:25-35.
3. Rack PH. Psychiatric disorders in immigrants. *Medicine* 1980;36:1871-4.
4. Odegaard O. Emigration and insanity. *Acta Psychiatr Neuro Scand* 1932;(Suppl 4).
5. McDonald R, Vecchi C, Bowman J, Sanson-Fisher R. Mental health status of a Latin American community in New South Wales. *Aust N Z J Psychiatry* 1996;30:457-62.
6. Hitch P, Rack PH. Mental illness among Polish and Russian refugees in Bradford. *Br J Psychiatr.* 1980;137:206-11.
7. Burnam MA, Hough RL, Escobar JI, et al. Six-month prevalence of specific psychiatric disorders among Mexican Americans and non-Hispanic whites in Los Angeles. *Arch Gen Psychiatry* 1987;44:687-94.
8. Vega WA, Kolody B, Aquilar-Gaxiola S, et al. Lifetime prevalence of DSM-III R psychiatric disorders among urban and rural Mexican Americans in California. *Arch Gen Psychiatry* 1998;55:771-8.
9. Escobar JI, Nervi CH, Gara MA. Immigration and mental health. Mexican Americans in the United States. *Harv Rev Psychiatry* 1998;8:64-72.
10. Berry JW. Psychology of acculturation. In: Berman JJ, editor. *Nebraska Symposium on Motivation, 1989. Cross-cultural perspectives.* Lincoln: University of Nebraska Press, 1990;201-34.
11. Murphy HBM. Migration, culture and mental health. *Psychol Med* 1977;7:677-84.
12. Shah NM, Al-Qudsi. Shah MA. Asian women workers in Kuwait. *Intern Migration Rev* 1991;25:464-86.
13. World Health Organization. *International Classification of Diseases. Mental and Behavioural Disorders, 10th revision.* Geneva: WHO, 1992.
14. Kuo W. Theories of migration and mental health. an empirical testing on Chinese-Americans. *Soc Sci Med* 1976;10:297-306.
15. Sue S, Morishima J. *The mental health of Asian Americans.* San Francisco, CA: Jossey-Bass, 1982.
16. Hirsh BJ. Psychological dimensions of social network: a multi-method analysis. *Am J Comm Psychol* 1980;7:263-77.
17. Wheaton, B. Models for the stress-buffering functions of coping resources. *J Health Soc Behav* 1985;26:352-64.
18. Ensel WM, Lin N. The life stress paradigm and psychological distress. *J Health Soc Behav* 1991;32:321-42.