Loneliness And Mental Health Among Indian Expatriates In Sharjah, United Arab Emirates

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Abstract
If not addressed with long-term mitigation practices, the high incidence of isolation is closely correlated with the likelihood of developing mental health problems such as anxiety, depression, and even vulnerability to suicidal ideation.
According to research, individuals who live away from their ancestral homelands are at a higher risk of depression and mental health problems. One of the main populations of expatriates living in the UAE is projected to be the Indian population. It has been proposed that expatriates, despite appearing to live a happy life, often face a variety of negative circumstances such as isolation, workplace distress, and worries about occupational security, all of which contribute to a rise in the prevalence of mental illnesses such as depression, stress, and anxiety. As a result, the following study sought to determine the prevalence of isolation, mental wellbeing, and the risk of mental health problems among Indians working in Sharjah, UAE. A quantitative cross-sectional design was used, along with data collection on demographics, mental wellbeing, and social functioning, using self-reported questions like the General Health Functioning-28 and the Social Functioning Questionnaire. Based on these results, the study was evenly distributed in terms of their risk of mental health illnesses and a high degree of social functioning, likely due to the inclusion of both single and non-single participants. Furthermore, demographic factors such as age, schooling, and occupational levels may be responsible for the equitable distribution of such risk and high levels of social functioning. Further research into the role of specific demographic factors in influencing mental health status and social functioning among Indian expatriates in the UAE is therefore needed.

Keywords: Loneliness, Mental Health, Depression, Social Functioning, Sharjah

1. INTRODUCTION

If not addressed with long-term mitigation practices, the high incidence of isolation is closely correlated with the likelihood of developing mental health problems such as anxiety, depression, and even vulnerability to suicidal ideation. According to research, individuals who live away from their ancestral homelands are at a higher risk of depression and mental health problems, according to research (Bierwiaczonek & Waldzus, 2016). In this regard, the following paper aimed to assess the prevalence of loneliness among Indians living in Sharjah, United Arab Emirates (UAE), and their risk of developing mental health or psychiatric disorders. This study used various self-reported questionnaires to assess the situation, with the findings being statistically evaluated to illustrate their importance to the stated goals and objectives.

2. BACKGROUND INFORMATION

Loneliness is described as an uncomfortable and unwelcome emotional reaction or feeling that occurs when one is alone or in a situation that appears to be isolated. Aside from living alone, factors such as low self-esteem, a lack of social support, the prevalence of underlying mental or physical health conditions, and circumstances of sadness and loss, such as the death of a partner, may all cause negative emotional responses and hence a sense of isolation in people (Hack-Polay, 2020). Loneliness has been linked to demographic factors such as age (as in the case of elderly people living in nursing homes), education (students living away from their families while studying abroad), and marital status (divorced or separated people) (Doki, Sasahara & Matsuzaki, 2018).

The rising prevalence of isolation among the world's population is regarded as a serious global issue. According to a survey conducted by The Economist and the Kaiser Family Foundation (KFF), more than two adult individuals in a group of ten are estimated to be lonely, both in the United Kingdom (23 percent) and the United States (22 percent) Howe et al., 2019).

Furthermore, according to a study published by the European Commission in 2018, an estimated 30 million Europeans live in isolation, with an estimated 75 million communicating with family or friends only once a month. As a result, such data demonstrate the global nature of the loneliness problem.

Additionally, as per a recent news article published in the Gulf, the Indian population has been estimated to comprise one of the largest communities of expatriates residing in the UAE, amounting to approximately 3.3 million. The reason for the same is the rising rates of Indians achieving remarkable professional achievements across professions such as medicine, information technology, engineering, and chartered accountancy, resulting in increased career prospects across nations other than their native homeland (Dhar, 2019). However, according to another news article published specifically in the UAE, expatriates, while appearing to live a comfortable life, frequently face a variety of negative circumstances such as isolation, occupational distress, and worries about occupational security, all of which contribute to a rise in the prevalence of mental illnesses such as depression, stress, and anxiety. Considering this existing background on an extensive Indian population and risk of mental health diseases due to loneliness reported in the UAE context, there is thus a need to implement further research on Indian expatriates currently residing in this region (Mannan, 2017).

3. RESEARCH RATIONALE

If not controlled, living in loneliness for prolonged periods has been evidenced to increase the risk for adverse physiological and psychological consequences. Chronic or prolonged loneliness have been evidenced to increase the risk of acquiring adverse psychiatric concerns such as depression, anxiety as well as increased risk of individuals engaging in poor lifestyle choices and behaviors such as smoking, alcohol consumption, intake of a nutritionally imbalanced diet, drug or substance abuse and suicide ideation (MUcci et al., 2019). As a result of loneliness, such risks are likely to pave the way for adverse physiological impacts such as cardiovascular diseases, diabetes, self-harm, and increased stress. Additionally, migrants or expatiates who are elderly and live lonely are also at an increased risk of experiencing falls, fractures, and temporary or complete loss of immobility. Thus, the increased risk of health, especially mental health adversities due to the loneliness and the importance of immediately addressing the same with evidence-based clinical interventions, thus form a major rationale underling the completion of this research (He, An & Berry, 2019).

Additionally, as discussed previously, the major section of the population in the UAE comprises Indian expatriates. While there exists some form of informal, publicly accessible information with regards to the prevalence of loneliness across Indian expatriates residing in the UAE, there is limited evidence concerning the prevalence of the same, as well as the risk of psychiatric disorders across those Indian expatriates residing in Abu Dhabi (Hack- Polay & Mahmoud, 2020). Further, to assist such at-risk populations, mental health interventions specific to the demographic backgrounds of such migrant individuals must be considered – another area of limited research – since loneliness is caused due to a multitude of risk factors. Thus, the prevalence of limited research and the importance of providing timely, person-centered interventions to expatriates living along thus form additional important rationales for completing this research (Giorgi, Montani, Fiz-Perez, Arcangeli & Mucci, 2016).

4. AIMS AND OBJECTIVES

Thus, as per the given research background, this research aims: 'To evaluate the prevalence of loneliness, state of mental health and the subsequent risk of mental health disorders across Indians working in Sharjah, UAE.' In doing so, this research addresses the following research objectives:

1. To explore the prevalence of loneliness and risk of mental health disorders across Indians working in Sharjah, UAE.
2. To examine the nature of social functioning across Indians working in Sharjah, UAE.
3. To assess the role of demographic factors, such as gender, occupational position, income, and education, in influencing the risk of mental health disorders and loneliness across Indians working in Sharjah, UAE.
4. To suggest recommendations and strategies based on which Indians working abroad can reduce their riskof mental health disorders despite loneliness.

5. RESEARCH QUESTIONS

Hence, the findings of this research focused on providing empirical and evidence-based answers to thefollowing research questions:

1. What are the prevalence of loneliness and associated risk of mental health disorders across Indians working in Sharjah, UAE?
2. What is the extent to which social functioning is affected or influenced across Indians working in Sharjah, UAE?
3. What is the role of demographic factors, such as gender, occupational position, income, and education, in influencing the risk of mental health disorders and loneliness across Indians working in Sharjah, UAE?
4. What are the strategies based on which Indians working abroad can reduce their risk of mental healthdisorders despite loneliness?

6. RESEARCH HYPOTHESIS

Thus, the findings of this research were evaluated against the following hypotheses:

- **Alternative hypothesis:** Indians residing in the UAE are at a statistically significantly increased risk of experiencing poor mental health status and inadequate social functioning due to loneliness.
- **Null hypothesis:** Indians residing in the UAE are not at a statistically significantly increased risk of experiencing poor mental health status and inadequate social functioning due to loneliness.

7. RESEARCH SIGNIFICANCE

The importance of the findings of this research lies in their ability to inform the public health workforce, especially in the context of India and UAE, on the importance of addressing the mental health needs of expatriates living alone. The findings of this study additionally have future implications and significance, in the form of educating such expatriate individuals, especially Indians, on the possible demographics factors which can increase the risk of mentalhealth issues while living abroad and alone, as well as possible strategies with which, they can mitigate the same (Wright-St Calir & Nazar, 2019). Additionally, the findings of this research will also prove to be useful in educating or guiding mental health practitioners, across both India and abroad, on specific risk factors to assess while examining the risk of mental health disorders across expatriates, especially those who are living abroad. Further, the findings of this research also prove to be significant in informing public health and governmental workforce, across both India and the UAE, on the importance of collaborating with each other in order to facilitate the development of policies specifically suited to address the mental health needs of Indian expatriates living alone (Banerjee et al., 2020). Lastly, the findings of this research will also be useful for researchers to conduct further research on the associations between loneliness, state of mental health, and specific demographic factors across Indians residing alone and away from their native lands (Wright-St Clair et al., 2018).

8. RESEARCH DISSEMINATION

It is worth noting that any research paper's findings can only be applied successfully to practical environments and real-life settings when the same is disseminated effectively (Ramis& Conception, 2020). Thus, to address the same, it is expected that the findings of this research will be disseminated across both online and offline platforms. The former will comprise publishing the findings of this research across academic and scholarly journals, which can be accessed online, to enable mental health practitioners, researchers, and government officials to access the same for future implementation in professional practice (Thoma et al., 2018). To facilitate dissemination of research findings across the public, and thus, the targeted population of migrants living alone, the same will also be published in the form of blogs, press releases, editorials, and newspaper articles, in lay language for improved understanding, which can be accessed both online as well as offline (Brown et al., 2017). Lastly, the findings of this research will also be disseminated across public platforms such as seminars, workshops, and conferences, both nationally and internationally, to further facilitate knowledge transmission across professional stakeholders such as researchers, academicians, and healthcare practitioners (Rabin & Brownson, 2017).

9. STATISTICAL ANALYSIS/METHODS RESEARCH PHILOSOPHY

In order to obtain findings specific to the research aims and objectives, the design of this study was formulated as
per the research philosophy of positivism. According to this research philosophy, the working and application of a phenomenon or issue can only be studied and validated with the help of objective observation of the same (Park, Konge&Artino Jr, 2020). While practicing a positivist research philosophy, it is expected that the researcher will study the chosen issue or phenomenon to be studied via a collection of objective data followed by interpreting the same within objective and quantitative analytical methods. Since this research focused upon understanding the relationship between loneliness and nature of mental health status across Indian expatriates in the UAE, by collecting real-life quantitative data and statistical analysis of the same, adoption of a positivist research philosophy was considered the most appropriate (Ryan, 2018).

10. RESEARCH DESIGN

This research was based upon a quantitative research design. A quantitative research design

is associated with the direct collection of primary empirical data by the researcher followed by objective statistical analysis of the same to evaluate its relevance to the chosen hypothesis (Leavy, 2017). Since this research comprised the objective analysis of the prevalence of loneliness and risk of mental health disorders across the Indian population residing in the UAE, a quantitative research design was considered the most important. Specifically, a cross-sectional research design was chosen for this study as a part of quantitative data collection and analysis. A cross-sectional research design is associated with observing and evaluating the relationship between two variables at a given point of time and across a specific population subset (Rahi, 2017). For this study, a cross-sectional study design was considered as the most appropriate since it focused upon objectively evaluating the associations between loneliness, mental health, and social functioning across a given section of the Indian population and at a given point of time.

11. RESEARCH METHODOLOGY

The independent variable for this study was the prevalence of loneliness. At the same time, the risk of poor mental health or psychiatric diseases and inadequate social functioning were considered the dependent variables since they were assessed against the independent variable. In order to obtain primary data relevant to the research aims and objectives, quantitative methods like self-reported surveys were used (Saleh & Bista, 2017). Self-reported surveys are useful since they are relatively simple to understand by both researchers and participants and facilitate collecting a large amount of data within a limited time frame. Considering that this research focused upon evaluating the prevalence of loneliness, the risk of mental health disorders, and poor social life functioning across a seemingly large population, that is, the population of Indian expatriates in the UAE, administration of self-reported surveys were considered as the most appropriate (Günther, El Shafey& Marcel, 2016).

12. DATA COLLECTION TOOLS AND ADMINISTRATION

Thus, the surveys used to collect primary, quantitative data relevant to the aims and objectives of the study, two survey questionnaires, the General Health Questionnaire – 28 (GHQ-28) and the Social Functioning Questionnaire (SFQ), were used. The GHQ-28 is a 28 item multiple-choice based questionnaire assessing the mental health and wellbeing as well as the prevalence of psychological disorders in individuals using a 4 point Likert scale where: 0 = Better than usual/not at all, 1 = same as usual/no more than usual, 2 = worse than usual/rather more than usual and 4 = much worse than usual/much more than usual. The scoring ranges from 0 to 84, with more than 24 indicatives of the risk of psychiatric disorders (Hjelle et al., 2019). The SFQ is used to measure the ability of an individual to demonstrate sound social engagement in both personal and community activities and is specifically useful for assessing individuals post-treatment or rehabilitation as an indicator of the quality of life and wellbeing. It comprises a total of 5 areas, with eight multiple choice-based questions, assessing the social functioning of individuals across sections like Domestic Skills, Self-care Skills, Social Skills Community Skills and Responsibility (Pallathra et al., 2018).

For administration of the given data collection tools, the researcher shared the specified questionnaires across social networks to propose to interested individuals to participate in the research. This was then followed by requesting such acquaintances to share the same with their own social acquaintances resulting in the collection of a total of 848 participant responses. The study was conducted within the month of January 2020. The data collection period took approximately 30 days to be completed from the start day of initial questionnaire sharing.

13. SAMPLING STRATEGY

To recruit sample participants relevant to the research question, a purposive or convenience sampling strategy was utilized. The purposive sampling strategy is a type of non-probability sampling comprising participants, with characteristics specific to the research question, only being selected for a study. Since this research focuses primarily on the prevalence of loneliness, mental health status, and social functioning across a population working and who are Indian, a purposive sampling strategy was found to be the most important (Etikan, Musa &Alkassim, 2016).

To ensure the same, the researcher communicated the purpose and details of the study, via virtual platforms, across acquaintances, who were then asked to share the same with their social networks and acquaintances. This process then resulted in the inclusion of approximately 848 participants as the study sample, based on the following inclusion criteria.

1. Indians aged 21 to 60 years of age to prevent the impact of age as a confounding factor since both adolescence and the elderly are also prone to mental health risks due to age-associated concerns compared to adults, which was beyond the scope of this study.
2. Indians are working in Sharjah, UAE, for the last 6 months or more.

14. SAMPLE DEMOGRAPHICS

Before administration of the chosen questionnaires as a part of primary data collection, participants were also asked to share their demographic data, which were then categorized as per the following divisions:

- **Gender:** Male and Female
- **Age:** 21 to 30 years, 31 to 40 years, 41 to 50 years, 51 to 60 years
- **Educational levels:** High School, Diploma, Graduate, Masters
- **Levels of Income (In United Arab Emirates Dirham or AED):** 1000 – 3000, 3001-6000, 6001-9000, 9001-12000, 12000 and above
- **Occupational Positions:** Top-level manager, Mid-level manager, other managerial work, no managerial work
- **Living Arrangements:** Categorized and coded as 1 (Living alone) and 2 (Not living alone). 'Living alone in this case was used to describe those individuals who were married but were living alone due to work demands away from their native homeland.

15. DATA ANALYSIS

To assess the distribution of participants in terms of demographics, the raw data was analyzed in the form of a percentage against a total population (N) of 848 participants. Additionally, the risk of mental health or psychiatric disorders across the sample was evaluated by categorizing the GHQ-28 responses as >24 being psychiatric and <24 being non-psychiatric (Hjelle et al., 2019). The participant distribution across these categories was then calculated using percentages. A similar approach was followed with regards to demographic factors like living arrangements where the distribution of participants living alone or not living alone was evaluated using percentages lastly; for analyzing SFQ scores, the total means of all the mean scores of participants for each of the five areas of Domestic Skills, Self-care Skills, Social Skills Community Skills, and Responsibility. Means values and percentages are useful for the summative calculation of averages from a large amount of numerical data and provide insights into the prevalence or distribution of specific factors or research issue of focus (Panis, Schmidt, Bergson and Racine, 2019). Considering that the research focused extensively upon assessing the prevalence of loneliness, the risk of mental health disorders, and the level of social functioning across an extensive population of Indians, the utilization of percentages and mean values was found to be appropriate. Furthermore, secondary data in the context of a narrative discussion of results from established academic research was used to analyze the significance of the collected primary

data concerning the researcher's goals, objectives, and questions. Thus, an unstructured method of data analysis proved to be useful for an in-depth discussion of key results that would not have been possible if objective, quantitative data had been used (Ruggiano & Perry, 2019).

16. RELIABILITY AND VALIDITY

Despite convenience and feasibility, a key issue with regards to the implementation of self-reported data collection measures like surveys are prone to limitations such as social desirability and bias often participants, in an attempt to present their responses as desirable or acceptable, tend to give biased, incorrect answers thus impacting the validity and reliability of the survey (Brenner &DeLamater, 2016). To address the same, however, before survey administration, the researcher engaged in gentle persuasion wherein all participants communicated the importance of maintaining honesty in their responses. Additionally, to further ensure the reliability or applicability of findings to other individuals residing in loneliness, the sampling strategy, and participant inclusion criteria were developed concerning the aims, objectives, and research topic of focus. Additionally, to ensure validity and reliability of data collection tools, survey questionnaires validated in previously published academic and scholarly literature were used for this research (Hjelle et al., 2019; Pallathra et al., 2018).

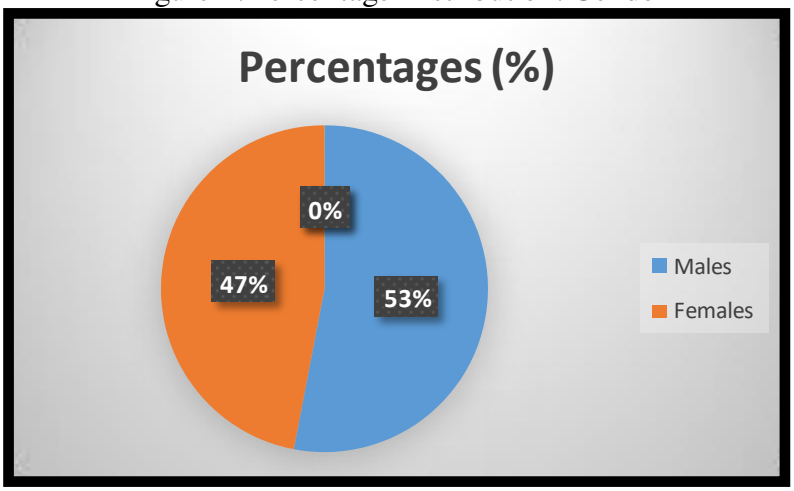
17. ETHICAL CONSIDERATIONS

Certain key ethical considerations were pursued to ensure that this study was respectful of the needs and concerns of all participants and related stakeholders. Informed consent was obtained before survey administration. All participants were told that their participation was voluntary and autonomous and that not doing so would have no effect on the nature of their current lifestyles (Miracle, 2016). The ethical dimensions of veracity were also found when the researcher communicated the study's information and intent to the participants. All participants' names and personal information were coded using numbers to protect ethical concerns of privacy and confidentiality. Participants were told that their data would not be exchanged with any group or stakeholder other than the researcher without their permission. Finally, the data and personal information obtained from participants were stored in a secure online database that was prohibited from access by unauthorized persons other than the researcher to ensure safety and security (Bracken-Roche, Bell, Macdonald & Racine, 2017).

18. RESULTS

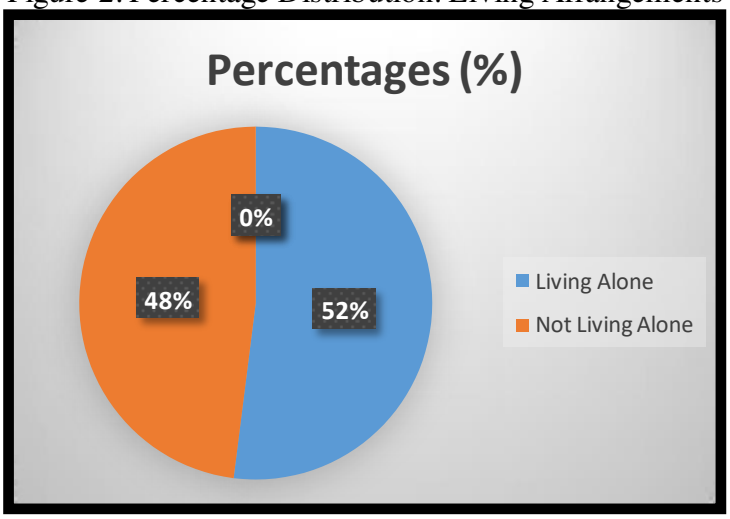
The following sections demonstrate a representation of the key findings obtained after evaluation of the raw primary data obtained from all participants. As mentioned previously, statistical methods such as percentages and descriptive statistics like means were utilized. A combination of both tabulated and pictorial presentations has been used to demonstrate key research findings to facilitate key understanding with regards to the research aims and objectives.

Figure 1: Percentage Distribution: Gender



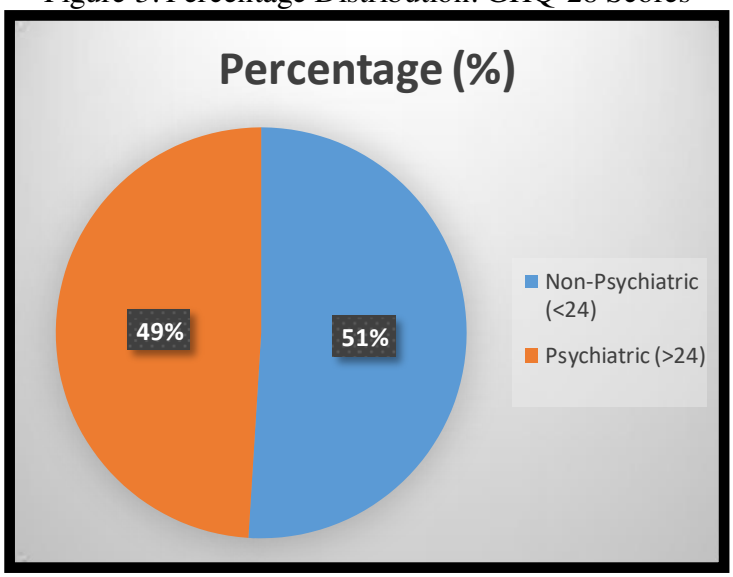
As per the given, it tabulated and graphical data (Figure 1). It can be implied that there is an almost equal distribution of males and females within the sample selected for the study (N = 848).

Figure 2: Percentage Distribution: Living Arrangements



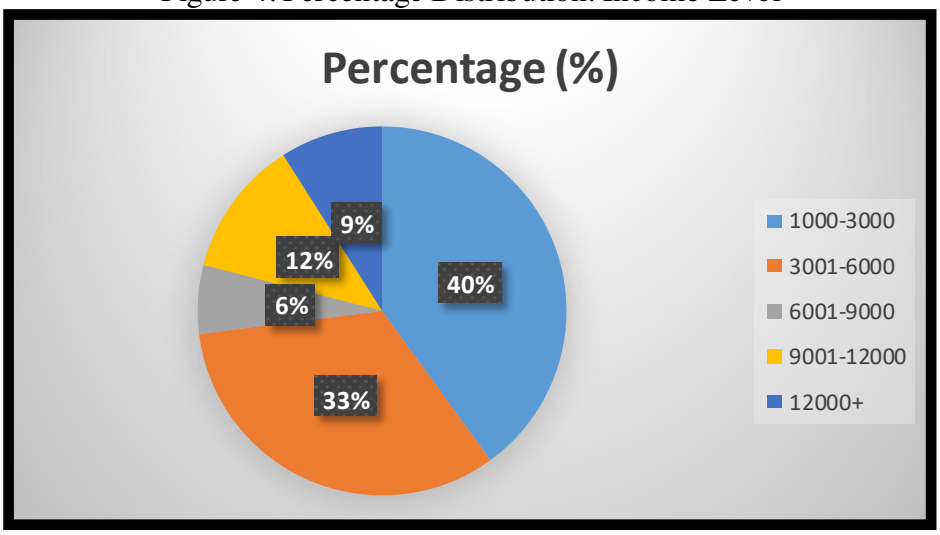
As per the given tabulated and graphical data (Figure 2), it can be implied that there is almost equal distribution of Indians living alone and not living alone in Sharjah, UAE, within the sample selected for the study (N = 848).

Figure 3: Percentage Distribution: GHQ-28 Scores



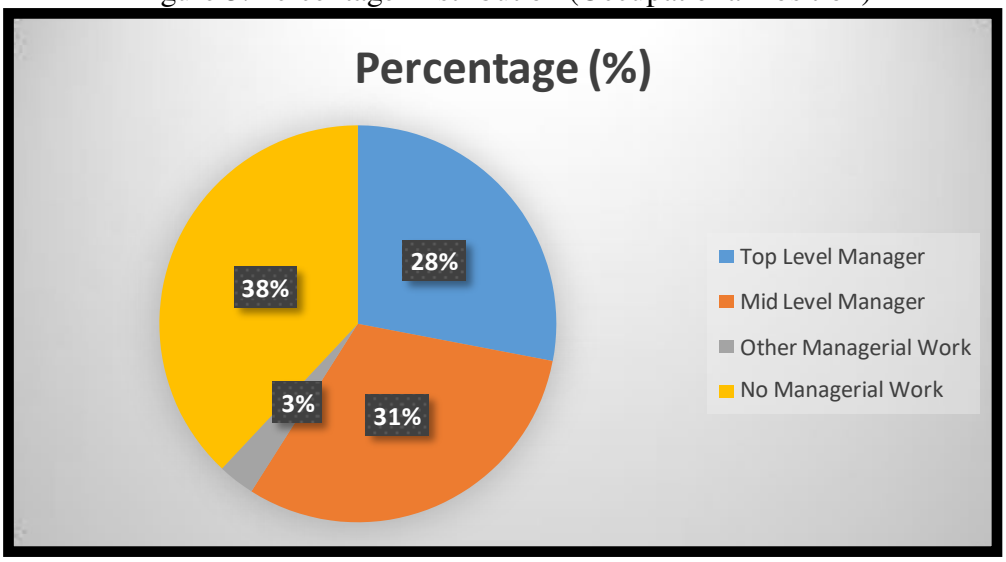
Thus, as presented in the given tabulated and graphical data (Figure 3), there is an almost equal distribution of the Indians at risk and not at risk of psychiatric disorders across the given population included in the study (N = 848) (Hjelle et al., 2019).

Figure 4: Percentage Distribution: Income Level



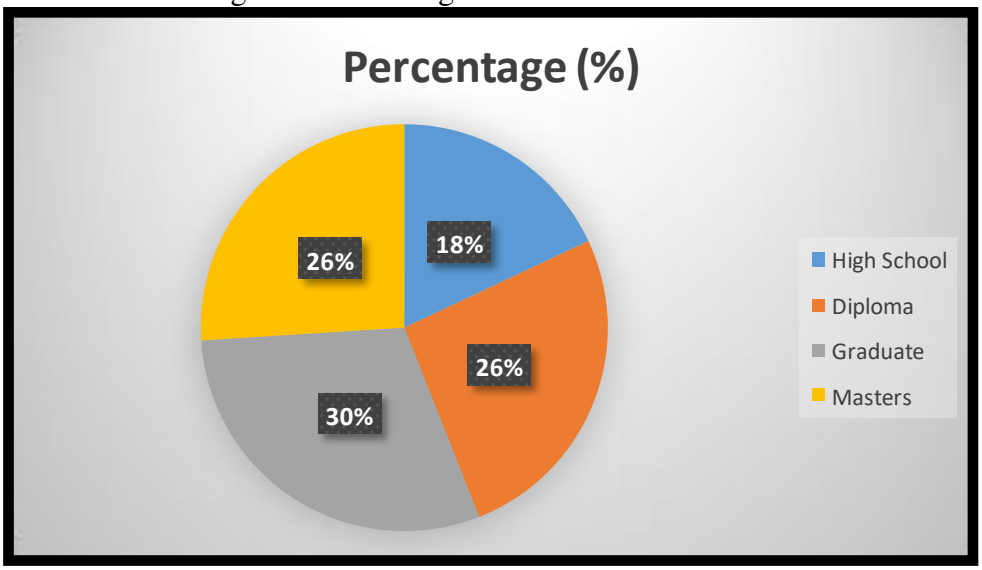
As per the given tabulated as well as graphical data (Figure 4), it can be observed that a majority of the participants belong to low (40%) or middle-income groups (33%). In contrast, the remaining participants can be observed to belong to higher income groups across the chosen sample (N = 848).

Figure 5: Percentage Distribution (Occupational Position)



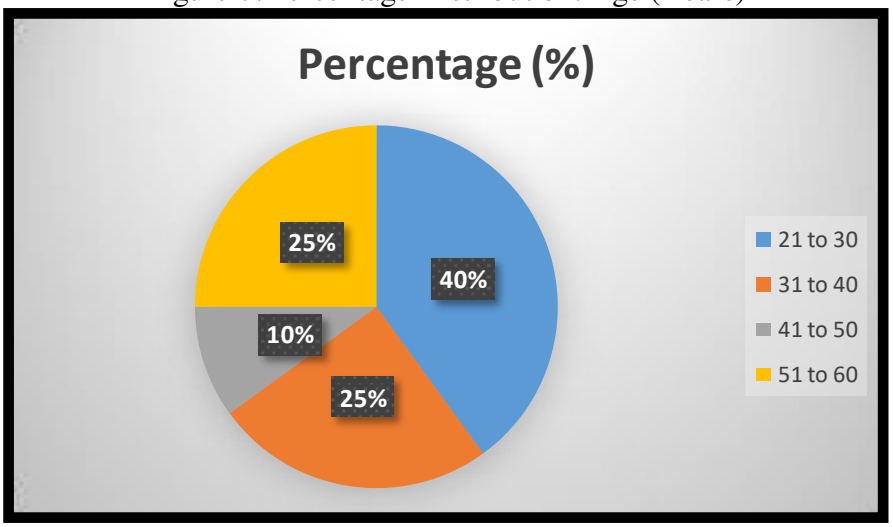
Thus, as observed from the given data (Figure 5), it can be observed that a majority of the participants in this population are not involved in any form of managerial work (388), followed by the participant with positions associated with middle (31%) or top-level managerial work (28%).

Figure 6: Percentage Distribution: Education



Thus, as per the given graphical and tabulated data (Figure 6), it can be observed that a majority of the participants in the sample had completed their educational level up to their graduation (30%), followed by an equal number of participants who have completed their diploma and masters (26%, 26%) and a limited number of participants who had completed their education till high school levels.

Figure 7: Percentage Distribution: Age (Years)



As per the given data (Figure 7), it can be observed that a majority of the participants comprise of young adults (40%), followed by those aged 31 to 40 years (25%), 51 to 60 years (25), and 41 to 50 years (10%), across the total sample participants of the study (N = 848).

Table 8: Total Mean Scores of SFQ

SFQ Areas	**Total Mean Scores**	**Level of Social Functioning**
Self-Care	3.74	High
Domestic	3.76	High
Community	3.73	High
Social	3.68	High
Responsibility	3.73	High

The given tabulated data indicate the mean levels of social functioning recorded the entire sample of participants (N
= 848), across five areas of self-care, domestic, community, social, and responsibility. As per the given data (Table 8), it can be observed that almost all participants demonstrate a reasonably high level of social functioning, of which, however, the 'Social' area reflected the lowest scores. While the score for this area, despite being the lowest, is still reasonably high, it is worth noting that this area of the questionnaire largely measures the extent and abilities to which individuals participate in social activities in their lives. With this respect, the comparatively lower scores thus demonstrate the potential of further examination, which have been expounded upon in the following sections of the paper.

19. DISCUSSION

Thus, as per the given findings (Table 3; Figure 3), it can be observed that there lie limited differences between Indians with the risk of psychiatric disorders and Indians who do not present with such risks, as per the GHQ-28 scores. Such equal distribution maybe because the given sample was equally distributed in terms of those living alone and those who are not living alone (Table 2, Figure 2).

This is because it has been evidenced that prolonged exposure to loneliness and social isolation are likely to increase the risk of mental health disorders such as anxiety, depression,

and suicide ideation (Callahan, King & Halversen, 2020). Such risks due to loneliness are also likely to increase across individuals living as expatriates or migrants away from their homesince immigration exposes them to novel cultures, practices, and lifestyles which often become difficult to adjust to, especially in the absence of social support (Ikafa & Perry, 2020). However, the risk of such illnesses due to loneliness has been evidenced to be mitigated when individuals are surrounded by social networks other than their spouses or family members in their homes, such as peers, workplace colleagues, and neighbors (Callahan, King & Halversen, 2020). Additionally, it must be noted that feelings of loneliness are perceived and subjective in nature, which is why an individual with extensive social networks may not perceive themselves to be lonely despite living alone. Thus, there is a need to explore further the prevalence and role of social support networks for Indians living alone in the UAE (Kanstrén & Mäkelä, 2020).

However, it has been evidenced that the risk of loneliness varies with age. While young adults and adolescents may be at risk of mental health disorders due to increased peer, familial and academic pressures, the prevalence of peer support networks often mitigate loneliness and the risk of the same. Such risks, however, may be higher concerning those who are older due to limited mobility, or age-associated loss of a spouse, or the emergence of age-associated health concerns. It is worth noting that the sample for this research comprised almost equal proportions of young adults followed by middle-aged adults with an absence of elderly, thus resulting in equal distribution of scores about mental health (Sterle, Fontaine, Moi &Verhofstadt, 2018).

It has been evidenced that loneliness and poor mental health can be mitigated by factors such as education and occupation since both improve awareness and financial ability of individuals to access healthcare or social resources for improved health and wellbeing. It must be noted that the sample in this study is largely comprised of individuals who have reached higher educational levels as well as those individuals with limited income or employment in middle-level managerial jobs. Such sample distribution thus could have caused the equal distribution of mental health risk, thus paving the way for further research on the role of such factors in the future (Warinsowski&Laakkonen, 2020).

Additionally, the findings also revealed (Table 8) that almost all participants demonstrated a high level of social functioning in terms of all areas as per the SFQ scores. Such findings, however, do not correlate with existing evidence. It has been evidenced that individuals exposed to loneliness and social isolation are likely to demonstrate a low level of social functioning. However, it must be noted that social functioning comprises several areas such as self-care and domestic and community-based responsibilities, which otherwise are likely to be restricted across elderly residing alone due to age-associated limitations in terms of mobility (Reza, Subramaniam & Islam, 2019).
It is worth noting that a majority of this sample comprises young adults or middle-aged individuals, free from any form of physical comorbidities that may be impacting their social functioning, thus resulting in such high scores. However, in criticism, it must be noted that the ‘Social’ area reflected the lowest scores (Table 8) (Sterle, Vervoort &Verhofstadt, 2018). While the score for this area, despite being the lowest, is still reasonably high, it is worth noting that this area of the questionnaire largely measures the extent and abilities to which individuals participate in social activities in their lives. With this respect, the comparatively lower scores may demonstrate the risk of loneliness and social isolation, especially across Indians living alone in the UAE, and thus call for more specific research (Chen & Lin, 2019).

20. IMPLICATIONS AND FUTURE DIRECTIONS

Thus, as per the findings of this research, it is recommended that further research be conducted concerning the prevalence of loneliness, mental health status, and social functioning, based on specific demographic factors such as gender, age, social support, education, and occupation. Additionally, it is recommended that healthcare professionals address mental health issues in lonely expatriates, provide interventions specific to such demographic factors. Additionally, it is recommended that both India and the UAE governments collaborate to develop virtual communication platforms as per which Indians living alone can contact or share their concerns via a helpline (Harper, 2016).

Lastly, it is recommended that such individuals access peer support networks or social support groups, referred to by mental health practitioners based on which they can share and gain assistance with regards to their mental health and loneliness since such groups have been evidenced to mitigate the same (Hofhuis, Hanke & Rutten, 2019). Lastly, it is recommended that the public be educated on the risk of such mental health issues across expatriates to facilitate improved awareness and self-care management by individuals. It is also recommended that governments and public health officials collaborate worth each other to develop specific health policies or packages based on which expatriates living alone can maintain a positive quality of life and mental wellbeing despite the absence of social support (Odedra, Blackwood & Thorn, 2018).

21. STRENGTHS AND LIMITATIONS

Despite the comprehensiveness of findings, it must be noted that the study is not devoid of certain limitations. One of the first limitations of this study is its cross-sectional design. While cross-sectional studies provide insights into the objective relationships between key variables, they comprise data collection across a specific point of time, thus limiting their ability to provide insights into a possible cause-cause effect relationship between variables across different points of time (Rahi, 2017). As a result, further research on the topic of loneliness and mental health is needed across expatriates using cohort study designs which will provide detailed data on the same across different life stages or time periods across a selected population considering that the risk of mental health disorders and even loneliness varies due to age (Rahi, 2017). Additionally, the inclusion of only self-reported data collection methods can be implied as a limitation of this study.

As mentioned previously, a major section of data collected for this study was based upon primary data collection methods such as surveys, which are often highly prone to social desirability and biased responses. While the researcher took the time to communicate to participants the importance of honesty and truthfulness in findings, the risk of bias in responses cannot be fully overlooked. Additionally, it is worth noting that loneliness and its associated perceptions and feelings may be highly subjective in nature and influenced by factors like culture, gender, or age (Warinowski & Laakkonen, 2020). While this study did explore the prevalence of demographic associations in loneliness and risk of mental health disorders, there was a limited exploration of specific cause-effect relationships between certain demographic factors, loneliness, and risk of poor mental health. There is also a need to conduct further qualitative research in this area since objective studies like this research may not accurately capture the true feelings and experiences contributed to loneliness, poor mental health, and social functioning across participants.

Restricting the sample to include only Indians is also a key limitation since it limits the ability of the findings to be applied or transferred across populations of diverse ethnicities. It must also be noted that this research merely focused on assessing the prevalence of loneliness and the risk of mental health disorders. There is a need to explore further associations between loneliness and specific mental health disorders using disease-specific diagnostic tools, which otherwise have not been covered by this research. Lastly, the sample selected in

this research was largely purposive in nature and comprised of the inclusion of well-known social networks who were well educated on the details of the study and were already living in the UAE for more than six months, which in turn, can serve to be confounding factor. Since such forms of sampling are prone to bias, there is a need to conduct further research using randomization and inclusion of expatriates based on their stay away from their homeland.

Despite such limitations, this study also demonstrated certain strengths, which in turn hold significance and future implications for further professional research and future practice. Most of the limitations of this study can be attributed to its limited scope as per the research aims and objectives outlined in the initial sections. It is worthwhile to note that this study was one of the few limited types of research to have explored the prevalence of loneliness and associated mental health status and social functioning across Indians – one of the largest populations of expatriates residing in the UAE.

With this respect, the findings of this study provide useful insights based on which future researchers and healthcare professionals can be prompted to explore the associations between loneliness, mental health status, and social functioning further concerning specific demographic factors. Additionally, the extensive sample size of participants and the inclusion of participants based on the research questions and highlighted the problem demonstrate considerable internal validity and reliability. The inclusion of valid data collection tools, which have been used extensively in previous academic research, further demonstrates the reliability and credibility of data collection and findings. Lastly, this study is one of the few of its kind to explore loneliness, mental health illness risk, and the level of social functioning simultaneously. Thus, the given comprehensiveness of findings can prove to be useful in prompted future practitioners in developing interventions targeting mental health status and social functioning improvement across individuals facing loneliness based on their specific demographic factors.

22. CONCLUSION

As a result, this paper sheds light on the links between the prevalence of isolation and the risk of poor mental health and social functioning among Indians living in the United Arab Emirates. The high number of Indian expatriates, combined with the risk of loneliness and poor mental health among migrants, were key motivators for conducting this study. A quantitative cross-sectional design was used, along with data collection on demographics, mental wellbeing, and social functioning, using self-reported questions like the General Health Functioning-28 and the Social Functioning Questionnaire. Based on these results, the study was found to be evenly distributed in terms of their risk of mental health illnesses and a high degree of social functioning, likely due to the inclusion of both single and non-single participants. Furthermore, demographic factors such as age, schooling, and occupational levels may be responsible for the equitable distribution of such risk and high levels of social functioning. To sum up, more research is needed into the role of specific demographic factors in influencing mental health and social functioning among Indian expatriates in the United Arab Emirates.

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