Original Article

DOI: 10.7860/JCDR/2026/85833.23609

Public Health Section

Understanding Resilience among Migrant Construction Labourers: A Qualitative Study on Social Support and Biopsychosocial-spiritual Challenges

ARON ANTONY RAJ[1], ALEX JOSEPH[2], DHASARATHI KUMAR[3], ROSHNI MARY PETER[4]

ABSTRACT

Introduction: Interstate migrant construction workers in India face severe psychosocial and health challenges characterised by high psychological distress, financial instability, and inadequate healthcare access.

Aim: The present study aimed to explore and understand the Biopsychosocial-Spiritual (BPSS) resilience of interstate migrant construction workers in the Chengalpattu district, Tamil Nadu, India.

Materials and Methods: A qualitative In-Depth Interview (IDI) based study was conducted at SRM Institute of Science and Technology (SRMIST), Kattankulathur, Chengalpattu district, Tamil Nadu, India from March 2025 to August 2025. The primary units of study in the current research were individual interstate migrant construction workers employed in the construction sector in Chengalpattu district, Tamil Nadu, India. Workers' of either gender (male or female), age range of 18-50 years who had Job roles within the construction sector (e.g., bricklayer, construction worker, assistant, manager) and duration of migration (ranging from 1 to 10 years) were included in the present study. Data were collected using a semi-structured interview guide, which was developed based on the BPSS framework. Each interview lasted approximately 30 to 45 minutes. Data collection was carried out over a defined time period and continued until thematic sufficiency was achieved. Data analysis was conducted using thematic analysis

Results: Seven IDIs were conducted with interstate migrant construction workers (five males, two females) aged 18-50 years from six states (Bihar, Odisha, Andhra Pradesh, West Bengal, Jharkhand, Chhattisgarh), with one local worker for contextual comparison (Tamil Nadu). Themes were finalised and organised into four major thematic areas: employment and lifestyle issues, physical and emotional well-being, assistance from friends and family, and faith, beliefs, and traditions as coping mechanisms. The present study found that interstate migrant construction labourers demonstrate resilience through social networks and spiritual beliefs within a BPSS framework.

Conclusion: Enhancing working conditions and formal healthcare access would address core vulnerabilities and lower long-term health hazards for interstate construction workers. The current study findings therefore support calls for mental-health approaches that integrate economic and relational realities rather than treating distress as an isolated clinical phenomenon.

Keywords: Construction industry, India, Migrants, Psychological, Spirituality

INTRODUCTION

People have travelled from one location to another throughout human history. The choice of if, how, and where to relocate is difficult and may be influenced by a number of variables [1]. The National Sample Survey Organisation (NSSO) estimated that 326 million of the population are migrants [2]. According to the Census of India 2011, 31.16% of the urban population are migrants and approximately 20.5 million individuals migrate annually to urban regions [3]. Migrant construction workers contribute to economic growth [4]. However, they often face informal work environments [5]. These jobs involve long hours, strenuous tasks, job insecurity, low pay, and limited access to basic facilities like sanitation and safety [6]. Migration can cause social dislocation. Workers may be separated from families, face language barriers, and struggle with cultural adjustments [7,8]. Access to healthcare, social security, and legal protections is often restricted. This is due to structural barriers, lack of awareness, financial issues, and fear of losing wages [9-11]. Such conditions increase risks for physical illness, psychological stress, and social isolation [12,13].

The BPSS model was first developed by Engel GL in 1977 and later expanded by Sulmasy DP in 2002. It offers a broad view of resilience that goes beyond traditional biomedical methods [14,15]. The BPSS model is a holistic healthcare framework that views human health as a dynamic interaction between biological, psychological, social, and spiritual dimensions. The model extends beyond traditional medical approaches by recognising that health outcomes result from complex, reciprocal interactions across multiple domains [16]. According to a study by Hodgson JL et al., 2016, the four core assessment dimensions include: biomedical (physical health), psychological (emotional/cognitive patterns), Social (relational support systems), and spiritual (personal beliefs and meaning) [17].

A study by Hatala AR et al., shows that the model is still evolving, with researchers arguing that spirituality remains marginalised in contemporary health perspectives 2013 [18]. While this model has been used for chronic illnesses [19] and first responders [20], its relevance for migrant construction workers in low-resource areas is still underexplored. Most studies on Indian construction workers focus on safety and mental health [21,22]. Numerous research shows that social support networks reduce psychological distress among Indian migrants [23,24]. Additionally, religious coping improves mental health in displaced groups worldwide [25,26]. However, no study has examined how these factors interact within a BPSS framework for interstate migrant construction workers in South India. Hence, the current study aimed to explore the experiences of interstate migrant construction workers regarding their job conditions and lifestyle challenges.

The primary objective of the present study was to explore and understand the BPSS resilience of interstate migrant construction workers in Chengalpattu district, Tamil Nadu, India, with particular focus on the role of interpersonal relationships and faith-based practices in coping with everyday challenges and to identify key BPSS factors that contribute to resilience among migrant construction workers in the absence of formal institutional support.

MATERIALS AND METHODS

The present qualitative IDI based study was conducted to explore BPSS resilience, focusing on physical, psychological, social, and spiritual dimensions of the participants' lives from March 2025 to August 2025 at SRM Institute of Science and Technology (SRMIST), Kattankulathur, Chengalpattu district in Tamil Nadu, India. The study was conducted in accordance with the principles outlined in the Declaration of Helsinki. Ethical approval was obtained from Institutional Ethical Committee (IEC) of the School of Public Health (SPH) with the number of 9129, SRM Institute of Science and Technology (SRMIST), Kattankulathur, and Tamil Nadu, India.

Researcher characteristics: The researcher served as the principal investigator and was directly involved in all stages of the current study, including participant recruitment, data collection, transcription oversight, and analysis. The researcher possessed prior academic training in qualitative research methods and had foundational knowledge of migrant health, psychosocial well-being, and resilience frameworks. The researcher adopted a participant-centred, empathetic, and non-judgmental stance during data collection to build rapport and encourage open sharing of experiences. Sensitivity to cultural, linguistic, and gender-related issues was maintained throughout the interviews, particularly given the vulnerability of interstate migrant construction workers. Fluency and functional familiarity with local languages (Tamil and Hindi), or the use of culturally competent support when required, enabled effective communication and minimised misinterpretation of participants' narratives.

Context of the study: Interstate migrant construction workers constitute a significant yet marginalised workforce in India's rapidly expanding construction sector. The present study workers migrate from Bihar, Odisha, Andhra Pradesh, West Bengal, Jharkhand, and Chhattisgarh to semi-urban and urban regions in search of livelihood opportunities. Chengalpattu district in Tamil Nadu has emerged as a major destination due to ongoing infrastructure development and proximity to Chennai.

Sample size calculation: The study employed a purposive sampling strategy with maximum variation sampling to capture diverse perspectives among interstate migrant construction workers in Chengalpattu district, Tamil Nadu, India. This approach was chosen to ensure inclusion of participants with varied backgrounds and work experiences, thereby enriching the depth and breadth of qualitative data.

The primary units of study in the present research were individual interstate migrant construction workers employed in the construction sector in Chengalpattu district, Tamil Nadu, India. Each unit of the study represented a single migrant worker who had migrated from another Indian state and was engaged in construction-related work

Participants were intentionally selected based on predefined criteria, including their state of origin (Bihar, Odisha, Andhra Pradesh, West Bengal, Jharkhand, Chhattisgarh, and Tamil Nadu etc.,). Workers' of either gender (male or female), age range of 18-50 years, who had been engaged in construction-related job roles such as assistant, manager, bricklayer, and construction worker, and length of migration between one and 10 years were included in the present study. Participants varied in terms of age, gender, state of origin, job role, and duration of migration, allowing for diverse perspectives on BPSS resilience. In addition, a local construction worker from Tamil Nadu was also included to provide contextual understanding and enable comparison with interstate migrant experiences.

Sampling continued until information-rich cases were obtained and thematic sufficiency was reached within the scope of the qualitative phase. The small sample size was consistent with the exploratory nature of IDIs and allowed for detailed exploration of BPSS resilience.

To ensure confidentiality and anonymity, no personal identifiers were recorded. Participants were assigned unique codes, and all identifying information was removed from transcripts and reports. Audio recordings, transcripts, and field notes were securely stored and accessible only to the research team. Given the vulnerability of migrant construction workers, special care was taken to minimise psychological distress. Interviews were conducted in a safe, private, and comfortable setting, and participants were free to skip any questions they found uncomfortable. Emotional sensitivity was maintained, particularly when discussing topics related to health, family separation, and financial hardship.

Study Procedure

Data collection methods: Data were collected using IDIs as the primary method, consistent with the qualitative and exploratory nature of the study. This method enabled an in-depth understanding of the lived experiences, perceptions, and coping strategies of interstate migrant construction workers.

A semi-structured interview guide was developed based on the BPSS framework. The guide included open-ended questions covering employment conditions, physical and mental health, social relationships, migration experiences, and faith or spiritual practices. Probing questions were used to elicit detailed responses and clarify meanings. Interviews were conducted by the Principal Investigator in participants' preferred languages, primarily Tamil and Hindi, to ensure comfort and accurate expression. Each interview lasted approximately 30 to 45 minutes and was carried out in a quiet and private setting near the participants' residence or workplace. With participants' permission, interviews were audio-recorded to ensure accurate data capture. In addition, field notes were maintained to document non-verbal cues, contextual observations, and the researcher's reflections immediately after each interview.

Data collection was carried out over a defined time period and continued until thematic sufficiency was achieved within the qualitative phase. All participants were reminded of their right to withdraw at any stage of the interview process.

The interview guide allowed flexibility for probing and follow-up questions to capture rich, detailed narratives. Interview transcripts were translated into English. All digital data were stored on password-protected devices, and hard copies of notes were securely maintained to ensure confidentiality and data protection.

Data processing: Following data collection, all audio-recorded interviews were transcribed verbatim by the research team. Interviews conducted in Tamil and Hindi was translated into English, with careful attention to preserving the original meaning and cultural context of participants' narratives. Translations were cross-checked for accuracy. Each transcript was reviewed multiple times by the Principal Investigator to ensure completeness and familiarity with the data. Transcripts were anonymised by removing personal identifiers and assigning unique participant codes.

Throughout the data processing phase, data security and confidentiality were maintained by storing digital files on password-protected devices and securing hard copies in locked storage accessible only to the research team. Data processing was conducted iteratively, allowing preliminary insights to inform ongoing analysis while maintaining the integrity and accuracy of the original data.

STATISTICAL ANALYSIS

Data analysis was conducted using thematic analysis. The present study's thematic synthesis followed the three-stage approach defined by Thomas J and Harden A (2008) [27]: 1) line-by-line coding of findings 2) development of descriptive themes and 3) generation of analytical themes. This method ensures a transparent link between primary data and our final conclusions and analytical rigor and transparency. The authors followed an inductive-deductive approach to capture both emerging themes and predetermined concepts aligned with the BPSS framework. The authors repeatedly read the transcripts, field notes, and reflexive journals to gain an in-depth understanding of the participants' experiences. Codes were initially reviewed, compared, and refined to ensure consistency and accuracy, after which similar codes were grouped and merged to form meaningful categories. These categories were then organised into broader themes capturing major patterns across the data by all team members. Themes were reviewed against the original data to ensure they accurately reflected the participants' perspectives. To enhance credibility and reliability, a subset of transcripts and coding was independently reviewed, and any discrepancies were discussed and resolved through consensus among all authors.

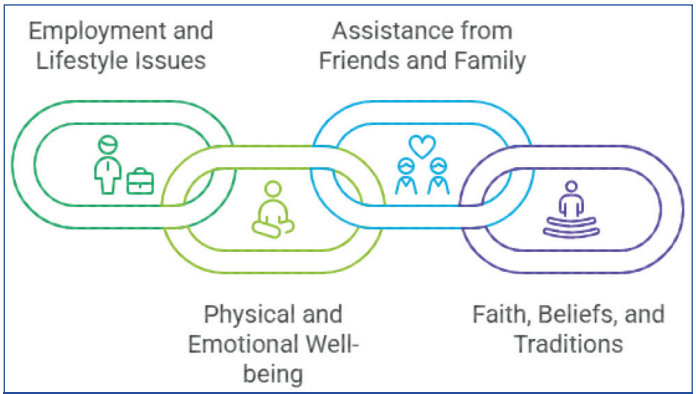
Techniques to Enhance Trustworthiness

To ensure the credibility, dependability, conformability, and transferability of the findings, the following strategies were implemented: The researcher spent sufficient time building rapport and understanding the context of the participants' lives, improving the depth and authenticity of the data. Data were collected through multiple sources, such as IDIs, field notes. Participants were given opportunities to review and confirm their responses or clarify meanings (where feasible), ensuring accurate representation of their narratives.

RESULTS

The findings from the IDIs reveal that interstate migrant construction workers in Chengalpattu experience multifaceted BPSS challenges, which significantly influence their resilience. Themes were finalised and organised into four major thematic areas [Table/Fig-1].

- Employment and lifestyle issues
- Physical and emotional well-being
- Assistance from friends and family
- Faith, beliefs, and traditions as coping mechanisms



[Table/Fig-1]: Major thematic areas (The diagram has been prepared by the authors based on the relevant model/framework used in the present study).

And themes were interpreted in relation to the BPSS framework [Table/Fig-1], existing literature, and the present study's research objectives. Findings were contextualised within the socio-economic realities of migrant construction workers.

Employment and Lifestyle Issues

Participants consistently described construction work as physically demanding, unregulated, and insecure, with inadequate rest, poor workplace facilities, and seasonal unemployment. These factors contribute to chronic stress and uncertainty.

A male participant who is 28 years, from Bihar described construction work as both physically taxing and structurally insecure, characterised by long working hours, minimal rest, and an absence of predictable income. He emphasised that work schedules were irregular and often extended beyond reasonable physical limits, leaving little opportunity for recovery. Seasonal fluctuations in employment, particularly during the monsoon, were described as a major source of anxiety and hardship. He explained, *"The work is very hard on the body. There is no fixed time,"* and further elaborated, *"Occasionally, we miss meals… in the rainy season, there's no employment."* The lack of income during these periods resulted in food insecurity and heightened financial stress, especially given his responsibility to send remittances to his family in Bihar. His narrative reflects the broader precarity that shapes the daily lives of migrant construction workers.

Long and irregular working hours, minimal rest, and the absence of predictable income created significant instability. Seasonal unemployment, particularly during the monsoon, resulted in periods without earnings, leading to food insecurity and financial hardship.

Physical and Emotional Well-being

Physical health problems such as musculoskeletal pain, injuries, and heat-related illnesses were common, yet formal healthcare was often avoided due to cost, time loss, and fear of wage deduction. This aligns with existing evidence that migrant workers rely on informal care and self-medication. Emotional distress emerged from family separation, loneliness, and financial insecurity. Female workers particularly reported feelings of sadness and longing for family, indicating a gendered emotional burden. The combination of physical exhaustion and emotional strain underscores the need for holistic health interventions that address both body and mind.

A female participant, who is 35-year-old from Odisha highlighted gender-specific challenges that compounded the already demanding nature of construction work. She described the work environment as unsafe and lacking basic infrastructure necessary for women's dignity and well-being. Inappropriate comments from male co-workers were reported as a recurring experience, which contributed to feelings of discomfort and vulnerability. She stated, *"Certain men express remarks it makes us uncomfortable."* In addition, the absence of sanitation facilities at worksites emerged as a critical concern, particularly during long working hours. She noted, *"The absence of restrooms at the location poses a significant issue for women."* These conditions not only affected her physical comfort but also undermined her sense of safety and self-respect in the workplace. Other participant also emphasised gender-specific workplace challenges, including unsafe conditions and the absence of basic sanitation facilities. Inappropriate remarks from male co-workers created an uncomfortable and hostile work environment. The lack of restrooms at worksites posed a significant daily challenge, particularly during long working hours.

A male participant who is 40 years, from Andhra Pradesh reported chronic physical health issues resulting from prolonged

engagement in manual construction labour. Common ailments included musculoskeletal pain, minor injuries such as cuts, and heat-related illnesses, which he described as part of daily life. Despite experiencing these health problems, he avoided seeking formal medical care due to financial constraints and fear of income loss. He explained, *"I typically obtain tablets from nearby pharmacies."* Recalling a period of illness, he stated, *"At one point, I had to be absent from work for a week. No compensation for that week."* His account illustrates how the lack of paid sick leave and employment security discourages migrant workers from accessing appropriate healthcare, potentially exacerbating long-term health risks.

Assistance from Friends and Family

In the absence of formal institutional support, strong peer networks and family ties served as critical resilience resources. Migrant workers formed informal associations based on language, region, and shared experiences. These networks provided practical support (food, money, accommodation), emotional support (companionship, encouragement), and informational support (job leads, healthcare advice). This social capital functioned as an informal safety net, highlighting how interpersonal relationships act as survival strategies and resilience enhancers in precarious environments.

Male participant, 38 years, from Chhattisgarh reinforced the theme of limited formal support by describing a reliance on mutual aid among co-workers. He reported minimal assistance from employers or government institutions, particularly during health-related or financial emergencies. He stated, *"There is no proper help from outside. We depend on each other."* Over time, these relationships evolved into surrogate familial bonds, offering both emotional and practical support. As he noted, *"People here become like brothers."* His account underscores the central role of collective solidarity in helping migrant workers cope with occupational risks and social isolation.

A female participant 32-year-old, from West Bengal elaborated on the emotional and psychological toll of migration, particularly the prolonged separation from her children. She described frequent episodes of sadness, loneliness, and emotional distress, which were intensified by limited social support and demanding work conditions. She shared, *"I shed tears occasionally,"* and added, *"I miss my children very much."* Despite these challenges, she articulated a strong sense of purpose that motivated her to continue working under difficult circumstances. She explained, *"I keep in mind the reason for my presence-ensuring a brighter future for them".* Her narrative highlights the gendered emotional burden experienced by migrant women, who often balance economic responsibilities with profound emotional sacrifice.

Faith, Beliefs, and Traditions as Coping Mechanisms

Spirituality emerged as a powerful coping resource. Prayer, religious rituals, temple visits, and faith-based community activities offered psychological comfort, hope, and a sense of meaning amid hardship. Religious beliefs helped participants interpret their suffering as temporary or purposeful, which strengthened their ability to endure challenges. Spiritual practices also created a sense of community and belonging, countering isolation and reinforcing resilience.

A male participant who is 45-year-old, from Jharkhand, emphasised the importance of informal social networks in mitigating the absence of formal institutional support. He described how migrant workers formed close-knit peer groups based on shared regional and linguistic backgrounds. These networks functioned as vital sources of emotional reassurance, financial assistance, and practical support during times of illness or crisis. He explained, *"If someone falls sick, we collect money. If someone is worried, we sit and talk."* He further stressed the indispensability of these relationships, stating, *"Without friends here, survival is very difficult."* Such peer-based support systems emerged as key coping mechanisms and sources of resilience among migrant workers.

A Male participant who is 30 years, from Tamil Nadu-local worker provided valuable contextual insight into shared coping strategies within the construction workforce. He emphasised the role of faith and religious practices as important psychological resources for both migrant and local workers. He stated, *"Many of us pray when things become difficult,"* and further explained, *"Going to the temple gives peace and strength to continue".* Participation in religious rituals and collective worship fostered a sense of hope, emotional relief, and community belonging, helping workers manage stress and uncertainty. These practices functioned as culturally embedded coping mechanisms that supported overall well-being.

DISCUSSION

The current study used a BPSS perspective to examine resilience in interstate migratory construction workers. The results show that, in situations of structural vulnerability, resilience is socially formed and spiritually maintained rather than just being an individual psychological skill. Participants used faith-based meaning systems, familial duties, and peer solidarity to navigate difficult working conditions, job insecurity, social displacement, and limited institutional protection.

The present study found that migrant construction workers in India face severe psychosocial and health challenges characterised by high psychological distress, financial instability, and inadequate healthcare access. The lack of protective measures and basic amenities reflects broader structural vulnerabilities that marginalise migrant workers, forcing them to accept hazardous working conditions to survive. The daily struggle for income and food security reinforces their vulnerability and shapes their coping strategies. This is consistent with previous literature reporting unemployment and financial problems [28], Poor living arrangements and inadequate social support [29], and workstation exposures and long working hours [30]. A study by Umberger W et al., 2024, recent applications demonstrate its potential in areas like pain management, where it helps explain complex health experiences, which is comparable with our study findings [31].

Prior studies have consistently demonstrated that migrant workers face a lack of legal protection, dangerous working conditions, and wage insecurity; all of which lead to long-term stress and poor health consequences [32,33]. Participants' descriptions of an unpredictable income gap support the idea that everyday vulnerability is shaped by macroeconomic systems rather than by personal inadequacies. These structural variables have an impact on reduced help-seeking, psychological distress, and biological strain within the BPSS paradigm.

Consistent with earlier studies, musculoskeletal pain, injuries, and heat exposure were normalised as routine aspects of work [34,35]. Yet, despite high morbidity, participants avoided formal healthcare because treatment costs, wage deductions, and job loss were perceived as greater threats than illness itself. Similar patterns of delayed care and self-medication among migrant workers have been reported across low-and middle-income settings [36]. Emotional distress linked to separation from family, loneliness, and financial pressure was prominent, particularly among women. This aligns with evidence that migrant women often carry dual burdens of productive labour and emotional caregiving across distances [37]. Multiple studies reveal significant mental health issues: according to the Danasekaran R et al., 2025 study, around 44% experiencing depression, 32% anxiety, and 38.6% stress among migrant workers [38]. A study by Sriramalu SB et al., 2023 identified that 64% of workers required psychosocial care, with females experiencing higher distress [39].

A central contribution of this study is the demonstration that peer relationships function as an informal welfare system. Workers relied on each other for loans, food, health advice, and companionship. These findings resonate with social capital theory, which posits that networks of trust and reciprocity are crucial resources for populations excluded from formal institutions [40]. Faith practices like prayer, temple visits, and collective rituals were described as sources of hope, strength, and emotional regulation. Participants frequently reframed hardship as temporary, purposeful, or divinely guided. This mirrors literature suggesting that spirituality enhances coping by fostering meaning-making and perceived control during adversity [41]. The current study findings therefore support calls for mental-health approaches that integrate economic and relational realities rather than treating distress as an isolated clinical phenomenon.

Strengths and Limitation(s)

By using in-depth qualitative interviews, the present study captured nuanced lived experiences rarely visible in administrative data. However, the small, location-specific sample may limit transferability. Future research could integrate longitudinal or mixed-methods designs to examine how BPSS resilience evolves over time.

CONCLUSION(S)

Participants demonstrated adaptive coping strategies backed by social networks and spiritual beliefs in spite of harsh work conditions, social isolation, and restricted access to official support. The results imply that community-based support networks should be incorporated into intervention techniques in addition to individual-focused initiatives. Resilience and well-being can be improved by bolstering social networks, providing culturally competent mental health care, and incorporating religious institutions into welfare programs. Enhancing working conditions and formal healthcare access would also address core vulnerabilities and lower long-term health hazards.

Acknowledgement

The authors gratefully acknowledge the support received from the SRM Medical College Hospital and Research Centre, SRM Institute of Science and Technology (SRMIST) and the faculty of the School of Public Health, SRMIST.

Authors' contributions: AAR: Conceptualisation, methodology, investigation (data collection), formal analysis (primary qualitative coding), writing - original draft preparation, and project administration; AJ: Conceptualisation, methodology, formal analysis (thematic validation), supervision, writing - review and editing, and guarantor (corresponding author); DK, RMP: Formal analysis (collaborative coding and thematic synthesis), writing - review and editing, and critical structural revision. All authors read, critically reviewed, and provided final approval of the submitted version of the manuscript.

Funding: The authors gratefully acknowledge the financial support provided by the SRM School of Public Health, Faculty of Medicine and Health Sciences, SRMIST, Kattankulathur, for partially defraying the publication costs of this article.

REFERENCES

[1] UNICEF. National workshop on internal migration and human development in India: Workshop compendium. Vol. 2, Workshop papers. New Delhi: UNICEF; 2011
[2] National Sample Survey Organisation (NSSO) Government of India: National Sample Survey Office, Ministry of Statistics and Programme Implementation. 2010. Migration in India, 200708: NSS 64th Round, July 2007-June 2008 (No. 533).
[3] Census of India Ministry of Home Affairs. Govt of India, New Delhi: Office of the Registrar General and Census Commissioner. 2011. Available from: https://www.censusindia.gov.in [Last accessed on 2026 Jan 12].
[4] Azam M. The role of migrant workers remittances in fostering economic growth: The four Asian developing countries' experiences. International Journal of Social Economics. 2015;42(8):690-705.
[5] Wan X. Migrant workers and informal employment. Social Sciences in China. 2008;29(3):187-200.
[6] Fields GS. Working hard, working poor: A global journey. New York: Oxford University Press; 2012.
[7] McGuire S, Martin K. Fractured migrant families: Paradoxes of hope and devastation. Family & Community Health. 2007;30(3):178-88.
[8] Pot A, Keijzer M, De Bot K. The language barrier in migrant aging. International Journal of Bilingual Education and Bilingualism. 2008;23(9):1139-57.
[9] Loganathan T, Rui D, Ng CW, Pocock NS. Breaking down the barriers: Understanding migrant workers' access to healthcare in Malaysia. PloS one. 2019;14(7):e0218669.
[10] Dupper O. Migrant workers and the right to social security: An international perspective. Stellenbosch Law Review. 2007;18(2):219-54.
[11] Taran PA. Human rights of migrants: Challenges of the new decade. International Migration. 2001;38(6):07-51.
[12] Hull D. Migration, adaptation, and illness: A review. Social Science & Medicine. Part A: Medical Psychology & Medical Sociology. 1979;13:25-36.
[13] Jang Y, Park J, Choi EY, Cho YJ, Park NS, Chiriboga DA. Social isolation in Asian Americans: Risks associated with socio-demographic, health, and immigration factors. Ethnicity & Health. 2022;27(6):1428-41.
[14] Engel GL. The need for a new medical model: A challenge for biomedicine. Science. 1977;196(4286):129-36.
[15] Sulmasy DP. A biopsychosocial-spiritual model for the care of patients at the end of life. The Gerontologist. 2002;42(suppl_3):24-33.
[16] Saad M, De Medeiros R, Mosini AC. Are we ready for a true biopsychosocial–spiritual model? The many meanings of "spiritual". Medicines (Basel). 2017;4(4):79.
[17] Hodgson JL, Lamson AL, Kolobova I. A biopsychosocial-spiritual assessment in brief or extended couple therapy formats. In: Hodgson JL, Lamson AL, editors. Techniques for the Couple Therapist. New York: Routledge; 2016. p. 213-217.
[18] Hatala AR. Towards a biopsychosocial–spiritual approach in health psychology: Exploring theoretical orientations and future directions. Journal of Spirituality in Mental Health. 2013;15(4):256-76.
[19] Williams-Reade J. Biopsychosocial–spiritual resilience interview: Understanding and promoting well-being in patients living with medical conditions. In: Eppler C, Martin R, editors. Cultivating systemic resilience in therapy: Applications and interventions for families, relationships, and individuals. New York: Routledge; 2024. p. 71-81.
[20] Layson M. Developing a Biopsychosocial-Spiritual Framework to Prevent Moral Suffering (Moral Injury) in Trauma-Exposed First Responder Communities. Available from: https://researchoutput.csu.edu.au/en/publications/developing-a-biopsychosocial-spiritual-framework-to-prevent-moral/.
[21] Biswas G, Bhattacharya A, Bhattacharya R. Occupational health status of construction workers: A review. International Journal of Medical Science and Public Health. 2017.
[22] Chellappa V, Srivastava V, Salve UR. A systematic review of construction workers' health and safety research in India. Journal of Engineering, Design and Technology. 2021;19(6):1488-0415.
[23] Raghavan R, Coope J, Brown B, Sivakami M, Jamwal S, Pendse T. The untold story of mental health and resilience of internal migrants in India. InMental Health, Mental Illness and Migration 2021 Sep 18 (pp. 247-259). Singapore: Springer Singapore.
[24] Sethuraman V, Srinivas V, Bathirasamy V. Inter-state migration, footloose labour and accessibility to health care: An exploration among metro workers of a camp in Bengaluru. Social Work & Society. 2024;22(1).
[25] Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. Journal of Health Psychology. 2004;9(6):713-30.
[26] Bryant-Davis T, Wong EC. Faith to move mountains: Religious coping, spirituality, and interpersonal trauma recovery. American Psychologist. 2013;68(8):675.
[27] Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Medical Research Methodology. 2008;8(1):45.
[28] Ramana AB, Singh S, Rupani MP, Mukherjee R, Mohapatra A. Plight of migrant construction-site workers during the COVID-19 lockdown in 2020: A qualitative exploration in Bhavnagar, Western India. Work. 2023;76(1):33-45.
[29] Singh GP. Psychosocial and mental health issues of the migrants amidst COVID-19 pandemic in India: A narrative review. Indian J Psychol Med. 2021;43(6):473-78.
[30] Tiwary G, Gangopadhyay PK. A review on the occupational health and social security of unorganized workers in the construction industry. Indian J Occup Environ Med 2011;15(1):18-24.
[31] Umberger W, Wilson M. Translating the biopsychosocial-spiritual model into nursing practice. Pain Management Nursing. 2024;25(1):01-03.
[32] Srivastava R, Sutradhar R. to the construction sector in India and its impact on rural poverty. Indian Journal of Human Development. 2016;10(1):27-48.
[33] Reja MS, Das B. Labour migration within India: Motivations and social networks. South Asia Research. 2019;39(2):125-42.
[34] Nenonen N, Saarela KL, Takala J, Kheng LG, Yong E, Ling LS, et al. Global estimates of occupational accidents and work-related illnesses 2014 made for the ILO Report at XX World Congress, Frankfurt. Doi: 10.13140/2.1.2864.0647.
[35] Takala J, Hämäläinen P, Sauni R, Nygård CH, Gagliardi D, Neupane S. Global-, regional-and country-level estimates of the work-related burden of diseases and accidents in 2019. Scandinavian Journal of Work, Environment & Health. 2024;50(2):73-82.

[36] Moyce SC, Schenker M. Migrant workers and their occupational health and safety. Annual review of public health. 2018;39(1):351-65.
[37] Deshingkar P, Akter S. (2009). Migration and human development in India. Human Development Research Paper. 13. Available from: https://www.researchgate.net/publication/40534191_Migration_and_Human_Development_in_India.
[38] Danasekaran R, Syed R, Natarajan SB, Sridharan V, Palaniappan P, Punniyamurthy M, et al. Psychological morbidity and its risk factors among migrant construction workers in Chengalpattu district–A cross-sectional study. International Journal of Occupational Safety and Health. 2025;15(3):250-61.
[39] Sriramalu SB, Elangovan AR, Annapally SR, Birudu R, Lakshmana G. Psychological distress and quality of community life among migratory construction workers in India. Journal of Neurosciences in Rural Practice. 2023;14(3):533-540.
[40] Putnam RD. Bowling alone: The collapse and revival of American community. New York: Simon & Schuster; 2000.
[41] Pargament KI. The psychology of religion and coping: Theory, research, practice. New York: Guilford Press; 2001.

PARTICULARS OF CONTRIBUTORS:
1. Medical Social Worker, Department of Community Medicine, SRM Medical College Hospital and Research Centre, Faculty of Medicine and Health Sciences, SRM Institute of Science and Technology, Kattankulathur, Chengalpattu, Tamil Nadu, India.
2. Professor, Division of Epidemiology, SRM School of Public Health, Faculty of Medicine and Health Sciences, SRM Institute of Science and Technology, Kattankulathur, Chengalpattu, Tamil Nadu, India.
3. Assistant Professor, SRM Centre for Clinical Trials and Research, SRM Medical College Hospital and Research Centre, Faculty of Medicine and Health Sciences, SRM Institute of Science and Technology, Kattankulathur, Chengalpattu, Tamil Nadu, India.
4. Professor, Department of Community Medicine, SRM Medical College Hospital and Research Centre, Faculty of Medicine and Health Sciences, SRM Institute of Science and Technology, Kattankulathur, Chengalpattu, Tamil Nadu, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:
Alex Joseph,
Professor, Division of Epidemiology, SRM School of Public Health, Faculty of Medicine and Health Sciences, SRM Institute of Science and Technology, Kattankulathur, Chengalpattu, Tamil Nadu, India.
E-mail: alexjosephdr@gmail.com; alexj@srmist.edu.in

PLAGIARISM CHECKING METHODS: [Jain H et al.]
- Plagiarism X-checker: Dec 14, 2025
- Manual Googling: Apr 15, 2026
- iThenticate Software: Apr 19, 2026 (1%)

ETYMOLOGY: Author Origin

EMENDATIONS: 6

AUTHOR DECLARATION:
- Financial or Other Competing Interests: None
- Was Ethics Committee Approval obtained for this study? Yes
- Was informed consent obtained from the subjects involved in the study? Yes
- For any images presented appropriate consent has been obtained from the subjects. Yes

Date of Submission: **Dec 11, 2025**
Date of Peer Review: **Jan 08, 2026**
Date of Acceptance: **Apr 21, 2026**
Date of Publishing: **Jun 01, 2026**