



Mental Health and Somatic Distress among Ethiopian Migrant Returnees from the Middle East

Waganesh Zelege^{1*}, Abebaw Minaye² and Gibbs Kygana³

Abstract

Objective: This study aimed to examine the mental health and somatic distress among migrant returnee population in Ethiopia.

Background: Mental health and psychosocial distress are frequent among people who have faced adversity, such as exposure to abuse, exploitation, loss, displacement, and human trafficking. Returned Migrants are the most vulnerable population for such adversities, especially when they work in under-regulated sectors such as domestic work entered through illegal migration. Addressing the mental health issues of returnees has to be a cross-cutting activity of any migration-crisis intervention. However, knowledge about the frequency, severity, and risk factors as they affect migrants' mental health in Ethiopia is limited at best.

Method: In a sample of 1,035 returnee migrants, data were collected on the mental distress based on SRQ-20 and somatic distress based on PHQ-15. A descriptive statistics correlation, t-test, and factorial MANOVA analysis were run to determine the distress status and the relationship between different variables.

Results: Using a cut of point of 8, 26.08% of the sample was considered to be a probable case (n=270), with females endorsing more items than males. Twenty-three percent (11.7%, Mild; 8.2% Moderate; and 3% Sever) of the participants reported somatic manifestation of psychological distress. A significant relationship is found between participants' mental health distress and somatic psychological distress. Religious affiliation and ethnicity are found to be associated with mental health distress, while gender and education are found to be significantly associated with somatic psychological distress.

Conclusion: Ethiopian migrant returnees deal with significant mental health distress and endorsed somatic symptoms in outpatient setting. Migrant returnees should access to a mental health service that is exclusively geared towards their mental health problems instead of clustering them together under the umbrella of general health services. Future studies are needed into the nature and efficacy of mental healthcare intervention in Ethiopia.

Keywords

Mental health status; Ethiopia; Returnee migrants; Somatization symptoms; Assessment

Introduction

Research says the instances of mental health and psychosocial problems are much more frequent among people who have faced adversity, such as exposure to abuse, human trafficking and "unsafe immigration". Migrant domestic workers experience various forms of abuse such as physical abuse, sexual assault, exploitation, maltreatment, and labour-rights violation, such as contract substitution and non-payment of wages because of their illegal status and/ or their gender, race and class [1].

The impacts of migration on Ethiopian migrants' mental health constitute an under-studied phenomenon despite the fact that a large number (for e.g. over 164,000 in 2013 only) Ethiopian illegal domestic migrants to the Middle East are returning to their country. The key reason behind this phenomenon is a lack of professionals or researchers who have expertise in the field, lack of awareness, stigma related to mental health, and partly because of the low level attention given to it by actors in various filed. The very few studies conducted on migrants who returned to Ethiopia due to their illegal migration status in the Middle East have mainly focused on the socioeconomic impact of the illegal migration rather than identifying the level of mental health problems [2-4].

The exact number of Ethiopian migrants to the Middle East is unknown as two-thirds of them migrate through undocumented means [5,6]. The Ethiopian Ministry of Labor and Social Affair (MOLSA), for example, reported that as recently as 2012, 80,000 Ethiopian women have legally migrated to the Middle East while in the same period, 60-70%. Ethiopians migrated through irregular routes. Close to 120,000 Ethiopians migrate every year [7]. This estimate surged to 600,000 in 2012/13 [8].

Most Ethiopians' migrate to Middle Eastern countries seeking employment. Because domestic work is not recognized as legitimate work in the Middle East, even legal migrants in this sector do not have access to social and legal protection. They also have limited access to health services and information, including mental health services [1,9].

Like many domestic migrant workers in the Middle East, Ethiopian migrants experience diverse problems at the various stages of their migration; pre-departure, en route, in the destination, and even after return from the Gulf States [3,4,10,11]. Study results show that Ethiopian returnee migrants experienced recurring incidents of inhumane treatment, enforced cultural isolation, undermining of cultural identity, and unmet expectations during their stay as domestic worker migrants in the Middle Eastern countries [2].

Women who migrated to the Middle East as domestic workers were two to five times more likely to experience mental health illness from than other females in the native population [12,13]. A study conducted by Zahid et al. [13], for example, examined the mental health stressors of migrants women from developing countries who work as domestic worker in the Middle East and found that 22.8% of the participants reported that they are worried due to maltreatment by their employing family and approximately 20% reported sexual harassment.

*Corresponding author: Waganesh Zelege, Department of Counseling, Psychology and Special Education, Duquesne University, 209-C Canevin Hall, 600 Forbes Avenue, Pittsburgh, PA, USA, 15282, E-mail: zelekew@duq.edu

Received: April 20, 2015 Accepted: August 26, 2015 Published: August 31, 2015

In November, 2013, however, the issue of illegal Ethiopian migration to the Middle East became a major social problem of international proportions, when over 164,000 irregular Ethiopian migrants were deported from the Kingdom of Saudi Arabia (KSA) following that country's crackdown on irregular migration [14]. In collaboration with other national and international organizations, the Ethiopian government responded to this migration crisis by providing assistance to returnees through management of transit sites and way stations, and providing ongoing transportation assistance along with temporary shelter upon the returnees' arrival. These returning migrant workers, especially those who experienced distress and abuse, were returned to their families and communities without adequate and sustained psychosocial support.

Despite the fact that hazards to general health and specifically mental health rank among the top experiences of trafficking and migrant returnees [3,11] the services addressing health, specifically mental health concerns of returnees during the recovery phase of the migration process are sparse due to factors such as little knowledge about the often fragile mental health status of the returned migrant population and health- service providers' inadequacy in addressing mental health problems (Ethiopia has only one mental health hospital in the country and only two returnee rehabilitation centres focusing on mental health of migrant returnees with a meagre capacity of 40-50 returnees) [3].

Michultka's study reported that, those triple trauma immigrants' experiences first in the country of origin that precipitated their flight, second the escape journey is also likely to be fraught with traumatic events, and lastly the relocation process is also the stage for a plethora of traumatic events. This list misses a fourth likely trauma, post- return adjustment problems including being perceived as an unsuccessful returnee and the associated discrimination by one's origin community and even family [15].

Another stage for trauma, return migration and mental health has received far too little attention in policy and crisis- intervention programs in Ethiopia which is evidenced by the absence of any system of safe houses and health referral. It is time to broaden the evidence on return migration and to examine all psychosocial dimensions of mental health and to identify factors underlying both vulnerability and resilience to social and economic upheaval in the aftermath of the migration crisis. Published works from non-governmental and governmental sectors emphasize crucial gaps in research, policy, and practice for return migrants implicating demand for deeper, more rigorous research to truly understand the psychosocial wellbeing and mental health challenges of returnees [14]. In this context, an assessment of mental health status and psychological distress is essential. Therefore, this article examined the mental health status, somatic psychological distress and psychosocial needs of Ethiopian returnee migrants from the Middle East and South Africa.

Methods

The purpose of the larger study on which this paper is based was to gain insight into the economical, psychosocial, legal, and mental health challenges of unsafe migration by examining the experience of Ethiopian migrant returnees from the Middle East and South Africa to draw implication for managing out migration from Ethiopia. In particular, this paper focuses on examining the mental health status and somatic psychological distress of Ethiopian returnee migrants from the Middle East and South Africa.

Sampling

The sample consisted of 1,035 Ethiopian citizens who returned home from the Middle East where they had immigrated to seek employment. Using stratified (sex) and availability-sampling techniques, 1035 returnees from the Middle East who were residing in seven different zones of five regions in Ethiopia were selected. The data was collected in February, 2014. Data collection was carried out by 21 data collectors (3 in each zone). Seven supervisors were managing the data collection (one in each zone; the zones are; Addis Ababa, Wollo, Jimma, Tigray, Hadiya, Wulqite, and Arsi). The data collectors included graduate students, and faculty members who received a full day orientation by the investigators. The supervisors were faculty at Addis Ababa University who were members of the thematic project (from the School of Psychology and Social Work).

The returnees were between the ages of 16 and 60 years ($M=27.55$; $SD 6.34$). Approximately 54.6% ($n=565$) of the sample was female and 44.5% ($n=461$) was male, while 1% ($n=9$) did not report their gender. Participants identified as Muslim (50%), Orthodox (28.8%), and Protestant (16.9%). In terms of ethnicity, the participants identified as Oromo (16%), Amhara (22.4%), Tigray (8.3%), Gurage (16.0%), and Hadiya (12.7%). The demographic profile of the sample is presented in Table 1.

Instrumentation

This paper used the SRQ-20, PHQ 15 data, and the demographic information from the survey. Demographics included age, gender, education, marital status, ethnic group, and religious affiliation. The total scores on the SRQ -20 measure mental health status and the total scores on PHQ-15 scales measure the somatic psychological distress.

The Self Reporting Questionnaire (SRQ-20)

The SRQ-20 is a twenty items subset of the SRQ developed by [16] for the World Health Organization collaborative study, to screen the presence of mental disorder in patients contacting primary healthcare settings. It is a self – or interviewer-administered measure of 'psychological distresses'. It does not provide, nor is it a substitute for, a clinical diagnosis; however, it can provide a general prevalence estimate of mental health problems. The complete SRQ consists of twenty-five questions, which have to be answered by 'yes' or 'no'. Of these twenty-five questions, twenty are related to neurotic symptoms, four to psychotic symptoms and one to convulsions.

The SRQ-20 consists of the neurotic items only. These reflect depressive symptoms, anxiety, and psychosomatic complaints and have been found to detect probable cases of common mental disorder with reasonable accuracy. The questions of the instrument are written in a simple, easy to understand language, and cover many important areas of psychopathology.

The SRQ-20 items are scored dichotomously (0= no, symptom absent; 1=yes, symptom present) over a 30-day recall period to obtain a maximum score of 20. Item scores are summarized to obtain a total score. The optimal cut-off point for the SRQ-20 has been generally reported to be 7/8 [17,18]. A score above the cut-off point indicates the existence of a probable mental disorder. However, optimal cut-off scores are shown to vary considerably across cultures, languages, settings, and gender. Factor structures of the SRQ-20 also vary across populations, ranging from two to seven. The SRQ-20 has been tested and validated in several African countries including Rwanda, Ethiopia, and Uganda [4,19,20]. The SRQ- 20 has been found to be

Table 1: Demographic Variables of the Sample.

| | | N | % |
|-----------------------------|-------------------------------|-----|------|
| Sex of the respondent | Male | 461 | 44.5 |
| | Female | 565 | 54.6 |
| Marital Status | Married | 448 | 43.3 |
| | Unmarried | 509 | 49.2 |
| | Divorced | 44 | 4.3 |
| Religion of the respondent | Orthodox | 298 | 28.8 |
| | Muslim | 433 | 50.9 |
| | Protestant | 126 | 17.2 |
| | Others | 27 | 2.6 |
| Ethnicity of the respondent | Oromo | 166 | 16.0 |
| | Amhara | 232 | 22.4 |
| | Tigray | 86 | 8.3 |
| | Gurage | 166 | 16.0 |
| | Hadiya | 131 | 12.7 |
| Education | No education | 65 | 6.3 |
| | Reading and writing | 77 | 7.4 |
| | Grade 1 to 4 | 89 | 8.6 |
| | Grade 5 to 8 | 266 | 25.7 |
| | Grade 9 to 10 | 321 | 31.0 |
| | Grade 11 to 12 | 132 | 12.8 |
| | Certificate/diploma and above | 74 | 7.1 |

reliable and valid in developing countries including Ethiopia. For the current study, the internal consistency estimate of the SQR-20 scale was high (Cronbach's alpha=0.91).

The Patient Health Questionnaire (PHQ-15)

Medically unexplained symptoms are prevalent in outpatient settings; somatization (the physiological symptoms of psychological distress were assessed using the Patient Health Questionnaire, the PHQ-15. The PHQ-15 is a self-administered screening instrument that has been used as a tool in a number of studies to screen somatic symptoms. Participants were asked to respond to the following questions: During the last four weeks, how much have you been bothered by any of the following problems? A response was elicited for severity of the following 13 symptoms: stomach pain, back pain, pain in arms, legs or joints, menstrual cramps or symptoms, pain with sexual intercourse, headache, chest pain, dizziness, fainting, pounding heart, and shortness of breath, gastrointestinal symptoms, and nausea. The severity of the symptoms were rated as 0=not being bothered at all, 1 being bothered a little, and 2 being bothered a lot. For scoring, response options for these two symptoms are coded as 0 ("not at all"), 1 ("several days"), or 2 ("more than half the days" or "nearly every day"). The total PHQ-15 score ranges from 0 to 30 and scores of ≥ 5 , ≥ 10 , ≥ 15 and represents mild, moderate and severe levels of somatization. The reliability and validity of the PHQ-15 are high in clinical settings [21].

We used a 13-item modified version of the PHQ-15 instrument, in which two of the items were incorporated into the other items. Therefore, scores on the modified instrument ranges from 0 to 26; and thus scores of ≥ 4.33 , ≥ 8.68 , ≥ 13 representing mild, moderate and severe levels of somatization. The internal consistency estimate of the modified instrument was high (Cronbach's alpha=0.88).

For this study, both the SRQ-20 and PHQ-15 items were translated into Amharic by a bilingual Ethiopian professor who is a professional psychiatrist and familiar with the mental health issues addressed by

the instrument. Two bilingual Ethiopian individuals performed blind back-translation jointly. The first translator together with five other research team members examined these back-translations.

Ethical consideration

The study was approved by the Addis Ababa University's Ethical Committee and Duquesne University IRB committee. The nature and scope of the research was explained to each participant before the survey began. Participants were informed that their participation is voluntary and each of them was assured that there would be no retribution for withdrawal the study at any time. All the participants had the opportunity to ask questions before the survey/interview began. They were also advised that any information provided would remain confidential.

Data Analysis and Results

In cases where it made conceptual sense, data was pre-screened to identify any outliers and missing data, and to collapse the response categories of the independent variables with small sample sizes. For example, in the original data, for the variable Education, the categories of 'Certificate/diploma' and 'First degree and above' were combined into one category 'Certificate/diploma and above'.

Variables

The main independent variables in this study are the demographic variables presented in Table 1; which are gender, religion, ethnicity, and education level. The dependent variables are mental health status, and somatic psychological distress.

The mental health status and somatic distress symptoms of participants

To determine the mental health status among the returnees, we used the clinical cut off score of 8 on the SRQ-20 scale. Table 2 shows that about 24.1% of the returnees registered score about or above the clinical cut off score of 8, which indicates a fairly high prevalence of mental health issues among the returnees when compared to the general Ethiopian population with a prevalence rate of 12 % (6 or of 13.8% p [22]).

We ran independent t-test to compare male and female returnees on each of the items of SRQ-20 (Table 3). Significant differences between males and females were observed in the following items: Low Food appetite; $t=-3.07$, $p<.01$, Irregular Sleep Pattern; $t=-2.80$, $p<0.01$; Frequent weeping; $t=-2.10$, $p<0.05$; and Crisis on daily activities; $t=2.22$, $p<0.05$

Figure 1 Summaries of the prevalence of mental distress for different SRQ-20 cut points for men and women, respectively. At the cut-off point of 8, we identified 170 out of 565 women and 110 out of 461 men cases of mental distress, yielding a prevalence of 28% in women and 24% in men. If lower cut-off points were used, the prevalence of mental distress would increase by at least 1.5 times at each lower threshold score.

To determine the prevalence of the somatic symptoms of psychological distress among the returnees, we obtained frequencies

Table 2: Frequencies of SQR-20 scores.

| SQR- 20 score range | Frequency | Percent | Cumulative Percent |
|---------------------|-----------|---------|--------------------|
| 0 to 8 | 670 | 75.9 | 75.9 |
| 10 to 20 | 270 | 24.1 | 100.0 |

of the scores on the modified PHQ-15 instrument, and these frequencies are reported in Table 4 below. About 11.7% of the respondents reported mild symptoms of somatisation disorder, 8.2% reported moderate symptoms and about 3% reported severe symptoms.

Using independent t-test, we also compare male and female returnees on each of the items of the Patient Health Questionnaire, the PHQ-15, except one of the item that ask about menstrual cramps or other problems with your periods (since this item doesn't apply to male respondent). Bonferroni adjustment was applied to account for multiple t tests Results in Table 5 shows that males and females were significantly different on dizziness; $t=-2.13$, $p<0.05$; feeling tired or having low energy; $t=-4.22$, $p<0.000$; and nausea, gas or indigestion; $t=-3.33$, $p<0.01$.

The association between mental health distress and endorsement

Table 3: Gender difference in SRQ-20.

| Variable | Male | | Female | | t | p-value |
|---|------|------------|--------|------------|--------|---------|
| | N | M (SD) | N | M (SD) | | |
| Repeated Headache | 323 | 0.40(0.49) | 388 | 0.42(.50) | -0.642 | 0.521 |
| Low Food appetite | 324 | 0.35(0.48) | 388 | 0.49(.50) | -3.074 | 0.002 |
| Irregular Sleep Pattern | 323 | 0.31(0.46) | 388 | 0.41(.49) | -2.795 | 0.005 |
| Easily Anxious | 321 | 0.25(0.43) | 387 | 0.27(0.44) | -0.512 | 0.609 |
| Hand Trembling | 324 | 0.16(0.36) | 387 | 0.12(0.33) | 1.280 | 0.201 |
| Spiritual Disturbance | 323 | 0.32(0.47) | 388 | 0.3(0.46) | 0.511 | 0.610 |
| Lack of food digestion | 324 | 0.24(0.43) | 387 | 0.24(0.43) | -0.083 | 0.934 |
| Lack of proper thinking | 323 | 0.18(0.38) | 388 | 0.18(0.39) | -0.118 | 0.906 |
| Loss of happiness | 321 | 0.37(0.48) | 385 | 0.37(0.48) | -0.176 | 0.861 |
| Frequent weeping | 324 | 0.19(0.39) | 387 | 0.25(0.43) | -2.099 | 0.036 |
| Loss of satisfaction on daily job performance | 324 | 0.27(0.45) | 387 | 0.25(0.43) | 0.865 | 0.387 |
| Lack of decision making | 321 | 0.20(0.40) | 386 | 0.15(0.36) | 1.729 | 0.084 |
| Crisis on daily activities | 323 | 0.22(0.42) | 387 | 0.15(0.36) | 2.225 | 0.026 |
| Problems carrying out responsibilities | 321 | 0.20(0.40) | 387 | 0.16(0.37) | 1.356 | 0.175 |
| Lack of interest in life | 321 | 0.24(0.43) | 386 | 0.27(0.44) | -0.819 | 0.413 |
| Feeling of valuelessness | 320 | 0.20(0.40) | 387 | 0.17(0.37) | 1.293 | 0.196 |
| Feelings of committing suicide | 320 | 0.16(0.36) | 385 | 0.12(0.33) | 1.206 | 0.228 |
| Feeling of exhaustion always | 319 | 0.33(0.47) | 388 | .36(.48) | -0.792 | 0.429 |
| Abdominal discomfort | 321 | 0.28(0.45) | 387 | 0.24(0.43) | 1.385 | 0.167 |
| Getting tired too easily | 322 | 0.33(0.47) | 387 | 0.38(0.49) | -1.560 | 0.119 |

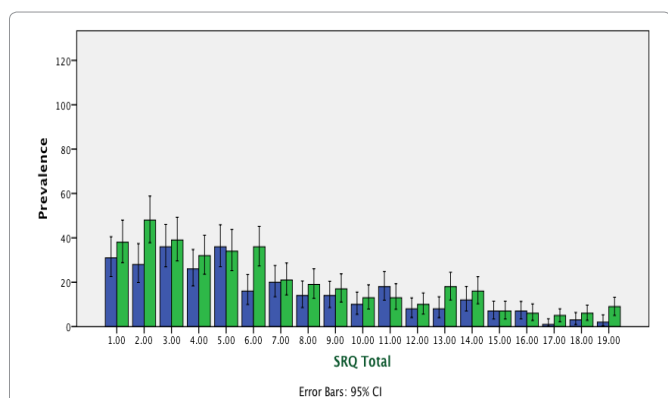


Figure 1: Prevalence of SRQ-20 using Different Cut-Points for Mental Distress by Gender.

Table 4: Frequencies of PHQ-15 scores.

| PHQ-15 score range | Frequency | Percent | Cumulative Percent |
|--------------------|-----------|---------|--------------------|
| 0 to 4.33 | 538 | 72.3 | 76.0 |
| 4.33 to 8.67 | 87 | 11.7 | 88.3 |
| 8.68 to 13 | 61 | 8.2 | 96.9 |
| ≥13 | 22 | 3.0 | 100.0 |
| Total | 708 | 95.2 | |

Table 5: Gender difference in PHQ-15.

| Variable | Male | | Female | | T | p-value |
|------------------------------------|------|-------------|--------|-------------|-------|---------|
| | N | M (SD) | N | M (SD) | | |
| Stomach pain | 321 | 0.58 (0.67) | 373 | 0.54 (0.71) | 0.72 | 0.472 |
| Back Pain | 318 | 0.26 (0.53) | 369 | 0.30 (0.58) | -0.79 | 0.429 |
| Pain in your arm, leg or joint | 321 | 0.22 (0.46) | 370 | 0.25 (0.53) | -0.95 | 0.344 |
| Shortness of breath | 319 | 0.24(0.51) | 372 | 0.31(0.59) | -1.89 | 0.060 |
| Headaches | 320 | 0.24(0.51) | 369 | 0.28(0.58) | -1.11 | 0.267 |
| Chest pain | 319 | 0.20(.50) | 374 | 0.22(0.5) | -.57 | 0.568 |
| Dizziness | 318 | 0.32(.59) | 370 | 0.42(0.65) | -2.13 | 0.034 |
| Feeling your hear pound | 322 | 0.21(.50) | 370 | 0.28(0.57) | -1.70 | 0.089 |
| Feeling tired or having low energy | 317 | 0.20 (.47) | 364 | 0.38 (0.64) | -4.22 | 0.000 |
| Nausea, gas or indigestion | 232 | 0.20(.52) | 367 | 0.37(0.62) | -3.33 | 0.001 |

Table 6: Correlation between SQR-20 and PHQ-15 scores.

| | | SQR-20 | PHQ-1 |
|--------|---------------------|--------|-------|
| SQR-20 | Pearson Correlation | 1 | |
| PHQ-15 | Pearson Correlation | 0.48** | 1 |

Note: **Correlation is significant at the 0.01 level (2-tailed).

of somatic symptoms among migrant returnees is presented in Table 6. The result revealed that there is a significant relationship between the participants' mental health status result and the somatisation symptoms as exhibited by their PHQ-15 and SQR-20 scores, $r=0.48$, $p<0.01$ tested using Pearson correlation coefficient.

Participants' mental health status based on gender, religion, ethnicity and education

A factorial MANOVA was conducted to evaluate the differences due to Gender, Religion, Ethnicity and Education on the two dependent variables of Mental Health Status and Somatic Psychological Distress. MANOVA results indicate that Religion [Wilks' $\Lambda=0.966$, $F(4, 1036)=4.622$, $p=0.001$, $\eta^2=0.02$] and Education [Wilks' $\Lambda=0.960$, $F(12, 1036) =1.838$, $p=0.038$, $\eta^2=0.02$] significantly affect the combined DV of Mental Health Status and Somatic Psychological Distress. Three interaction effects were significant; Religion x Education [Wilks' $\Lambda=0.919$, $F(24, 1032)=1.927$, $p=0.005$, $\eta^2=0.04$], Sex x Religion x Ethnicity [Wilks' $\Lambda=0.979$, $F(4,1032)=2.866$, $p=0.022$, $\eta^2=$], and Sex x Religion x Ethnicity x Education [Wilks' $\Lambda=0.973$, $F(4, 1032)=3.686$, $p=0.005$, $\eta^2=0.03$].

We conducted Univariate ANOVA as a follow-up test for MANOVA for each dependent variable. The main effects of Sex [$F(1,534)=4.859$, $p=0.028$, $\eta^2=0.01$] and Education [$F(6,534)=2.202$, $p=0.04$, $\eta^2=0.02$] were significant for Somatic Psychological Distress but not on Mental Health Status. On the other hand, Ethnicity [$F(4,534) =2.450$, $p=0.045$, $\eta^2=0.02$] and Religion [$F(2, 534)=7.419$, $p=0.001$, $\eta^2=0.03$] were significant for the Mental Health Status but not the Somatic Psychological Distress. The interaction effects

of Religion x Education [F (12, 534)=2.499, p=0.003,=0.05]; SexxReligionxEthnicity [F(2,534)=3.564, p=0.029,=0.01]; SexxReligionxEthnicityxEducation were significant on Somatic Psychological Distress [F (24,534)=5.816, p=0.003, =0.02], but not on the Mental Health Status. Post- hoc tests were conducted using Tukey and the results revealed that the differences due to Religion were between Orthodox Christians and Muslim (p<0.01); Orthodox and Protestant (p<0.01); but there were no differences between Muslims and Protestants (p=0.499). For Ethnicity, the post- hoc tests revealed that the differences were between the Tigray ethnic group and all the other four ethnic groups (p<0.01). The other four groups were not significantly different from each other.

Discussion and Future Direction

This paper describes the findings of the study of returnee migrants' mental health status and the level of somatic psychological distress in Ethiopia. Although psychological distress has been observed to be higher among migrants to the Middle East who migrated as domestic workers [2,23], little is known about the prevalence and severity of mental health distress and somatic symptoms associated with psychological distress, particularly among migrant returnees population.

The findings presented here come from large database representing five different regions of Ethiopian migrant returnees and helps to extend our knowledge in the field by provide empirical data that can serve as input for informed intervention.

Our study found that migrant returnees from the Middle East deal with significant mental health distress and endorsed somatic symptoms in outpatient setting. This result supports the conclusion that mental health is a significant issue among migrant returnees in Ethiopia, with probably mental health problems present in nearly one in four (24.1%) returnee migrants and 23% of somatic symptoms ranging from mild to severe. To date, no previous research has examined the prevalence rate of mental health distress of migrant returnee population in Ethiopia, so nothing exists with which we could compare the current study's result; however, we found the prevalence rate of mental health dress of current study [15,24] higher than the prevalence of common mental disorder symptoms (13.8%) of the general population in Ethiopia [22] and the prevalence of mental health stressors of migrants women from developing countries (22.8%) who work as domestic worker in the Middle East [13]. The standardization of the screening instruments (i.e. SRQ-20 and PHQ-15) and the optimal cut-off point for SRQ-20 (i.e. 8, higher than generally reported cut-off point [17] was used in this study to increase likelihood of accuracy in our results. The 24.1% finding of mental distress confirms the general assertions of studies by Anebasse [2] and Abebaw [3] reporting on psychiatric problems of migrant returnee Ethiopian women.

Our findings show high prevalence estimates of mental distress among women compared with men are consistent with most previous studies [2,5,25-27]. Researches have shown that mental health problems particularly mental health distress and somatic complaints affect women to a greater extent than men across diverse societies and social contexts [24,28]. Pressures created by their multiple role and responsibilities, and associated factors such as gender based violence; contribute to women's poor mental health [6].

A significant relationship was found between participants' mental health distress and somatisation psychological distress. We found

this result interesting, especially considering Ethiopian culture in which most people tend to express psychological distress through nonorganic physiological compliant. In Ethiopia, mental health issues are commonly believed to have supernatural causes such as possession by an evil spirit and people with mental illness are seen as violent sinners and therefore, it is presumed they will never recover. As a result, Ethiopians don't tend to seek professional help to address their psychological distress and mental health problems. Because of this, efforts to address returnee migrants' mental health challenges in the Ethiopian context should always include: cultivating public awareness about mental health and psychological distress, identifying the magnitude of the problem, and developing a policy and culturally sensitive intervention strategies. Hendricks [29] pledged for a culturally competent social practice with immigrant populations where a range of cultures, histories, worldviews, values, and beliefs need to be considered.

The combination of low education and gender inequality to poor mental health status among returnee migrants noted in this study has been previously well established in both developed and developing countries. Even though migration as domestic worker to the Middle East adversely impacts the mental health status of both men and women, it seems that traditional gender values still play an important role in everyday life of women and that the overload of responsibilities and expectations on them has a directly devastating impact on their mental health, especially if they do not have strong social support during their stay in the destination country and after they return. Previous research documented that multiple complications like physical, sexual and emotional abuse, salary denial, and violation of expectations each contribute to the decline in mental health of domestic work migrant returnees [2,3].

Overall, the profile of mental health status and somatic psychological distress of returned migrants indicates the need for developing a mental health service that is exclusively geared towards returnees' mental health problems, instead of clustering them together under the umbrella of general health services.

Limitations

Some limitations of this study should be noted. Even though the SRQ-20 is a brief, cost-effective and reasonably valid measure of mental distress and has been used in many studies of developing countries, it does not provide a specific psychiatric diagnosis. In addition, it may measure both the presence of symptoms and a respondent's inclination to answer questions about their physical health symptoms. This may also be the case for some migrant returnees, which we considered somatising subject, which may or may not have had some degree of associated physical disease. In other words, an increased number of false positives may appear in populations with chronically poor physical health, and likewise, a higher number of false negatives may result from the social stigma associated with the reporting of mental illness.

Unfortunately we were not able to verify these assumptions at this stage of the study. Future investigations will need (e.g., including different form of clinical interviews) to overcome these limitations to further understand the nature of mental health distress and the contribution of somatic symptoms to the psychological distress of Ethiopian migrant returnees.

To summarize, just being a migrant by itself is a difficult experience that requires resilience, creativity, hard work, and ability to navigate

among different cultures, languages, and systems. Domestic workers, who migrated illegally, are clearly placed in situations where they face additional psychosocial stressors brought about not only by their working and living conditions and lack of legal status. Hanlon [27] indicated that migration takes a psychological toll producing anxiety, posttraumatic stress disorder, depression, and sleep disturbances, which compromise quality of life for migrants. Taken together, these findings prompt the need for the Ethiopian government to address the mental healthcare desires of returnee migrants. Future studies are needed into the nature and efficacy of mental healthcare intervention in Ethiopia: research must be accompanied by actual implementation of mental health intervention to returnee migrants [30,31].

References

1. Mahdavi P (2011) "But we can always get more!" Deportability, the State and Gendered Migration in the United Arab Emirates. *Asian and Pacific Migration Journal* 20: 413- 431.
2. Anbesse B, Hanlon C, Alem A, Packer S, Whitley R (2009) Migration and mental health: A study of low-income Ethiopian women working in Middle Eastern countries. *International Journal of social Psychiatry* 55: 557-568.
3. Abebaw M (2013) Experiences of trafficking returnee domestic workers from the Gulf States: Implications for policy and intervention. Unpublished doctoral dissertation. Addis Ababa University.
4. Samuel (2012) Smuggling experiences of Ethiopians in South Africa: The case of Hosaena. Addis Ababa University School of Graduate Studies Institute of Psychology. Unpublished MA thesis.
5. Emebet K (2002) Ethiopia: An assessment of the international labor migration situation: The case of female labor migrants. Gender Promotion Program International Labor Office (GENPROM) working paper number 3, series on home migration, Geneva.
6. WHO (2002) Gender disparities in mental health. World Health Organization. Department of Mental Health and Substance Dependence. Geneva, Switzerland.
7. Asaminew E, Ahmed G, Abera Km, Makonnen T (2011) International migration, remittance and poverty alleviation in Ethiopia. *Ethiopian Journal of Development Studies* 33: 125-170.
8. Abebaw M, Thomas A (2013) Assessment of human trafficking and smuggling in Ethiopia with the view of enhancing national capacity to combat human trafficking and enhance national security. IGAD Security Sector Program. Addis Ababa.
9. Chammartin GM (2004) Women Migrant Workers Protection in Arab League State. In: Gender and Migration in Arab States: The Case of Domestic Workers. Simel Esim and Monica Smith (eds). International Labour Organization, Beirut.
10. Meskerem Mulatu (2011) Psychosocial and Economic Experiences of Gulf States Returnee Ethiopian Women Domestic Workers. Addis Ababa University School of Graduate Studies, Institute of Gender Studies.
11. Meseret A (2012) Mental health status of Ethiopian women returnees from domestic work in the Middle East countries, unpublished, MA thesis, Addis Ababa University, School of Psychology.
12. Zahid MA, Fido AA, Alowais R, Mohsen MA, Razik MA (2002) Psychiatric morbidity among housemaids in Kuwait: The precipitating factors. *Annals of Saudi Medicine* 22: 384-387.
13. Zahid MA, Fido AA, Razik MA, Mohsen MAM, El-Sayed AA (2004) Psychiatric morbidity among housemaids in Kuwait. a. Prevalence of psychiatric disorders in the hospitalized group of housemaids. *Medical Principles & Practice* 13: 249-254.
14. International Organization for Migration (2014) International migration and development: Report of the Secretary-General to the sixty ninth General Assembly of the UN, A/69/207
15. Michultka D (2009) Mental health issues in new immigrant communities. In: F. Chang-Muy, EP Congress (eds) Social work with immigrants and refugees: Legal issues, clinical skills, and advocacy. New York: Springer Publishing Company.
16. Harding TW, de Arango MV, Baltazar J, Climent CE, Ibrahim HH, et al. (1980) Mental disorders in primary health care: a study of their frequencies and diagnosis in four developing countries. *Psychological Medicine* 10: 231-241.
17. Harpham T, Reichenheim M, Oser R, Thomas E, Hamid N, et al. (2003) Measuring mental health in a cost-effective manner. *Health Policy and Planning Health Policy Plan* 18: 344-349.
18. Hanlon C, Medhin G, Alem A, Araya M, Abdulahi A, et al. (2008) Detecting perinatal common mental disorders in Ethiopia: Validation of the Self-Reporting Questionnaire and Edinburgh Postnatal Depression Scale. *Journal of Affective Disorders* 108: 251-262.
19. Halcón LL, Robertson CL, Savik K, Johnson DR, Spring MA, et al. (2004) Trauma and coping in Somali and Oromo refugee youth. *Journal of Adolescent Health* 35: 17-25.
20. Nakimuli-Mpungu E, Mojtabai R, Alexandre PK, Katabira E, Musisi S, et al. (2012) Cross-cultural adaptation and validation of the self-reporting questionnaire among HIV+ individuals in a rural ART program in Southern Uganda. *HIV AIDS (Auckl)* 4: 51-60.
21. Kocalvent R, Hinz A, Brahler E (2013) Standardization of a screening instrument (PHQ-15) for somatization syndromes in the general population. *BMC Psychiatry* 13: 91.
22. Fekadu A, Medhin G, Selamu M, Hailemariam M, Alem A, et al. (2014) Population level mental distress in rural Ethiopia. *BMC Psychiatry* 14: 194.
23. Abebaw M (2012) Trafficked to the Gulf States: Experiences of Ethiopian returnee women. *Journal of Community Practice* 20: 112-133.
24. Abdulahi H, Haile Mariam D, Kebede D (2001) Burden of disease analysis in rural Ethiopia. *Ethiopian Medical Journal* 39: 271-281.
25. Alem A, Kebede D, Woldesemiat G, Jacobsson L, Kullgren G (1999) The prevalence and socio-demographic correlates of mental distress in Butajira, Ethiopia. *Acta Psychiatry Scand Suppl* 397: 48-55.
26. Amare D (2005) Awareness and attitude towards common mental health problems, Agaro town, South Western Ethiopia. *Ethiopian Journal of Health Sciences* 15: 1-19.
27. Kebede D, Alem A, Rashid E (1999) The prevalence and socio demographic correlates of mental distress in Addis Ababa, Ethiopia. *Acta Psychiatr Scand Suppl* 397: 5-10.
28. Gelaye B, Arnold D, Williams MA, Goshu M, Berhane Y (2009) Depressive Symptoms Among Female College Students Experiencing Gender-Based Violence in Awassa, Ethiopia. *J Interpers Violence* 24: 464-481.
29. Hendricks CO (2009) Immigration and social work practice. In: F. Chang-Muy & E.P. Congress (Eds). Social work with immigrants and refugees: Legal issues, clinical skills, and advocacy. New York: Springer Publishing Company.
30. Richardson L, Amstadter A, Kilpatrick D, Gaboury M, Tran T, et al. (2010) Estimating Mental Distress in Vietnam: the Use of the SRQ-20. *International Journal of Social Psychiatry* 56: 133-142.
31. Scholte WF, Verduin F, van Lammeren A, Rutayisire T, Kamperman AM (2011) Psychometric properties and longitudinal validation of the Self-Reporting Questionnaire (SRQ-20) in a Rwandan community setting: A validation study. *BMC Medical Research Methodology* 11: 116.

Author Affiliations

Top

- ¹Department of Counseling, Psychology and Special Needs Education, Duquesne University, Pittsburgh, Pennsylvania, USA
- ²Department of Psychology, Addis Ababa University, Addis Ababa, Ethiopia
- ³Department of Educational Foundation and Leadership, Duquesne University, Pittsburgh, Pennsylvania, USA