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Economic development of countries of origin and distress among married immigrant men and women in Toronto

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ABSTRACT

We investigate if the "immigrant health paradox", as measured by distress, is evident among male and female partners married *before* immigration to Canada. We also examine if initial-status and change in distress are modified by the level of economic development of the origin-country. Our analysis of married immigrants to Toronto, Canada ($N = 615$), suggests that, contrary to findings of an "immigrant health paradox," recent immigrants from *less developed* countries experience elevated rates of distress in the first 5 years post-arrival, which declines with time in Canada. Immigrants from developed countries do not experience a difference in initial status or a subsequent change in distress with increase in time.

1. Introduction

Mental health is an important central indicator of the adaptive response to immigration and acculturation (Ataca & Berry, 2002). While a large body of research has examined the physical health of the foreign born (Albrecht, Diez Roux, Kandula, Osypuk, & Shrager, 2012; Dunn & Dyck, 2000; Jasso, Massey, Rozenweig, & Smith, 2004; Kim, Carrasco, Muntaner, McKenzie, & Noh, 2013; McDonald & Kennedy, 2004), research on the mental health of immigrants is more limited. Existing research that examines the effect of immigration on psychological health, as well as studies on self-rated general health – a more global measure of health that can capture both physical and mental health experiences (Bailis, Segall, & Chipperfield, 2003), report mixed findings. Some studies find that immigrants have poor or the same mental health (including self-assessed health) upon arrival (Casillas et al., 2012; McDonald & Kennedy, 2004 (men only); Newbold, 2005) that improves with increase in length of residence (McDonald and Kennedy, 2004; Tran, Manalo, & Nguyen, 2007). However, the majority of studies that examine the psychological health of individual migrants – in terms of a range of emotional and behavioral problems such as depression, alcohol dependence, or anxiety – report an "immigrant health paradox": superior or the same mental health than the native born at the time of arrival, which then declines with increase in time in the host country (Aglipay, Colman, & Chen, 2013; Ali, 2002; Burnam, Hough, Karno, Escobar, & Telles, 1987; Cook, Alegria, Lin, & Guo, 2009; Kim et al., 2013; Vega

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& Rumbaut, 1991). The initial mental health advantage reported in the latter group of studies may be due in part to the selection of healthier individuals to migrate (Jasso et al., 2004; Read, Emerson, & Tarlov, 2005). Immigration policy may also indirectly encourage positive mental health among immigrants. In Canada, for example, the points system in place since 1967 promoted immigrants who were well-educated, skilled, employed, parents, and married (Boyd & Vickers, 2000), thus indirectly affecting the mental health profile of the immigrant population (Montazer & Wheaton, 2011). The decline in mental health as length of residence in the host country increases has been at least partly attributed to increase in stressors associated with acculturation (Berry, 2006; Casillas et al., 2012; Cook et al., 2009; Noh & Avison, 1996).

With few exceptions, much of the work done on immigration and mental health has examined the overall effect of migration on individual psychological outcomes and not how the context of exit from countries of origin and length of residence (LOR) *together* may alter adjustment. In addition, the differential mental health pathways of married partners are not usually the focus in this research. This is problematic because immigration often occurs at the family level. The Canadian immigration policy, for example, stresses family reunification. Consequently, married couples constitute a large portion of immigrants to Canada (Ataca & Berry, 2002). Indeed, although it has seen a decline since the 80s and 90s, the family class is still the second largest migration category in Canada, after the economic class (Chagnon, 2013). Married immigrant men and women may have different experiences and psychological responses in a new cultural setting at both the individual and the family level as both the person and the marriage have to adapt to a new culture (Ataca & Berry, 2002). Thus, it is important to concurrently examine and compare the mental health of immigrant partners in the same context and under similar influences (Ataca & Berry, 2002).

The differential experience of immigration for married men and women may be further complicated by the context of origin. The majority of research on the mental health of immigrants has focused on specific immigrant groups, such as Hispanics in the United States (Aglipay et al., 2013). Studying individual groups recognizes the uniqueness of the migration experience. However, due to the large number of sending countries, studies that examine the mental health trajectory of specific immigrant groups may not generalize to other immigrants from other countries (Jasso et al., 2004), or point to a more general model of the ways in which contexts of exit matter (Montazer & Wheaton, 2011). Furthermore, studies that treat the foreign-born generally (Newbold, 2005) may miss divergent patterns in mental health trajectories with time – some positive, some negative – that may be conditional on origin. If there are both positive and negative trajectories, the problem that results will be a cancelling out of any effect among the foreign-born. In this paper, we move away from a case by case comparative approach and consider the context of origin more broadly by distinguishing immigrants by the level of economic development of countries of origin *at the time of immigration*. The level of economic development – as denoted by the Gross National Product, for example – stands for a wide range of differences in the structure of opportunities, the quality of life, and availability of resources in countries of origin that may affect the initial selection and subsequent ease of adjustment among immigrants and thus their mental health outcome over time (Dalgard, Thapa, Hauff, Mccubbin, & Syed, 2006; Montazer & Wheaton, 2011; Urquia, Frank, & Glazier, 2010).

Health selection might be highest among immigrants from the poorest countries, partly because the cost of migration from such countries is greater and may require more resources (Jasso et al., 2004; Read et al., 2005). If this is the case, then one can imagine better mental health among immigrant men from less developed countries of origin, as they are often the primary applicants and initiators of the migration process (Beiser et al., 1988). Conversely, married women, who are less likely to be selected in the first place, may have elevated mental health problems at the time of immigration because they are being separated from their own backgrounds, and not necessarily by volition but by necessity. This vulnerability may be exacerbated by the level of economic development of the origin-country. Married women from less developed contexts of origin are often from countries where traditional gender roles are more prevalent (Dalgard et al., 2006) and thus may be more likely to be confined to the domestic sphere upon immigration. This in turn implies more isolation and restriction after immigration, and more vulnerability to developing mental health problems (Ataca & Berry, 2002) in the first few years post arrival.

The level of economic development of the home country also suggests different acculturation dynamics post immigration for married men and women. Male partners from less developed countries may experience greater acculturative stress with increase in time since they may have a harder time finding suitable employment because education, skills and experience obtained in underdeveloped economies are less transferable to more developed countries of destination labor markets (Bratsberg & Ragan, 2002; Friedberg, 2000; Kanas & van Tubergen, 2009). The inability to find suitable employment, or the inability to provide for one's family on one income when employed, likely necessitates the entrance of female partners into the labor force (Kim & Grant, 1997). While female partners' entrance in the labor force may be beneficial as it can lead to improvement in life conditions, it could also lead to a feeling of emasculation (Ataca & Berry, 2002; Gill & Matthews, 1995), and, consequently, mental health problems among men from less developed countries of origin – these men are more likely to be from cultures where traditional gender ideologies emphasizing a man's role as the primary financial provider prevail than in more economically developed settings (Clark & Clark, 2004; Gill & Matthews, 1995).

The role of time in the mental health of immigrant women may be less predictable. On the one hand, with increase in time in the host country women may enter the labor force. Entrance in the labor force is likely to increase their contact with the outside world and their earnings relative to that of their partners, and, consequently, increase their sense of empowerment, autonomy, and mental well-being (Ghosh, 2009; Hondagneu-Sotelo, 1999; Menjívar, 1999; Ross & Mirowsky, 1992; Schnittker, 2007). On the

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