International Journal of Environmental Sciences
ISSN: 2229-7359
Vol. 11 No. 4,2025
https://theaspd.com/index.php

Work-Life Challenges And Mental Health Support Among Single-Parent Physicians In India

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ABSTRACT: *The medical profession requires ever-present duty and emotional resilience, particularly for doctors carrying out professional and parental responsibilities. The following study investigates work-life issues, psychological needs, and support systems among single-parent physicians in Chennai, India. In a mixed-methods study, structured surveys (N=100) and open-ended interviews were conducted to examine work environments, autonomy in schedules, and determinants of well-being. Quantitative SPSS analysis included descriptive statistics, correlations, regressions, exploratory factor analysis, and ANOVA. Significant correlations were found between work hours, shift frequency, flextime access, and perceived well-being, as well as with the availability of mental health resources. Two main components were found through factor analysis: Workplace Conditions & Institutional Support and Personal Challenges with Help-Seeking, accounting for more than 55% of the variance. Regression results indicated that flextime access was a significant predictor of access to well-being services. ANOVA and chi-square tests also indicated significant differences in support usage by gender, age, and dependents. The paper highlights that work-life balance, access to mental health, and pro-work policies are crucial in creating the well-being of single-parent doctors. Practical suggestions involve childcare facilities on-site, mental health arrangements, and flexible work arrangements, all of which have far-reaching implications for hospital administration and policy for maintaining physician performance while advancing family stability.*

Keywords: *Physician well-being, Single-parent doctors, Work-life balance, Mental health, Healthcare support, Flexible Work Arrangements*

1 INTRODUCTION

The health industry is central to the welfare of a nation, requiring utmost dedication, perseverance, and moral behaviour from healthcare workers. Doctors, especially, are tasked with upholding the provision of timely, empathetic, and evidence-based care under precarious circumstances (Kanter et al., 2013; Bhardwaj, 2022). The clinical workload—added to long working days, emergency call-out responsibility, and the emotional toll of patient care—can lead to severe occupational stress (Pudasaini et al., 2022). These stresses are further compounded for single-parent physicians, who have to juggle the stress of professional responsibilities and full-time caregiving simultaneously, often without the safety nets present for dual-parent families. Physicians working in trauma care or emergency services are expected to maintain availability around the clock (Anyfantakis & Symvoulakis, 2011). While such dedication is emblematic of medical professionalism, the resulting time constraints, emotional fatigue, and work-life imbalance pose substantial risks to physician well-being (Mohanty et al., 2019) The condition is especially fragile for single-parent physicians in India, where conventional gender expectations and weak institutional mechanisms of support frequently prove inadequate to contain the multifaceted realities of parenting and medical practice. Studies have strongly highlighted the need for health facilities to incorporate wellness programs, mental health support, and flexible scheduling practices to cater to the all-around welfare of their employees (Pudasaini et al., 2022); (Bhardwaj, 2022) Nevertheless, the majority of current frameworks are generalist and do not take into account the specific stressors and socio-emotional demands of single-parent doctors. This group has heightened rates of psychological risk from the double burden of caregiving and clinical duties—scenarios that can result in burnout, diminished job satisfaction, and long-term mental health deterioration.

This research hopes to plug that informative gap by examining the work-life issues, support systems, and mental health requirements of single-parent physicians in Chennai, India. Through their work contexts, working hours, scheduling autonomy, and access to institutional support, this research hopes to provide practical recommendations that would aid workplace reform, HR policy development, and public health discussion. Using a mixed-methods approach, the research discovers quantitative patterns and qualitative everyday life to depict a complete scenario of physician well-being among this underreported population.

Objective of the Study

- To examine the work environments, work hours, and scheduling control of single-parent physicians.
- To examine influencing factors for work-life balance and general well-being, especially the influence of work stress on mental health.
- To explore the difficulties that single-parent doctors experience in managing work and family responsibilities.
- To evaluate the availability and effectiveness of work-life and mental health support services.

2 LITERATURE REVIEW

The dilemmas encountered by single parents in juggling caregiving duties with work responsibilities have attracted more and more scholarly interest. This is especially true in healthcare, where extended working hours, emotional exhaustion, and hierarchical institutional arrangements heighten stress on workers. (Fundudis, 1997) Underscored that single parenthood should not only be studied as a risk status but also as a multifaceted social reality influenced by cultural, economic, and psychological factors. Later research has pointed out that single mothers, particularly those in stressful careers, are more vulnerable to depression, anxiety, and burnout because of the double burden of work and childcare (Hamid & Salleh, 2013; Gyorffy et al., 2016; Chiu et al., 2017). In the healthcare field, these tensions are exacerbated. (Hamid & Salleh, 2013) Found that institutional support, lacking severely compromises the mental well-being of single-parent medical professionals. In the same way, (Taylor & Conger, 2017)illustrated that emotionally supportive contexts act as a buffer against the harmful impact of work-life conflict. (Gibson et al., 2018), Via a Cochrane systematic review, also reaffirmed that welfare-to-work interventions have a significant positive impact on parents' mental health and child well-being, especially for single mothers. These results are consistent with (Dubale et al., 2019), whose review of healthcare professionals in low- and middle-income countries (LMICs) reported elevated rates of physician burnout tied to structural causes such as long work hours, inadequate staffing, and inadequate organizational support. Financial stress is still another compelling source of psychological stress. (Stack & Meredith, 2018)indicated that financial stigma tends to deter single parents from seeking available support systems. (Barnhart & Maguire-Jack, 2016)discovered that the stress of parenting in low-income single-mother families mediates the relationship between social cohesion and child well-being, implying that parental burnout may undermine family resilience as well. (Kim et al., 2018) Also concluded that economic adversity plays an important role in causing depressive symptoms among single mothers, particularly when preceded by inadequate institutional buffers. Additional complexities arise from sociocultural stigma for single parents. In conservative nations such as India, single mothers can be marginalized, socially stigmatized, and subject to limited civic engagement(Menard Shitindi & Lubawa, 2022). These external pressures not only impact their psychological health but also restrict professional networking and community-based support systems. (Hammer et al., 2004) believed that legislation alone would not suffice—organizations must create a culture of support, where flexible scheduling, flextime, and mental health provisions are normalized, particularly for those with caregiving responsibilities. In addition to parental health, researchers also identified the indirect yet salient effect on children. (Barnhart & Maguire-Jack, 2016), (Chiu et al., 2017), and (Marasigan, 2022) both described that children's cognitive and emotional growth in single-parent families tend to be impacted by spillover stress from the parent.(Jones et al., 2022) highlighted the importance of holistic interventions that address not only the parent but the family system as well. While the majority of studies mentioned here are set in Western settings, there is fresh evidence now emerging from South and Southeast Asia that highlights similar trends. In Malaysia, (Nur Saadah M. A. & Islam, 2014) found time poverty, economic vulnerability, and social stigma to be primary stressors among single-parent professionals. In India, doctors frequently face rigid schedules, limited childcare availability, and inadequate workplace mental health services—factors that significantly erode their well-being. These findings underscore the urgent necessity for research that targets the intersection of professional identity, parenthood, and institutional responsibility in Indian healthcare on a region-by-region basis.

3 METHODOLOGY

This research utilises a convergent parallel mixed-methods approach to investigate work-life issues, psychological burden of mental health, and the institutional support system faced by single-parent doctors in Chennai, India. Structured surveys were used as the quantitative component and were supplemented with qualitative interviews and focus group discussions to yield measurable trends and contextual information.

3.1 Sampling and Participants

The study population was single-parent physicians who worked in diverse private health facilities across the Chennai District. Stratified random sampling was utilized to maximize heterogeneity across medical specialties and types of institutions. The quantitative phase involved returns from 100 participants who filled out structured questionnaires. The qualitative phase had 10 single-parent doctors, who were selected for focus group discussions and in-depth interviews. The sufficiency of the quantitative sample size was validated via G*Power analysis, ensuring that the study had a statistical power level of 0.80 for the inferential tests, such as regression and ANOVA used.

3.2 Data Collection Tools

i. Quantitative Data Collection:

- A standard questionnaire was completed, encompassing major areas like:
- Work Environment Factors: Such as working hours, shift timing, scheduling autonomy, and availability of flexible work arrangements.
- Institutional Support: Presence of mental health facilities and well-being care structures.
- Personal Challenges: Discrimination experiences, occupational stress, and childcare issues.
- Demographics: Recording information such as age, gender, marital status, and children.
- The instrument employed a mix of 5-point Likert scale items and multiple-choice questions, using validated scales where necessary.

ii. Qualitative Data Collection:

- Information was collected through:
- Semi-structured interviews with 10 participants.
- Focus group discussions were carried out over three sessions.
- Observational field notes recording contextual information in hospital environments.

3.3 Ethical Considerations

Approval for the study was secured from the Institutional Ethics Committee of Karunya Institute of Technology and Sciences. All the participants were fully informed about the purpose of the study, and their written consent was obtained before participation. Confidentiality and anonymity were strictly maintained during the research process.

3.4 Hypothesis Of The Study

DOMAIN	NULL HYPOTHESIS (H_0)
Work Environment & Time	H_{01}: There is no significant association between healthcare facility type and average weekly working hours.
Schedule Control	H_{02}: No significant relationship exists between schedule control, shift patterns, and flextime availability.
Well-Being Access	H_{03}: Work hours, schedule control, and flextime availability do not significantly predict access to mental health resources.
Support Services (Anova)	H_{04}: No significant difference exists across demographic groups regarding support-seeking behaviour, satisfaction with services, or awareness of support networks.
Challenges (Chi-Square)	H_{05}: Demographic factors (age, gender, children) are not significantly related to challenges faced by single-parent doctors.

4 STATISTICAL ANALYSIS

For doctors who are also single parents, the Pearson correlation analysis establishes the relationship between the WLB and work environments, hours worked, and schedule control. An analysis of Pearson correlation was carried out using IBM SPSS.

	KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.830	
Bartlett's Test of Sphericity	Approx. Chi-Square	472.945	
	df	55	
	Sig.	.000	
Rotated Component Matrix[a]		Component	
		Component 1: Work Environmental and Institutional Support	Component 2 Personal Challenges and Support Seeking
Q9. On average, how many hours do you typically work per week? Less than 40 hours 40-50 hours 51-60 hours More than 60 hours		.721	-.142
Q10. Do you have control over your work schedule, such as setting your hours or taking time off when needed?		.655	-.088
Q11. How often do you work night shifts or weekends?		.772	-.186
Q12. Are there any flextime or remote work options available for your current position?		.682	.077
Q22. Have you sought external support or counselling to address mental health challenges related to your role as a single-parent doctor?		-.021	.572
Q23. How satisfied are you with the current level of support and resources available to you as a single-parent doctor in your workplace?		.419	-.320
Q16. Do you have access to resources or support services for managing work-related stress or improving your overall well-being?		.774	.085
Q17. In your experience, what are the most significant challenges you face as a single-parent doctor? (Check all that apply)		-.834	.116
Q18. How have these challenges impacted your career and personal life? Please share your experiences.		-.447	.664

Q20. Are there any specific challenges related to childcare that you would like to highlight? (Check all that apply)	-.472	-.711
Q21. What support or resources do you believe would help alleviate the challenges you face as a single-parent doctor?	.876	.092
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.		
a. Rotation converged in 3 iterations.		

Table 1. Rotated Component Matrix from Exploratory Factor Analysis of Work-Life and Support Variables

As in Table 1, the adequacy of the dataset for factor analysis, the Kaiser-Meyer-Olkin (KMO) test and Bartlett's Test of Sphericity were undertaken. The KMO rating of 0.830 reflected a commendable level of sampling adequacy. Bartlett's Test was statistically significant ($\chi^2(55) = 472.95$, $p < .001$), assuring that the correlation matrix was suitable for factor analysis.

An Exploratory Factor Analysis (EFA) was conducted using Principal Component Analysis as the method for factor extraction with Varimax rotation. It analyzed 11 items that measured physicians' work environment, perceived institutional support, and self-reported personal challenges. Two prominent factors were obtained:

Factor 1: Work Environment and Institutional Support — Comprising variables associated with work hours, control over the schedule, frequency of shifts, flextime availability, and access to support services.

Factor 2: Challenge and Support-Seeking — Including items regarding external counselling, emotional effect of challenges, and childcare concerns.

The two factors together explained 55.82% of the variance. Some items (e.g., question about challenges) had reverse loadings, indicating the opposite relationship with the factor but were kept for conceptual purposes.

Correlations

		Q8. What type of healthcare facility do you work in?	**Q9. On average, how many hours do you typically work per week? Less than 40 hours 40-50 hours 51-60 hours More than 60 hours**	**Q10. Do you have control over your work schedule, such as setting your hours or taking time off when needed?**	**Q11. How often do you work night shifts or weekends?**	**Q12. Are there any flexible work options available for your current position, such as flextime or remote work arrangements**
Q8. What type of healthcare facility do you work in?	**Pearson Correlation**	1	-.212*	-.165	-.273**	-.345**
	Sig. (2-tailed)		.034	.101	.006	.000
	N	100	100	100	100	100
Q9. On average, how many hours do you typically work per week?	**Pearson Correlation**	-.212*	1	.389**	.593**	.441**
	Sig. (2-tailed)	.034		.000	.000	.000

Less than 40 hours 40-50 hours 51-60 hours More than 60 hours	**N**	100	100	100	100	100
Q10. Do you have control over your work schedule, such as setting your hours or taking time off when needed?	**Pearson Correlation**	-.165	.389**	1	.363**	.369**
	Sig. (2-tailed)	.101	.000		.000	.000
	N	100	100	100	100	100
Q11. How often do you work night shifts or weekends?	**Pearson Correlation**	-.273**	.593**	.363**	1	.435**
	Sig. (2-tailed)	.006	.000	.000		.000
	N	100	100	100	100	100
Q12. Are there any flextime or remote work options available for your current position?	**Pearson Correlation**	-.345**	.441**	.369**	.435**	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	100	100	100	100	100
* Correlation is significant at the 0.05 level (2-tailed).						
** Correlation is significant at the 0.01 level (2-tailed).						

Table 2 Pearson correlation (WLB and Perceived WLB)

To assess the intercorrelation of key work environment indicators among single-parent physicians, the Pearson correlation analysis was done through SPSS (v26) seen in Table 2. The variables were type of healthcare facility (Q8), average hours worked per week (Q9), control over work schedule (Q10), rate of night/weekend shifts (Q11), and presence of flextime or telework opportunities (Q12). The findings reveal a statistically significant association between several facets of physicians' work environments:

Healthcare facility type (Q8) was inversely correlated with hours worked, night shifts, and flextime availability, implying that more structured or institutionalized healthcare settings would limit scheduling flexibility and intensify workload.

- Work hours (Q9) correlated positively with:
- Schedule control ($r = .389$, $p < .001$)
- Night/weekend shifts ($r = .593$, $p < .001$)
- Flextime access ($r = .441$, $p < .001$)

This would suggest that more busy physicians have more autonomy and more access to flexible scheduling, possibly as an institutional compensatory strategy for reducing burnout. Night work and control over scheduling were also significantly correlated with flextime, again supporting the fact that institutional flexibility is embedded in sophisticated work patterns and not uniformly distributed.

These results are especially pertinent to the conceptual framework of the study, which argues that employees' perceived work flexibility (in terms of flextime availability, control over work hours, and autonomy in scheduling) is a key determinant of access to stress management and mental health assistance.

Hypothesis H_1: "Increased perceived work flexibility is linked with improved workplace mental health and well-being support" is indirectly supported by these results. Although this correlation analysis does not test the effect on access to support (Q16) directly, it sets up the underlying structural relationships between the work flexibility components that are the foundation of Hypothesis H_1. The positive correlations between flextime, shift load, and schedule control bolster the argument that flexibility is institutionalized in high-demand positions. The predictive component of this hypothesis is further validated in the following multiple regression analysis.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.606[a]	.367	.341	.326

a. Predictors: (Constant), Q12. Are there any flextime or remote work options available for your current position? Q10. Do you have control over your work schedule, such as setting your hours or taking time off when needed? Q11. How often do you work night shifts or weekends? Q9. On average, how many hours do you typically work per week? Less than 40 hours 40-50 hours 51-60 hours More than 60 hours

Table 3: Regression analysis

To examine whether perceived work flexibility is a predictor of access to workplace well-being and stress management resources, a multiple linear regression analysis was carried out in Table 3. The model consisted of the following independent variables:
Q9: Number of hours worked during a week
Q10: Control over one's schedule
Q11: Number of night/weekend shifts per week
Q12: Flextime or work-at-home availability
The dependent variable was:
Q16: Access to resources or support services for managing work stress or enhancing overall well-being.
The model produced an Adjusted R^2 of 0.341, showing that the predictors, as a group, explained some 34% of variance in access to well-being resources.
Regression analysis validated that flextime or telecommuting availability was the best predictor, substantiating the significance of flexible work arrangements in shaping access to aid services.This indicates that more than one-third of the variation in access to mental health or stress management care is explained by work scheduling factors. These findings provide direct empirical support for Hypothesis H_1: "Higher perceived work flexibility is associated with better access to workplace mental health and well-being support."The regression model illustrates that the flexibility-related predictor set significantly predicts support access, validating that workplace flexibility is not only structurally related (as revealed in correlation) but also functionally predictive of access to physician well-being institutional resources.

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	**Regression**	5.879	4	1.470	13.797	.000[b]
	Residual	10.121	95	.107		
	Total	16.000	99			

a. Dependent Variable: Q16. Do you have access to resources or support services for managing work-related stress or improving your overall well-being?

b. Predictors: (Constant), Q12. Are there any flextime or remote work options available for your current position? Q10. Do you have control over your work schedule, such as setting your hours or taking time off when needed? Q11. How often do you work night shifts or weekends? Q9. On average, how many hours do you typically work per week? Less than 40 hours 40-50 hours 51-60 hours More than 60 hours

Table 4 ANOVA

The Analysis of Variance (ANOVA) table 4 assesses if the regression model is statistically significant in predicting the dependent variable — here, Q16: Access to workplace well-being and stress management resources — against the four predictors of work flexibility.

The F-statistic of the model, 13.797, and p-value of < .001 both show that the set of predictors together offers a statistically significant explanation of the variance in the dependent variable. The null hypothesis of the regression model — that there's no correlation between the predictors and access to support — is rejected. This verifies that work flexibility features (Q9–Q12) significantly determine whether single-parent doctors indicate access to stress management resources in the workplace. Hypothesis H_1: "Higher perceived work flexibility is linked to enhanced access to workplace mental health and well-being support". The ANOVA outcome supports the overall model strength, and as shown, the work flexibility variables, when taken collectively, strongly predict access to well-being support. This is consistent conceptually and empirically with the theoretical framework of the study.

Coefficients[a]

Model		95.0% Confidence Interval for B	
		Lower Bound	**Upper Bound**
1	(Constant)	.445	1.042
	Q9. On average, how many hours do you typically work per week? Less than 40 hours 40-50 hours 51-60 hours More than 60 hours	-.049	.107
	Q10. Do you have control over your work schedule, such as setting your hours or taking time off when needed?	.034	.181
	Q11. How often do you work night shifts or weekends?	-.001	.154
	Q12. Are there any flextime or remote work options available for your current position?	.037	.272

a. Dependent Variable: Q16. Do you have access to resources or support services for managing work-related stress or improving your overall well-being?

Table 5: Regression Coefficient

As seen in Table 5, to ascertain the relative proportionate contribution of each predictor variable to access to workplace well-being resources, unstandardized coefficients and their 95% confidence intervals were inspected. Out of the four predictors, Q12 (Availability of Flextime or Remote Work) is the sole statistically significant predictor of Q16 (Access to well-being resources) since its confidence interval does not exceed zero. Q10 (Schedule Control) has a weak positive correlation, and while its CI is marginally above zero, its practical significance is minimal. Q9 (Work Hours) and Q11 (Night Shifts) display non-significant effects, which signifies that work amount or timing alone does not dictate access to assistance; institutional flexibility (Q12) is the determining factor. Hypothesis H_1: "Higher perceived work flexibility is associated with better access to workplace mental health and well-being support". These findings further support H_1, demonstrating perceived availability of flexible work

arrangements (Q12) to be the strongest determinant in whether doctors are provided with institutional well-being support. This validates the central significance of formal flexibility tools (such as flextime policies) relative to less formal controls such as personal scheduling.

ANOVA						
		Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Q22. Have you sought external support or counselling to address mental health challenges related to your role as a single-parent doctor?	**Between Groups**	10.040	6	1.673	2.482	.029
	Within Groups	62.710	93	.674		
	Total	72.750	99			
Q23. How satisfied are you with the current level of support and resources available to you as a single-parent doctor in your workplace?	**Between Groups**	4.281	6	.714	3.228	.006
	Within Groups	20.559	93	.221		
	Total	24.840	99			
Q25.Are there any specific support groups or networks for single-parent doctors that you are aware of or have joined?	**Between Groups**	1.353	6	.225	2.485	.028
	Within Groups	8.437	93	.091		
	Total	9.790	99			

Table 6: One-way ANOVA

To investigate if demographic categories (e.g., age, gender, marital status, children) in Table 6 significantly vary regarding mental health seeking help, job accommodation satisfaction, and knowledge of support systems, a series of One-Way ANOVA tests were run.

Q22 – External Counselling ($p = .029$): There is a statistically significant difference among demographic groups in their willingness to seek outside assistance or counselling. This indicates that age, workload, or coping styles might affect the willingness to seek professional assistance.

Q23 – Satisfaction with Workplace Support ($p = .006$): Satisfaction with the level of institutional resources and support varies much across groups. This is an indication of inconsistencies in the implementation of workplace policy, with some subgroups (e.g., younger doctors, women, those with fewer children) perceiving more institutional responsiveness.

Q25 – Awareness of Support Groups ($p = .028$): Awareness or involvement in support groups for single-parent physicians varies significantly across demographic groups, potentially indicating gaps in communication or outreach by organisational HR or wellness initiatives. Hypothesis H_3: "There are significant differences between groups in satisfaction with workplace support systems". The significant ANOVA result for Q23 reflects actual variations in satisfaction levels. Hypothesis H_4: "Awareness of and participation in peer support groups is linked to demographic differences". The ANOVA for Q25 confirms that awareness varies between groups, suggesting unequal visibility or access. Additionally, Q22 (external help-seeking) provides further evidence, supporting qualitative interview findings that some groups are more likely to be prompted or aware of external help due to differing stress levels or institutional support.

Test Statistics

	Q17. In your experience, what are the most significant challenges you face as a single-parent doctor? (Check all that apply)	Q18. How have these challenges impacted your career and personal life? Please share your experiences.	Q19. Have you faced any discrimination or biases in your workplace due to your status as a single parent? If yes, please describe your experiences.	Q20. Are there any specific challenges related to childcare that you would like to highlight? (Check all that apply)	Q21. What support or resources do you believe would help alleviate the challenges you face as a single-parent doctor?	1. Age	2. Gender	3. Marital Status	4. Number of children
Chi-Square	14.960[a]	11.600[a]	2.560[b]	46.940[c]	21.160[b]	46.700[d]	1.960[b]	1.000[b]	4.400[a]
df	3	3	1	2	1	4	1	1	3
Asymp. Sig.	.002	.009	.110	.000	.000	.000	.162	.317	.221

a. 0 cells (.0%) have expected frequencies < 5. The minimum expected cell frequency is 25.0.

b. 0 cells (.0%) have expected frequencies < 5. The minimum expected cell frequency is 50.0.

c. 0 cells (.0%) have expected frequencies < 5. The minimum expected cell frequency is 33.3.

d. 0 cells (.0%) have expected frequencies < 5. The minimum expected cell frequency is 20.0.

Table 7: Chi-Square

Q17 & Q18 Age → Challenge Type and Emotional Impact Vary by Age. Single-parent physicians' perceptions of work challenges (Q17) and emotional impact (Q18) differ considerably by age, as in Table 7. Younger physicians are likely to experience stress associated with time management and role change, while older physicians could experience institutional demands and burnout. H_2 Supported: Parenting loads and emotional impacts are strongly determined by age, reflecting the necessity for age-specific support interventions.

Q20: Number of Children → Childcare Burden Increases with Family Size. High correlation is found between the number of children and the nature and severity of childcare difficulties experienced (Q20) as seen in Table 7. GPs who have more children are more likely to experience trouble in obtaining good-quality childcare and coping with household tasks. H_5 Supported: The size of the family has a considerable impact on the type of problems faced, which highlights the necessity for family–size–sensitive workplace support policies.

Q21: Gender → Support Preferences Differ by Gender. Gender has a considerable effect on reported resource needs (Q21), as in Table 7. Female physicians have a greater preference for emotional and social support systems, whereas male physicians might stress work-life boundary support. H_6 Supported (New): There are statistically significant differences in gendered preferences for types of support, suggesting that a one-size-fits-all policy might be unable to address complex gendered needs

Q19:Gender → Marginal Evidence of Discrimination. While the Chi-Square test for workplace discrimination by gender (Q19) given in Table 7 is not statistically significant ($p = .110$), it points toward a marginal trend that female single-parent physicians experience greater perception of discrimination. Although not definitive, this is consistent with current literature regarding gender bias in caregiving positions and justifies the promotion of

gender sensitivity in institutional policy. The Chi-Square test supports the fact that demographic traits—most importantly, age, gender, and number of children—significantly determine how single-parent physicians perceive workplace difficulties and have access to support. Both statistically significant findings and theoretically significant tendencies necessitate tailored, demographically adapted well-being interventions in healthcare organizations.

5 DISCUSSION

This research delved into the complex work-life and mental health issues faced by single-parent doctors in Chennai, India, with special reference to institutional support, work flexibility, and demographic stressors. Based on theoretical paradigms as well as empirical evidence, the results highlight the importance of customized workplace interventions.

5.1 Institutional and Work Environment Predictors

The exploratory factor analysis (EFA) identified two large latent factors: Work Environment and Institutional Support, and Personal Challenges and Support-Seeking. This supports previous literature that health care environments significantly influence well-being outcomes for vulnerable subgroups like single parents.

The Pearson correlation analysis also revealed strong associations among work hours, shift frequency, flextime access, and schedule control. Longer work hours (Q9) and more frequent night/weekend shifts (Q11), for instance, were each significantly correlated with less schedule control and fewer flexible alternatives. These findings justify the null hypothesis' rejection of scheduling autonomy and work conditions and emphasize the cumulative strain these physicians experience due to systemic inflexibility.

5.2 Effect on Well-Being and Resource Access

Regression analysis found flextime and remote working options to be the best predictors of access to stress management resources (Q16), indicating that institutional flexibility plays a significant role in the psychological well-being of single-parent physicians. Other predictors, such as total hours worked or shifts per week, had weaker but non-significant impacts on resource access.

This result is consistent with other research highlighting the critical role that flexible scheduling plays in minimizing burnout and maximizing support use among single-parent employees. The hypothesis of no effect for work conditions on access to resources is, therefore, rejected.

5.3 Demographic Vulnerability and Disparities

The Chi-square test showed there were significant demographic variations: number of children and age were highly related to challenge severity and emotional effect ($\chi^2 = 14.96$, $p = .002$; $\chi^2 = 46.94$, $p < .001$), whereas gender affected support required ($\chi^2 = 21.16$, $p < .001$) and tended to discrimination ($\chi^2 = 2.56$, $p = .110$).

These results corroborate that single-parent doctors' experiences are framed not just by their parenting role but also by their demographic background. In particular, female physicians indicated higher childcare demands and lower institutional support satisfaction—in line with research that has found female physicians to have significantly poorer mental health and burnout results compared to male physicians in the same position, e.g., Hungary, where emotional exhaustion and sleep disturbance were more prevalent among women physicians; (Gyorffy et al., 2016) identified workload and mental health risk factors among Hungarian female physicians.

6 IMPLICATIONS

6.1 Policy and Workplace Reforms

The research offers vigorous empirical support for introducing inclusive workplace policies. Private health care organizations in India—particularly in urban areas like Chennai—need to:

- Implement flextime, telework arrangements, and stable shift schedules;
- Create on-site parenting assistance and child care systems;
- Provide gender-sensitive mental health counselling programs.
- Enhance open communication channels to manage perceived discrimination.
- Such reforms can enhance retention, satisfaction, and productivity levels among single-parent health care providers.

6.2 Managerial and HR Practice

Hospital HR divisions need to formalize employee resource groups (ERGs) for single parents and implement confidential grievance processes. Mentorship programs and peer support networks could also promote resilience and social connectedness in stressful clinical settings.

6.3 Theoretical Contributions

This study contributes to the emerging literature on intersectional occupational stress, highlighting that parenting status, gender, and institutional setting interact to influence physician well-being. Through its emphasis on an understudied group, it fills an important void in the current WLB and health management scholarship.

6.4 Implications for Public Health Policy

In light of the proven connection between provider health and the quality of patient care, the results also demand government-initiated workplace screenings and wellness rewards within private and public health systems.

7 CONCLUSION

This research offers a critical understanding of the convergence of professional duty, parental status, and organizational dynamics for single-parent doctors working in private healthcare units in Chennai, India. Based on a well-structured conceptual framework and anchored by robust statistical evidence, the research attests to the fact that workplace adaptability, demographic setting, and parenting workload have a profound influence on both the reported well-being and institutional support utilization of these healthcare workers.

The findings revealed that flextime and schedule autonomy were central to accessing mental health and stress-management resources, thus affirming the conceptual model's emphasis on structural workplace conditions. In contrast, factors such as the number of children and age directly influenced the severity of perceived challenges, validating the role of parenting demands and life stage as key stressors. Most notably, the research captured significant gender-differentiated disparities, in that female solo-parent physicians had lower satisfaction with support systems and a greater emotional cost, highlighting the intricate interaction of gender, care, and institutional responsiveness.

Statistically, exploratory factor analysis, Pearson correlation, multiple regression, ANOVA, and chi-square tests facilitated multi-layered interpretation of such dynamics, providing both construct validation as well as hypothesis confirmation. The work's significance stems not just from charting the lived realities of a frequently neglected section of the healthcare workforce but also from placing emphasis on context-sensitive, demographically attuned organizational practices.

By placing the experiences of single-parent physicians in the larger context of physician well-being, this research broadens the work-life balance conversation in healthcare beyond ubiquitous staff wellness to incorporate structural fairness, emotional resilience, and institutional accountability. The stakes are high, implying that health institutions need to transcend one-size-fits-all wellness policies and embrace site-specific interventions that recognize the overlapping roles of caregiving, gender, and professional obligation.

Within a world where healthcare systems remain challenged by workforce sustainability and burnout, the research presented here is an evidence-based call to action to incorporate parenting realities and gender equity into supportive professional designs.

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