Are Left-behind Wives of Overseas Migrants More Mentally Vulnerable? : Evidence from CHAMPSEA - Thailand

Aree Jampaklay, Patama Vapanawong, and Abdun-Aziz Prasithima

Institute for Population and Social Research, Mahidol University

Extended Abstract

Background

Existing studies on impacts of overseas migration on stay-behind family tend to focus on the impacts on wellbeing of children, on migrant parents' strategies of communication with their stay-behind children, on the migrant mother's role as a carer for the sick, the young and the elderly in receiving countries, as well as on elderly both with and without task as carers of stay-behind grandchildren.

Impacts of parental overseas migration on left-behind family are little understood in the Thai context, where most of overseas migrants are males. Thus, mother carer remains the norm. Overseas migration not only impacts left-behind children of migrants but also left-behind wives who burden double roles as mothers and fathers. Compared to other Asian countries, overseas migration is relatively less feminized in Thailand. According to official statistics, women account for around 80 percent for Indonesia, 49 percent for the Philippines and 23 percent for Vietnam, while women account for just 16.6% of overseas migrants from Thailand. As the phenomenon of transnational migration is not universally in similar patterns across contexts, it is important to understand transnational migration and its effects on a context-specific basis.

Our study is an initial attempt to tackle questions of how the wellbeing of left behind wives is and whether they are more or less vulnerable compared to wives of non-migrant husband. We are particularly interested in the psychological aspect of women's wellbeing. We employ data from CHAMPSEA-Thailand, a comparative study in 4 countries, Philippines, Indonesia, Thailand, and Vietnam. The sample size of the study is roughly 1,000 households including equal number of overseas migrant households of which one parent or both work abroad and usually-resident households where both parents live with children. Included in our analysis are mothers of the

children of 2 age-groups, young child (aged 3-5) and older child (aged 9-11). We use SRQ-20 (Self Reporting Questionnaire -20) to measure mental health of mothers.

Methodology

The data set used in this study is the first data set in Thailand that comprehensively focuses on impacts of overseas parental migration on health and wellbeing of stay-behind children. The project, CHAMPSEA (Child Health and Migrant Parents in Southeast Asia), was led by researchers at NUS and St. Andrews, UK in collaboration with researchers in academic institutes in 4 countries, Philippines, Indonesia, Thailand, and Vietnam. The fieldwork in these 4 countries was conducted by an academic institute in the country. For CHAMPSEA-Thailand, the study is taken care of by Institute for Population and Social Research, Mahidol University.

The project took both quantitative and qualitative approaches. In the quantitative survey, details on household characteristics, main carers of the children, and the physical and psychological features of children and carers were collected. Three sets of questionnaires were designed to collect data at the household level from the target child's responsible adult, from the child's main carer, and from the older child. The data set allows us to compare characteristics of carers of overseas migrants' children, especially their mental health, with those of non-migrant parents.

Following the quantitative fieldwork, qualitative research using in-depth interviews were conducted with 41 main carers of the target child. Information from the in-depth interview provides more detail on data collected in the questionnaires including the relationship between the migrant parent and the carer, between the target child and the carer, between the target child and the migrant parent(s), and between the target child and other people. Among 41 respondents, 28 are biological mothers of the child and 13 are other relatives, i.e. 6 maternal grandmothers, 2 paternal grandmothers, 2 biological fathers, 2 father's sisters, and 1 sister of the child. In relation to the target child's age, 21 respondents are carers of the young child, while 20 are carers of the older child.

In each country, the sample size is roughly 1,000 households with approximately equal number of overseas migrant households, which one parent or both are abroad for at least 6 months, and usually resident households where parents live with children. Broken families or single-parent households were not included. The children included in eligible households are in 2 age-groups, young child (aged 3-5) and older child (aged 9-11). Quota sampling was developed for equal size

not only in terms of type of household (migrant and usually-resident parent household), but also in terms of age (young and older) and gender of the target child. Thus, the target children in the survey include virtually the same amount of boys and girls, young and older children.

As used in CHAMPSEA study, this analysis measures mental health status of carers using SRQ-20, the Self Reporting Questionnaire 20 (SRQ-20), which is an effective and low-cost screening measure of mental health, developed by the World Health Organization (WHO). The tool is deliverable to populations with low literacy and low infrastructure (WHO, 1994). WHO formally recommends the use of the SRQ-20 as a valid and adaptable method for evaluating mental distress (WHO, 1994). The SRQ-20 is a self- or interviewer-administered measure of 'psychological distress'. Although SRQ does not provide, nor does it substitute for, a clinical diagnosis, it can provide general prevalence estimates of mental health problems. Previous study also acknowledges that SRQ-20 is an effective screen for determining the likelihood of psychiatric disturbance in an individual (Harpham *et al*., 2003).

The SRQ-20 contains a 20-item self-report mental health measure, marked dichotomously (YES = 1, NO = 0) over a 30-day recall period. Thus, the maximum score is 20. Previous literature recommended a cut-off of 7/8 (i.e. 7 = probable non-case; 8 = probable case). Each item does not stand for itself but is representative of several mental health constructs, and is not intended to be reported separately. Results are recommended to be reported as a dichotomous 'case' or 'non-case'. However, the contribution of individual items to this measure of 'caseness' may be suggestive of the particular category of mental disorder they represent. Our descriptive analysis, therefore, also presents proportions of mothers reporting each item. In our multivariate analysis, we use whether a carer reported at least 8 symptoms as indicative of probable case and employ logistic regression to estimate coefficients of possible related independent variables of probable case. In addition, we will experiment another measure of mental vulnerability as the dependent variable using a report of at least one symptom. Other potential factors related to mental health will be included in the multivariate analysis, e.g. demographic characteristics of mothers and of the children, household economic status, family and social support.

Qualitative data will also be used to help explain results from the multivariate analysis.