Coping Strategies of Asylum Seekers from Sub-Saharan Africa in New Zealand

Bernard Sama Nde

A thesis submitted to

Auckland University of Technology

in partial fulfilment of the requirements for the degree

of

Master of Health Science (MHSc)

2017

Faculty of Health and Environmental Sciences

School of Public Health and Psychosocial Studies

Primary Supervisor: Dr. Grace Wong

Secondary Supervisor: Dr. Nick Garrett

Abstract

The experiences that push people to leave their countries to seek asylum in foreign countries are stressful and in some cases traumatic. Unfortunately, in many countries, the immigration procedure that asylum seekers traverse to be officially recognised as refugees is complex and arduous. It may exacerbate their existing stress and re-traumatise them. In New Zealand, besides stress from the refugee status determination process, asylum seekers have less access to government funded resources than their counterparts, resettled refugees. Given this environment, the primary question addressed in this thesis is: what are the coping strategies used by asylum seekers to manage stress from the refugee status determination process?

To address this question, I study a sample of asylum seekers from Sub-Saharan Africa in New Zealand using an explanatory mixed methods research approach. The mixed methods design consisted of two phases. In the first phase (quantitative), I used the Brief COPE scale (Carver, 1997) to collect data on the coping strategies of the asylum seekers. The objective of this phase was to assess and describe their major strategies of dealing with stress from the refugee status determination process. In the second phase (qualitative), I used semi-structured interviews to collect data on the experience of coping from a smaller number of asylum seekers selected from the quantitative sample. The objective of this phase was to describe their perceptions and experiences of the coping strategies assessed in the Brief COPE scale, and to investigate the appropriateness of the Brief COPE scale for Sub-Saharan African asylum seekers.

Despite the stressful nature of the process, the asylum seekers tend to endorse more adaptive than maladaptive coping behaviours. Their levels of use of various coping behaviours differs significantly by the stage of their progress though their refugee claim process. Religion is a fundamental coping strategy for the sample, and self-blame is conceptualised in a different way from the Western worldview. The study also provides a new perspective on self-distraction as an adaptive coping. Lastly, the results indicate that the Brief COPE scale is appropriate for assessing coping behaviours in asylum seekers from Sub-Saharan Africa, although adaptation is recommended on two items - humour and self-distraction.

The implications of the results to New Zealand and other destination countries for asylum seekers are far reaching. They indicate that asylum seekers are endowed with

strengths, capabilities and resilience in spite of the challenges and vulnerabilities they experience. Thus, they could quickly and readily grow into becoming assets to the host countries with more timely interventions, opportunities and resources. Practitioners could tap into their strengths to support them more effectively. There is a need for research about strengths-based interventions in order to promote adaptive coping behaviours, and encourage change in order to decrease maladaptive coping behaviours.

Table of Contents

List of Figures

List of Tables

List of Abbreviations and Acronyms

%	Percent
χ^2	Chi-squared
AC	Adaptive coping strategies
ARMS	Auckland Regional Migrant Services
ARCC	Auckland Resettled Community Coalition; formerly Auckland Refugee Community Coalition
ASST	Asylum Seeker Support Trust
AU	African Union
CALD	Culturally and Linguistically Diverse
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1987
DHB	District Health Board
HIV	Human immunodeficiency virus
HNZ	Housing New Zealand
ICCPR	International Covenant on Civil and Political Rights 1976
INZ	Immigration New Zealand
IPT	Immigration and Protection Tribunal
IRD Number	Inland Revenue Department Number
KMGC	King's Mercy Global Church
MC	Maladaptive coping strategies
MBIE	Ministry of Business Innovation & Employment
MRRC	Mangere Refugee Resettlement Centre
N	Number
N/A	Not available
NZRCS	New Zealand Red Cross Services
OAU	Organisation of African Unity
PSS-10	The Perceived Stress Scale 10 Item

PTSD	Post-traumatic stress disorder
RASNZ	Refugees as Survivors New Zealand
RCNZ	Refugee Council of New Zealand
RSB	Refugee Status Branch
RSD	Refugee status determination
SD	Standard deviation
SPSS	Statistical Package for the Social Sciences - IBM SPSS Statistics 23
STDs	Sexually transmitted diseases
SVS	Stress Vulnerability Scale
TB	Tuberculosis
UK	United Kingdom
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees
UNMISS	United Nations Mission in the Republic of South Sudan
USA	United States of America
WHO	World Health Organisation
WINZ	Work and Income New Zealand

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature:

Name: **Bernard Sama Nde**

Date: 15 April 2017

Acknowledgements

It would be impossible for me to complete this thesis without the guidance, comments and supports from so many people whom I would like to acknowledge my heartfelt appreciation.

First, a colossal thanks to my primary supervisor Dr. Grace Wong for providing her knowledge, advice, patience, time amid her very busy schedule, and most of all, for pushing me to do the best I can. I would also like to acknowledge the invaluable statistical assistance and encouragement given to me by my second supervisor Dr. Nick Garrett. I thank both of these supervisors for their invaluable feedback. A thank you goes as well to Professor Max Abbott for overseeing the thesis.

I extend my gratitude to other administrative and teaching staff at AUT during my study. Most especially, I say thank you to Caril Cowan and Melinda Gama. Without their encouragement and mentoring, I would not have come as far as completing a Master's thesis. I express my gratitude to Dr. Sari Andajani for having reviewed and approved my proposal for this research. I am grateful to Dr. Heather Came for her assistance in solving academic and procedural problems I encountered during my application for admission and review of my research proposal. My appreciation also goes to Anni Krageloh in the School of Public Health and Psychosocial Studies for administrative support with the completion of the research proposal and the ethics application. Charles Grinter (the Research Ethics Advisor) viewed, commented and reorganised various aspects of my application for ethics approval. I acknowledge his constructive contribution. I also thank Bib Hughes for proofreading.

I thank equally all the participants who took part in the survey and interview. Words alone cannot express how much I am touched by the fact that you gave up your precious time to contribute in this study. I thank particularly those asylum seekers who are still going through the refugee status determination process yet you have found time despite the stressful nature of the process and lack of resources, to engage in the purpose of this research. This study would have been unattainable without your invaluable participation.

I thank many of the community leaders involved in this research including Celia Brandon from New Zealand Red Cross and Apostle Prince Chekezie from King's Mercy Global Church for providing cultural support and support letters for this research. I

acknowldge the helpful discussions I had with Abann Yorr of Auckland Resettled Community Coalition (ARCC); leaders of the Asylum Seekers Support Trust (ASST); staff of Refugees as Survivors New Zealand (RASNZ); members of the Friends of Friends Fellowship (FFF). I thank the Auckland Regional Migrant Services (ARMS) and the various community organisations for helping me to disseminate information about the research. Most importantly, I thank Carine Mokelle for reaching out to other research participants, and Pastor David and members of Redeem Christian Church of God - Avondale for providing a financial support for my study. The management of Walsh Trust Ltd, and my colleagues at work including especially Jeannie Colmer, Michael Yapp, Tim Weston, Jessica and Cecelia, and most especially the clients I support every day at work, have been very supportive of my studies from the very onset. I thank them.

Finally, I express my sincere gratitude to family and friends including Fri Valerie, Hubert Asiedu and Rhoda, Dr. Dominic Dagbanja, Gloria Wajina, Mme Angela Rubaduka and family, Santos Mukete and family, Amanda Khumalo, Dr. Frank Ropheka-Bekomson and family, Roland Ayangwe and family, Roy Musodi, Colins Ndango, Jean Makoto and everyone else who has supported me directly or indirectly during this journey. Most especially, I thank Ma Monica Lemospereira and family, the Kwende, Nde-Asanga, and Fombe-Nduma family for their continuous moral support and encouragement so I can be the man I want to be.

Ethics Approval

AUT University Ethics Committee (AUTEC) approved the ethics application for this research on 18 May 2016. Approval number 16/119.

Dedication

This thesis is dedicated to Faith M. Sama, Brenda A. Fombe, and Sandrine M. Sama

CHAPTER 1: INTRODUCTION

1.1 Overview

The number of peoples seeking asylum in the world has grown exponentially, reaching a record high in 2014/2015 (UNHCR, 2015a; UNCHR, 2016c). While the migration of asylum seekers has attracted substantial interest in the media, as well as intense political wrangling in many destination countries, research about asylum seeking populations is not at an equivalent level.

Moreover, research on asylum seeking populations has tended to report numbers, countries of origin, destination countries, approval, decline and repatriation rates, policy/legislation affecting asylum seekers and other similar topics. Studies that have explored the experiences of peoples seeking asylum have mainly focused on pre-migration and post-migration stressors; documenting experiences of traversing the refugee status determination processes in destination countries; accessibility of services in the destination countries; community integration and others. More often than not, such studies emphasise the trauma and challenges faced by the asylum seekers and refugees rather than their overall experiences (Marlowe, 2010; Shakespeare-Finch, Schweitzer, King & Brough, 2014). For example, there are no New Zealand based studies about the strengths of the asylum seekers, their coping behaviours, or the areas where they are achieving. Overseas studies on asylum seekers have barely incorporated this very important aspect (Raghallaigh & Gilligan, 2010). This thesis takes a step in this direction by exploring the coping strategies of Sub-Saharan African asylum seekers in New Zealand.

In the sections below I state the personal experience that led me to studying asylum seekers. I describe the background of the problem and provide a problem statement and the purpose of the study. The significance of the research topic, research questions, research design, and an overview of the chapters in the thesis follow.

1.2 Autoethnographic synopsis

I came to New Zealand several years ago from a country in the Sub-Saharan Africa, made a claim for refugee status and was recognised as a refugee. My journey from my country of birth and through the other countries that I passed to finally arrive in New Zealand was extremely stressful. The stress further increased, sometimes unbearably, when I was completing the confirmation of claim for refugee status in New Zealand, when I attended the refugee status interview, and when I was responding to the critical issues raised in my interview report.

Primarily, during the entire duration of my refugee status determination process, I was very worried because I was not able to provide precisely the evidence required by immigration authorities to support my claim. I feared that I would be deported. These fears were not the only things that made my life miserable during the period of my refugee status claim. Other problems included not finding affordable accommodation at the level of the income support I was getting from the government; not eating regular and healthy meals because I could not afford them; and not being able to find a job that was proportionate to my level of education. Despite this I had to support my family in my country of origin.

Fortunately, during that period of my refugee status claim, I was supported by friends and some people in the community. Some of my friends who supported me were lucky because they had been brought to New Zealand by the government as refugees. They were given furnished flats and could access unemployment benefits and job seminars at Work and Income New Zealand (WINZ). They had social workers. New Zealand community members checked on them regularly and supported them to go shopping and to other places. I could not access any of these supports because I was an asylum seeker.

When I was recognised as a refugee, I took the letter of recognition of refugee status and tried to apply for a flat from Housing New Zealand (HNZ) like my refugee friends. I was told I had to be put on a waiting list. I was also told that I could only access a Housing New Zealand flat in the same way as all other New Zealanders, unlike the refugees who were brought to New Zealand by the government. I tried to apply for an unemployment benefit but I was told I was only entitled to the emergency benefit and not the unemployment benefit.

Eight months passed between the time I was recognised as a refugee and applied for permanent residence in New Zealand. I was granted permanent residence. I took the

permanent residence and went back to WINZ and HNZ to apply for the unemployment benefit and a flat, respectively. I was told the same story as before regarding housing, however this time I was able to access the unemployment benefit and was put on job seminars.

It was then that I started asking myself why former asylum seekers, who are officially recognised as refugees, are not treated in the same way as the other refugees brought into the country by the government. Why was I treated in a different way from my friends who were also refugees? During this time I also supported (emotionally and materially) other people in my community who were seeking asylum, and I noticed that they were living through the same stressful situations that I had been through. Through socialising with other asylum seekers, I observed that the challenges I faced were common to the other asylum seekers.

Some of my friends (asylum seekers) managed to cope with the process very well but others really struggled. Yet, we all managed to cope somehow, but just in different ways. My experience led me to my interest in the coping behaviours of asylum seekers. I wanted to find out if there were any commonalities given that everyone seemed to cope with the same situation in different ways. I wanted to know what behaviours work and do not work for asylum seekers during the refugee status determination process.

My overarching objective for this study is the improvement of welfare for asylum seekers, as they are in a more vulnerable position than the other refugee group in New Zealand. My personal experiences, and that of the other asylum seekers, have led me to subscribe to the transformative theory (also known as the transformative perspective or transformative lens) (Creswell, 2009; Mertens, 2013; Mertens, 2003; Sweetman, Badiee & Creswell, 2010).

The transformative theory holds that issues of social justice and human rights should be brought to the foreground in all aspects of a study (Mertens, 2013). Such a lens consists of incorporating intent to advocate for an improvement in human interests and society through addressing issues of power and social relationships (Sweetman et al., 2010). The power and social issues of the day that could be dealt with through the transformative lens include empowerment, inequality, oppression, domination, suppression and alienation (Creswell, 2009). Creswell asserts as well that a transformative research study should provide a voice for the participants, raise their consciousness, and contribute an action agenda for reform that may change theirs and the researchers' lives.

1.3 Background of the problem

Approximately 300 asylum seekers claimed refugee status annually in New Zealand from 2005 to 2015 (Immigration New Zealand, 2016d). Before 2005, the number was considerably higher. For example, refugee status claims tendered in the financial year 2001/2002 numbered 1441. That number dropped dramatically to 317 in the financial year 2005/2006 (Department of Labour, 2012) when Immigration New Zealand progressively introduced advanced passenger screening in 2003 (Dalzie, 2003), and in so doing tightened the borders. Asylum seekers whose refugee status claims are successful or approved are known as convention refugees (Department of Labour, 2004; Human Rights Commission, 2010).

Since 1987 New Zealand has also received and resettled an annual average of 750 refugees under the Refugee Quota Programme (Department of Labour, 2004; Mortensen, 2011; Gruner & Searle, 2011). In 2016 following the Syrian refugee crisis, the government of New Zealand announced that it would increase the quota refugee numbers to 1000 annually from 2018/2019 onwards (Woodhouse, 2016). Quota refugees are people whom the United Nations High Commissioner for Refugees (UNHCR) has mandated as refugees offshore (Department of Labour, 2004).

In addition to the convention and quota refugees, New Zealand offers 300 places each year for eligible convention and quota refugees resident in New Zealand to sponsor their family members to join them. The Refugee Family Quota Category was introduced in 2002 (Department of Labour, 2004). Refugees who come to New Zealand under the Refugee Family Quota Category are known as family reunion refugees (Department of Labour, 2004). This thesis focuses solely on asylum seekers.

In theory, asylum seekers who have been recognised as convention refugees through the official refugee determination process in New Zealand have rights as per the United Nations 1951 Convention Relating to the Status of Refugees. In practice, they do not qualify for the services and settlement support available to the quota refugees. The situation for asylum seekers who are still going through the refugee status determination is even more problematic. For example, while they have access to subsidised primary healthcare services, access to secondary and specialist services remains difficult and is unfunded in most cases (Bloom & Udahemuka, 2014; Bloom et al., 2013).

Besides the issues above, there is a shortage of culturally appropriate and trained professionals to support asylum seekers to cope with experiences unique to their

circumstances such as trauma resulting from torture in their countries of origin and time spent in refugee camps or transitory countries (Bloom & Udahemuka, 2014; Department of Labour, 2004; Mortensen, 2011; Te Pou, 2010; Uprety, Basnet & Rimal, 1999). In addition, the process of claiming refugee status by asylum seekers itself is often stressful with the claimants remaining in limbo for lengthy periods of times (Bloom et al., 2013; Tribe, 2002, Uprety et al., 1999).

During the refugee status determination process, the asylum seeker faces uncertainty and the prospect of deportation (Bloom et al., 2013; Tribe, 2002, Uprety et al., 1999). In addition to these anxieties, the interrogatory style of interviews by immigration service officials can result in re-traumatisation (Uprety et al., 1999; Schock, Rosner, Knaevelsrud, 2015). The asylum seeker may also face challenges from immigration officials regarding the veracity of their story, and the re-telling of personal stories may trigger symptoms of mental disorders (Te Pou, 2010). This compounds existing stress.

Furthermore, the period between the submission of refugee status claim and a decision being made by the Refugee Status Branch of Immigration New Zealand can be approximately three months (Immigration New Zealand, 2015a) and even longer in some cases (Te Pou, 2010). Cases on appeal take considerably longer periods; for example, between 2013 to 2016 it took around 12 months from the receipt of an appeal to the release of the decision by the Immigration and Protection Tribunal of the Ministry of Justice (Spiller, 2016). Accordingly, asylum seekers have long waiting periods. Tribe (2002) postulates that waiting times may be a period when the psychological well-being of the asylum claimant becomes extremely fragile.

Besides the direct stress from the long waiting times, it has been observed that asylum seekers may experience other stressors in their host countries. For example, it was found in an Australian study that the stressors in the host country may be as powerful as those experienced in countries of origins (Sinnerbrink, Silove, Field, Steel & Manicavasagar, 1997). In this regard, comments from New Zealand indicate that asylum-seekers, both in detention and community-dwelling often show signs of profound depression, hopelessness and helplessness that reflect current and past experiences (Uprety et al., 1999). The refugee status claimant may experience depression and/or panic due to issues such as extreme concern about family members left in dangerous circumstances in their country of origin (Te Pou, 2010), and they may be stressed by the general challenges of acculturation.

The focus of the studies on asylum seekers has mainly been on the challenges faced by the asylum seekers as illustrated by the foregoing information. Accordingly, Tribe (2002) observed that many earlier studies on refugee mental health attempted to find a link between numbers and severity of traumatic events without due consideration of the meaning of these developments to the individuals. He noted, however, that some studies have begun including the meaning of the experiences to the asylum seekers. Despite Tribe's observation, there are scarcely any peer reviewed journal articles on the experience of asylum seekers in New Zealand. Moreover, no study on asylum seekers in New Zealand has explored the experience of the asylum seekers from a strengths perspective.

Interestingly, the United Nations High Commissioner for Refugees (UNHCR) asserts that, amidst the adverse experiences that many refugees might have lived through in their home countries, refugees are often people with resilience and a strong determination to survive. It is because of that resilience that many can survive as refugees (UNHCR, 1996). It follows from the foregoing that it is therefore not surprising that many asylum seekers are able to cope with the stress from the refugee status determination process amidst the limited resources they have. This strengths based research study would explore the coping behaviours in order to find out the positive behaviours that help them through the refugee status determination process, so as to support and encourage those behaviours.

1.4 Statement of the problem

The few studies on asylum seekers in New Zealand (for example, Bloom & Udahemuka, 2014; Department of Labour, 2004; Uprety et al., 1999, Young & Mortensen, 2003) have not explored their coping behaviours. Studies on asylum seekers and refugees in other countries have barely incorporated this important factor (Marlowe, 2010; Raghallaigh & Gilligan, 2010). The focal point of this thesis is therefore to contribute to filling this existing gap.

1.5 Purpose of the study

The goal of this mixed methods study is to explore and describe the ways in which asylum seekers cope with stress from the refugee status determination process.

1.6 Significance of the study

Overall, the study will contribute to understanding the coping behaviours of asylum seekers. It will inform policy makers, refugee communities, organisations providing services to the asylum seekers, and immigration authorities on the coping behaviours of asylum seekers. It will also ascertain whether or not the Brief COPE scale is an appropriate tool for professionals assessing coping strategies of asylum seekers from Sub-Saharan Africa.

A study that seeks to understand how asylum seekers deal with stressful situations is of particular importance because of growing concern over the mental health of refugees in New Zealand (Mortensen, 2011). The Department of Labour (2004) observed in research, which included the settlement experiences of convention refugees, that the need for emergency psychiatric teams to work with refugees was increasing, and more than one-third of newly arrived convention refugees reported experiencing emotional problems in their first six months. Taking this background into consideration, a study that seeks to explore how asylum seekers can cope well in the community is justified.

1.7 Primary research questions

The central issue is, what are the coping strategies used by asylum seekers to manage the stress from the refugee status determination process?

The following are sub questions:

1.7.1 Quantitative research questions:

- What coping strategies do the asylum seekers use most?
- Is there a difference in coping behaviours across the three groups (1 = in process group; 2 = declined group; and 3 = approved group)?

1.7.2 Qualitative research questions:

- What are asylum seekers' experiences of the coping strategies included in the Brief COPE scale?
- How appropriate is the Brief COPE scale for measuring coping behaviours in asylum seekers from Sub-Saharan Africa?

1.8 Research design

A two stage explanatory mixed methods design was used in the study (Creswell & Plano Clark, 2011). The first phase (quantitative) entailed using the Brief COPE scale (Carver, 1997) to collect data on the coping strategies of asylum seekers from Sub-Saharan Africa in New Zealand. The objective of this phase was to assess and describe their major strategies of dealing with stress related to the refugee status determination process. In the second phase (qualitative), a smaller number of asylum seekers derived from the first phase sample group participated in semi-structured interviews to investigate their experiences of coping. The objective of this phase was to describe their perceptions and experiences of the coping strategies assessed in the Brief COPE scale, thereby exploring the appropriateness of the tool for this sample.

The philosophical assumptions underpinning the study are postpositivist (Guba, 1990; Lincoln & Guba, 1985; Trochim, 2000); and the methodology is the sequential explanatory design (Creswell & Plano Clark, 2011; Creswell & Sheldon, 2006; Tashakkori & Teddie, 1998). Quantitative descriptive techniques were used in the quantitative phase to collect and analyse the data (Dulock, 1993; Hopkins, 2000). Similarly, qualitative descriptive techniques were employed in the qualitative phase to gather and analyse the data (Hopkins, 2000; Meininger, 2011; Sandelowski 2000). It is hoped that the quantitative and qualitative descriptive methods will achieve both depth and breadth on the phenomenon of 'coping' that the quantitative or qualitative methods may not achieve individually.

1.9 Outline of the study

Chapter Two of the study establishes the background to the study, highlighting definitions and complexities in data and the categorisation of refugees and asylum seekers in New Zealand and globally. New Zealand's refugee status determination process is described. An overview is provided of the Sub-Saharan African region and the Sub-Saharan African asylum seekers. The literature review in Chapter Three discusses research on asylum seeking populations in New Zealand. It discusses as well the assessment of the coping strategies and the use of the Brief COPE scale for this assessment. Chapter Four describes the theoretical framework, methodology and methods used in the study. The ethical application and ethical issues that arose from the study, and the trustworthiness and rigour of the results are also addressed.

The quantitative findings are presented in Chapter Five. Chapter Six presents the qualitative results, and is structured in three parts. Part One describes the participants' perceptions and experiences of each coping strategy assessed in the Brief COPE scale. Part Two combines the quantitative and qualitative results because it provides the participants' explanations for the significant results observed in the quantitative phase. Part Three outlines four additional themes that emerged from the participants' description of their coping strategies. Chapter Seven contains the discussion of the results, the limitations, recommendations and conclusions drawn from the study.

Chapter summary

I have discussed my personal experience and the background problem that led to the study. The problem statement and purpose of the study have been stated. A brief overview of the significance of the study, the research questions, the study design, and an outline of the thesis has been provided. The next chapter will build upon this and among other things, will discuss definitions and the relevant data to asylum seekers in New Zealand and globally.

CHAPTER 2: BACKGROUND TO THE STUDY

In this chapter, I discuss the definition of 'refugee' both in the context of New Zealand and globally. The categories of refugees in New Zealand are identified and two main groups from the categories – 'quota refugee' and 'asylum seeker' - are then discussed. Differences in terms of services available to quota refugee and asylum seekers are outlined. The definition of migrant is discussed and differences between migrants and refugees are outlined. An overview of the global refugee crisis is provided and the impact of the global refugee crisis on New Zealand is described.

Comparisons are made between New Zealand's approval rate of asylum claims and Australia and selected European countries. I argue that, despite the stability of the annual numbers of asylum seekers since 2005 in New Zealand, the approval rate remains low compared to some European countries. Lastly, I describe the Sub-Saharan African region, identifying the sub-regions and countries that make up Sub-Saharan African and review data on Sub-Saharan African asylum seekers internationally and in New Zealand.

2.1 Definitions of refugee, asylum seeker and migrant

In this section, I discuss the definition of refugee both under the domestic context in New Zealand and internationally. The refugee groups (that is, categories of refugees in New Zealand) are identified. Differences, mostly in terms of services available to quota refugee and asylum seekers, are highlighted. The definition of migrant is discussed and the differences between migrants and refugees are outlined.

2.1.1 Definition of refugee

New Zealand is a party to the United Nations 1951 Convention Relating to the Status of Refugees, and the 1967 Protocol Relating to the Status of Refugees, also known as the Refugee Convention (Brookers Ltd, 2010). The definition of a refugee in New Zealand is derived verbatim from the Refugee Convention. It is used in Schedule 6 of the Immigration Act 2009. Article 1(A)(2) of the 1951 United Nations Convention Relating to the Status of Refugees defines a refugee as a person who:

> *owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.*

While a person who is seeking recognition as a refugee in New Zealand has to establish that their circumstances specifically meet this United Nations' definition, the UNCHR has a broader scope for recognition of refugees. The definition of a refugee by the UNHCR is not limited to the 1951 United Nations Convention Relating to the Status of Refugees. It includes individuals recognised under the 1969 Organisation of African Unity (OAU), now African Union (AU) Convention Governing the Specific Aspects of Refugee Problems in Africa (UNHCR, 2015a).

The 1969 African Union (AU) Convention Governing the Specific Aspects of Refugee Problems in Africa is the regional legal instrument governing refugee protection in Africa. Its first article provides two refugee definitions: one replicating the 1951 United Nations Convention Relating to the Status of Refugees, and a second unique definition in article I (2)

> *the term refugee shall also apply to every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality.*

Both definitions are employed by UNHCR in its operations in Africa (United Nations General Assembly, 1994; UNHCR, 2015a). Furthermore, the UNHCR refugee definition includes those recognised by the UNHCR Statute, individuals granted complementary forms of protection, and those enjoying temporary protection. Complementary protection refers to

> *protection provided under national, regional, or international law to persons who do not qualify for protection under refugee law instruments but are in need of international protection because they are at risk of serious harm* (UNHCR, 2015a, p. 56).

In New Zealand, such protection is assessed under Sections 130 and 131 of the Immigration Act 2009, which codifies New Zealand' obligations to 'protected persons'.

According to the Immigration Act 2009, persons needing complementary protection are those to whom New Zealand owes protection obligations under the 1987 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); and the 1976 International Covenant on Civil and Political Rights (ICCPR) (Brookers Ltd, 2010).

Additionally, the UNHCR refugee definition includes persons in refugee-like situations. Persons in refugee-like situations are

> *groups of persons who are outside their country or territory of origin and who face protection risks similar to refugees but for whom refugee status has, for practical or other reasons, not been ascertained* (UNHCR, 2015a, p 56).

A notable difference between the UNHCR and New Zealand's definition of a refugee is that a person who is recognised as a 'protected person' under New Zealand's Immigration Act 2009, would have met the criteria for a refugee under the UNHCR's definition of a refugee. However, for the practical purpose in New Zealand, the person is a 'protected person' and not a refugee (Brookers Ltd, 2010). Despite this apparent difference, Section 126 of the Immigration Act 2009 allows people who have been recognised as refugees by the UNHCR to be resettled in New Zealand under the Refugee Quota Programme. Consequently, many 'protected persons' have been resettled in New Zealand under the Refugee Quota Programme (Immigration New Zealand, 2016c).

In sum, the UNHCR's definition of refugee is broad including the African Union's definition, and individuals granted complementary forms of protection - 'protected persons' and individuals in refugee-like situations. However, these words do not have the same legal implications in the context of the laws of member states to the Refugee Convention as is the case with New Zealand. For example, refugees have specific rights as spelled out in the 1951 Convention Relating to the Status of Refugees (Hathaway, 2005). 'Protected persons' do not have the same rights.

2.1.2 Categories of refugees in New Zealand

The person who officially is a refugee in New Zealand would have acquired that designation in one of the following ways:

- Resettled under the Refugee Quota Programme. Refugees under this category are known as quota refugees or mandated refugees.

- Gained recognition as a refugee while already in New Zealand through seeking asylum. Refugees under this category are known as convention refugees or spontaneous refugees.
- Family member of quota or convention refugees who are resident in New Zealand and sponsored under the Refugee Family Quota Category. Refugees under this category are known as family reunion refugees (Department of Labour, 2004; Human Rights Commission, 2010; Immigration New Zealand, 2016).

2.1.3 Quota refugee

A quota refugee is a person who is considered for resettlement in New Zealand via the Refugee Quota Programme under Section 126 of the Immigration Act 2009. The person must already have recognition offshore as a refugee under the mandate of the UNHCR and be referred for resettlement by the UNHCR (Department of Labour, 2004). Quota refugees are granted permanent residence visas on their arrival in New Zealand (MBIE, 2015).

A formal Refugee Quota Programme was established in New Zealand in 1987 for the resettlement of refugees (MBIE, 2015; Mortensen, 2011). Originally, it allowed an annual quota of 800 refugees identified by UNHCR to be resettled in New Zealand. However, the annual quota was decreased by 50 places in 1997, and it had been 750 annually (MBIE, 2015; Mortensen, 2011) until 2015 when the number was increased (see Section 2.3).

The introduction of the Refugee Quota Programme in 1987 also saw New Zealand remove preferences for specific nationality, ethnicity and religious groups (Mortensen, 2011). Consequently, the profile of quota refugees resettled in New Zealand from 1987 has included peoples from Africa, the Middle East, Asia, and South America (Department of Labour, 2011; Department of Labour, 2006; Immigration New Zealand, 2016a; Mortensen, 2011). Table 1 illustrates the nationalities of quota refugees in New Zealand between 2005 and 2015. Nationalities with less than 10 people have been summed up under 'other'.

Table 1: Nationalities of quota refugees resettled in New Zealand from 2005 to 2015

Nationality	2005 to 2015
Afghanistan	650
Bhutan	961
Burundi	79
China	29
Colombia	582
Congo	109
D R Congo	197
Ecuador	80
Eritrea	196
Ethiopia	86
India	15
Indonesia	13
Iran	200
Iraq	684
Mauritania	10
Myanmar	2333
Nepal	30
Palestine	149
Rwanda	39
Somalia	92
Sri Lanka	230
Sudan	140
Syria	83
'Other'	73
Total	**7060**

Source: Immigration New Zealand (2016a)

2.1.4 Definition of asylum seeker

An asylum seeker is "a person who says he or she is a refugee or protected person, but whose claim has not yet been decided" (MBIE, 2015b, p. 15). The UNHCR refers to the same people as "asylum seekers with pending cases" (UNHCR, 2015a, p. 56). If successful in the claim for refugee status, the person is no longer an asylum seeker but is a refugee under international law (Bogen & Marlowe, 2017). In New Zealand however, that person is commonly referred to as a convention refugee.

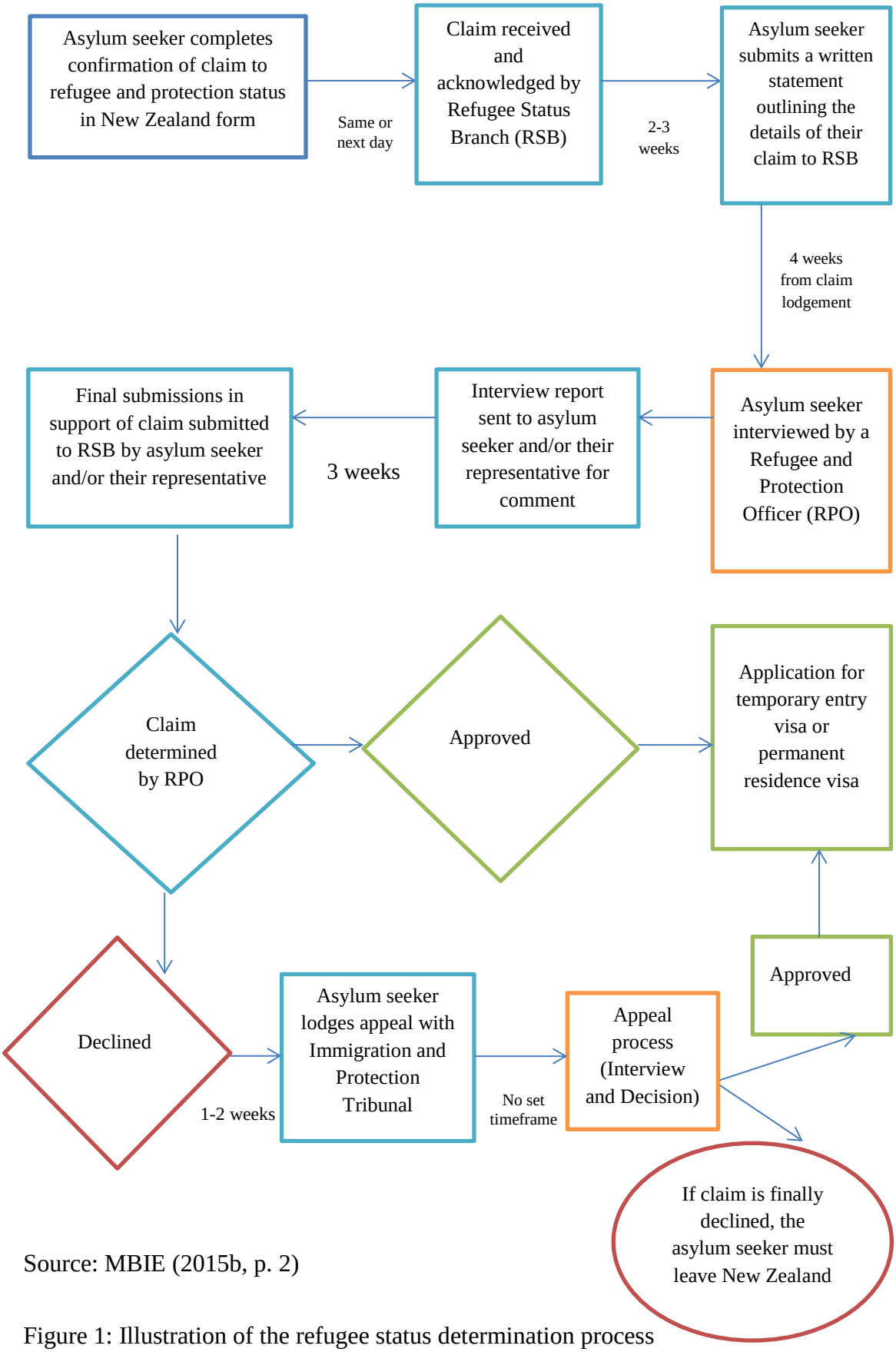
Unlike the individuals who have been granted recognition as refugees overseas by the UNCHR, asylum seekers make their way to New Zealand independently and then claim refugee status either on arrival or some time after arrival (Department of Labour, 2006). Despite the 1951 Refugee Convention making no distinction between refugees who are accorded status by the UNHCR overseas, and those who arrive in a territory and apply for asylum (Bogen & Marlowe, 2017), quota refugees and convention refugees are

differentiated in New Zealand. They are treated differently both in law and in practice (Bloom & Udahemuka, 2014).

Asylum seekers have to traverse the 'refugee status determination' process to be recognised as refugees. The refugee status determination is the legal or administrative process by which governments or UNHCR determine whether a person seeking international protection is a refugee under international, regional or national law (UNHCR, 2005). Through the refugee status determination process, determination authorities establish if a person who has submitted a claim for refugee status or otherwise expressed the need for international protection is indeed a refugee. A recognition decision that the person is a refugee is declaratory: that is, it acknowledges and formally confirms that the individual concerned is a refugee (UNHCR, 2005).

In New Zealand, asylum seekers must establish that they meet the universal definition of a refugee as codified in the Immigration Act 2009 (Brookers Ltd, 2010). The Immigration Act 2009 (the Act) sets out the refugee and protection decision-making framework. It incorporates into legislation the Refugee Convention and codifies New Zealand's existing immigration-related protection obligations under CAT 1984 and ICCPR 1966 (Brookers Ltd, 2010; Department of Labour, 2011). The Act also sets out clear processes and protocols for managing claims for refugee and protection status.

Requests for asylum in New Zealand are assessed in the first instance by designated Refugee and Protection Officers at the Refugee Status Branch (RSB) of Immigration New Zealand (Ministry of Justice, 2016; Refugee Health and Screening Service, 2016). It takes approximately three months from the lodgement of the claim to the release of the decision at the RSB (Immigration New Zealand, 2015a). Declined claims can be appealed to the Immigration and Protection Tribunal (IPT) of the Ministry of Justice. The IPT assesses refugee and protection appeals on a de novo basis (Department of Labour, 2011; Ministry of Justice, 2016; Refugee Health and Screening Service, 2016). It takes approximately 12 months from the receipt of an appeal to the release of a decision by IPT (Spiller, 2016; 2015; 2014). Figure 1 illustrates the refugee status determination process in New Zealand.



Source: MBIE (2015b, p. 2)

Figure 1: Illustration of the refugee status determination process

Asylum claimants who are unsuccessful on appeal are liable for deportation from New Zealand (Ministry of Justice, 2016). Successful asylum claimants have a pathway to New Zealand permanent residency and citizenship, even though it is not guaranteed that these will be granted (Bloom et al., 2013; Department of Labour, 2011; MBIE, 2015). Table 2 shows the top 10 source countries of convention refugees and protected persons who were granted permanent residence in New Zealand from 2010 to 2015 (MBIE, 2015).

Table 2: Convention refugees and protected persons granted residence by source country, 2010-2015

Source country	**2010 to 2015**
Iran	126
Pakistan	101
China	95
Iraq	66
Sri Lanka	65
Afghanistan	56
Fiji	44
Saudi Arabia	34
Syria	29
Egypt	25
Other countries	253
Total	**894**

Source: MBIE (2015, p. 63)

In practice, asylum seekers in the community, apply for and are usually granted temporary work visas by Immigration New Zealand while their refugee status claim is being processed. Asylum seekers in detention because of national security/public safety concerns do not have these opportunities (Bloom & Udahemuka, 2014; Department of Labour, 2011; MBIE, 2015b).

While in the community, the support services available to asylum seekers/convention refugees are not equivalent to that accessible by quota refugees. Inequalities exist in several areas including orientation and settlement support, housing, health care, employment support and others (Bloom et al., 2013). Table 3 shows the disparities in support between asylum seekers/convention refugees and quota refugees.

Asylum seekers in New Zealand can be categorised into three categories:

1. The asylum seeker who is in the process for the first time at the RSB or has been declined by the RSB and is appealing for the first time at the IPT (asylum seeker with a pending decision or asylum seeker still in process).

2. The asylum seeker who has been declined both at first instance by the RSB and declined on appeal by the IPT (failed asylum seeker or declined asylum seeker).
3. The asylum seeker who has had a positive outcome in the claim for refugee status (approved asylum seeker or convention refugee).

This thesis includes all three categories of asylum seekers.

Table 3: Processes and entitlements between asylum seekers/convention and quota refugees.

Asylum seekers/convention refugees	Quota refugees
Have been determined to be refugees in accordance to the criteria set out in the Immigration Act 2009.	Have been determined to be refugees in accordance to the criteria similar to those set out in the 1951 Refugee Convention by the UNHCR according to the UNHCR Statute (or acting partners) in refugee camps or other refugee populated areas.
Are outside their country of origin and have entered another country to seek protection and asylum.	Are outside their country of origin and have entered another country to seek protection and asylum.
'Self-referred' i.e. applied for refugee status upon arrival in New Zealand (or some time after).	Referred by the UNHCR for resettlement. Selected by the New Zealand Government while offshore.
Must apply for permanent residency after recognition of refugee status; permanent residency is not guaranteed.	Are granted permanent residency by the New Zealand Government before resettlement in New Zealand.
Secure their own accommodation on arrival at own cost, unless: -Housed at the asylum seekers' hostel in Auckland which is ran by the Asylum Seeker Support Trust. -Detained or released on conditions to the Mangere Refugee Resettlement Centre (MRRC). -Detained in prison (depending on security concerns).	Are provided with free food and accommodation and fully supported for their first six weeks in New Zealand at the MRRC; after this period given priority social housing, New Zealand Red Cross Services (NZRCS) assist refugees in securing social housing or affordable private rentals.
Eligibility and access to fee-free English language study is ad hoc.	Receive six weeks of free language training while at MRRC and are then entitled for up to 12 hours a week for two years.
Receive no introductory programme to New Zealand culture.	Receive an orientation to New Zealand programme upon arrival while at MRRC.
Are provided with legal aid to apply for refugee status.	Receive the support of agencies at the MRRC: AUT University; Refugee Health Screening Service; Refugees as Survivors New Zealand (RASNZ); and NZRCS
Are unassisted in their day to day lives while applying for refugee status or for permanent residency.	Receive support from NZRCS for the first 12 months of resettlement in the form of: - Advocacy and support (social, case, cross-cultural workers, volunteers). - Housing needs (that is, the provision of furniture and housing advocacy).
Must make own appointment with WINZ and apply for assistance.	Families and individuals go through WINZ application process during six

	weeks at MRRC and/or when in community with support of NZRCS staff and volunteers.
Eligible for emergency benefits or assistance and may be entitled for temporary additional support and re-establishment grant through WINZ. All border claimants released to the community on conditions are entitled to financial assistance of $85 per week administered by Immigration New Zealand for the duration of their claim.	Entitled to job seeker benefit and re-establishment grant, in addition to accommodation supplement and childcare subsidies; may be entitled to temporary additional support through WINZ.
Have no access to the New Zealand labour market or emergency assistance unless they have a work visa.	Are entitled to work immediately upon arrival (see above).
Must regularly apply for - and renew - work visas until permanent residency has been achieved or finally declined; period of time that work visas cover are administered at Immigration Officer's discretion - may be 3 months, 6 months, or 12 months.	Automatic permanent residency status secures entitlement to work in New Zealand.
Usually takes time to apply for and obtain a community services card, Inland Revenue Department number (IRD number).	Application for Community Services Card, IRD number organised by support staff at MRRC.
Are responsible for legal fees and associated costs of applying for permanent residency.	Permanent residency granted by New Zealand Government prior to arrival in New Zealand at no cost.
Responsible for own costs.	Free meals and board provided for first six weeks until moved into the community.
Do not have access to comprehensive healthcare.	Entitled to free and subsidised comprehensive healthcare.

Source: Bloom et al. (2013, p. 19)

2.1.5 Definition of migrant

In this section, I define 'migrant' and describe the differences between a refugee and a migrant. The UNHCR describes a migrant as any person who moves, usually across an international border, to join family members already abroad, to search for a livelihood, to escape a natural disaster, or for a range of other purposes (UNHCR, 2016b). Migrants choose to move not because of a direct threat of persecution or death, but mainly to improve their lives by finding work, or in some cases, for education, family reunion, or other reasons. Unlike refugees who cannot safely return home, migrants face no such impediment to return. If they choose to go home, they will continue to receive the protection of their government (Edwards, 2015). Refugees flee their country of origin to save their life or preserve their freedom (Edwards, 2015; UNHCR, 2016b).

The UNHCR note however that refugees and migrants often employ the same routes, modes of transport, and networks (UNHCR, 2016b), and this can lead to both words

being used interchangeably and incorrectly in public and media discourse (Edwards, 2015). The large numbers of boat peoples arriving in Greece and Italy via the Mediterranean Sea in 2016 were a mixture of both refugees and migrants (Magyar, 2016); but they encountered the same deterrent measures from some of the destination countries, regardless of whether they were refugees or migrants.

In the Asia-Pacific region for example, Australia adopted a hard-line approach in 2013 to stem the flow of boat migrants and asylum seekers by transferring them to other overseas territories (Refugee Council of Australia, 2016; The New York Times, 2015). Likewise in 2015, several countries in Europe mounted fences along their borders to stop both migrants and asylum seekers from entering their territories (Batchelor, 2015; Friedman, 2016). In January 2017, the President of the United States of America (USA) signed executive orders for a wall to be built on the border between the USA and Mexico to stem the flow of asylum seekers and migrants from Central and South America (Davis, 2017; Diamond, 2017; Smith, 2017). The increasing trend in deterrent measures for both refugees and migrants and the failure to uphold their human rights by some of the member states of the United Nations has prompted the United Nations General Assembly (2016) to draft a document addressing the human rights for large movements of refugees and migrants. Table 4 shows the differences between migrants and refugees.

Table 4: Differences between migrants and refugees

Migrants	Refugees
Migrants choose to leave their homeland and settle in a country of their choice. They arrange the most suitable method of travel and pack the possessions they wish to take. They can sell or dispose of possessions they do not wish to take.	Refugees do not choose to leave their homeland. They flee in response to a crisis. They have little choice about where they go and by what means they will travel. They have no time to pack or to distribute possessions. Almost everything is left behind.
Migrants have time to prepare emotionally for their departure and to farewell friends and family appropriately.	Refugees, due to their quick and often secret departure are unprepared emotionally for leaving, and may not have time to farewell loved ones.
Migrants take with them their travel documents, passports, and other documentation, including educational qualifications.	Refugees often flee without any documentation whatsoever.
Migrants usually emigrate with their families.	Refugees must often leave family members behind, or lose track of them during flight.
Migrants depart for their new country knowing that they can return to their homeland for visits, or return permanently if they cannot settle.	Refugees, although they dream of returning home, know that this is unlikely to happen.
Migrants are usually well-prepared and well-motivated to settle in a new country. Many will have found out about schools, employment and local conditions before they left their homeland.	Refugees arrive in their new country ill-prepared and often traumatised. They have little in the way of possessions and financial resources. They are often debilitated by a pervading sense of loss, grief, worry and guilt about the family left behind.
Migrants, due to their better levels of health, education and economic independence, are less likely to encounter negative attitudes in their resettlement country.	Refugees may experience stigma and prejudice in their resettlement country about cultural differences, disease prevalence, low education levels and perceived burdening of the welfare system.

Source: Department of Labour (2006, p. 2).

It is worth noting from the foregoing that in same manner that the words refugee and migrant are used exchangeable and often incorrectly, so too are the words refugee and asylum seeker. For instance, while the individuals in large movements who are escaping persecution, war and other similar situations are generally referred to as refugees (as in the case of Syrian refugees or Iraqi refugees fleeing from the oppressive regime in Syria, and/or the Islamic State of Iraq and Syria (ISIS)), they are in fact asylum seekers until they have been accorded recognition as refugees under international, regional or national law (UNHCR, 2005).

2.2 An overview of the global refugee crisis

In this section, I provide an overview of the global refugee crisis. I discuss the sources and destinations of the world's refugees and asylum seekers.

Over the last decade, a record number of peoples have fled their homes to seek refuge and safety elsewhere because of persecutions, conflicts, generalised violence or human rights violations (UNCHR, 2015a). By the end of 2014, an estimated 59.5 million peoples were forcibly displaced in the world, compared to 51.2 million a year earlier, and 37.5 million a decade earlier (UNCHR, 2015a). At the end of 2016, the number had risen to 65.3 million individuals. They include refugees, asylum-seekers and internally displaced peoples (UNHCR, 2015b).

2.2.1 World's refugees

2.2.1.1 Overview

The total number of the world's refugees has been on a rise over the past five years. The global number of refugees under UNHCR's mandate was estimated at 10.4 million by the end of 2011. The number increased to 10.5 million in 2012, then to 11.7 million in 2013, and to 14.4 million in 2014 (UNHCR, 2015f). By the end of 2015, it had reached an estimated 16.1 million, the highest level in the past 20 years (UNCHR, 2016c).

2.2.1.2 Countries of origin of refugees

The main contributing factor to the increase in the number of refugees has been the war in the Syrian Arab Republic (UNCHR, 2016c). There were also significant outflows of refugees from armed conflicts or deterioration of on-going ones in Afghanistan, Burundi, the Democratic Republic of the Congo, Mali, Somalia and South Sudan (UNCHR, 2016c; UNHCR, 2015f). Table 5 presents the top 50 countries of origin of refugees in the world by the end of 2015.

Table 5: Country of origin of refugees and asylum seekers by 31 December 2015

Country or territory of origin	Refugees	People in refugee-like situations	Total	Rank	Asylum seekers	Rank
Syria	4,850,792	21,793	4,872,585	1	245,844	2
Afghanistan	2,662,954	3,300	2,666,254	2	258,892	1
Somalia	1,123,022	30	1,123,052	3	56,772	12
South Sudan	778,629	68	778,697	4	4,237	58
Sudan	622,463	6,307	628,770	5	45,102	16
Dem. Rep. of Congo	541,291	208	541,499	6	76,418	5
Central African Rep.	471,104	-	471,104	7	10,668	37
Myanmar	198,685	253,122	451,807	8	60,659	8
Eritrea	379,766	31,576	411,342	9	63,446	7
Colombia	90,836	249,404	340,240	10	6,905	49
Ukraine	321,014	286	321,300	11	22,574	24
Vietnam	313,155	1	313,156	12	4,372	56
Pakistan	277,344	20,491	297,835	13	64,085	6
Burundi	292,764	-	292,764	14	26,893	22
Rwanda	286,366	-	286,366	15	10,957	36
Iraq	261,107	3,000	264,107	16	237,166	3
China	212,911	-	212,911	17	57,705	9
Nigeria	152,136	15,852	167,988	18	51,863	14
Mali	154,211	-	154,211	19	9,906	40
Sri Lanka	121,435	-	121,435	20	14,869	28
Western Sahara	90,541	26,000	116,541	21	1,446	87
Palestinians	97,973	-	97,973	22	4,338	57
Ethiopia	85,834	-	85,834	23	77,924	4
Iran	84,949	-	84,949	24	57,084	11
Côte d'Ivoire	71,105	-	71,105	25	13,788	31
Russian Federation	67,050	-	67,050	26	27,514	20
Turkey	59,559	-	59,559	27	12,104	34
Serbia and Kosovo	38,273	364	38,637	28	53,309	13
Haiti	34,774	-	34,774	29	9,272	42
Mauritania	34,664	-	34,664	30	7,485	46
Croatia	33,451	-	33,451	31	90	133
Ghana	22,978	-	22,978	32	10,965	35
Zimbabwe	21,344	-	21,344	33	57,431	10
Senegal	21,280	-	21,280	34	14,318	30
Bosnia and Herzegovina	18,748	21	18,769	35	7,023	48
Egypt	17,930	-	17,930	36	12,168	33
Bhutan	17,720	-	17,720	37	227	114
Guinea	17,005	-	17,005	38	17,886	26
Yemen	15,896	-	15,896	39	10,075	39
Tibetan	15,071	-	15,071	40	8	178
Chad	14,940	-	14,940	41	3,293	64
Congo, Republic of	14,781	-	14,781	42	4,121	59
El Salvador	14,778	-	14,778	43	31,454	18
Indonesia	9,261	4,695	13,956	44	2,652	70
Cambodia	12,799	4	12,803	45	376	105
Bangladesh	12,172	1	12,173	46	30,798	19
Angola	11,869	-	11,869	47	3,270	65
Mexico	11,333	-	11,333	48	46,253	15
Armenia	11,218	-	11,218	49	8,502	44
Cameroon	10,581	-	10,581	50	7,409	47
Other countries (159)	224,450	1,011	225,461		304,247	
Stateless	37,426	-	37,426		18,609	
Various/unknown	120,155	-	120,155		1,035,169	
Total	**15,483,893**	**637,534**	**16,121,427**		**3,219,941**	

Source: Refugee Council of Australia (2016)

2.2.1.3 Refugee hosting countries

By the end of 2015, Sub-Saharan Africa was host to the largest number of refugees (4.4 million) (UNCHR, 2016c). The European region hosted slightly fewer - just below 4.4 million. The Asia and Pacific regions hosted 3.8 million refugees, followed by the Middle East and North Africa regions, with about 2.7 million refugees. The America region hosted 746,800 refugees (UNCHR, 2016c). Refugees resided in over 175 countries or territories in the world (Refugee Council of Australia, 2016; UNCHR, 2016c). Table 6 shows the top 46 refugee hosting countries in the world by 31 December 2015. Some of the countries that hosted the largest number of refugees in regions of the world by the end of 2015 were

- Turkey and Germany in Europe
- Ethiopia and Kenya in Africa
- Pakistan and China in Asia
- Lebanon and Iran in Middle East
- United States of America and Venezuela in America
- Australia in Pacific.

Table 6: The top 46 refugee hosting countries by 31 December 2015

Refugee hosting countries	Refugees	People in refugee-like	Total	Rank
Turkey	2,541,352	-	2,541,352	1
Pakistan	1,561,162	-	1,561,162	2
Lebanon	1,070,854	-	1,070,854	3
Iran	979,437	-	979,437	4
Ethiopia	736,086	-	736,086	5
Jordan	664,118	-	664,118	6
Kenya	553,912	-	553,912	7
Uganda	477,187	-	477,187	8
Dem. Rep. of Congo	383,095	-	383,095	9
Chad	369,540	-	369,540	10
Cameroon	327,121	15,852	342,973	11
Germany	316,115	-	316,115	12
Russian Federation	314,506	-	314,506	13
Sudan	309,639	-	309,639	14
China	301,052	-	301,052	15
Iraq	277,701	-	277,701	16
United States	273,202	-	273,202	17
France	273,126	-	273,126	18
Yemen	267,173	-	267,173	19
South Sudan	263,016	-	263,016	20
Afghanistan	237,069	20,485	257,554	21
Bangladesh	31,958	200,000	231,958	22
Egypt	212,500	-	212,500	23
Tanzania	211,845	-	211,845	24
India	201,381	-	201,381	25
Venezuela	6,694	167,060	173,754	26
Sweden	169,520	-	169,520	27
Rwanda	144,737	-	144,737	28
Canada	135,888	-	135,888	29
Niger	124,721	-	124,721	30
United Kingdom	123,067	-	123,067	31
South Africa	121,645	-	121,645	32
Ecuador	53,191	68,344	121,535	33
Italy	118,047	-	118,047	34
Thailand	55,145	53,116	108,261	35
Algeria	94,182	-	94,182	36
Malaysia	94,030	136	94,166	37
Netherlands	88,536	-	88,536	38
Mauritania	51,394	26,000	77,394	39
Switzerland	73,336	-	73,336	40
Austria	72,216	-	72,216	41
Burundi	53,363	-	53,363	42
Norway	50,389	-	50,389	43
Congo, Republic of	44,955	-	44,955	44
Israel	361	38,139	38,500	45
Australia	36,917	-	36,917	46
Other countries (130)	617575	48,402	665811	
Total	**15,483,893**	**637,534**	**16,121,427**	

Source: Refugee Council of Australia (2016)

2.2.2 World's asylum seekers

2.2.2.1 Overview

As with the increase in refugees, the number of people seeking asylum in the world have been on the rise since 2011 (UNCHR, 2014). An estimated 866,000 asylum claims were recorded in 2014 in 44 industrialised countries (some 269,400 claims more than in 2013) (UNHCR, 2015b). By mid-2015 asylum claims in 44 industrialised countries were up 78 per cent (993,600) (UNHCR, 2015b), surpassing the all-time high of almost 900,000 that was recorded in 1992 (UNCHR, 2014). At the end of 2015, asylum-seekers in the world submitted a record high number of new claims for refugee status, estimated at two million (UNCHR, 2016c). Germany was the world's largest recipient of new individual asylum claims, with 441,900 claims for refugee status (UNCHR, 2016c).

2.2.2.2 Countries of origin of asylum seekers

The top 10 countries of origin of asylum seekers were located in developing regions. The Syrian Arab Republic was the top source country of asylum seekers at the end of 2015. Afghanistan followed it, then Somalia, South Sudan, Sudan, Democratic Republic of the Congo and Central African Republic (Refugee Council of Australia, 2016; UNCHR, 2016c). Table 5 also comprises the main sources of asylum seekers in the world at the end of 2015.

2.2.2.3 Destination countries of asylum seekers

An estimated 3.2 million peoples in the world were still awaiting decisions on their asylum claims by the end of 2015 (UNCHR, 2016c). Table 7 shows the top 48 countries in the world that registered asylum seekers by 31 December 2015 (Refugee Council of Australia, 2016). The countries that hosted the largest numbers of registered asylum seekers were

- Turkey, Serbia and Kosovo in Europe
- Tanzania and South Africa in Africa
- Lebanon and Jordan in the Middle East
- Malaysia and Japan in Asia
- USA and Brazil in America
- Australia in Pacific.

Table 7: Asylum claimants by country where the claim was lodged, 31 December 2015

Country where the claim was lodged	Individual asylum claims	Group recognition	Temporary protection applications	Total asylum claims	Rank
Turkey	134,826	-	946,790	1,081,616	1
Serbia and Kosovo	578,065	-	-	578,065	2
Germany	476,649	-	-	476,649	3
Hungary	351,565	-	-	351,565	4
Russian Federation	152,489	-	149,550	302,039	5
Sweden	173,845	-	-	173,845	6
United States	135,964	-	-	135,964	7
Tanzania	1,706	123,387	-	125,093	8
South Africa	120,531	-	-	120,531	9
France	118,469	-	-	118,469	10
Austria	89,900	-	-	89,900	11
Uganda	35,922	53,947	-	89,869	12
Sudan	7,116	79,183	-	86,299	13
Italy	83,243	-	-	83,243	14
Ethiopia	943	74,566	-	75,509	15
Rwanda	240	72,844	-	73,084	16
Cameroon	6,023	65,472	-	71,495	17
Lebanon	18,209	407	45,291	63,907	18
Dem. Rep. of Congo	209	62,362	-	62,571	19
Jordan	19,627	23	39,402	59,052	20
United Kingdom	53,345	-	-	53,345	21
Belgium	49,250	-	-	49,250	22
Niger	33	6,886	38,321	45,240	23
Netherlands	45,101	-	-	45,101	24
Switzerland	39,523	-	-	39,523	25
Norway	36,657	-	-	36,657	26
Kenya	15,984	15,807	-	31,791	27
Finland	29,452	-	-	29,452	28
Egypt	23,128	-	5,897	29,025	29
Denmark	22,713	-	-	22,713	30
Malaysia	22,656	-	-	22,656	31
Bulgaria	20,392	-	-	20,392	32
Canada	19,511	-	-	19,511	33
Greece	17,211	-	-	17,211	34
Australia	16,117	-	-	16,117	35
Spain	14,881	-	-	14,881	36
Brazil	14,770	-	-	14,770	37
Poland	12,242	-	-	12,242	38
South Sudan	797	10,530	-	11,327	39
Congo, Republic of	3,150	8,032	-	11,182	40
Japan	10,706	-	-	10,706	41
Pakistan-	8,860	-	-	8,860	42
India	7,215	-	-	7,215	43
Djibouti	6,560	-	-	6,560	44
Somalia	1,270	5,153	-	6,423	45
South Korea	5,711	-	-	5,711	46
Chad	2,617	2,999	-	5,616	47
Syria	5,162	257	-	5,419	48
Other countries (117)	83,721	3,512	3,223	90,456	
Total	**3,094,276**	**585,367**	**1,228,474**	**4,908,117**	

Source: Refugee Council of Australia (2016)

What is concerning about the global data on refugees and asylum seekers is the fact that the UNCHR notes that the increase in a number of wars, conflicts, generalised violence or human rights violations are likely to produce more refugees, asylum seekers, and internally displaced peoples (UNCHR, 2015a; UNCHR, 2015b; UNCHR, 2015c). Even more concerning is the fact that the number of asylum seekers and refugees able to return to their country of origin has trended downward, indicating that many asylum seekers and refugees will continue to reside in exile for years to come (UNHCR, 2015f). Thus, people who became asylum seekers and refugees in 2015 and beyond, have lower chances of returning to their homes than at any time in the past 30 years (UNHCR, 2015b).

Following this assertion, it can be argued therefore that it is unlikely that many asylum seekers in industrialised countries will return voluntarily to their country of origin. Thus, there is a compelling need for asylum/refugee hosting countries (New Zealand included) to review their refugee status determination process to enable asylum seekers to receive sufficient and timely support with coping and acculturation. This is particularly important given that the refugee communities in New Zealand have highlighted that refugees and their communities can experience complex and long-term challenges when their needs are not met early enough or are met insufficiently (Auckland Refugee Community Coalition, 2015).

2.3 Impact of the refugee crisis on New Zealand

In this section, I discuss the impact of the global refugee crisis on New Zealand. Although New Zealand is distant from Africa and Europe where there are mass movements of refugees, the effects of the growing number of refugees have also been felt in New Zealand. The mass migrations of Syrians and other refugees in treacherous conditions in the Mediterranean Sea and across newly mounted borders in Europe in the period leading to 2016 resulted in unprecedented exposure of New Zealanders to the refugee crisis via the media (Auckland Refugee Community Coalition, 2015). The media exposure generated dialogue in the New Zealand Parliament, and the public, for the government of New Zealand to welcome more refugees into the country (Amnesty International, 2015; Bonnett, 2016; Collins, 2016; Little, 2016; Roche, 2016; Woodhouse, 2015). It led to initiatives in New Zealand communities investigating how asylum seekers and refugees could be supported appropriately (Auckland Refugee Community Coalition, 2015).

An example of the dialogue and community initiatives on the refugee crisis includes a symposium that was held on 10 September 2015. It was titled *'Asylum-Seekers: The New Zealand Experience'*. The symposium was organised by the New Zealand Centre for Human Rights Law, Policy and Practice. On 5 March 2016, the Refugee Council of New Zealand (RCNZ) organised a consultative meeting with civil society in Auckland. The aim of the meeting was to discuss critical issues relating to the refugee status determination process and support services for asylum seekers. The meeting was preceded by a meeting organised by RCNZ with asylum seekers and their communities on the same issue.

Contemporaneously, there were voices in the community calling on the New Zealand Government to increase the refugee quota in the wake of the Syrian refugee crisis. The climax of this movement was a delivery of a petition from 20,000 New Zealanders to the Parliament of New Zealand calling for the refugee quota to be doubled. The petition was received by the Government including Members of Parliament from other political parties such as the United Future New Zealand, ACT New Zealand, New Zealand Labour Party, and the Green Party of Aotearoa New Zealand (Little, 2016; Moir, 2016; Roche, 2016).

Furthermore, a nation-wide candlelit vigil was also held on the 10 September 2016, where thousands of New Zealanders had a moment of silence for the lives lost by people in refugee-like situations. Attendees lit candles for the additional lives that could have been saved had the government of New Zealand doubled the number of refugees it admits into the country for resettlement (Amnesty International, 2015). There were discussions as well in the media calling on the Government of New Zealand to increase its intake of refugees (Bonnett, 2016: Collins, 2016).

In response to the pressure from community initiatives and the public, on 7 September 2015 the Government announced that New Zealand would welcome an additional 750 Syrian refugees over two and a half years (Woodhouse, 2015). Another announcement was made on 13 June 2016 that from 2018, the Government will increase the size of its Refugee Quota Programme from 750 to 1000 places per year (Woodhouse, 2016).

These examples demonstrate that the increase in the number of refugees in the world and the plights they face are not only a foreign affair. This study fits within the scope of an evolving discourse on the global refugee crisis and the increasing need for governments to support refugees. It seeks to contribute useful knowledge about the

ways in which asylum seekers cope with stress from the refugee status determination process.

2.4 New Zealand's asylum seeker population compared to the rest of the world

In this section, I compare New Zealand's approval rate of asylum claims to Australia's and some European countries.

Despite an unprecedented increase in the number of peoples who have sought asylum elsewhere in the world over the past decades, the levels have remained stable at some 300 claims annually in New Zealand (Table 8).

Table 8: Top ten Refugee Status Branch claims by origin and financial year, 2005 to 2015

Nationality	2005/06	Nationality	2006/07	Nationality	2007/08	Nationality	2008/09	Nationality	2009/10
Iran	31	China	38	Iraq	47	Iran	28	Fiji	57
Iraq	28	Iran	32	Sri Lanka	36	Sri Lanka	24	Sri Lanka	34
Bangladesh	23	Iraq	28	Iran	22	China	23	Iran	30
India	20	Sri Lanka	20	China	16	Fiji	23	China	25
Czech Republic	19	Bangladesh	17	Malaysia	11	Iraq	17	India	24
China	18	India	12	Zimbabwe	10	Czech Republic	14	Iraq	24
Sri Lanka	17	Czech Republic	9	Bangladesh	9	India	12	Czech Republic	22
Somalia	15	Fiji	7	Pakistan	9	Bangladesh	10	Pakistan	18
Romania	12	Pakistan	7	Fiji	8	Syria	10	South Africa	18
Zimbabwe	10	Zimbabwe	7	Myanmar	8	Malaysia	7	Slovakia	16
Others	124	Others	67	Others	91	Others	78	Others	114
Total Claims	**317**	**Total Claims**	**244**	**Total Claims**	**267**	**Total Claims**	**246**	**Total Claims**	**382**

Nationality	2010/11	Nationality	2011/12	Nationality	2012/13	Nationality	2013/14	Nationality	2014/15
Fiji	50	Iran	35	Sri Lanka	36	Sri Lanka	41	China	27
Iran	44	Fiji	34	Iran	33	China	26	Fiji	27
China	20	China	32	Fiji	26	Fiji	25	Pakistan	25
Sri Lanka	20	Pakistan	25	Pakistan	20	Pakistan	19	Sri Lanka	20
South Africa	17	Egypt	18	Saudi Arabia	20	Turkey	15	Iran	17
Bahrain	16	Sri Lanka	18	China	18	Syria	13	India	15
Pakistan	15	Czech Republic	12	Afghanistan	12	India	11	Libya	14
Afghanistan	12	Bangladesh	9	Czech Republic	12	Iraq	11	Colombia	12
Iraq	12	Syria	9	Bangladesh	11	Afghanistan	10	Syria	12
Saudi Arabia	11	Turkey	8	Iraq	11	Egypt	7	Afghanistan	11
Others	116	Others	103	Others	107	Others	109	Others	148
Total Claims	**333**	**Total Claims**	**303**	**Total Claims**	**306**	**Total Claims**	**287**	**Total Claims**	**328**

Source: MBIE (2016)

New Zealand's total number of asylum seekers is substantially fewer than other countries in the Organisation for Economic Cooperation and Development (OECD) with similar size of national populations (Table 9).

Table 9: Number of asylum claims in New Zealand, Ireland and Norway, 2010 to 2015

Country	National population	2010	2011	2012	2013	2014	Total
New Zealand	4 509 700	340	310	320	290	290	**1550**
Ireland	4 609 600	1940	1290	940	950	1440	**6560**
Norway	5 137 000	9220	8680	10690	13280	12640	**54510**

Source: UNHRC (2015d)

Besides the relatively low and stable number of asylum claims processed annually in New Zealand, the approval rates of the refugee status is low, sitting around 26% at first instance at the Refugee Status Branch of Immigration New Zealand (RSB) (MBIE, 2016) (Table 10).

Table 10: Percentage of asylum claims approved at the RSB between 2005 and 2014

Year	Decisions	Declined	Approved	Percentage
	n	n	n	%
2005/06	340	272	68	20.0
2006/07	278	212	66	23.7
2007/08	277	196	81	29.2
2008/09	242	170	72	29.8
2009/10	335	244	91	27.2
2010/11	289	250	39	13.5
2011/12	363	244	119	32.8
2012/13	321	235	86	26.8
2013/14	287	218	69	24.0
2014/15	285	185	100	35.1
Totals	**3017**	**2226**	**791**	**26.2**

Source: MBIE (2016)

Among the declined claimants who lodge an appeal, around 42% will be approved by the Immigration and Protection Tribunal of the Ministry of Justice (IPT) (Hastings, 2012; Hastings, 2011; Spiller, 2016; 2015; 2014) (Table 11).

Table 11: Percentage of asylum claims approved on appeal at the IPT, 2010 to 2016 (June to June)

Year	Total	Allowed	Percentage
	n	n	%
2010/11	62	27	43
2011/12	150	63	42
2013/14	121	53	44
2014/15	191	81	42
2015/16	147	52	35
Mean			**42.2**

Source: Hastings (2012); Hastings (2011); Spiller (2016); Spiller (2015); Spiller (2014).

The overall success rate for asylum seekers claimants in New Zealand (when RSB and IPT decisions are combined) is somewhat similar to Australia. For example, in 2011 to 2012, asylum claimants arriving by plane in Australia were 25% successful at first instance and 44% on appeal (on review). In that same year, the rates of success for asylum claimants arriving by boat in Australia were 71.1% at first stance and 91% on review. However, when combined, the success rate after primary claim and review of all asylum seekers (boat and plane arrivals) in Australia was 67.7% in 2011 to 2012 (Reilly, 2013). In that same 2011 to 2012 period the combined RBS and IPT success rate for asylum seekers in New Zealand was 74.8%.

There seems to be a significant disparity with New Zealand's approval rate of asylum claims compared to some European countries. In 2015, for example, at an approval rate of 35.1% at first instance, New Zealand was low compared to Bulgaria where asylum seekers recorded a 91% positive outcome at first instance decisions. Denmark and Malta also had approval rates around 75% at first instance. Bulgaria and Finland had approval rates around 50% at the appeal (final instance) (Eurostat Statistics Explained, 2016), which was higher than New Zealand's 42%.

On the other hand, New Zealand's approval rate of asylum claim was much higher than Latvia, Hungary and Poland, which recorded approval rates below 16% at first instance in 2015. Likewise, New Zealand scored exceptionally high compared to Estonia, Lithuania and Portugal where all final instance (appeal) decisions were negative (Eurostat Statistics Explained, 2016).

Reilly (2013) notes that caution must be exercised in making comparisons with acceptance (approval) rates of asylum claims between countries. The difference in acceptance rates may have nothing to do with the systems of review of applications.

Refugee-receiving countries around the world are dealing with populations from different regions. The levels of humanitarian crisis differ from country to country. Moreover, even where the types of crisis are similar, asylum seekers from some areas may fit neatly within the United Nation Convention's definition of a refugee and be eligible for state protection, while others may not. Furthermore, the rates of success of asylum seekers from the same country can vary markedly from year to year due to individual country's geopolitical circumstances.

In sum, this review shows that the number of people seeking asylum in New Zealand has been stable over the last decade and is low when compared to rest of the world and with OECD countries of similar sized population. To some extent, New Zealand is on par with Australia in approval rates of asylum claims but is lagging behind countries like Bulgaria and Denmark.

The review shows that the approval rate at the first instance is low (26%), which suggests that most claimants (74%) have to appeal to the IPT. This could be an indication of the stressful nature of the refugee status determination process that asylum seekers have to encounter since a majority of them will have to progress to an appeal.

Moreover, amongst the number that will appeal, only 42% of them are likely to be successful. Unsuccessful claimants would have to endure the stress of awaiting a decision on a humanitarian appeal (if applicable) or deportation (Hastings, 2012; Hastings, 2011; Spiller, 2016; 2015; 2014).

2.5 Sub-Saharan African asylum seekers globally and in New Zealand

In this section I describe the Sub-Saharan African region and identify the sub-regions and countries that make up Sub-Saharan Africa. Data on Sub-Saharan African asylum seekers in the world and New Zealand is reviewed.

2.5.1 Sub-Saharan Africa

Sub-Saharan Africa is the term used to describe the area of the African continent that lies south of the Sahara Desert. Geographically, the demarcation line of Sub-Saharan Africa is on the southern edge of the Sahara Desert (New World Encyclopedia, 2015). Culturally, the dark-skinned peoples south of the Sahara, that make up Sub-Saharan Africa, developed in relative isolation from the rest of the world compared to those

living north of the Sahara, who were more influenced by Arab culture and Islam (New World Encyclopedia, 2015; Essential Humanities, 2016).

The Sub-Saharan African region has several sub-regions and is made up of more than 40 countries (Essential Humanities, 2016; New World Encyclopedia, 2015; The Library of Congress, 2017). Table 12 shows the sub-regions and corresponding countries in Sub-Saharan Africa.

Table 12: The regions and nations of Sub-Saharan Africa

West Africa
Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, the Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Mauritania, and Togo
Central Africa
Cameroon, Chad, Central African Republic, Congo, Equatorial Guinea, Gabon and Sao Tome & Principe
Eastern Africa
Rwanda, Burundi, Comoros, Democratic Republic of Congo (Congo DRC), Djibouti, Ethiopia, Eritrea, Kenya, Madagascar, Seychelles, Somalia, South Sudan, Sudan, Tanzania and Uganda
Southern Africa
Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe

Source: United Nations Economic Commission for Africa (2017)

2.5.2 Sub-Saharan African asylum seekers globally

Wars, conflicts, and poor human situations in some Sub-Saharan African such as Mali, Nigeria, Central African Republic, Democratic Republic of Congo, South Sudan, Somalia, Burundi and others, have led to forced displacements of Africans. It is estimated that the Sub-Saharan Africa region produced 4.4 million refugees by the end of 2015 (UNCHR, 2016c). Thousands of Africans fleeing their national territories submitted asylum claims in other African countries and in 44 industrialised nations in the world (UNHCR, 2015d). By the end of 2014, Eritrea was the leading country in Sub-Saharan Africa where asylum seekers came from with a total of 48,402. It was followed by Nigeria (22,100) and Somalia (19,900) (UNHCR, 2015d). In 2015, Ethiopia (77,924), Democratic Republic of Congo (76,418), Eritrea (63,446), Senegal

(57,431), Somalia (56,772) and Nigeria (51,863), were among the leading sources of asylum seekers from Sub-Saharan Africa (Refugee Council of Australia, 2016).

2.5.3 The Sub-Saharan African asylum seekers in New Zealand

Several hundred Sub-Saharan Africans have lodged claims for refugee status in New Zealand even though it is distant to and somewhat inaccessible from Africa. The majority of asylum claims between 1997 and 2012 came from Zimbabwe (356), followed by Somalia (228) and Nigeria (108). Table 13 shows the origins of the Sub-Saharan African asylum seekers in New Zealand (Immigration New Zealand, 2012).

Table 13: Asylum claimants from Sub-Saharan Africa in New Zealand, 1997 to 2012

Nationality	**1997 to 2012**
Angola	3
Burundi	5
Cameroon	6
Chad	12
Congo	25
D. R. Congo	41
Djibouti	1
Eritrea	13
Ethiopia	86
Ghana	30
Guinea	1
Ivory Coast	1
Kenya	3
Liberia	24
Madagascar	7
Mali	5
Mozambique	2
Namibia	3
Nigeria	108
Rwanda	11
Sierra Leone	48
Somalia	228
South Africa	161
Sudan	40
Tanzania	5
Togo	7
Uganda	12
Zambia	2
Zimbabwe	356
Total	**1,246**

Source: Immigration New Zealand (2012)

It is important to note that the total of 1,246 claims extends over 15 years. Some of the former asylum seekers may have voluntarily left New Zealand, been deported or died. It is worth noting that the total of 1,246 does not include asylum claimants from the period 2012 to 2016. This is because the data is limited by information that Immigration New Zealand has released to the public at the time of this study. There may be hundreds of Sub-Saharan African asylum seekers or former asylum seekers in the community between 2012 and 2017 who have not been included in the data. For example, in 2015 New Zealand processed 22 claims for refugee status from persons from South Africa alone (Immigration New Zealand, 2016d), but this number has not been counted in the 1,246.

Chapter summary

The term 'refugee' has been defined both in the context of New Zealand and globally. Quota refugees and asylum seekers have been discussed as the main categories of refugees in New Zealand, and differences between them highlighted. Differences have also been highlighted between migrants and refugees. Notably, I have identified that this thesis focuses on all three categories of asylum seekers, that is, the asylum seekers with pending decisions or those still in process, failed or declined asylum seekers, and approved asylum seekers or convention refugees.

This chapter has explored as well the impact of the global refugee crisis on New Zealand. I have illustrated that, despite that New Zealand's number of asylum seekers being stable over the past decade, the approval rate is low compared to some of the European countries. I argue also that, because a majority of the asylum seekers in New Zealand have to endure a decline at the first instance and at the appeal, this may suggest that the refugee status determination process is stressful on them. The Sub-Saharan African region has been described and an overview has been presented of the Sub-Saharan African asylum seekers in the world and New Zealand. The next chapter is the literature review.

CHAPTER 3: LITERATURE REVIEW

In this chapter, I review the literature on asylum seekers' experiences in New Zealand. The review focuses as well on the assessment of coping and the use of the Brief COPE scale for this assessment. I have used a narrative overview for the review. A narrative overview is a comprehensive narrative synthesis of previously published information. In narrative overviews, the authors' findings are reported in a condensed format that typically summarises the contents of each article (Johnson, 2006). Some researchers have suggested that a proper narrative overview should critique each study included (DePoy & Gitlin, 1993; Gastel & Robert, 2016). Other authors argue that is not necessary (Helewa & Walker, 2000; Johnson, 2006). In this narrative overview, I subscribe to the latter and critically review only the literature on asylum seekers' experiences in New Zealand.

3.1.1 Method: Search strategy

The literature search aimed to identify empirical research on asylum seekers in New Zealand. Scopus was searched using the following combinations of terms and Boolean operators: 'asylum' AND 'seeker' AND 'refugee' AND 'Zealand' from 1960 through 05 November 2016. The final search was conducted on 5 December 2016. It generated 29 articles. Additionally, I conducted a search on Google and Google Scholar. Three texts were found - all grey literature. I also located and refer to literature from overseas but focused on the New Zealand literature in Table 14.

I screened the articles manually, reviewing the titles and abstracts and applied the following inclusion and exclusion criteria:

3.1.2 Inclusion criteria

- Studies on asylum seekers and convention refugees in New Zealand.
- Studies with accounts of asylum seekers that analyse their words.
- Studies that describe asylum seekers' experiences of refugee status determination process in New Zealand.

- Literature on asylum seekers or convention refugees that have used quantitative, qualitative, or mixed methods research techniques.
- Studies that included a mixed sample of asylum seekers, quota and convention refugees.

3.1.3 Exclusion criteria

- Studies entirely on quota refugees.

By applying these inclusion and exclusion criteria, the literature in Table 14 was identified for the review.

Table 14: Articles on asylum seekers in New Zealand

Focus	Author (Year)	Type of literature	Method	Sample (n)	Description
Media and political discourse					
	Beaglehole (2013)	Book	N/A	N/A	Addresses shifts in refugee political discourse and changes in refugee policies in New Zealand.
	Sulaiman-Hill, Thompson, Afsar and Hodliffe (2011)	Peer reviewed journal article	Literature review (content and thematic analysis).	N/A	Assesses the political climate, public attitudes and overall focus of opinion around refugee and asylum seeker issues in the print media reporting in Australia and New Zealand between 1998 and 2008.
Policy and legislation					
	Beaglehole (2013)	Book	N/A	N/A	As above
	Bloom and Udahemuka (2014)	Peer reviewed journal article	Qualitative	18 asylum seekers/convention refugees. The study also included interviews with key agencies and service providers, as well as reviews of existing policies and procedures for asylum seekers.	The study portrays the lived experience of asylum seekers and explores the extent to which they realise their rights and opportunities to participate in New Zealand. It summarises some of the policies that present challenges for asylum seekers/convention refugees in New Zealand.
	Bogen and Marlowe (2017)	Peer reviewed journal article	Literature review	N/A	A policy analysis about asylum seekers and an examination on the associated discourses in the international context. Addresses the culture of indifference towards asylum seekers in New Zealand, and discusses how the social work profession can respond to this culture through addressing oppressive asylum policies, and the need for stronger advocacy.
	Marlowe and Elliott (2014)	Peer reviewed	Literature review	N/A	Focuses on the understandings of settlement and policy in relation to quota refugees,

		journal article			family reunion refugees and asylum seekers. Advocates settlement policies that ensues all refugees are able to participate as fully as possible in New Zealand society regardless of whether they came via the quota or convention pathways.
	Neumann (2016)	Peer reviewed journal article	N/A	N/A	Discusses Germany, Australia and New Zealand's policy and motives for accepting refugees
	West-Newman (2015)	Peer reviewed journal article	Qualitative	Interviews with twenty Māori participants and reviews law reports, submissions, and case analyses by refugee and human rights lawyers.	Discusses the legal and political management of asylum seekers as they go through the process of acceptance or rejection as residents, and ultimately citizens of New Zealand. Argues that current negative attitudes against asylum seekers could be mitigated by the adoption of the Māori values of manaakitanga to create a more hospitable reception for asylum seekers.
Experiences of asylum seekers and convention refugees					
	Bloom, O'Donovan and Udahemuka (2013)	Report	Qualitative	18 asylum seekers/convention refugees and discussions with five staff from agencies and service providers working with asylum seekers.	Documents the experiences of 18 asylum seekers who have been recognised as convention refugees and of staff from relevant service provision agencies.
	Bloom and Udahemuka (2014)	Peer reviewed journal article	Qualitative	As above	As above
	Department of Labour (2004)	Report	Mixed methods research Face-to-face interviews	398 refugees were interviewed for the research. They fell into two groups. The first group, recently arrived refugees, consisted of	The focus of the research was to describe refugees' resettlement experiences over a broad range of areas including their

			with participants. The interviews were supplemented with material from focus groups.	quota, convention and family reunion refugees who were interviewed after six months in New Zealand (209 people) and then again at two years (162 people). The second group, established refugees, included quota refugees who had been in New Zealand for around five years (189 people).	backgrounds, the information they had about New Zealand prior to arrival, their arrival experiences, housing, getting help, family reunification, health, learning English, adult education, labour force and other activities, financial support, children and teenagers, social networks, discrimination, cultural integration and settling in New Zealand.
	Young and Mortensen (2003)	Peer reviewed journal article	Case study	Asylum seeker (1)	Focuses on the experience of an unaccompanied Afghani minor (13 years) old asylum seeker in the emergency department in a hospital in Auckland.
	Uprety, Basnwet and Rimal (1999)	Report	Mixed methods research: Quantitative (analysed patients' records, as filed, dating from 1992 to October 1998). Also gathered qualitative information from a conference on refugee and asylum seekers' health.	Asylum seekers and refugees (sample number = N/A)	The study focuses on the health needs of asylum seekers and refugees for early intervention. It analysed relevant information, available through patient records, in order to identify any actual or potential mismatch between health care facilities available to asylum seekers.
Services					
	Te Pou (2010)	Report	N/A	N/A	Focuses on therapeutic guides for mental health and addiction practitioners working with refugees, asylum seekers and new migrants.

3.2 A narrative overview of literature on asylum seekers in New Zealand

The literature on asylum seekers and convention refugees in New Zealand can be categorised into four groups:

- Media and political discourse about asylum seekers and convention refugees.
- Policy and legislation to deter asylum seekers.
- Experiences of asylum seekers and convention refugees as they go through the refugee status determination process and settlement in New Zealand.
- Service delivery for asylum seekers.

3.2.1 Media and political discourse

This section reviews the literature about the media and political environment that asylum seekers are immersed in when they arrive in New Zealand. Bogen and Marlowe (2017) note that, in the many occasions where issues concerning asylum seekers are covered in the press and political discourse, the attention given is most often negative. A position also held by West-Newman (2015) who analysed New Zealand news media reporting on refugees since 2000 and found two dominant narratives. There was the good news about generous communities receiving new arrivals. However, this was relatively rare. Then to a large extent, there were the negative reports of people-smuggling, criminal convictions and cancellations of refugee status before deportation (West-Newman, 2015). The rhetoric on asylum seekers in the media and political discourse in New Zealand and across many countries was largely described as concerning (Bogen & Marlowe, 2017; West-Newman, 2015; Sulaiman-Hill, Thompson, Afsar & Hodliffe, 2011).

International research has demonstrated that news stories have a significant influence on the formation of public attitudes toward asylum seekers and refugees (O'Doherty & Lecouteur, 2007; Sulaiman-Hill et al., 2011). Thus, politicians and the media promote division and panic through a discourse constructed around notions of queue-jumpers, illegals, boat peoples, bogusness, invasion and swamping (Briskman & Cemlyn, 2005). A political language, for example, with intended negative implications on asylum seekers was a press release that announced the 2013 Immigration Amendment Act in New Zealand. In the release, the immigration minister Michael Woodhouse emphasised that New Zealand was a growing target for boats from Asia (Bogen & Marlowe, 2017).

Bogen and Marlowe (2017) argue that the Minister's language was clearly chosen as a deterrent and connects the mass arrival of asylum seekers to people smugglers. The media release focused as well on the potential risks to public safety and national security and did not mention the vulnerable and traumatic plights of asylum seekers, nor the country's obligations under the 1951 Refugee Convention (Bogen & Marlowe, 2017).

Media and political discourse also exacerbate public fears through discourse that labels asylum seekers as dangerous, dishonest, destitute, and deviant (Bogen & Marlowe, 2017; Sulaiman-Hill et al., 2011). This narrative intensifies issues of discrimination and the settlement difficulties for asylum seekers and consequently increases their vulnerabilities in the community (Bogen & Marlowe, 2017; Pickering & Lambert, 2001). The hostile political attitudes against asylum seekers represents a trend that is seen lately in many Western regions including Australia, United Kingdom (UK), Europe and North America (Bloch & Schuster, 2002; Gale, 2004; Malloch & Stanley, 2005; Neumann, 2016; O'Doherty & Lecouteur, 2007; Pickering, 2001; Pugh, 2004; Sulaiman-Hill et al., 2011). Gale (2004) notes that this fear against asylum seekers was escalated by the September 11, 2001 incident as some of the perpetuators of the terrorist attack were asylum seekers.

3.2.2 Policy and legislation

This section reviews the literature on policy and legislation, and how this has been used as a deterrent for asylum seekers and convention refugees, leaving them in a more disadvantaged position in the community compared to their counterparts - quota refugees.

The New Zealand government has passed increasingly deterrent and punitive legislation concerning asylum seekers; a trend preceded by the UK, Australia and most recently the European Union (Bogen & Marlowe, 2017): and currently - the USA. The Immigration Act 2009 and Immigration Amendment Act 2013 represent the New Zealand government's response to international events and concerns of the new millennium (West-Newman, 2015). The legislations are used as a weapon to dissuade potential asylum seekers (and people smugglers) from choosing New Zealand as an attractive place for refuge (Bogen & Marlowe, 2017).

West-Newman (2015) asserts that, as in other larger and more influential Western nations, policy and practice in New Zealand has arguably been driven by fear and

shaped through ethnic stereotyping that reflects perceptions of threat from dangerous strangers, despite the absence of local empirical evidence to that effect. Marlowe and Elliott (2014) as well as Bloom and Udahemuka (2014) advocate for settlement policies that ensure all refugees are able to participate as fully as possible in New Zealand society regardless of whether they came via the quota or convention pathways.

3.2.3 Experiences of asylum seekers and convention refugees

Besides the media and political discourses, and the use of policy and legislation as a deterrent for asylum seekers, few scholars have explored the experiences of asylum seekers as they go through the refugee status determination process in New Zealand. As this is the focus of this study, the relevant papers and reports are critically reviewed. The studies are Bloom et al. (2013), Bloom and Udahemuka (2014), Department of Labour (2014), Young and Mortensen (2003), and Uprety et al. (1999). Although there are five studies in this list, in actual fact, there are four studies. Bloom et al. (2013), and Bloom and Udahemuka (2014) are essentially the same study. The study was first published as a report under Bloom et al. (2013), and then was subsequently published as a peer reviewed journal article under Bloom and Udahemuka (2014). In the sub-section that follows, I review the methodologies of each of the studies and assess their trustworthiness or rigour (where relevant). The results of the studies are reviewed in another sub-section.

3.2.1.1 Methodology, trustworthiness and rigour of the studies on the experiences of asylum seekers in New Zealand

Bloom and Udahemuka (2014) is a qualitative study on the experiences of 18 asylum seekers/convention refugees, comprising eight women and 10 men. The study included interviews with key agencies and service providers, as well as a review of policies and procedures for asylum seekers. The participants were over 18 years of age. They came from a range of countries from within Africa, Asia, Europe and the Middle East. The participants were recruited through snowball sampling/third party recruitment methods.

Given that it is a qualitative research, and the scope of the research in terms of sample size, sampling method (snowball sampling/third party recruitment methods) and the regions where participants were recruited and interviewed, it cannot be said that the findings within the paper are representative of the entire population of asylum seekers and convention refugees living in New Zealand. Direct quotes from the participants' account were stated in the results of the study. This enhances credibility and

transferability. The demographic characteristics in the study were listed. This enhances dependability as other researchers can follow the criteria of the study. However, the methodology and strategy for data analysis and interpretation were not discussed. This is likely to have compromised rigour (credibility, dependability, transferability and confirmability) (Guba & Lincoln, 1981; Sandelowski, 1986).

Uprety et al. (1999) is a mixed methods research report that focuses on the health needs of asylum seekers and refugees for early intervention. The quantitative phase analysed patients' records (refugees and asylum seekers) as filed dating from 1992 to October 1998; and the qualitative phase was information gathered from a conference on refugees and asylum seekers' health on the 17-18 November 1998. Although the study had a quantitative component, it is difficult to conclude whether the findings from the study are generalisable or transferable as there is no indication in the study whether or not the data gathered was based on a sample size calculation.

Moreover, the quantitative data was gathered only from two sources - patient records from the Refugee Health Centre (RHC), and records of New Zealand Immigration Services. Other sources like patients' records from primary health services (GP services) and secondary health services (hospitals) were not included. While generalisability is contested, there is no opportunity to critique internal validity and reliability of the study since the quantitative element of the study design did not include repeated measures. However, there is no reason to believe that these criteria, including objectivity, were not met. The study also had a qualitative component based on data gathered from a conference. It is likely that rigour (credibility, dependability, transferability and confirmability) may have been compromised in the qualitative phase as the methodology and methods of data collection, analysis and interpretation has not been discussed.

Young and Mortensen (2003) is a peer reviewed journal article that focuses on the case of an unaccompanied Afghani minor (13 years old) asylum seeker in the emergency department in Auckland. More of the article is dedicated on the literature review and guidelines on how to care for people from refugee backgrounds in emergency departments, than on the actual experience of the asylum seeker. The researchers have reported or described the participant's experience without direct quotes. Direct quotes can enhance credibility. It is likely that rigour (credibility, dependability, transferability and confirmability) may have been compromised as the methodology and methods of data analysis and interpretation has not been discussed.

Department of Labour (2004) is a report with a mixed methods research design. The design comprised of face-to-face interviews that were supplemented with material from focus groups. A total of 398 refugees were interviewed for the research in two groups. The first group were recently arrived refugees, consisting of quota, convention and family reunion refugees who were interviewed after six months in New Zealand (n=209) and then again at two years (n=162). The second group, established refugees, included quota refugees who had been in New Zealand for around five years (n=189).

The large sample makes it the most comprehensive qualitative research study involving a sample of asylum seekers in New Zealand. However, it is not clear from the sample how many asylum seekers/convention refugees were recruited in the study. The strengths of the study were enhanced by the fact that the interviews were carried out in the participants' own languages. The interviews were supplemented with material from focus groups. Thus, it can be said that credibility was enhanced in the study through the ability of the participants to express themselves in their own language. It is likely that this would have given room for depth in the understanding of the settlement experiences of refugees and asylum seekers. However, credibility was undermined in the results by the fact that direct quotes from the participants were not included.

Another strength of the study is the fact that participatory research principles guided the project and resulted in the recruitment of research associates from refugee communities who trained as research assistants and interviewers. It is stated that the research associates had a deep understanding of the cultures of the people they interviewed and were able to build trusting relationships with them. An advisory group also provided input into the design of the research. In addition, the participants came from diverse demographic backgrounds, and the selection criteria included a balance on gender, nationality, age and family size. These factors are likely to have enhanced dependability, transferability and confirmability. The study was however limited to refugees living in Auckland, Hamilton, Wellington and Christchurch. The methods of data analysis and interpretation have not been discussed as well. This is likely to have compromised rigour (credibility, dependability, transferability and confirmability).

3.2.1.2 The results from the studies on the experiences of asylum seekers

The results from the studies on the experiences of asylum seekers can be grouped into two themes. To a large extent, results describing the negative and challenging

experiences of asylum seekers; and much more rarely, results describing the positive experiences of asylum seekers in New Zealand.

To begin first with the results on the negative and challenging experiences of asylum seekers, all the research on the experiences of asylum seekers in New Zealand have had significant reports of negative and challenging experiences (Bloom et al., 2013; Bloom & Udahemuka, 2014; Department of Labour, 2014; Young & Mortensen, 2003; Uprety et al., 1999).

It is observed in Uprety et al. (1999) that, in addition to the psychological impact of continuous exposure to intense, repeated, and often prolonged traumatic experiences such as war, rape, starvation, torture, loss of their families in the country of origin, asylum seekers have usually left without having made any provisions for the future. Thus, asylum seekers both in detention and the community show evidence of profound depression, hopelessness and helplessness. Being away from their countries and separated from close family and community ties have led to most asylum seekers and refugees suffering from anxiety, depression, and other mental health problems. Continued unemployment and poverty compounded personal and family stress levels thereby negatively impacting the mental health of asylum seekers (Uprety et al., 1999).

Bloom and Udahemuka (2014) observes as well that, from the point of arrival, the process of seeking asylum is problematic. Asylum seekers experiences of traumatic events in their countries of origin were exacerbated by the anxiety, uncertainty and, in some cases, destitution experienced while going through the process of their asylum and permanent residency applications in New Zealand (Bloom & Udahemuka, 2014). Many asylum seekers claiming refugee status remain in limbo for lengthy periods of time and face the prospect of deportation. Anxiety/depression in asylum seekers and refugees was more than twice as prevalent as other health complaints. The interrogatory style of interviews by immigration service officials result in re-traumatisation for asylum seekers, especially given the previous experiences a majority of asylum seekers have had with government officials in their countries of origin (Uprety et al., 1999).

Similarly, studies overseas have found that asylum seekers experience stress, uncertainty, fear and anxieties during the asylum process (Sinnerbrink et al., 1997; Tribe, 2002). It is noted that past traumatic events in the countries of origin are exacerbated (Sinnerbrink et al., 1997), and there is significant re-traumatisation by the refugee status interview (Schock et al., 2015). Moreover, asylum seekers in detention at the time of the refugee status claim experienced significant negative impacts on their

physical and psychological wellbeing (Robjant, Hassan, & Katona, 2009; Silove, Austin & Steel, 2007).

Uprety et al. (1999) report a high level of communicable diseases in asylum seekers. Some asylum seekers arrive with highly communicable disease, for example tuberculosis (TB), the human immunodeficiency virus (HIV), sexually transmitted diseases (STDs), hepatitis and others, and this presents the local community with a high public health risk (Uprety et al., 1999). Young and Mortensen (2003) conclude that refugees have some of the poorest health outcomes in New Zealand society. Uprety et al. (1999) note that it is ironical that the health facilities and social services that asylum-seekers were entitled to, were limited, even though the magnitude of health needs of asylum-seekers were greater and more serious than that of quota refugees (Uprety et al., 1999). Despite the observation being made close to two decades ago, there is hardly any evidence in literature in New Zealand today that indicates whether or not the poorer health outcome for refugees (in this case - asylum seekers and convention refugees) has improved. This suggests that current research is needed on the prevalence of mental illness and other illnesses in asylum seekers and convention refugees.

Furthermore, asylum seekers experience challenges with accessing housing, healthcare, English language classes, welfare support and employment (Bloom & Udahemuka, 2014). It is observed that low income, non-recognition of qualifications, poor quality housing, and lack of social support serve only to compound the day-to-day stress levels, which have been identified as one of the more significant determinants of the ill health of asylum seekers. Asylum seekers experience challenges with food and overcrowded housing leading to the spread of communicable diseases such as respiratory disease and skin diseases (Uprety et al., 1999). Young and Mortensen (2003) note in this regard that there is an increase in the use of emergency departments by refugee and migrant groups in Central Auckland. They postulate that the factors that may account for the proportionately higher rate of presentation in the emergency department by refugees with urgent and non-emergency complaints includes many refugees having experienced physical and mental trauma and ill health, and they live with greater adversity - that is, more illness, unemployment, poverty and isolation from support networks.

In addition, refugees typically have come from countries with high rates of communicable diseases and little or no functioning health care systems. Often, secondary care has been interrupted and long-term illnesses left untreated during civil war and refugee flight. Asylum seekers and refugees experience difficulty in

understanding how the New Zealand health system works, in particular the role of primary health care. Difficulties with transportation, and a preference for hospital-based care also accounts for the disproportionate number of people from this this background presenting to emergency departments (Young & Mortensen, 2003).

Bloom and Udahemuka (2014) found in their study that asylum seekers attributed some of their difficult experiences to a lack of access to accurate and appropriate information, and limited knowledge of and access to appropriately delivered services and support. A position equally held by Young and Mortensen (2003) who assert that most refugee families are unused to the system of general practice and need instruction about how and when to use primary health and emergency services. Uprety et al. (1999) observed as well that services accessibility was difficult due to a lack of culturally appropriate visual aids and trained personnel for dealing with asylum seekers' health and social problems. Women and children are more vulnerable (Uprety et al., 1999). It follows from the forgoing that people from refugee backgrounds have difficulties differentiating between when to use primary or secondary healthcare services, and this is further compounded by the lack of information and culturally appropriate aids/personnel.

Other significant barriers to accessing primary health care identified include affordability and the inability to communicate (Young & Mortensen, 2003). Asylum seekers experience minimal access to interpreters, a lack of communication from officials, and limited assistance. Systemic issues such as a severely under-resourced sector; the negative portrayal of asylum seekers by politicians and the media; an unwillingness to prioritise the rights of asylum seekers and convention refugees; and the need for more cross agency collaboration, are also recognised among the challenges asylum seekers face (Bloom & Udahemuka, 2014; Uprety et al., 1999). Systemic information and service delivery gaps results in discrimination by the general public and exploitation by people from refugee communities, with instances of intimidation, provision of false information and illicit fees being charged for advice on seeking asylum from people without expertise in the field (Bloom & Udahemuka, 2014; Manning & James, 2011; Young & Mortensen, 2003). Somewhat similar trends of difficulties have been reported in studies with asylum seekers overseas (Briskman & Cemlyn, 2005; Lamb & Smith, 2002; Sales, 2002).

In addition, Bloom and Udahemuka (2014) observes the lack of appropriate policies to protect and support convention refugees severely compromises the very safety and protection New Zealand is obliged to provide to all refugees under international human

rights law and domestic human rights legislation. The asylum seekers' experiences from arrival in New Zealand to waiting for refugee status and permanent residency status indicate a continuity of the threat to their safety, protection and well-being (Bloom & Udahemuka, 2014).

Lastly, it is stated that, although there is no distinction between convention and quota refugees under the 1951 Refugee Convention, convention refugees cannot access services, resources, and settlement support available to quota refugees resettled as per the UNHCR programme. Convention refugees, including those who obtain permanent residency, are not eligible for the support services available to quota refugees and have disproportionately different resettlement experiences from quota refugees (Bloom & Udahemuka, 2014; Department of Labour 2014; Human Rights Commission, 2010).

Besides the negative and challenging experiences, there is a small account of positive experiences. In this regard, Bloom et al. (2013) note that, while some participants had some positive experiences, this was an exception rather than the rule. Some of the asylum seekers' experiences highlighted that they received invaluable support from the goodwill of a few individuals and community members (Bloom & Udahemuka, 2014).

The Department of Labour (2004) observe that, overall, convention refugees are able to read and write more languages than quota or family reunion refugees. They have completed a higher level of education and a higher proportion of them have work experience. They are generally positive about the refugee status determination process. Convention refugees are the most satisfied with their housing. They rely more on friends and government agencies for help, and tend to have better English language ability on arrival than other refugees. Having spent more time in education, having had more work experience and better English language ability, and having had access to a work permit as asylum seekers, convention refugees are more likely to have found work than quota or family reunion refugees (Department of Labour, 2004).

This literature review shows that, while the challenges that asylum seekers faced have been emphasised in literature in New Zealand, there is a significant lack of studies on their overall experiences. There is no study in New Zealand that has explored how asylum seekers cope with the stress from the refugee status determination process or copes with the trauma or illnesses. There is also a shortage of literature overseas on the coping strategies of asylum seekers and refugees in general.

Only a small number of studies abroad have explored coping by this population, compared to the studies that have explored their plights. Regarding this, Shakespeare-Finch et al. (2014, p. 311) note that “refugee stories are most often characterized by experiences of trauma, hardship, and despair while ordinary stories and experiences of adaptation and resilience are largely neglected". Marlowe (2010, p. 183) note similarly that

> *the story of a person's experience(s) of trauma associated with forced migration and how it has negatively influenced his/her life can overshadow other co-existing stories which can emphasize something very different about what a person values and readily identifies with.*

Raghallaigh and Gilligan (2010, p. 226) state likewise that, although increasing attention has been paid to their capacity for resilience in asylum seekers, little research has been done on the exact manner in which they cope.

Studies overseas suggest that, amidst the trauma and other difficulties, asylum seekers and by and large refugees, have remarkable coping abilities. For example, results from an Australian study on coping among asylum seekers suggests that physical activity, coupled with other strategies, are important for some asylum seekers in trying to manage the distress of being denied the right to work and living with prolonged uncertainty (Hartley, Fleay & Tye, 2017). Shakespeare-Finch et al. (2014) found in another Australian study on refugees that, in addition to themes of distress, extraordinary adaptive capacity and strengths existed, both individually and collectively. Specific adaptive strategies included religiousness and a sense of duty to family, community and country.

In similar manner, Marlowe (2010) found in an Australian study that, while the Sudanese refugee men spoke about traumatic and life-threatening experiences, they also acknowledged that what helped them through hardship included their culture, parental teachings, spirituality and how they maintained hope. Lastly, Raghallaigh and Gilligan (2010) found in a study in Ireland on unaccompanied minors who were seeking asylum, that their coping strategies included maintaining continuity in a changed context, adjusting by learning and changing, adopting a positive outlook, and suppressing emotions and seeking distraction.

3.2.4 Service delivery for asylum seekers

In this section I review the literature that has focused on the improvement of service delivery for asylum seekers and convention refugees. Given the existing background of challenges for the asylum seekers, several articles have suggested ways by which services delivered to asylum seekers could be improved.

West-Newman (2015) note that the negative attitudes towards asylum seekers could be mitigated by the adoption of the Māori values of manaakitanga to create a more hospitable reception for asylum seekers. She also proposes that the refugee lawyers' intimate knowledge of asylum seeker needs and experiences could be deployed to enhance protection for the human rights of those who seek refugee status in New Zealand.

Bloom and Udahemuka (2014) argue that, to mitigate exploitation, disorientation, discrimination and insecurity, information and education on the right to seek asylum and the process of seeking asylum needs to be provided to immigration staff, asylum seekers, refugee communities in New Zealand and the general public alike. They propose that the support and entitlements available to quota refugees should be extended to convention refugees to ensure self-sufficiency, participation, education, health/well-being, and housing outcomes for all refugees in New Zealand.

On their part, Bogen and Marlowe (2017) argue that social workers have an obligation to respond and raise consciousness about asylum seeker issues among the general public and to challenge the negative discourse that creates a public fearful of asylum seekers, and justifies discriminatory practices in New Zealand. They argue that social workers can advocate for asylum seekers, ultimately influencing national policies that are not only exclusionary but also breach the country's international obligations.

Te Pou (2010) proposes that healthcare practitioners should pay close attention to potential issues of vicarious traumatisation, transference and role clarity when working in environments with complex cultural backgrounds such as asylum seekers, refugees and new migrants. Te Pou notes that, while the mental health needs of resettled refugees and new migrants are similar in some ways to that of any other person using services, key differences exist in understanding, experiences of health systems, education, family and community. This means that mental health professionals may need to apply special attention and new skills if they are to help this group of people achieve a sense of well-being in a country and society where many cultural values and practices are new to

them. Accordingly, Te Pou outlines therapeutic approaches which it considers efficient and culturally appropriate for refugees, asylum seekers and new migrants.

Te Pou (2010) suggests as well a holistic approach to assessing the needs of refugees and asylum seekers beyond the rigid diagnostic categories of pathology to considering the whole person, including their strengths, cultural resources and aspirations. Despite the traumatic experiences that could affect any ordinary person, and could lead to mental health problems, refugees have often learned how to survive and cope in profoundly difficult situations, and practitioners could tap into this strength.

Lastly, Young and Mortensen (2003) propose specific considerations for the care of people from refugee backgrounds in emergency departments. The guideline focuses on the use of interpreters, decision making, symptomisation, somatisation, communicable disease control; and the management of trauma, sexual and reproductive health, family violence, and prescription medication.

In sum, this literature review has shown that studies and articles in New Zealand have explored the depiction of asylum seekers, the use of policy/legislation as a deterrent to asylum seekers, the experience of asylum seekers, and have made suggestions for the improvement of services for asylum seekers. However, there is a lack of literature both in New Zealand and overseas on the coping experience of asylum seekers. The dominant narrative on asylum seekers is negative. There are hardly any studies that have explored the experience of asylum seekers from a strengths-based approach. This thesis takes a step in the direction of filling this gap. In the section that follows, I discuss the assessment of the coping behaviours and the use of the Brief COPE scale for this assessment.

3.3 Coping

Overview

This section starts with a definition of coping and coping strategies. It is then followed by a summary of some of the instruments that have been used in the assessment of coping skills. The Brief COPE scale is identified as an abridged tool for assessing coping strategies. The instrument is described, and the coping strategies it assesses are explained. A section focused on the categorisation of the coping strategies in the Brief COPE scale is included.

3.3.1 Definition of coping

The term ‘coping’ has been defined variously. Lazarus (1966) provides a straightforward definition of coping as a process of executing a response to a stressor. Cooper, Katona and Livingston (2008) describe it as a process by which people manage stress. Lazarus and Folkman (1984) explained coping from a transactional perspective. They state that coping is when individuals faced with situations, appraise them in the light of their values, beliefs, and intentions; then considers solutions and resources available, whether consciously or not, and formulate responses. It can be said that coping is a process of responding to a stressful situation.

Coping strategies, on the other hand, are defined as specific efforts, both behavioural and psychological that people employ to master, tolerate, reduce or minimise stressful events (Yusoff, Low, & Yip, 2010). Coping strategies are said to have two primary functions. The first is to manage problems that are causing stress to an individual. The second is to govern the emotions that are related to these stressors (Folkman & Lazarus, 1980; Lazarus & Folkman 1984).

3.3.2 Assessment of coping strategies

Coping is a very broad concept, and several measures of coping have been developed. These include

- the Ways of Coping Questionnaire (Folkman & Lazarus 1985);
- the Coping Orientation to Problems Experienced - COPE Inventory (Carver, Scheier & Weintraub, 1989);
- the Coping Strategies Inventory (Tobin, Holroyd, Reynolds & Wigal, 1989);
- Multidimensional Coping Inventory (Endler & Parker, 1990);
- the Coping Responses Inventory-Youth (Moos, 1993);
- the Coping Inventory for Stressful Situations (Endler & Parker, 1994);
- the Coping Scale for Adults (Frydenberg & Lewis, 1996);
- other coping inventories and checklists include Billings and Moos (1981); McCrae (1984); Pearlin and Schooler (1978); and Stone and Neale (1984).

Some of these coping measures have been used in studies to assess coping responses in clinical conditions such as cancer, HIV and mental illness (Carver, 1997). Other coping tools have been used to evaluate coping in immigrants and non-western populations (Lee, Suchday & Wylie-Rosett, 2012; Hwang, 1979; Shek & Cheung, 1990).

Carver (1997) argues that a major drawback of many of the coping tools above is their length and the time needed for completion. For example, the Coping Scale for Adults has 75 items and 19 scales, while COPE Inventory has 60 items and 15 four-item subscales. On average the scales have 48 to 66 items. Many of the coping measures are burdensome for research subjects and involve retrospective reporting, raising concerns about reporting bias or the impact of memory on accurate recall (Snell, Siegert, Hay-Smith, & Surgenor, 2011). There is redundancy in some of the measures: of coping (Carver, 1997). These drawbacks have made it somewhat difficult for the measures to be used in clinical settings, especially when implementing extended research protocols (Monzani, Steca, Greco, D'Addorio, Capelletti & Pancani, 2015). As a result, Carver (1997) proposes the Brief COPE scale.

3.4 The Brief COPE scale

The Brief COPE scale (Carver, 1997) is an abridged version of the COPE Inventory (Carver et al., 1989). It has 28 items, which are rated using a four-point Likert scale. The 14 coping concepts it measures are active coping, planning, positive reframing, acceptance, humour, religion, use of emotional support, use of instrumental support, self-distraction, denial, venting, substance use, behavioural disengagement, and self-blame. There are two items about each concept.

The instrument was piloted in a racially diverse sample in the USA in a community recovering after Hurricane Andrew (Carver, 1997). Carver tested the validity of the instrument in the initial study. He conducted an exploratory factor analysis on the item set using an oblique rotation to permit correlation amongst factors. The analysis yielded nine factors with eigenvalues greater than 1.0, which together accounted for 72.4% of the variance in responding. The results established the strengths of the Brief COPE scale as an accurate instrument for assessing coping strategies. After a follow-up test in the pilot study, Carver (1997, p. 98) confirmed the internal reliability of the Brief COPE scale as a tool for the “wider examination of coping in naturally occurring settings”.

The validity and reliability of the Brief COPE scale as an instrument for assessing coping behaviours in diverse settings has been confirmed in several other studies (Cooper et al., 2008). For example, it has been used effectively in empirical research evaluating the role of coping with different types of stressors including the following

- Heart failure (Paukert, LeMaire & Cully, 2009)

- HIV disease (Sanjuán, Molero, Fuster & Nouvilas, 2013)
- Terrorism (Stein, Schorr, Litz, King, King, Solomon & Horesh, 2013)
- Caregiving for a family member with mental illness (Wrosch, Amir & Miller, 2011).
- International students (Miyazaki, Bodenhorn, Zalaquett & Kok-Mun, 2008)
- Preparing for examination (Doron, Stephan, Maiano & Le Scanff, 2011)
- Medical students (O'Brien & Leafman, 2012; Yusoff, 2010)
- Caregivers of individuals with dementia (Cooper et al., 2008)
- Inpatient psychiatric patients with severe mental illness (Meyer, 2011)
- Female breast cancer patients (Yusoff et al., 2010)
- Mild traumatic brain injury (Snell et al., 2011)
- Peoples living in refugee camps (Chase, Welton-Mitchell & Bhattarai, 2013; Sarfo-Mensah, 2009).

The Brief COPE scale has also been translated into numerous languages and used to assess coping in many settings including in non-western and immigrant populations (Baumstarck et al., 2017; Chase et al., 2013; Kapsou, Panayiotou, Kokkinos & Demetriou, 2010). However, a search I conducted on 03 March 2017 on the Scopus database and Google search engine revealed that the Brief COPE scale had been used only twice to assess coping in refugees - in Ghana (Sarfo-Mensah, 2009) and Nepal (Chase et al., 2013). Moreover, to the best of my knowledge, it has never been used before to assess coping in asylum seekers. Accordingly, this study is the first to use the Brief COPE scale to assess coping in asylum seekers.

3.4.1 Description of the coping strategies in the Brief COPE scale

Table 15 summarises the explanations for each of the coping strategies in the Brief COPE scale. The statements of each coping strategy are of particular importance as they serve as the framework against which the descriptions of the coping experiences by the asylum seekers in this study were interpreted (see Section 4.7.5.2. Part One).

Table 15: Explanation of the coping strategies in the Brief COPE scale

Coping strategy	Description
Active coping	is the process of taking active steps to try to remove or circumvent the stressor or to ameliorate its effects. Active coping includes initiating direct action, increasing one's efforts, and trying to execute a coping attempt in a stepwise fashion (Carver et al., 1989).
Planning	is thinking about how to cope with a stressor. Planning involves coming up with action strategies, thinking about what steps to take and how best to handle the problem (Carver et al., 1989).
Positive reframing	is an emotion-focused coping strategy aimed at managing distress emotions rather than dealing with the stressor per se. It is suggested that constructing a stressful transaction in positive terms should intrinsically lead the person to continue (or to resume) active, problem-focused coping actions (Carver, 1997).
Acceptance	is a functional coping reaction, in that an individual who accepts the reality of a stressful situation would seem to be a person who is engaged in the attempt to deal with the situation (Carver et al., 1989; Yusoff et al., 2010). One might expect acceptance to be particularly important in circumstances in which the stressor is something that must be accommodated for, as opposed to conditions in which the stressor can easily be changed (Carver et al., 1989).
Humour	is the tendency to make jokes or fun of the situation (Carver, 1997). Focusing on the ironic or funny aspects of one's experience has also been proposed as a useful coping strategy (Witztum, Briskin & Lerner, 1999), although the benefits of this strategy are not always clear (Gelkopf & Sigal, 1995).
Religion	One might turn to religion when under stress for multiple reasons. Religion might serve as a source of emotional support, as a vehicle for positive reinterpretation and growth, or as a tactic of active coping with a stressor (Carver et al., 1989).
Use of emotional support	is the aspect of coping that refers to getting moral support, sympathy, or understanding (Carver et al., 1989; Yusoff et al., 2010). Carver et al. (1989) posit that the tendency to seek out emotional, social support is a double-edged sword. It would seem to be functional in many ways. That is, a person who is made insecure by a stressful transaction can be reassured by obtaining this sort of support. This strategy can thereby foster a return to problem-focused coping. On the other hand, sources of sympathy sometimes are used more as outlets for the ventilation of one's feelings (Carver et al., 1989). There is evidence that using social support in this way may not always be very adaptive (Billings & Moos, 1984; Costanza, Derlega & Winstead, 1988).
Use of Instrumental support	is seeking advice, help or information (Carver et al., 1989; Yusoff et al., 2010). Carver et al. (1989) assert that, although the distinction between seeking emotional and instrumental support exist conceptually, in practice, however, emotional and instrumental support often co-occur.
Self-distraction	Previously labelled mental disengagement by Carver et al. (1989), self-distraction occurs through a wide variety of activities that serve to distract the person from thinking about the behavioural dimension or goal with which the stressor is interfering (Carver et al., 1989). Self-distraction is when one focuses explicitly on doing things to take one's mind off the stressor (Carver, 1997). Tactics that reflect self-distraction include using alternative activities (such as daydreaming, escape through sleep, or escape by immersion in TV) to take one's mind off the situation (Carver et al., 1989). O'Brien and Leafman (2012) posit that, in the short term, self-distraction can be positive, but in the long term may worsen the situation.

Denial	is the refusal to believe that the stressor exists or when one tries to act as though the stressor is not real (Carver et al., 1989). Carver et al. argue that denial is somewhat controversial. On the one hand, denial can be useful in minimising distress thereby facilitating coping (Breznitz, 1983). On the other hand, it can also create additional problems unless the stressor can profitably be ignored. That is, denying the reality of the event allows the event to become more severe, thereby making the eventual coping more difficult (Matthews, Siegel, Kuller, Thompson & Varat, 1983). A third view is that denial is useful in the early stages of a stressful situation but impedes coping later on (Mullen & Suls, 1982).
Venting	is the tendency to focus on whatever distress or upset one is experiencing and to ventilate those feelings. Such a response may sometimes be functional; for example, if a person uses a period of mourning to accommodate the loss of a loved one and move forward. However, focusing on these emotions (particularly for long periods) can impede adjustment (Carver et al., 1989).
Substances use	is when one uses alcohol or other drugs to make oneself feel better or to help one get through the stressful situation (Carver, 1997).
Behavioural disengagement	includes reducing one's effort to deal with the stressor, or even giving up the attempt to attain goals with which the stressor is interfering (Carver et al., 1989). Carver et al. posit that behavioural disengagement is reflected in phenomena that are also identified with terms such as helplessness (Carver et al., 1989). Although disengaging from a goal is sometimes a highly adaptive response (Klinger, 1975), this response often impedes adaptive coping (Billings & Moos, 1984).
Self-blame	is when one criticises or blames oneself for the situation or the problem (Carver, 1997). Self-blame has been found in research on coping measures to be a predictor of poor adjustment under stress (Bolger 1990; McCrae & Costa, 1986).

3.4.2 Categorisation of the coping strategies in the Brief COPE scale

In addition to the description of the individual coping strategies seen above, several studies have collapsed the coping scales into different categories.

Folkman and Lazarus provided an enlightening categorisation in 1980. They divided the coping strategies into two categories: problem-focused versus emotion-focused coping.

i. Problem-focused coping includes strategies aimed at solving and actively responding to stressful situations (Folkman & Lazarus, 1985). It includes taking action to deal with the situation and getting the necessary support from others (Snell et al., 2011). The examples of problem-focused coping strategies from the Brief COPE scale include planning, active coping, and use of instrumental support (Cooper et al., 2008).
ii. Emotion-focused coping includes strategies aimed at managing or reducing emotions and feelings that are embedded within stressful situations (Folkman & Lazarus, 1980; Yusoff et al., 2010). Emotion-focused coping is often divided

into two subcategories: active emotion-focused coping and avoidant emotion-focused coping (Holahan & Moos, 1987). Active emotion-focused is when one takes steps, accepts or tries to deal or cope with the feelings or emotions from the stressor. It is viewed as being an adaptive emotion regulation strategy. Examples of active emotion-focused coping strategies from the Brief COPE scale include acceptance, use of emotional support, positive reframing, and religion (Cooper et al., 2008; Snell et al., 2011). Whereas avoidant emotion-focused coping is when one tries to avoid the stressor. It is generally seen as a maladaptive emotion regulation strategy (Holahan & Moos, 1987). Examples of avoidant emotion-focused coping strategies from the Brief COPE scale include behavioural disengagement, denial, self-distraction, self-blame, substance use, and venting (Cooper et al., 2008; Snell et al., 2011).

Carver et al. (1989) added a third dimension to Folkman and Lazarus' (1980) initial problem-focused versus emotion-focused coping categorisation. This third category was labelled dysfunctional coping styles. Dysfunctional coping involves strategies such as giving up (Snell et al., 2011). In light of the Brief COPE scale, behavioural disengagement, denial, self-distraction, self-blame, substance use, and venting have been classified as the dysfunctional coping styles (Cooper et al., 2008; Snell et al., 2011).

Carver et al. (1989) distinguished as well between approach and avoidance coping. Approach coping strategies, according to Monzani et al. (2015), are aimed at dealing actively with the stressor, or related emotions whereas avoidance coping are strategies designed to avoid stressful situations. Active coping, planning, use of emotional support, use of instrumental support, positive reframing, acceptance, religion, and humour make up the approach coping strategies in the Brief COPE scale. While venting, denial, substance use, behavioural disengagement, self-distraction, and self-blame make up the avoidance coping strategies in the Brief COPE scale. It has been suggested that people who use more problem-focused and approach coping responses keep on being committed to and striving for their goals; consequently, they are more likely to report higher rates of progress with the situation (Monzani et al., 2015).

Unlike the categorisation (provided by Folkman & Lazarus, 1989; Carver et al., 1980), Meyer (2001) classified the coping strategies from the Brief COPE scale into adaptive versus maladaptive groups. I subscribe to this adaptive and maladaptive categorisation. A coping response is generally considered adaptive when it is aimed at dealing actively

with the stressor or related emotions, and it leads to a greater likelihood of making more progress with the situation (Monzani et al., 2015). Examples of adaptive coping strategies from the Brief COPE scale include active coping, planning, use of emotional support, use of instrumental support, positive reframing, acceptance, religion, and humour (Meyer, 2001).

On the contrary, maladaptive coping responses are aimed at avoiding the stressful situations and are more likely to interfere with goal-directed behaviours and subsequent levels of performance (Monzani et al., 2015). Examples of maladaptive coping strategies from the Brief COPE scale include venting, denial, substance use, behavioural disengagement, self-distraction, and self-blame (Meyer, 2001). The adoption of adaptive coping strategies has been associated with the desirable outcome; whereas adoption of maladaptive coping behaviours is associated with undesirable outcome (Carver et al., 1993).

Several other categorisations of coping strategies have been offered including effective versus ineffective (Rohde, Lewinsohn, Tilson, & Seeley, 1990); positive versus negative (O'Brien & Leafman, 2012); approach coping; avoidance coping; and social or help-seeking coping styles (Snell et al., 2011). Solberg Nes and Segerstrom (2006) offer a slightly more multifaceted categorisation of the coping behaviours. However, I deduced from the foregoing that the various categorisations, for example, 'effective', 'adaptive', and 'positive', are used interchangeably to refer to the same coping strategies from the Brief COPE scale, likewise 'ineffective', 'maladaptive', and 'negative'.

Chapter summary

This narrative overview has revealed that there is a dearth of literature, particularly peer-reviewed studies on the overall experience of asylum seekers in New Zealand. It also revealed that no study has been conducted in New Zealand on how asylum seekers cope with stress from the refugee status determination process. Consequently, this thesis focuses on exploring how asylum seekers cope with this stress. Coping has been defined, and some of the instruments that have been used for the assessment of coping strategies were cited among which the Brief COPE scale was identified as an abridged and widely used tool for assessing coping strategies in various settings including refugees. The coping strategies in the Brief COPE scale and categorisation it offers have

been discussed. I adopt the adaptive and maladaptive categorisation in this study. It is observed that the Brief COPE scale has never before been used to assess coping in asylum seekers and has been used twice in studies on refugees. Thus, this study is the first to have used the Brief COPE scale in this population. The next chapter focuses on the research design, methodology and methods.

CHAPTER 4: THE RESEARCH DESIGN

This chapter focuses on the research design. Mixed methods research is defined and justified as the design for this study. The term research paradigm is defined, and postpositivism is discussed as the paradigm for the study. The methodology - sequential explanatory design (participant selection model) is explained and illustrated; and the quantitative descriptive and qualitative descriptive methods are described. The ethical issues that arose from the study are addressed. Trustworthiness and rigour of the results is also discussed.

4.1 Mixed methods research

Mixed methods research developed from an existing background of separate quantitative and qualitative research approaches (Creswell, 2008).It has been referred to as a 'third wave' or 'third movement' in the evolution of research methodology (Creswell & Garrett, 2008; Johnson & Onwuegbuzie, 2004). And there is still a growing discussion on what mixed methods research is and what constitutes its elements (Creswell & Garrett, 2008; Johnson & Onwuegbuzie, 2004). Several definitions have been postulated for mixed methods research. I summarise these definitions under two categories.

The majority of scholars have defined mixed method research as the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, or concepts into a single study (for example, Creswell, 2009; Creswell & Garrett, 2008; Creswell & Plano Clark, 2007; Griensven, Moore & Hall, 2014; Johnson & Onwuegbuzie, 2004; Johnson, Onwuegbuzie & Turner, 2007; Mertens, 2003; Miller & Gatta, 2006; Morse, 2003; Newman, Ridenour, Newman & DeMarco, 2003; Tashakkori, & Teddlie, 1998; Tashakkori, & Teddlie, 2003).

A few scholars have dissented and argued that mixed methods research is not only limited to a combination of qualitative and quantitative research, but could also involve combinations of different approaches, methods, data, and analyses within a quantitative or a qualitative approach (Bazeley, 2006). In this light, Hunter and Brewer (2003) state

that an example of mixed method research could be a qualitative participant observation with qualitative in-depth interviewing. Alternatively, it could be a quantitative survey research with quantitative experimental research (Hunter & Brewer, 2003).

In this study, I subscribed to the definition of mixed methods research provided by the former. Hence I defined mixed methods research as an approach to research that combines elements of both quantitative and qualitative research designs in a single study.

4.2 Justification of mixed methods research for this study

The key questions I seek to answer in this section is why mixed methods research is used for this study? Why not exclusively a quantitative or qualitative design? While not underrating the potential of either of these approaches, several factors accounted for the selection of a mixed methods design. Primarily, the use of both the quantitative and qualitative research methods in the study allowed the strengths of both approaches to be combined and led to a better understanding of the research problem than a mono-method approach would have (Creswell & Garrett, 2008; Creswell & Plano Clark, 2007). It allowed for the neutralisation and cancellation of limitations and biases that are inherent in any of the quantitative or qualitative approaches (Creswell, 2009).

In addition to the above, the nature of the research problem in this study lends itself to a mixed methods study. The purpose of the study was to investigate the coping strategies of asylum seekers from Sub-Saharan Africa. The Brief COPE scale was used to collect quantitative data on the participants' coping abilities. Given that the Brief COPE scale was developed in a Western setting, accompanying qualitative interviews were conducted to ascertain the participants' description of their experience of the coping behaviours assessed in the Brief COPE scale. Through this, I was able to explore whether or not the Brief COPE is effective for measuring coping behaviours in asylum seekers from Sub-Saharan Africa. Thus mixed methods research presented an appropriate design to explore the research question.

In the sections that follows, I discuss the philosophical framework (also known as paradigm), the methodology and research methods used in this study.

4.3 Philosophical framework

The word paradigm has been defined variously, but Thomas Kuhn (1922-1996) has gained credence over the years on the definition of paradigm. Kuhn (1970) postulated several definitions for paradigm. In one of the definitions, he states that a paradigm stands for the entire constellation of beliefs, values, and techniques shared by the members of a given community. He also defines a paradigm as an integrated cluster of substantive concepts, variables and problems attached with corresponding methodological approaches and tools (Kuhn, 1970). In accordance with Kuhn, Guba (1990) defines paradigm as a core set of beliefs that guides action, whether of the everyday garden variety or action that was taken in connection with a disciplined inquiry. I surmise, as does Grant and Giddings (2002), that paradigm refers to a set of beliefs, values, and assumptions that a community of researchers has in common regarding the nature and conduct of the research.

Historically, many paradigms have been used in guiding actions, for example adversarial paradigm, judgemental paradigm, and religious paradigms; and those that guide disciplined inquiry, for example positivism, postpositivism, critical theory and constructivism (Guba, 1990). Although there is on-going debate on the clustering of paradigms, four paradigms are generally considered. Grant and Giddings (2002) clusters paradigms into positivist, interpretivist, radical and poststructural. Creswell (2009) clusters them into postpositivism, constructivism, advocacy/participatory and pragmatism.

Despite the historical debate on paradigms as well as the emerging contenders in the field, scholars have agreed that a research paradigm is generally characterised by the way the proponents respond to three basic questions - epistemology, ontology and methodology (Guba, 1990). Ontology raises basic questions about the nature of reality. What is the nature of reality? Epistemology asks, how do we know the world? What is the relationship between the inquirer and the known? The methodology focuses on how we gain knowledge about the world. How should the inquirer go about finding out knowledge? (Guba, 1990; Guba & Lincoln, 1998).

The fundamental features of this study, that is, an initial use of the Brief COPE scale, followed by interviews to construe the participants' experience of the coping strategies assessed in the Brief COPE scale, point towards the postpositivist paradigm as that which is most reflective for this study.

4.4 Tenets of postpositivism

Creswell (2009) suggests that, when writing about worldviews, the researcher might also include a section that addresses "a definition of basic considerations of that worldview" (p. 6). In line with Creswell's suggestion, in the sections that follow, I discuss the key features of the postpositivist paradigm.

Postpositivism developed as a reformation of positivism. The works of several philosophers including Sir Francis Bacon (1561-1626); Karl Popper (1902-1994); Thomas Kuhn (1922-1996); Ian Hacking (born 1936); Peter Galison (born 1955); and Nancy Cartwright (born 1944), have contributed immeasurably to the development of the philosophy of postpositivism.

Postpositivists reject positivism and argue that knowledge comes from many realities rather than one reality. They believe that knowledge is valued and biased, and that true objective knowledge is difficult, or even impossible to accomplish. They also maintain that researchers cannot separate cause from effect because these exist together. Therefore the causal relationship becomes unachievable (Lincoln & Guba, 1985). The tenets of postpositivism therefore are:

Ontologically, postpositivism moves from what is recognised as a naive realism posture (Guba, 1990) to one often termed critical realism (Cook & Cambell 1997). The critical realism is critical of our ability to know reality with certainty. Postpositivist critical realism believes that the goal of science is to hold steadfastly to the goal of apprehending reality, even though we can never achieve that goal (Trochim, 2000). The essence of this position is that reality is assumed to exist but to be only imperfectly apprehendable because of flawed human intellectual mechanisms and the fundamentally intractable nature of phenomena (Guba & Lincoln, 1998). Postpositivism concurs with positivism in that there is a real world driven by real natural causes, but disagrees that it is impossible for humans to perceive it objectively. Inquirers, therefore, need to be critical about their work precisely because of human frailties (Guba, 1990).

Epistemologically, postpositivism recognises the absurdity of assuming that it is possible for the human inquirer to step outside the pale of humanness while conducting an inquiry (Guba, 1990). Positivists believe that objectivity is a characteristic that resides in the individual scientist. Scientists are responsible for putting aside their biases and beliefs and seeing the world as it 'really' is. Postpositivists reject the idea that any

individual can see the world perfectly as it is. Our best hope for achieving objectivity is to triangulate across multiple fallible perspectives (Trochim, 2000).

Thus, postpositivists counsel a modified objectivity, hewing to objectivity as a regulative ideal but recognising that it cannot be achieved in any absolute sense (Guba & Lincoln, 1998). Objectivity can be achieved reasonably closely, by striving to be as neutral as possible by coming clean about one's own predispositions (Guba, 1990) so that the reader can make whatever adjustments to the proffered interpretations of findings that seem appropriate. This can be achieved by relying on the critical tradition and the critical community (Guba, 1990; Guba & Lincoln, 1998).

Methodologically, postpositivism emphasises critical multiplism (Letourneau & Allen, 1999), which might most usefully be thought of as a form of elaborated triangulation (Guba, 1990). Because all measurement is fallible, the postpositivist emphasises the importance of multiple measures and observations, each of which may possess different types of error, and the need to use triangulation across these multiple errorful sources to try to get a better understanding on what is happening in reality. The postpositivist also believes that all observations are theory-laden and that scientists are inherently biased by their cultural experiences, worldviews and other values (Bryman, 1984; Guba, 1990; Guba & Lincoln, 1998).

Postpositivists reject the relativist idea of the incommensurability of different perspectives. That is, the idea that we can never understand each other because we come from different experiences and cultures. Just because I have my worldview based on my experiences and you have yours does not mean that we cannot hope to translate from each other's experiences or understand each other. Most postpositivists are constructivists who believe that we each construct our view of the world based on our perceptions of it (Trochim, 2000). Thus, a major part of the postpositivist agenda has been devoted to redressing scientific imbalances by doing inquiry in more natural settings, using more qualitative methods (Bryman, 1984; Guba, 1990; Guba & Lincoln, 1998).

In the section that follows, I define the term methodology, as well as explain the sequential explanatory design as the methodology for this study.

4.5 Methodology

A methodology, according to Howell (2013), is the general research strategy that outlines the way in which research is to be undertaken and, among other things, establishes the methods to be used in the study. Creswell (2009) asserts that the strategies of inquiry are types of qualitative, quantitative, and mixed methods designs or models that provide specific direction for procedures in a research design. In this study, I adopt the definition of methodology provided by Grant and Giddings (2002). They assert that a methodology is to do with the abstract theoretical assumptions and principles that underpin a particular research approach, often developed within specific scientific or social science disciplines. It guides how a researcher frames the research question and decides on the process and methods to use (Grant & Giddings, 2002). Put simply; methodology is the systematic, theoretical analysis of the body of methods and principles associated with a field of study.

It has been postulated that there are major types of methodologies in mixed methods research and several variations within them (Creswell & Plano Clark, 2007). For example, Creswell and Plano Clark (2007) advance four major types of mixed methods designs, which include the triangulation design, the embedded design, the explanatory design and the exploratory design. On the contrarily, Creswell (2009) proposes three methodologies and several variations within them including

- the sequential mixed methods design (sequential explanatory or sequential exploratory design);
- the concurrent mixed methods design (concurrent triangulation or concurrent embedded or concurrent transformative design); and
- the transformative mixed methods design.

In this study, I adopt the sequential explanatory design proposed by Creswell (2009). The sequential explanatory design is explained in the section that follows.

4.6 Sequential explanatory design

A sequential explanatory design is characterised by the collection and analysis of quantitative data in the first phase of research followed by the collection and analysis of qualitative data in a second phase (Creswell, 2009; Creswell & Plano Clark, 2007; Ivankova, Creswell & Sheldon, 2006; Tashakkori & Teddie, 1998). The overall purpose

of explanatory mixed methods design is that the qualitative data helps explain, interpret or build upon initial quantitative results (Creswell, Plano Clark, Gutmann & Hanson, 2003). The design is well suited to studies in which a researcher needs data to explain significant and non-significant results, outlier results, or surprising results. It is also used when a research wants to form groups based on quantitative results and follow up the groups through subsequent qualitative research or to use quantitative participant characteristics to guide purposeful sampling for a qualitative phase (Creswell, 2009; Creswell & Plano Clark, 2007). Figure 2 illustrates the sequential explanatory design (Creswell, 2009, p. 209). The words quantitative and qualitative have been shortened in the illustration to read "quan" and "qual" respectively.

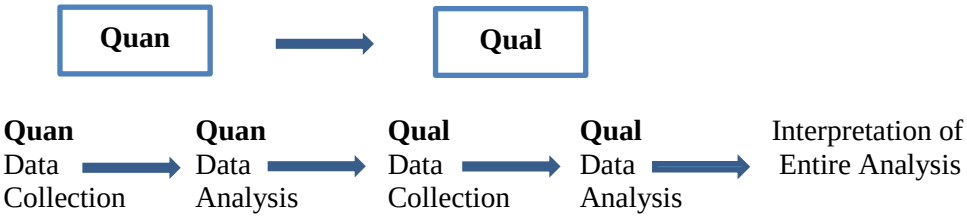


Figure 2: Sequential explanatory design

There are two variances of sequential explanatory designs

- the explanatory design: follow-up explanations model (quantitative emphasised); and
- the explanatory design: participant selection model (qualitative emphasised).

Although both models have an initial quantitative phase followed by a qualitative phase, they differ in the connection of the two phases, with one focusing on results to be examined in more detail and the other on the appropriate participants to be selected. The model employed in this study is the participant selection model. The participant selection model is used when a researcher needs quantitative information to identify and purposefully select participants for follow-up, in-depth, qualitative study. The emphasis in this model is usually on the second qualitative phase (Creswell, 2009; Creswell & Plano Clark, 2007; Tashakkori & Teddie, 1998).

4.6.1 Application of the sequential explanatory design to the study

The first phase of the study entailed using the Brief COPE scale (Carver, 1997) to collect data on the coping strategies of the asylum seekers. Following analysis from the first phase, a smaller number of participants were purposefully selected for the second phase of the study. In the second qualitative phase, semi-structured interviews were used to collect data on the participants' experiences of the coping concepts assessed in the Brief COPE scale. Figure 3 illustrates the participant selection model (Qual emphasised) (Creswell & Plano Clark, 2007, p. 73).

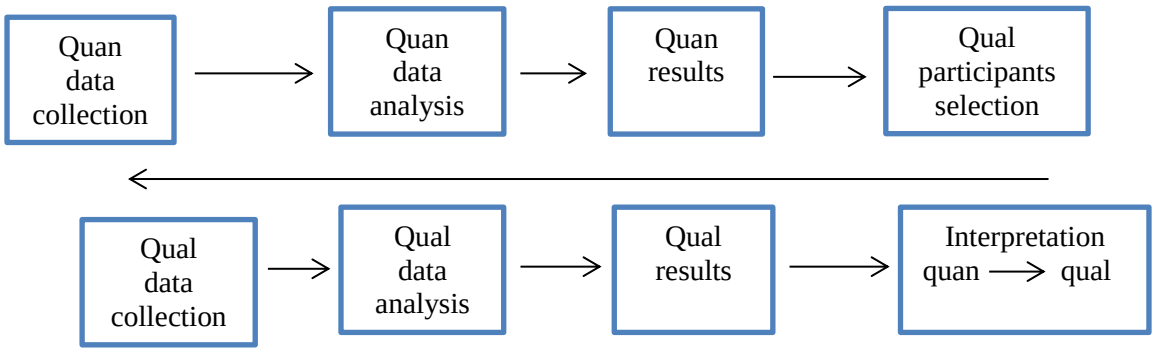


Figure 3: Participant selection model

4.7 Research methods

The research methods used in the quantitative and qualitative phases of this sequential explanatory design are discussed below. Research methods are the practical means and tools for collecting, analysing and interpreting the data (Creswell, 2009; Creswell & Plano Clark, 2011; Grant & Giddings, 2002; Onwuegbuzie & Leech, 2005).

The research studies, that is, peer reviewed journal articles on the experiences of asylum seekers in New Zealand (Bloom & Udahemuka, 2014; Young & Mortensen, 2003) have essentially utilised the mono-method. However, in this study, I employ a mixed methods design, which makes use of quantitative and qualitative research methods. I follow Creswell and Plano Clark's (2011) suggestion that research methods should involve as many diverse data collection and analysis procedures as the researcher think appropriate and should result in a thorough integration of findings and inferences. I do this with the hope that the results and inferences from the quantitative and qualitative techniques will produce a deeper understanding of the phenomenon of 'coping',

compared to the mono-method approaches. Thus in this study, I employ quantitative descriptive techniques in the quantitative phase and qualitative descriptive techniques in the qualitative phase.

With regards to the use of quantitative descriptive techniques, Burns and Grove (as cited in Dulock, 1993) postulate that quantitative descriptive studies are a means of discovering new meanings through analysing relationships between variables, describing what exists, and determining the frequency with which something occurs. The use of quantitative descriptive techniques in this study allows for the variables which make up the coping behaviours of asylum seekers to be measured and their patterns described (Hopkins, 2000).

In light of the use of qualitative descriptive techniques, Sandelowski (2000) asserts that qualitative descriptive designs are typically an eclectic but reasonable and well-considered combination of sampling, data collection, analysis, and representational techniques. She states as well that

> *Qualitative descriptive studies have as their goal a comprehensive summary of events in the everyday terms of those events. Researchers conducting qualitative descriptive studies stay close to their data and to the surface of words and events ... Qualitative descriptive study is the method of choice when straight descriptions of phenomena are desired* (Sandelowski, 2000, p. 334).

The use of qualitative descriptive techniques in this study provides the opportunity for the coping behaviours of the asylum seekers to be described with more depth in everyday terms (Hopkins, 2000; Meininger, 2011; Sandelowski, 2000). In the section that follows, I explain the sample, procedures, and instruments used for recruitment of the participants, and the data collection, analyses and interpretations.

4.7.1 Sample population

The criteria for selection of the participants in the study was based on persons who (a) had a ‘personal lived experience’ of the refugee status determination process in New Zealand, (b) came from a Sub-Saharan African country, (c) were 18 years or older, (d) were able to communicate in English or Pidgin. English is largely used in Sub-Saharan Africa, and Pidgin is spoken in West African and some parts of Central Africa.

4.7.2 Sample size

4.7.2.1 Quantitative phase

I recruited 31 participants in the quantitative phase of the study. The goal of the sampling in the quantitative phase was to obtain a representative sample as far as possible, but this was limited by the time frame and resources for the master's thesis.

4.7.2.2 Qualitative phase

A total of 7 participants were recruited in the qualitative descriptive phase of this study. I followed Creswell (1998); Giddings and Grant (2007); Manen (1990); and Smythe and Giddings' (2007) suggestion for a small sample where saturation has been reached.

4.7.3 Sampling technique

This study explores a phenomenon that is unique to asylum seekers. Several scholars (for example, Crabtree & Miller, 1992; Krueger, 2000; Patton, 1990; Sandelowski, 2000; Schwandt, 1997; Welman & Kruger, 1999) suggest that sampling methods such as convenience sampling and purposive sampling are suitable for a study that focuses on looking for those who have had experiences relating to the phenomenon to be researched. Convenience sampling and snowball sampling were used in the quantitative phase of the study, and maximum variation sampling was used in the qualitative phase of the study.

4.7.3.1 Quantitative phase

The study was advertised in community organisations in the wider Auckland region that offer support services to asylum seekers. This included the

- Auckland Refugee Community Coalition (ARCC), now the Auckland Resettled Community Coalition (ARCC)
- New Zealand Red Cross Services (NZRCS)
- Refugees as Survivors New Zealand (RASNZ)
- Asylum Seeker Support Trust (ASST)
- Auckland Regional Migrant Services (ARMS)
- King's Mercy Global Church (KMGC)

The advertisement (poster) was posted on notice boards of the said organisations. The primary researcher's telephone number and email address were stated in the poster

(Appendix A: Poster). Most of the participants who responded positively to the advertisement were from ARCC, ASST and KMGC, where many of the asylum seekers and convention refugees had stronger social networks, making the sampling more of a self-selected convenient sample. Convenience sampling is a specific type of non-probability sampling method that relies on data collection from population members who are conveniently available to participate in the study. A self-selected sample is a type of convenience sample comprising research participants or subjects who have volunteered to participate, often in response to an advertisement (Crabtree & Miller, 1992; Patton, 1990; Schwandt, 1997). Snowball sampling was also used to a small extent. Some of the participants who responded positively to the advertisement recruited other participants from among their acquaintances in the community.

4.7.3.2 Qualitative phase

The participants for the qualitative phase were recruited from those who had completed the quantitative phase. A question was included in the questionnaire used in the quantitative phase, asking whether or not the participants would like to participate in the interview phase of the research. Eleven respondents gave a positive response that they would like to be interviewed. Seven of the eleven respondents were interviewed. The procedure I used to select the seven participants was as follows.

The Kruskal-Wallis Test was used to investigate differences in the utilisation of the coping strategies among the participants. The participants were divided into three groups according to the status of their refugee status claim (Group 1 = in process; Group 2 = declined; and Group 3 = approved). The results from Kruskal-Wallis Tests indicated that there were significant differences between Group 1, Group 2 and Group 3 in the utilisation of some of the coping strategies.

Given the statistically significant results, my attention then changed to purposefully find the participants from the sample for the interview that would provide in-depth data to explain the significant differences observed between Group 1, Group 2 and Group 3. At this stage, I employed maximum variation sampling to select the participants that maximize the diversity relevant to Group 1, Group 2 and Group 3. Table 16 illustrates the diversity of the participants that I selected. I started the interviewing process with the first participant and stopped interviewing at the seventh when saturation was reached. The remaining four respondents that were interested to be interviewed but could not be interviewed were informed that the study had reached a saturation point.

Maximum variation sampling is a purposive sampling technique used to capture a broad range of perspectives, for example to understand how a phenomenon is seen and understood among different people, in different settings and/or different times, and to gain greater insights relating to the phenomenon. It focuses on the cases that maximize the diversity relevant to the research question (Crabtree & Miller, 1992; Patton, 1990; Sandelowski, 2000; Schwandt, 1997).

Table 16: Characteristics of participants selected for the qualitative phase

Participant	S	Region	Education	Status	Additional description
Interviewee 1	M	East Africa	Tertiary	Approved	Single at the time of the RSD. Short RSD process (less than 6 months).
Interviewee 2	M	West Africa	Tertiary	Declined on appeal	With dependent children in NZ at the time of RSD. A very long period of RSD process.
Interviewee 3	F	West Africa	Tertiary	In process	Without partner and dependents in NZ. Long initial RSD process.
Interviewee 4	F	Southern Africa	Secondary	Declined/in process	Single parent with dependent children in NZ.
Interviewee 5	F	Southern Africa	Primary	Declined/in process	Dependent children overseas at the time of RSD. Long RSD process.
Interviewee 6	F	Central Africa	Secondary	Declined on appeal	Dependent children overseas at the time of RSD. Long RSD process.
Interviewee 7	M	Central Africa	Tertiary	Approved	Single at the time of RSD. Short RSD process (less than 6 months).

4.7.4 Data collection

Data collection in the study will be discussed under procedure and collection instruments:

4.7.4.1 Procedure

According to Cresswell and Plano Clark (2007), data collection in mixed methods sequential explanatory design can be conceptualised into three stages (Table 17):

- Stage One is the collection and analysis of quantitative (numeric) data;
- Stage Two is decision making, which is, working out what results to take forward; and
- Stage Three is the collection and analysis of qualitative (text) data.

Table 17: Stages of data collection

Stage One	Stage Two	Stage Three
Collection and analysis of quantitative (numeric) data	Decisions on how results from Stage One will be used to influence Stage Three	Collection and analysis of qualitative (text) data

Source: Cresswell and Plano Clark (2007)

Stage One began with the recruitment of the participants in the quantitative phase (see Section 4.7.3.1), and then the collection of the data using a Brief COPE scale, which included socio-demographical characteristics and other questions (see Section 4.7.4.2.1). The data was analysed in the Statistical Package for the Social Sciences - IBM SPSS Statistics 23 (SPSS). The statistical techniques were mainly descriptive (see Section 4.7.5.1).

In Stage Two, I followed Cresswell and Plano Clark's (2011) suggestion to purposefully select the participants for further investigation by basing judgement on the results from the quantitative phase. The procedure that I followed to select the participants in Stage Two has been discussed in Section 4.7.3.2.

In Stage Three, the participants identified in Stage Two were investigated in more detail through semi-structured interviews. Data was collected on the participants' experiences of the various coping strategies assessed in the Brief COPE scale (see Section 4.7.4.2.2). The qualitative data was analysed manually (see Section 4.7.5.2).

4.7.4.2 Instruments

4.7.4.2.1 Quantitative data collection

I followed Gelo, Braakmann and Benetka's (2008) suggestion that a test or standardised questionnaires should be used for the collection of data in quantitative studies. Hence the instrument used for data collection in the quantitative phase was the Brief COPE scale (Carver, 1997) (Appendix B: Brief COPE scale). The Brief COPE scale assesses the self-perception of the coping behaviours. It asks the respondents to rate the items on a four-point Likert scale, ranging from one "I've not been doing this at all" to four "I've been doing this a lot". Table 18 shows the 14 conceptually differentiable coping reactions it measures, categorised into adaptive and maladaptive.

Table 18: The coping strategies of the Brief COPE scale: adaptive versus maladaptive

Adaptive coping strategies	Maladaptive coping strategies
1. Active coping	9. Self-distraction
2. Planning	10. Denial
3. Positive reframing	11. Venting
4. Acceptance	12. Substance use
5. Humour	13. Behavioural disengagement
6. Religion	14. Self-blame
7. Use of emotional support	
8. Use of instrumental support	

Each of the measures of the coping reactions comprises two items. The total scores on each of the scales are calculated by summing the appropriate items for each scale. No items are reverse scored. The total scores on each scale range from two (minimum) to eight (maximum). There is no overall total score, only total scores for each of the scales. Higher scores indicate increased utilisation of that specific coping strategy (Carver, 1997). An explanation of the coping strategies in the Brief COPE scale and the validity and reliability of the Brief COPE scale has been discussed under Section 3.4.

The Brief COPE scale was printed in English and distributed as a self-administered questionnaire. I printed a total of 100 questionnaires. I included an almost equivalent number of stamped addressed envelopes for the return of the completed questionnaires. I handed some of the questionnaires and envelopes to several participants who contacted me after viewing the advertisement. The remaining questionnaires were deposited at community settings that asylum seekers patronise (see Section 4.7.3).

I received 40 completed questionnaires. Nine of those were disqualified because the respondents were not from Sub-Saharan Africa. Another two questionnaires were partly completed. I contacted the respondents for clarification whether it was an omission or they had skipped the questions on purpose. These two participants needed some clarifications with the questions that were omitted. I gave them the clarifications and the incomplete questionnaires were eventually completed. A total of 31 completed questionnaires were entered into the SPSS.

Included in the Brief COPE scale were socio-demographical questions on marital status, educational status, employment status, age group, among others. Another question

asked the respondents whether or not they would like to participate in the interview. There were other questions on identifying the stage at which the respondents were in the refugee status determination process (Appendix B: Brief COPE scale).

There was a question as well that asked the respondents to rate the level of stress from the refugee status determination (RSD) process on a scale of one to ten, with one being not stressful at all and ten being extremely stressful. The purpose of this question was to get a summary indication of the nature of stress from the RSD process as it would have been unsubstantial assessing how the asylum seekers cope with stress from the RSD without establishing whether or not the process is in fact stressful.

To date, Connor, Vaishnavi, Davidson, Sheehan and Sheehan (2007) is the only study that has established the validity and reliability for a single-item, self-rated measure of perceived stress. They found that a conceptually similar one-item scale - the 'Stress Vulnerability Scale' (SVS) (Sheehan et al., 1990) demonstrates good reliability and validity (acceptable psychometric properties as a measure of vulnerability to perceived stress), and it correlates very strongly with another 10-item scale - the 'Perceived Stress Scale' (PSS-10) (Cohen et al., 1983). Elsewhere, Anderson et al. (2010) have used the same one-item scale in a study of stress in the USA. Their study showed that a majority of Americans live with moderate levels of stress (between four and seven) on a total of ten.

The data on coping strategies collected in the Brief COPE scale, including the socio-demographic characteristics, level of stress, and the other questions, were entered concurrently into SPSS as I received the completed questionnaires from the respondents. Upon collecting the questionnaires from the respondents, I checked with them how long it took to complete the questionnaires. Most of the respondents reported taking approximately 30 minutes. The quantitative data was gathered over a period of two months (mid-May to mid-July 2016).

4.7.4.2.2 Qualitative data collection

The collection of the qualitative data was achieved through semi-structured, one-on-one interviews. I followed Pietkiewicz and Smith’s (2014) description of semi-structured interviews. They state it allows the researcher and the participant to engage in a dialogue in real time. It also gives enough space and flexibility for original and unexpected issues to arise, which the researcher may investigate in more detail with further questioning.

The responders were asked questions that elicited their experience of copings as assessed in the Brief COPE scale (Cresswell, 2003; Creswell, Plano Clark, Gutmann, & Hanson, 2003; Rossman & Wilson, 1985; Tashakkori & Teddlie, 1998). The interview was aimed at eliciting rich, every day and first-person accounts of phenomena of coping from the asylum seekers' perspective. Questions such as *what was it like for you, what does it mean to you, how did you use it*, were central to the qualitative exploration (Appendix C: Indicative Qualitative Questions). The interviews took place from the end of July to mid-September 2016. Each interview lasted about an hour.

Before the interview, the responders were asked where they thought was safe for the interview to take place. This was to enhance participation, provide choice and protect privacy. A room at AUT North-shore campus was offered as a possible safe location. Two of the participants chose to do the interviews at AUT North-shore campus. The remaining five interviews were in the community at the participants' homes. All of the seven participants spoke in English, although during the interviews there were some brief and spontaneous moments where some of the participants also spoke in Pidgin. As I am fluent in Pidgin, I understood what they said. I followed Oppenheim (2000), Kvale (1996), and Sukamolson's (2014) recommendation to audio tape and transcribe the interviews. The audios and transcripts were stored in secured locations for analysis.

I agree with Pietkiewicz and Smith's (2014) suggestion that researchers should be cautious when applying theories developed in one setting to explain phenomena experienced by people in another setting. Thus, before the interviews with the research participants, I attended a pre-assumptions interview with my supervisor. The interview enabled me to check my assumptions about the topic. It also allowed me to focus the interviews on the participants' subjective experiences of copings, and recognise where my own views affected data collection more clearly.

4.7.5 Data analysis

Data analysis in the study was accomplished in two main phases - quantitative and qualitative.

4.7.5.1 Quantitative analysis

The analysis of the quantitative data was accomplished using different statistical techniques in the SPSS. I followed guidelines from Pallant (2013) in the analysis of the data. First, descriptive statistics were conducted to investigate the frequencies in the

socio-demographic characteristics, and frequencies in the levels of stress reported by the participants (see Section 5.1. for the results). Second, descriptive statistics were used to analyse the levels of coping reported by the participants and to investigate whether the participants used more of adaptive or maladaptive coping strategies (see Section 5.2 for the results). Third, Kruskal-Wallis Test was used to investigate differences in the utilisation of the coping strategies among the participants (see Section 5.3 for the results).

4.7.5.2 Qualitative analysis

The qualitative analysis was conducted in three Parts. In Part One, I used abductive reasoning in conjunction with deductive reasoning. In Part Two, I used abductive reasoning in conjunction with inductive reasoning. In Part Three, I used the conventional approach to content analysis.

Part One

I used abductive reasoning to explore the participants' description of their lived experience of coping as assessed in the Brief COPE scale. Abductive reasoning is a form of logical inference, which goes from an observation to a theory that accounts for the observation, ideally seeking to find the simplest and most plausible explanation (Aliseda, 2006; Dong, Lovallo & Mounarath, 2015; Folger & Stein, 2016; Lycke, 2011; Peirce, 1998). It is the creative, imaginative or insightful moment in which understanding is grasped (Lipscomb, 2012).

The analysis in Part One also constituted deductive content analysis. Deductive reasoning is the process of reasoning from a general premise to a specific conclusion (Burns & Grove 2005). Deductive content analysis is used when the structure of analysis is operationalised on the basis of previous knowledge and the purpose of the study is to test a previous theory in a different situation or to compare categories at different time periods (Andersson et al., 2015; Catanzaro, 1988; Selo & Kyngas, 2008; Sandstrom, Willman, Svensson & Borglin, 2015). Primarily, deductive content analysis was included because the 14 coping strategies listed in the Brief COPE scale were used as a structured background (arguably, somewhat of a matrix) for the analysis of the data.

The analysis process in Part One started with a reading of the data from a pre-assumptions interview that I did with my supervisor. This enabled me to be aware of the biases that I have held from my experience of the refugee status determination process in New Zealand. It enabled me to be aware as well of assumptions I had regarding the description of the coping strategies of asylum seekers from Sub-Saharan Africa in New Zealand.

I progressed from reflecting on the pre-assumptions interview to reading the transcripts of the interviews. I read these twice for familiarity. Then I coded emerging themes on the margins according to the structured categorisations available in the Brief COPE scale. I did a third reading focusing on similarities and comparisons in the participants' description of their coping. More themes and subthemes that describe each coping category emerged at this stage. Another reading was done to verify the categorisation according to the coping strategies assessed in the Brief COPE scale.

During this reading, some of the themes and subthemes were further developed. Some subthemes were merged to form leading themes, and others that were deemed insufficient were omitted. The data was reviewed for content and to ensure that it corresponds with the Brief COPE scale. The subthemes, themes and descriptions were then stated as the participants' description of their copings strategies (see Section 6.1 for the results). The analysis process was achieved following suggestions from Andersson et al. (2015), Selo and Kyngas (2008), and Sandstrom et al. (2015).

Part Two

I used abductive reasoning to explore the participants' description of the statistically significant differences observed between those who were still in process versus those who had been approved or declined. The analysis also constituted inductive content analysis. Inductive reasoning is the derivation of general principles from specific observations (Chinn & Kramer 1999). Inductive content analysis is used in cases where there are no previous studies dealing with the phenomenon or where such may exist but is fragmented. Inductive reasoning allows theory and themes to emerge from the raw data through repeated examination and comparison (Catanzaro, 1988; Selo & Kyngas, 2008; Sandstrom, Willman, Svensson & Borglin, 2015).

The focus of analysis in Part Two was to find themes from the data that illustrates the participants' description of the statistically significant results. The question I sought to

answer through abductive and inductive reasoning was - *what are the participants' explanations for the statistically significant results*? I began the process abductively by studying the significant results observed from Kruskal-Wallis Tests, which indicated that there were differences between Group 1, Group 2 and Group 3 in the reported utilisation of some of the coping strategies.

Drawing from Selo and Kyngas (2008), I then subjected data to inductive content analysis. The analytic process focused on the latent content. This involved an exploration of underlying meanings in the data other than that already seen in the categorisations in the Brief COPE scale. Particularly, I followed Sandstrom et al. (2015) to explore possible explanations for the significant results from the participants' perspectives. I used codes to organise portions of the data into subthemes and themes. Some of the subthemes and themes confirmed guesses I had made, and there were others that emerged from the data that I had not anticipated.

I also followed Andersson et al. (2015), Burnard (1996), Hsieh and Shannon (2005), Robson, 1993, and Selo and Kyngas (2008) to read through the transcripts again. I wrote more subthemes and themes in the margins. Some of the subthemes and themes were then merged to form leading themes that emerged as the participants' explanation for the significant results. The themes provided additional descriptions of the coping behaviours and increased the understanding of the differences observed between Group 1, Group 2 and Group 3 in the reported utilisation of the coping strategies (see Section 6.2 for the results).

Part Three

In Part Three, I used the conventional approach to content analysis. The conventional content analysis is used with a study design whose aim is to describe a phenomenon. Researchers that use the conventional content analysis gain the insights by immersing themselves in the data and avoid using preconceived categories, instead allowing the categories to flow from the data (Hsieh & Shannon, 2005).

I followed the process of conventional content analysis suggested by Hsieh and Shannon (2005). Before beginning the conventional content analysis, I was already well immersed in data as I had read it several times in Part One and Part Two above. During

those readings, I observed few key concepts or theories that were not related to the categories in the Brief COPE scale. I read all data again to achieve more immersion.

I then approached the data by making notes of my impressions, thoughts, reflections and analysis. As this process continued, more codes emerged that were reflective of new insights of the data. The codes were then sorted into categories. These new categories were organised into meaningful clusters of themes. A definition for each theme was developed. In total four new themes emerged from the conventional content analysis (see Section 6.3 for the results).

4.8 Ethical issues

Several ethical issues were anticipated, raised and/or encountered in the study, and were addressed accordingly. I discuss these below. An application for ethics approval was made to the Auckland University of Technology Ethics Committee (AUTEC). The application was approved on 18 May 2016, for 3 years until 16 May 2019. The approval number is 16/119 (Appendix D: Ethics Approval). In July 2016 I made another application for an amendment to AUTEC, to change the inclusion criteria allowing for the capture and inclusion of data from incidental participants. That application was approved on the 20 July 2016 (Appendix E: Approval of Amendment to Ethics).

Mortensen (2011) states that the profile of refugees settled in New Zealand from 1987 has been characterised by ethnic, cultural and religious diversity. Statistics from Immigration New Zealand indicate the vast majority of asylum claimants in New Zealand are people from non-western cultural backgrounds (Bloom & Udahemuka, 2014; Human Rights Commission, 2010; MBIE, 2015). Hence a rational discussion on the ethical issues raised in the study, must also take into account the context of multiculturalism in New Zealand as well as the long history of biculturalism (between Pākehā and Māori).

An overwhelming body of literature in New Zealand highlight the importance to engage and work with others in a manner that is culturally safe and sensitive (Crocket, Agee & Cornforth, 2011; Mental Health Commission, 2012; Mental Health Commission, 1998; Te Pou, 2010; Te Pou, 2009). In light of this proposition, the first step towards the implementation of cultural safeness and sensitivity in the study was consultations with the refugee communities in Auckland, and community organisations such as ARCC, ASST, NZRCS, and KMGC that are in the usual business of offering services to asylum

seekers. These organisations provided the initial cultural forethought needed for the research and highlighted some of the sensitive ethical issues in asylum seeking populations. Interviewing gay people from Sub-Saharan Africa was identified as a sensitive area. I also inquired about the interpersonal skills (O'Hagan, 2001; UNHCR, 1996) to use when working with peoples from Sub-Saharan Africa and with Muslims as I am a Christian. They recommended that sensitive cultural cases such as women from Muslim backgrounds should be excluded from the study. Some of the organisations approved and provided letter of support for the research project (Appendix F: Support Letter from NZRCS; Appendix G: Support Letter from KMGC).

Besides the cultural consultation, the research was executed in a way that upholds the principles of the Treaty of Waitangi 1840 (the Treaty). The Treaty, often referred to as the founding and single most important document of New Zealand (Toki, 2009), commends the Crown to partner with, protect, and to ensure that Māori people participate in processes involving Māori (Cole, 2000; Mental Health Commission, 1998; Toki, 2009). Although in its original context the Treaty was signed between Pākehā and Māori (Statistics New Zealand, 2012), its three principles of Partnership, Protection and Participation (3Ps) have been interpreted generously to include non-Māori in the multicultural context of New Zealand today. Refugees and asylum seekers also constitute the list of non-Māori populations in New Zealand.

In practice, the application of the 3Ps in addressing ethical issues in research has meant that there has to be full disclosure of the intentions of the study including potential risks to the research subjects, and the possible benefits to the research subjects. The research subjects who consent to participate in the study must also be made aware of their right to withdraw at any time (Crocket, Agee & Cornforth, 2011): a position also held in customary international law under the Nuremberg Code of Ethical Practice 1949. The recent Guidelines on Informed Consent by the New Zealand Psychologists Board 2016, emphasises same in the field of psychological research. This research would fit appropriately within the area of psychological research.

Accordingly, all the participants in the study were provided full information about the research (Appendix H: Information Sheet) and they had to sign a Consent Form (Appendix I: Consent Form) before participation (Bailey, 1996). AUTEC provided a template for the Consent Form and a template for the Information Sheet. The Consent Form, Information Sheet, Advertisement (Poster), Brief COPE scale, and Indicative Qualitative Questions used in the study were examined and approved by AUTEC.

Furthermore, steps were taken to avoid coercion of the research subjects and to safeguard voluntary participation. The study was advertised in refugee communities; and the information packs (which was made of the Information Sheet, Consent Form, Brief COPE scale, and stamped addressed return envelopes) were deposited at some of the community centres where the study was advertised. Some of the persons that saw the advertisement and were interested contacted the researcher via the phone number provided for more information. Others completed the Consent Form and Brief COPE scale and returned them to the researcher.

Steps were taken as well to protect the researcher's and the participants' private information. The contact details used for communications about the research was not my private contact details. I used my AUT student email address and a new mobile phone number that was bought solely for the purpose of this research project. My personal phone number and residential address were not disclosed to the participants. Likewise, the Consent Forms, which have the contact details of the participants, have been stored in a locked cabinet separate from the other data provided by the participants.

Besides protecting private information, the data gathered from the participants has been stored securely and data no longer needed has been shredded or deleted. The audio tapes that the participants consented to it being recorded during the interview have been deleted. The transcripts are still saved in a secured folder on my laptop as I may need to refer to them until this study has been completed. Codes were used on the transcripts, and not the participants' names. Codes were used on the Brief COPE scale and not the participants' names. The completed Brief COPE scales have been stored in a locked cabinet. The Brief COPE scale will be shredded once the study has been completed. Information about the research participants has not been shared with anyone outside of the research team.

Still on confidentiality, the UNHCR (1996) note that many refugees have lived in cramped quarters without privacy and "may not feel that to talk with you is in their best interest. They may be afraid that everyone else will hear about their problems. Being a refugee often takes away a person's self-respect." (UNHCR, p. 10). With this in mind, the research process was implemented such that the dignity and privacy of the participants were respected and safeguarded within their community. Interviews were arranged at safe environments for example at the AUT University North-shore campus

or at a safe place in the community chosen by the participant. The findings in the study have been reported anonymously.

The UNCHR (1996) note as well that, while many refugees suffer physically from injury, far more will suffer psychological harm, and the consequences are not always short-lived as some can last a lifetime. The participants that were deemed vulnerable were not included in the study. These included those receiving treatment for a mental illness (psychiatric disabilities) in hospitals and community settings, and asylum seekers in immigration detention facilities and prisons. Furthermore, I excluded Muslim women from the study and the asylum seekers I had professional and/or financial relationships with in the community. This was to ensure that there was no power imbalance between the participants and myself.

Furthermore, steps were taken to ensure that there were appropriate interventions for the participants who experienced re-traumatisation as a result of the study (Holloway, 1997; Kvale, 1996). An agreement was reached with the AUT Health, Counselling and Wellbeing on 01 March 2016 (Appendix J: Memorandum from AUT Counselling), allowing research participants who became distressed or re-traumatised by the study to seek help from the service. This memorandum was crucial to the research process given that studies in asylum seeking populations have indicated that the refugee status determination process is stressful and re-traumatising (Uprety et al., 1999; Bloom & Udahemuka, 2014). Fortunately, no participant in the study was re-traumatised by the study. Ethical principles such as non-maleficence, beneficence, and autonomy (Crocket, Agee & Cornforth, 2011; DAPAANZ, 2005; Seedhouse, 2009) were followed during the research process and the research subjects were treated with dignity and respect, and none of the research participants have complained or reported being harmed by the research.

In addition to above, during the interview process, the participants were accorded the status of experts of their experiences, and all attempts were made to avoid questions or insinuations that undermined their experiences and/or personalities. It was also anticipated that some of the questions in the interviews could pose some level of discomfort or embarrassment to the participants, especially participants who might have engaged in maladaptive coping behaviours. During the interviews, the participants who showed signs of discomfort or embarrassment were informed that they did not have to answer the question. I also informed the participants that they could terminate the interview and/or withdraw from the study. However, all the participants were okay to

carry on with the interview to the end. There were times when I suspected that the participants were distressed or in discomfort yet they were willing to carry on with the study. At such times, I gave the participants some quiet time to recover and I suggested that we take a break.

Through these ethical measures, I ensured that the research process absorbed the participants' rights as protected by the laws in New Zealand such as the Bill of Rights Act 1990; the Privacy Act 1993; and Human Rights Act 1993. The research process also respected the participants' rights as stated in international human rights instruments such as the

- 1951Convention Relating to the Status of Refugees;
- 1965 International Convention on the Elimination of All Forms of Racial Discrimination;
- 1966 International Covenant on Civil and Political Rights;
- 1966 International Covenant on Economic, Social and Cultural Rights;
- 1979 Convention on the Elimination of All Forms of Discrimination Against Women; and
- 1984 Convention Against Torture and Other Cruel, Inhumane, or Degrading Treatment or Punishment.

Lastly, each participant was acknowledged for their participation in the study with a koha (a Paknsave gift voucher of $25.00 in the quantitative phase, and another Paknsave gift voucher of $25.00 in the qualitative phase). The koha was to thank them for participation in the study and compensate for their time and money spent on transport. The final results or summary of the findings from the study will be distributed to the participants who have indicated interest in the findings.

4.9 Trustworthiness and rigour

In this section, I discuss the trustworthiness of the quantitative phase and the rigour of the qualitative phase. The criteria use for the assessment of trustworthiness in quantitative research is internal validity, reliability, objectivity and generalisability. In qualitative research, rigour is assessed through credibility, dependability, transferability and confirmability (Cook & Campbell, 1979; Guba & Lincoln, 1981; Hamberg, Johansson, Lindgren & Westman, 1994; Polit & Hungler, 1999; Sandelowski, 1986; Streubert & Carpenter, 1999).

4.9.1 Quantitative phase

4.9.1.1 Internal validity

Internal validity, also known as the 'truth value' (Ryan-Nicholls & Will, 2009) of a quantitative inquiry, is based on the extent to which the researcher establishes how things really are and really work (Guba & Lincoln, 1989). The truth value of a research is usually determined by how well threats to internal validity have been managed, and by the validity of the instrument as measures of the phenomenon under study. When there is confidence that the study findings are representative of the variables being studied and cannot be attributed to the research procedures, the research design is said to be internally valid (Sandelowski, 1986; Ryan-Nicholls & Will, 2009).

4.9.1.2 Reliability

Reliability is typically a precondition measure for validity because a study cannot possess validity if it is unreliable (Lincoln & Guba, 1985). It is the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure (Polit & Hungler, 1999). Reliability refers to a study's consistency, dependability, stability, predictability and/or accuracy (Ryan-Nicholls & Will, 2009). It is based on the assumptions that replication of testing procedures is possible and that replication of testing procedures does not influence the object being studied. It is also based on the assumption that there is an observable regularity about human experiences that is a function of those experiences and not of the testing procedure; and that, if more than one person observes the same thing, it exists in that manner (Ryan-Nicholls, Will, 2009; Sandelowski, 1986).

The internal validity and the reliability of the Brief COPE scale as an instrument for assessing coping behaviours in diverse settings was established (Carver, 1997) and confirmed in several other studies (Cooper et al., 2008) (see Section 3.4). Besides, the Brief COPE scale has been translated into numerous languages and used to assess coping in many settings including in non-western and immigrant populations (Baumstarck et al., 2017; Chase et al., 2013; Kapsou, Panayiotou, Kokkinos & Demetriou, 2010). The scale had also been used to assess coping strategies in refugees in Ghana (Sarfo-Mensah, 2009) and elsewhere in Nepal (Chase et al., 2013).

Despite this background, it cannot be taken for granted that, because the internal validity and the reliability of the Brief COPE scale has been established and confirmed

in several other studies including studies in refugee populations, it produced valid results in this study. There were a few points that arose with the usage of the Brief COPE scale in this study that may have direct implications on internal validity and reliability. Regrettably, the design of this study did not suit the assessment of coping on two or more occasions; thus, the internal validity and reliability of Brief COPE scale as used in the study cannot be ascertained mathematically. However, it is still worthwhile to highlight the factors that may have influenced (perhaps weakened or strengthened) internal validity and reliability of the scale.

The first factor relates to the fact that the Brief COPE scale was developed and used in a Western context but was used in this study in a population from Africa. In this regard, several scholars have cautioned researchers against using Western developed scales in non-western populations (Mann & Fazil 2006; Shoeb, Weinstein & Mollica, 2007). It is suggested that the most appropriate way to use a Western developed scale in refugees (or generally, non-western populations) would be to translate and adapt the scale to the context of the given population (Sarfo-Mensah, 2009). In the context of this study, the Brief COPE scale was not translated or adapted. The breadth of the countries and languages that make up Sub-Saharan Africa made it practically impossible to translate or adapt the scale to the population that made up this study. Nonetheless, English is a dominant language in Sub-Saharan Africa and it was deemed reasonable to use the English version of the Brief COPE scale.

In addition, several of the robust statistical techniques that could be used to investigate the relation between stress and coping (Pearson correlation); or the association between demographic characteristic and stress (Chi-square test); or the association between demographic characteristic and coping (analysis of variance - ANOVA) could not be relied on. Several factors accounted for the difficulties using these statistical tests. The sample size was small (31 participants) and some of the main assumptions of parametric techniques (normality and homogeneity of variances) were violated. Furthermore, the relationship between stress and coping could not be projected because the scale used to assess the levels of stress was not suitable for comprehensive analysis. Moreover, all the participants in the study had recorded very high levels of stress, making it almost irrelevant for comparisons to be made between the different groups in the population.

Even though these factors obstructed the usage of robust parametric techniques that could have increased the validity of the results from this study, descriptive statistics and non-parametric alternative (Kruskal-Wallis Test) was used. The results from the study

are trustworthy as the Kruskal-Wallis Test is robust enough to handle a sample size of 31 participants (Pallant, 2013; Tabachnick & Fidell, 2013). Another strength of the study was the combination of quantitative and qualitative research methods that enabled the contextualisation and explanations of the trends observed in the coping behaviour of the asylum seekers.

4.9.1.3 Objectivity

Objectivity is said to exist where there is freedom from bias in the research process and product (Sandelowski, 1986). Empirical scientists believe that the study of phenomena must be devoid of subjectivity and they contend that objectivity is essential in leading the way to truth (Streubert & Carpenter, 1999). Objectivity is established and maintained through the use of well-established and clearly delineated boundaries between researcher and subject (Ryan-Nicholls & Will, 2009). Ryan-Nicholls and Will (2009) claim that objectivity is accomplished when reliability and validity are achieved in the quantitative sense.

Although I strived for objectivity in this study, I must admit that my inclinations to the emancipatory and advocacy theory and personal experiences as a former asylum seeker in New Zealand definitely influence the process in this study. This is evident in the fact that the study is situated in the postpositivist paradigm. Postpostitivism recognises that knowledge is valued and biased, and that true objective knowledge is difficult, or even impossible to accomplish. Postpositivists hold the view that we are all biased, and all of our observations are affected (theory-laden) (Lincoln & Guba, 1985; Trochim, 2000). Therefore, the inquirer needs to be critical about their work precisely because of human frailties (Guba, 1990) (see Section 4.4).

In light of the foregoing, Hamberg et al. (1994) note that, while the researcher's earlier experiences can be beneficial in enhancing theoretical sensitivity, it is also important that the researcher stays aware of preconceptions in order to avoid conceptual blinders. Taking Hamberg et al.'s remarks into consideration, I completed a pre-assumptions interview with my primary supervisor, which helped me to identify and become aware of conceptual blinders that came up during the data collection, analysis and interpretation. This helped to enhance the objectivity in the study. Objectivity was enhanced as well through triangulation; that is, the collection and analysis of quantitative data on the Brief COPE scale, accompanied by collection and analysis of qualitative the data on the coping strategies assessed in the Brief COPE scale.

4.9.1.4 Generalisability

Generalisability also known as external validity (Ryan-Nicholls & Will, 2009) focuses on the extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects (Guba & Lincoln, 1989). It is the approximate validity with which we infer that the presumed causal relationship can be generalised to and across alternate measures of the cause and effect, and whether the study results will apply across different types of persons, settings, and times (Cook & Campbell, 1979). The main question I seek to answer in this section is whether or not the findings in the quantitative phase of this study can be generalised to the population of Sub-Saharan African asylum seekers in New Zealand.

The study presents an indication of the coping strategies of the asylum seekers from Sub-Saharan Africa in New Zealand but cannot be generalised or taken as conclusive of the coping strategies of this population. The aim of the sampling in the quantitative phase was to obtain a representative sample as far as possible. The study was advertised in community organisations in Auckland region that offer support services to asylum seekers (see Section 4.7.3.1). A majority of the participants in the study came only from three of the community organisations where the advertisement where posted, making the sampling more of a self-selected convenient sample. Moreover, the study was advertised only in Auckland and not all-over New Zealand where a representative sample would have been achieved. Consequently, the findings in the quantitative phase of this study are only a suggestion of the coping strategies of asylum seekers from Sub-Saharan Africa, and cannot be generalised to the population of asylum seekers from this region.

4.9.2 Qualitative phase

4.9.2.1 Credibility

Credibility attempts to establish how accurate the researcher is when representing the participants' experiences (Coughlan & Cronin, 2017). Through the measure of credibility, the truth of the account is assessed in terms of the researcher's reflection on the research process and the participants' ability to recognise their experience in the research account (Lincoln & Guba, 1985; Ryan-Nicholls & Will, 2009). A well-structured methodology is a prerequisite for credibility (Hamberg et al., 1994; Lincoln & Guba, 1985).

Credibility in this study was enhanced through the use of triangulation to ensure that the study records a rich, robust, comprehensive and well-developed account of the participants' coping behaviours. This was achieved through the assessment of the participants' coping behaviour using the Brief COPE scale, and then a description of the participants' experiences of the coping strategies assessed by the Brief COPE scale. The results include direct quotes from the participants. This enhances credibility as the audience is able to link the subthemes, themes and the participants' accounts. Credibility was also enhanced by the fact that two participants requested to see a copy of the transcripts of their interviews. They read through the transcripts, added minor comments and then confirmed that the interview was an adequate and fair description of their coping behaviours.

Furthermore, credibility was affected by the approach I used to collect the data. Data collection in the qualitative phase of this study depended heavily upon how well I asked open-ended questions, followed-up unclear meanings, and invited the participants to deepen and develop their thoughts and ideas. In the early stages of qualitative data collection (that is, the first and second interviews), it was difficult for me to avoid using leading questions and avoid interrupting the conversation with closed-ended questions such as *when did it happen?* I should have deepened my understanding of the phenomenon of coping by asking open-ended questions, and listened even to the silent moments. As I got to the third and other participants that I interviewed, my confidence had improved and I tended to use more of open-ended questions, and appropriate body gestures. This enabled the participant to speak more and to describe their coping behaviours in a way that they understood best, thereby enhancing credibility in the data collected.

In addition, credibility was enhanced by the fact that I had disclosed to the participants before the interviews began that I am a former asylum seeker and from Sub-Saharan Africa. I believe this had the strength of normalising the relationship between the participants and me as they would have seen me as someone who was once in the situation that they were. There is therefore the possibility that they might have been more motivated to share their experiences and beliefs with me, given that I have experienced what they were going through.

On the other hand, given that I am from the same cultural background as the participants, there is a possibility that the participants might have withheld information on the coping behaviours that are generally seen as shameful in the African culture, for

example the smoking of cannabis by males or the smoking of cigarettes by females or vice versa. It is possible as well that the participants might have withheld information on maladaptive coping behaviours that they think could endanger their circumstances as asylum seekers in New Zealand. That said, the nature of the data gathered in this study and the incidences of maladaptive coping behaviours reported by the participants indicate that participants were honest in their response, thus credibility may not have been compromised significantly.

4.9.2.2 Dependability

Dependability, also known as auditability is said to exist when there is sufficient information presented for the reader to recognise and follow the decision trail (Coughlan & Cronin, 2017; Guba & Lincoln 1981, Morse, 1998). The decision trail discusses how decisions in relation to the theoretical, methodological and analytical choices were made (Coughlan & Cronin, 2017; Koch, 2006). Ryan-Nicholls and Will (2009) claim that a study is said to be auditable when another researcher could reach the same or similar conclusions with the use of the researcher's perspective, data and situation. Hamberg et al. (1994) note, however, that dependenbility means that the study adapts to changes in the studied environment and to new inputs obtained during the study period.

In the earlier sections of this chapter, I have explained and where appropriate sketched the philosophical framework, methodology and methods used in this study. This in itself enhances dependability as other researchers could follow the decision trails that I have advanced for situating the study within the postpositivist paradigm, and for using the sequential explanatory design, and quantitative/qualitative descriptive methods. Dependability was enhanced as well by flexibility and adjustments that were made in the process of the study. For example, I collected the qualitative data and then transcribed it simultaneously. This gave me an opportunity to identify some of the issues that the first and second interviewees gave only short and limited descriptions of coping experiences. It also gave me an opportunity to note cases where I did not use the proper probing techniques that would have elicited deeper discussions on the subject. Hence during subsequent interviews with the remaining participants, I rehearsed and improved my interpersonal skills and where relevant, I asked for clarifications and examples. Another example that enhanced dependability in the study is the fact that the total number of participants that I interviewed was not decided in advance. Instead, the interviewing was terminated when saturation was reached.

4.9.2.3 Transferability

Transferability, also known as applicability or fittingness (Guba & Lincoln, 1981), is based on the degree to which the study's findings fit into other situations that are outside the context of the study. Transferability is said to be present when readers can apply the study's results to their own experiences or when the findings are applicable to others not involved in the study (Coughlan & Cronin, 2017). Ryan-Nicholls and Will (2009) propose that transferability can be used to measure the applicability of qualitative research findings by those who may want to apply the study to their personal situations, instead of merely providing the confidence limits of the study. I subscribe to Hamberg et al.'s (1994) claim that, to make transferability judgements possible, it is necessary to describe the context in which the study took place; and it is important to describe demographics such as ethnicity, family situation and socioeconomics in the population or group investigated. This will make it possible for others to decide whether the findings are relevant in other situations (Hamberg et al., 1994).

Consequently, in this study I used a purposive sampling method to select the participants for the interview. Following results from the quantitative phase, participants in the qualitative phase were selected based on demographics such as country of origin and sub-region of origin in Sub-Sub Saharan Africa; family situation; educational status; the stage at which they were in the refugee status claim; and other criteria (see Section 4.7.3.2). The participants were interviewed in the community setting in their homes except for two who preferred to be interviewed at a neutral location. This procedure cannot claim representativity, but leads to recognisable selection criteria that could be used in other studies.

4.9.2.4 Confirmability

Confirmability is the standard by which neutrality is judged in qualitative research (Guba & Lincoln, 1981). It is about offering a clear demonstration of how interpretations were made and conclusions were drawn (Coughlan & Cronin, 2017), and an inclusion of procedures to verify that the findings and concepts described were founded in the data (Hamberg et al., 1994), not on the objective or subjective perspective of the researcher (Ryan-Nicholls & Will, 2009). Hamberg et al. (1994) claims that confirmability calls for a method so systematic and thorough that the researcher continuously has to question the findings, rethink and critically review the material. Ryan-Nicholls and Will (2009), however, suggest that the steps taken to

ensure confirmability are dependent on the purpose of the study, the type of data collection techniques used, the kind of evidence used and the analysis techniques used. I subscribed to Koch (2006) and Thomas and Magilvy's (2011) proposition that confirmability is deemed to have occurred when credibility, transferability, and dependability have been established.

In this this study, I strived for confirmability by reading the transcripts several times, using codes, and reflexive thinking in the analytical stage of the study. In addition, all methods used and decisions made in the analysis were supported by literature. Furthermore, confirmability was tested by my primary supervisor as she verified two of the audio recordings, and corresponding transcripts and the codes on the margin of the transcripts, to ensure that the results were from the participants' data.

In sum, it is worth noting that the single most important fact that has strengthened the trustworthiness and the rigour in this study has been the use of triangulation. The use of both the quantitative and qualitative research methods in the study led to a broader and deeper understanding of the concepts of coping than would have been achieved if any one method was used alone. In this light, many authors have emphasised the benefits of methodological triangulation (Barbour, 1999, Creswell, 2009; Creswell & Garrett, 2008; Creswell & Plano Clark, 2007; Foss & Ellefsen, 2002; Jones & Bugge, 2006; Rose & Webb, 1997). Triangulation has been commended as a methodology that promotes more rigorous understanding (Jones & Bugge, 2006) and strengthens scientific rigour (Foss & Ellefsen, 2002).

Chapter summary

In this chapter, mixed methods research has been defined and discussed as the design for this study. The paradigm of the study is identified as postpositivism, and the tenets of postpositivism have been illustrated. The term methodology was defined, and sequential explanatory design (participant selection model) was illustrated as the appropriate methodology for the study. The quantitative descriptive and qualitative descriptive techniques used in the collection, analysis, and interpretation of the data have been explained. Lastly, the ethical issues that arose in the study, and the trustworthiness and rigour of the results have been discussed. The subsequent chapter discusses the results of this study, beginning first with the quantitative results.

CHAPTER 5: QUANTITATIVE RESULTS

In this chapter, I present the quantitative results from this study. The chapter starts with a summary of the socio-demographic background; then patterns in the participants' coping behaviours are described. The last section of the chapter investigates the difference in coping levels among the participants who were still in the process of the claim, and those who had been declined or approved.

5.1 Socio-demographic characteristics

Table 19 shows the socio-demographic background of the sample. Regarding country of origin, Cameroonians (23%, number = 7) and Nigerians (23%, number = 7) formed the largest proportion of the study. They were followed by Zimbabweans (16%, number = 5) and South Africans (13%, number = 4). The other participants came from Somalia, South Sudan, Congo DRC, Ethiopia and Chad. A total of nine participants were recruited from the Southern Africa region, eight from the Central African region, and seven each from the East and West African regions.

The sample comprised mostly of males (67%, number = 20), and a majority of the participants (80%, number = 26) were between 25 to 44 years. Nearly half of the entire sample (48%, number = 15) were in a relationship at the time of their refugee status claim, and a majority of them had dependent children (74%, number = 23) in their country of origin. In terms of education and employment, a vast majority of the participants had at least a secondary education (90%, number = 28), and approximately half (54%, number = 17) were in some form of employment which included full-time, part-time and voluntary.

The number of participants were fairly balanced between those who were still in the process (35.5%, number = 11), those who had been declined (32.3%, number = 10), and those who had been approved (32.3%, number = 10). A significant amount of them (42%, number = 13) had been in the claim process for more than 12 months. The shortest length of stay in New Zealand was three months, and the longest was about seven years.

Lastly, regarding the levels of stress from the refugee status determination process, over 80% of the participants recorded the process as extremely stressful at 10. The mean score for levels of stress for the entire population in the study was 9.7. All the female participants recorded the process as extremely stressful at 10, whereas 70% of the males recorded it at 10. The minimum score for males was seven.

Table 19: Socio-demographic characteristics of participants

Socio-demographic	Number Total=31	Percentage (%)
Central Africa region		
Cameroon	7	22.6 (%)
Chad	1	3.2 (%)
West African region		
Nigeria	7	22.6(%)
Southern African region		
Zimbabwe	5	16.1(%)
South Africa	4	12.9(%)
East African region		
Somalia	3	9.7(%)
South Sudan	2	6.5(%)
Congo DRC	1	3.2(%)
Ethiopia	1	3.2(%)
Sex		
Male	20	64.5(%)
Female	11	35.5(%)
Age group		
35 to 44 years	14	45.2(%)
25 to 34 years	12	38.7(%)
18 to 24 years	2	6.5(%)
45 to 54 years	2	6.5(%)
55 to 64 years	1	3.2(%)
Employment status		
Unemployed	13	41.9(%)
Fulltime employment	11	35.5(%)
Part-time employment	3	9.7(%)
Volunteering	3	9.7(%)
Student	1	3.2(%)
Educational status		
Tertiary education	15	48.4(%)
Secondary education	13	41.9(%)
No education at all	2	6.5(%)
Primary education	1	3.2(%)
Relationship status		
In a relationship	16	51.6(%)
Not in relationship	15	48.4(%)
Families with dependents		
Dependents in NZ	2	6.5(%)
Dependents in country of origin	23	74.2(%)

No dependents	6	19.4(%)
Duration of the claim		
Under 12 months	18	58.1(%)
Above 12 months	13	41.9(%)
Status of the claim		
In process	11	35.5(%)
Declined	10	32.3(%)
Approved	10	32.3(%)

Levels of stress from the RSD

	Number	**Mean**	***SD***
Male	20	9.5	.9
Female	11	10.0	.0
Male and Female	31	9.7	.8

5.2 Coping strategies

Table 20 details the scores for the coping strategies as per the respective questions in the Brief COPE scale. The scores on each question (coping item) range from one (minimum) to four (maximum). Higher mean scores indicate increased utilisation of the coping item.

Table 20: The details of the Brief COPE scale (refer to Section 4.7.4.2.1)

	Male			Female			Male & Female		
Coping strategies and corresponding questions	**Mean**	***SD***	**Number**	**Mean**	***SD***	**Number**	**Mean**	***SD***	**Number**
Self-distraction									
01. I've been turning to work or other activities to take my mind off the claim.	2.70	1.08	20	3.73	.91	11	**3.06**	**1.12**	**31**
19. I've been doing something to think about it less such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	3.25	1.02	20	3.82	.60	11	**3.45**	**.93**	**31**
Active coping									
02. I've been concentrating my efforts on doing something about the situation I'm in.	3.25	1.16	20	3.73	.91	11	**3.42**	**1.09**	**31**
07. I've been taking action to try to make the situation better.	3.15	1.04	20	3.36	1.21	11	**3.23**	**1.09**	**31**
Denial									
03. I've been saying to myself "this isn't real."	2.20	1.06	20	2.45	1.21	11	**2.29**	**1.10**	**31**
08. I've been refusing to believe that it has happened.	2.40	1.05	20	2.27	1.27	11	**2.35**	**1.11**	**31**
Substance use									
04. I've been using alcohol or other drugs to make myself feel better about the claim.	2.25	1.37	20	2.73	1.42	11	**2.42**	**1.39**	**31**
11. I've been using alcohol or other drugs to help me get through the claim.	2.15	1.35	20	2.82	1.47	11	**2.39**	**1.41**	**31**
Use of emotional support									

05. I've been getting emotional support from others.	3.00	1.03	20	3.45	.93	11	**3.16**	**1.00**	**31**
15. I've been getting comfort and understanding from someone.	2.70	1.22	20	3.91	.30	11	**3.13**	**1.15**	**31**
Behavioural disengagement									
06. I've been giving up trying to deal with the claim.	2.00	1.08	20	1.73	1.10	11	**1.90**	**1.08**	**31**
16. I've been giving up the attempt to cope.	2.10	.97	20	1.73	1.01	11	**1.97**	**.98**	**31**
Venting									
09. I've been saying things to let my unpleasant feelings escape.	2.60	.94	20	2.73	1.01	11	**2.65**	**.95**	**31**
21. I've been expressing my negative feelings about the claim.	2.60	1.05	20	2.55	.93	11	**2.58**	**.99**	**31**
Use of instrumental support									
10. I've been getting help and advice from other people.	3.10	1.07	20	3.73	.65	11	**3.32**	**.98**	**31**
23. I've been trying to get advice or help from other people about what to do.	2.65	1.27	20	3.64	.51	11	**3.00**	**1.16**	**31**
Positive reframing									
12. I've been trying to see the claim in a different light, to make it seem more positive.	3.05	1.05	20	3.64	.67	11	**3.26**	**.97**	**31**
17. I've been looking for something good in what is happening.	3.10	1.12	20	3.82	.60	11	**3.35**	**1.02**	**31**
Self-blame									
13. I've been criticizing myself.	2.10	.85	20	2.45	1.21	11	**2.23**	**.99**	**31**
26. I've been blaming myself for things that happened.	2.25	1.12	20	2.55	1.04	11	**2.35**	**1.08**	**31**
Planning									

14. I've been trying to come up with a strategy about what to do.	3.20	.89	20	3.55	.93	11	**3.32**	**.91**	**31**
25. I've been thinking hard about what steps to take.	3.30	1.08	20	3.91	.30	11	**3.52**	**.93**	**31**
Humour									
18. I've been making jokes about it.	1.65	.81	20	1.73	1.19	11	**1.68**	**.95**	**31**
28. I've been making fun of the situation.	1.65	.86	20	1.64	1.03	11	**1.65**	**.92**	**31**
Acceptance									
20. I've been accepting the reality of the fact that it has happened.	3.00	1.12	20	3.73	.47	11	**3.26**	**1.00**	**31**
24. I've been learning to live with it.	3.05	.95	20	3.36	.81	11	**3.16**	**.90**	**31**
Religion									
22. I've been trying to find comfort in my religion or spiritual beliefs.	3.00	1.34	20	3.18	1.25	11	**3.06**	**1.29**	**31**
27. I've been praying or meditating about the claim.	3.45	1.10	20	3.73	.91	11	**3.55**	**1.03**	**31**

Research question: *What coping strategies do the participants use most?*

Null Hypothesis (H_0)

There is no significant difference in use of adaptive and maladaptive coping strategies.

Alternate Hypothesis (H_1)

There is a significant difference in use of adaptive and maladaptive coping strategies.

The coping strategies most frequently reported by the participants were planning, active coping, positive reframing, religion, self-distraction, acceptance, use of instrumental support, and use of emotional support. Each had mean scores greater than six on a total of eight. These coping strategies are classified in this study as the adaptive coping strategies. Venting, substance use, denial, and self-blame were reported at a moderate levels (mean = 5). These coping strategies are classified as the maladaptive coping strategies. Behavioural disengagement (mean = 3.9) and humour (mean = 3.2) are the least reported coping strategies and are in the maladaptive and adaptive coping strategies, respectively (see Section 3.4.2). Substance use and religion have the most spread out scores with standard deviations of 2.8 and 2.1 respectively, demonstrating more variability in the sample than other coping strategies.

Table 21 shows the occurrence of the coping strategies as reported by the participants. The total mean scores on each strategy range from two (minimum) to eight (maximum). They are calculated by summing the appropriate items for coping strategy. AC stands for adaptive coping strategies and MC stands for maladaptive coping strategies. It can thus be inferred from these descriptive statistics that, on average, the participants reported using more of the adaptive coping strategies than maladaptive coping strategies.

Table 21: Descriptive statistics of the coping strategies (refer to Section 4.7.4.2.1)

Coping strategies	Mean score	Standard deviation
Planning **(AC)**	6.84	1.51
Active coping **(AC)**	6.65	1.91
Positive reframing **(AC)**	6.61	1.84
Religion **(AC)**	6.61	2.11
Self-distraction **(AC)**	6.52	1.59
Acceptance **(AC)**	6.42	1.29
Use of instrumental support **(AC)**	6.32	1.89
Use of emotional support **(AC)**	6.29	1.70
Venting **(MC)**	5.23	1.65
Substance use **(MC)**	4.81	2.78
Denial **(MC)**	4.65	1.79
Self-blame **(MC)**	4.58	1.63
Behavioural disengagement **(MC)**	3.87	1.81
Humour **(AC)**	3.32	1.80

5.3 Difference in levels of coping among the asylum seekers

Research question: *Is there a difference in levels of coping across the three groups?*

Null Hypothesis (H_0)

There is no difference in levels of coping across the groups.

Alternate Hypothesis (H_1)

There is a difference in levels of coping across the groups.

The participants were divided into three groups according to the status of their refugee status claim (Group 1 = in process; Group 2 = declined; and Group 3 = approved). Kruskal-Wallis Tests were conducted for each coping strategies in order to evaluate the difference in coping levels between the three groups. The results in Table 22 show that the ‘in process’ group was statistically significantly lower than the declined and

approved groups in use of self-distraction, active coping, substance use, use of emotional support, use of instrumental support, positive reframing and planning.

Table 22: Kruskal-Wallis Test Results

Coping strategies	**Groups**	**Number**	**Median**	χ^2	***p-value***
Self-distraction **(AC)**	In Process	11	5.00	10.66	.01*
	Declined	10	8.00		
	Approved	10	7.50		
Active coping **(AC)**	In Process	11	6.00	13.90	.00*
	Declined	10	8.00		
	Approved	10	7.50		
Denial **(MC)**	In Process	11	5.00	1.64	.44
	Declined	10	4.50		
	Approved	10	4.00		
Substance use **(MC)**	In Process	11	2.00	8.19	.02*
	Declined	10	8.00		
	Approved	10	7.50		
Use of emotional support **(AC)**	In Process	11	5.00	14.49	00*
	Declined	10	8.00		
	Approved	10	7.00		
Behaviour disengagement **(MC)**	In Process	11	5.00	4.35	.11
	Declined	10	3.00		
	Approved	10	2.00		
Venting **(MC)**	In Process	11	5.00	.43	.81
	Declined	10	5.50		
	Approved	10	5.50		
Use of instrumental support **(AC)**	In Process	11	5.00	11.47	.00*
	Declined	10	8.00		
	Approved	10	7.00		
Positive reframing **(AC)**	In Process	11	6.00	10.50	.01*
	Declined	10	8.00		
	Approved	10	8.00		
Self-blame **(MC)**	In Process	11	5.00	2.43	.30
	Declined	10	4.00		
	Approved	10	5.00		
Planning **(AC)**	In Process	11	6.00	13.60	.00*
	Declined	10	8.00		
	Approved	10	8.00		
Humour **(AC)**	In Process	11	3.00	.67	.72
	Declined	10	2.00		
	Approved	10	3.00		
Acceptance **(AC)**	In Process	11	5.00	2.60	.27
	Declined	10	7.00		
	Approved	10	7.00		
Religion **(AC)**	In Process	11	8.00	.19	.91
	Declined	10	8.00		
	Approved	10	8.00		

Chapter summary

The results from this chapter suggest that the asylum seeking process is extremely stressful. It suggests as well that the asylum seekers tend to use planning, active coping, positive reframing, religion, self-distraction, acceptance, instrumental support, and emotional support more frequently than the other coping strategies. Hence it can be said that they tend to use more of the adaptive coping strategies than the maladaptive coping strategies. The results also show that the levels of coping (that is, use of self-distraction, active coping, substance use, use of emotional support, use of instrumental support, positive reframing and planning) among the asylum seekers who were still in process were significantly lower than those who had been declined, and those who had been approved. The next chapter will focus on the qualitative results. It presents the participants' description of the coping strategies assessed in this chapter and the participants' explanations for the differences in levels of coping among those who were in process, and those who had been declined or approved.

CHAPTER 6: QUALITATIVE RESULTS

The qualitative results from this study are presented in this chapter. The results are organised in three parts. The first part (Part One) describes the participants' subjective experience of the coping strategies assessed in the Brief COPE scale. The 14 coping strategies and their related questions are presented. Themes are then presented that described each of the coping strategies. The second part (Part Two) focuses on the themes that illuminate the participants' description of the statistically significant differences in levels of coping among those who were in process, and those who had been declined or approved. The themes are derived from the participants' subjective description of their coping experience. The third part (Part Three) describes stress, re-traumatisation, stigma and stereotyping, and hope as four additional themes that have emerged from this study.

6.1 Part One

The 14 coping strategies in the Brief COPE scale (self-distraction, active coping, denial, substance use, use of emotional support, behavioural disengagement, venting, use of instrumental support, positive reframing, self-blame, planning, humour, acceptance, and religion) are presented below. The corresponding questions that assess each coping strategies are presented; and then the themes drawn from the analysis about each coping strategy are described. Quotes from the participants' description are also cited.

6.1.1 Self-distraction

The items in the Brief COPE scale that measured 'self-distraction' were

01. I've been turning to work or other activities to take my mind off the claim.

19. I've been doing something to think about it less such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.

Use of self-distraction as a coping mechanism can be classified into the following themes: use of religious activities for self-distraction; use of vocational activities for

self-distraction; use of physical exercise for self-distraction; use of social activities for self-distraction; and keeping busy at home to self-distract.

6.1.1.1 Use of religious activities for self-distraction

The participants described using religion as the main platform to distract self from the stress from the claim. They attended church, prayed, and meditated regularly. This gave them time off their claim. They also took their minds off the claim by participating actively in events at church such as the choir, groups and conferences.

> *The main activity I did was attending church like regularly and involving, getting involved like in church activities: singing and um involving myself as much as possible in events at the church, maybe conferences yea singing and all that.* (Interviewee 3, Female, p. 30)

6.1.1.2 Use of vocational activities for self-distraction

The participants narrated also using occupational activities for self-distraction. This included taking up paid and/or voluntary employment, helping others in the community, and taking up extra shifts at work in order to stay busy and keep their minds off the stress from the claim.

6.1.1.3 Use of physical exercise for self-distraction

Both the males and females participants in the study described engaging in walks as a means of self-distraction. A majority of the male participants described engaging in indoor soccer (football) as a means of keeping their mind off their claim, whereas the females mostly described using the gym, yoga, cycling and swimming as a means to distract self from the stress.

6.1.1.4 Use of social activities for self-distraction

The participants reported distracting themselves by attending social gatherings in the community. This included Miss and Mr Africa New Zealand (MANZ), and cultural events organised by the African Communities Forum Incorporated (ACOFI), as well as socialising at the Ethnic Soccer Tournament. They also participated in community events organised for refugees including those organised by the Auckland Resettled Community Coalition (ARCC) and Refugees As Survivors New Zealand (RASNZ). Other African community events such as celebrations by the ‘Ndi-Igbo Community in New Zealand’, the Nigerian, Ghanaian, and Kenyan independence day celebrations and

others, were described by the participants as events they attended in order to distract self from the stress from the claim.

In addition to above, the participants narrated distracting self from the claim by chatting with and spending time with flatmates, visiting friends, night clubbing on weekends, and talking on the phone to relations in their country of origin. They browsed the internet as well as use social media platforms such as 'Facebook', 'WhatsApp', IMO, Skype and other messengers to take their minds of the claim.

> *I would use all those, like the various social media to just distract myself and watching soccer or something and other things and eh, on TV watching movies.* (Interviewee 7, Male, p. 71)

A female participant added that she would dress fancifully, and would go out window shopping, and use the public transport as a means of self-distraction.

> *I get vexed and on some days I just dress well, and just go to all these expensive, very expensive shops in the city, just go around, doing window shopping from one place to the other. I will take the bus from one part of the town to the other. I will take the train …* (Interviewee 3, Female, p. 31)

6.1.1.5 Keeping busy at home to self-distract

The female participants reported distracting self from the claim by keeping busy at home. They involved themselves in everyday jobs such as cleaning the house, cooking, and babysitting.

> *Since I have children I think that is like my distraction. Because I have a lot on my plate, so having to take children to school, having to help them with their school work, taking care of them at home as well, that's my day.* (Interviewee 4, Female, p. 43)

Besides keeping busy, both female and male participants also described taking their mind off the claim by listening to music and singing, watching regular programs on television, going to movies, reading, and sleeping for longer hours.

6.1.2 Active Coping

The items in the Brief COPE scale that measured 'active coping' were

> *02. I've been concentrating my efforts on doing something about the situation I'm in.*
>
> *07. I've been taking action to try to make the situation better.*

The participants' descriptions of active coping can be classified into two main themes: taking action to improve the outcome of the claim, and not taking action to improve the outcome of the claim.

6.1.2.1 Taking action to improve the outcome of the claim

A majority of the participants described concentrating effort to improve the outcome of their claim. They spent much time preparing and submitting the claim, attending their refugee status interview, and responding to critical issues raised in their interview report.

> *It took like months and months, and many ups and downs on the application for me to finally fill everything and submit it. Then I also spent so much time preparing for the interview... After the interview, they still sent an interview report with very difficult questions for me to answer. But I managed to spend sleepless nights answering the questions and getting the evidences they wanted*. (Interviewee 1, Male, p. 12)

Some of the actions taken by several of the participants to improve the outcome of their claim included

- Researching on the internet about what it means to be an asylum seeker, and reading about the experiences of others who have been through the asylum process in New Zealand and in other countries.
- Participation in local community activities to demonstrate good citizenship and to solicit support letters for their asylum claim from New Zealanders.
- Seeking professional help from lawyers, psychologists, social workers and peer support from other asylum seekers and friends.

> *I tried to browse through the [United Nations High Commissioner for Refugees] site to see what will happen to me.* (Interviewee 7, Male, p. 71)

> *I always sought help, the help of a psychologist that will always help … me guide my mind, and help me focus on the things that I had to do at every point in time*. (Interviewee 3, Female, p. 31)

6.1.2.2 Not taking action to improve the outcome of the claim

A few of the participants stated that besides submitting the refugee status claim, attending the interview, and responding to issues raised in the refugee interview report, they did not take any other actions to try to improve the outcome of the claim. They did

not know of any other steps possibly that they could have taken to make the situation better.

> *There is really nothing else you can do. Ya, I just have to wait.* (Interviewee 4, Female, p. 43)

6.1.3 Denial

The items in the Brief COPE scale that measured ‘denial’ were

> *03. I've been saying to myself "this isn't real."*
>
> *08. I've been refusing to believe that it has happened.*

Two themes emerged on denial: living in denial, and not living in denial.

6.1.3.1 Living in denial

A few of the participants described living in denial. They stated that they were in denial of what had happened in the country of origin to make them flee as refugees. That is, the participants could not still believe that they have lived through challenging and traumatic experiences. The participants also described not having come to terms with the fact that they were seeking protection as refugees in New Zealand.

> *It is like a dream that [I am] going through it.* (Interviewee 7, Male, p. 73)

Another participant added that she was so immersed in denial to the extent that she decided to dress up and went out shopping so as to deny herself the fact that she was a refugee.

> *I dressed up flamboyantly and went into shops for window shopping. By doing this I was indirectly telling myself that this is not happening to me. It is not me going through it.* (Interviewee 3, Female, p. 32)

6.1.3.2 Not living in denial

Although some of the participants were in denial, a majority were however not in denial. For example, a male participant reported that the refugee status determination process had gone on for a long period of time that he was of the understanding that living in denial would not be helpful. A female participant also stated that she had accepted that becoming a refugee is a matter of fate, and it was meaningless worrying about something she could not change. This group of participants see the refugee status determination process as a temporary and necessary process they must traverse in order to be recognised as refugees in New Zealand.

> *No I haven't been like in denial. I know that this is happening. I think it is just easy to be, I don't know, honest with yourself rather than denying it, I think, is making your situation even worse. You just have to accept that this is what is happening now, and be hopeful. They say no situation is permanent. And I know that at some point, it will end.* (Interviewee 4, Female, p. 43)

6.1.4 Substance use

The items in the Brief COPE scale that measured 'substance use' were

> *04. I've been using alcohol or other drugs to make myself feel better about the claim.*
>
> *11. I've been using alcohol or other drugs to help me get through the claim.*

Two themes emerged on substance use: reliant on substance, and not reliant on substance.

6.1.4.1 Reliant on substance

Two male participants described drinking alcohol (beer and wine) to cope with the stress from the claim. These participants described drinking frequently and mostly on weekends and with flatmates. They described the drinking as helping them to forget about the stress from the refugee status claim.

> *At the time my claim was being processed I was a frequent drinker and mostly on weekends. I mostly drank in the company of [the] kiwi family I was living with... It gave some solace and helped me to sleep and forget about the stress.* (Interviewee 1, Male, p. 12)

Similarly, three female participants described relying on prescription medications to sleep, relief anxiety, and to cope with the stress from the claim.

> *I used uh antidepressants um sleeping medications to help me sleep because sometimes at the middle of the night I get up from sleep and can't go back to sleep because I am thinking a lot.* (Interviewee 3, Female, p. 32)

6.1.4.2 Not reliant on substance

The remaining two participants (a male and female) reported that they did not use the substance (whether alcohol, drugs, cigarettes, or prescriptions medications) to cope with the stress.

> *I haven't been using any alcohol or drugs.* (Interviewee 4, Female, p. 44)

6.1.5 Use of emotional support

The items in the Brief COPE scale that measured 'use of emotional support' were

05. I've been getting emotional support from others.

15. I've been getting comfort and understanding from someone.

Use of emotional support as discussed by the participants in this study can be classified into the following themes: emotional support from family; emotional support from professionals (therapists); emotional support from other asylum seekers (peer support); and emotional support from church members.

6.1.5.1 Emotional support from family

A majority of the participants regarded the host families in New Zealand including family members in the country of origin and elsewhere as being the main source of their emotional support during the asylum seeking process. They identified emotional support as including encouragement, empathy, reassurances, care, listening, and comfort.

> *My siblings became of great emotional support, always encouraging me.* (Interviewee 3, Female, p. 34)

> *They said things like I shouldn't feel bad, and that I should relax, be happy, and just have fun, and take every day as it comes.* (Interviewee 1, Male, p. 17)

6.1.5.2 Emotional support from professionals (therapists)

The participants also described seeking emotional support from persons in professional roles such as therapists (including external supervisors at work, psychologists, and social workers).

> *I found it relieving talking to someone who had some understanding about the situation… My psychologist, she has always been like the person that I can always go to whenever I feel like pouring it out.* (Interviewee 3, Female, p. 33)

6.1.5.3 Emotional support from other asylum seekers (peer support)

The participants interviewed in this study also stated that it was very helpful (emotionally) talking to someone who has had a lived experience of the refugee status determination process in New Zealand. They explained that other former asylum seekers tend to have a good understanding of what they were going through and were very supportive.

I do get some comfort from talking to other people who came as asylum seekers in New Zealand. (Interviewee 4, Female, p. 45)

I have some other friends who have gone through this, so at times when I find myself in a stressful situation I visit them and they try and encourage me. (Interviewee 6, Female, p.65)

6.1.5.4 Emotional support from church members

The participants reported that their church communities served as a supportive environment. They described the church members as being there for them in times of emotional distress. For example, a participant recounted that when her mum died during the refugee status determination process, her church community became her source of emotional support in New Zealand during the very difficult moment.

Like when my mum passed away in my home country, ah they [the church members] were the first people to respond, to come because I went as far as screaming but I had no one around me to wipe my tears. They were the first people to respond... And whenever I needed encouragement, I would call them and they would listen to me talk, and I was free to cry. (Interviewee 3, Female, p. 33)

6.1.6 Behavioural disengagement

The items in the Brief COPE scale that measured 'behavioural disengagement' were

06. I've been giving up trying to deal with the claim.

16. I've been giving up the attempt to cope.

Two themes emerged on behavioural disengagement: contemplative state of giving up; and gave up on the coping and the claim.

6.1.6.1 Contemplative state of giving up

The participants in this group described contemplating suicide or abandoning the refugee status claim. This group of participants are described as being in a contemplative state of giving up. For example, a female participant described the refugee status determination process as extremely stressful, and as a result, she idealised suicide.

Sometimes I feel like, feel like uh I've had enough of this. Sometimes I even thought of taking my life. (Interviewee 3, Female, p. 34)

A male participant stated that he contemplated giving up, that is, abandoning his claim for refugee status. Yet, he felt at the same time that he was bound to follow it through since he had no choice but to traverse the refugee status determination process in New Zealand.

> *I have thought about trying to give up on the claim, but again in my mind I say if I give up, what will I do after that. So I resolved that I don't have a choice but to carry on.* (Interviewee 2, Male, p. 24)

6.1.6.2 Gave up on the coping and the claim

The participants in this group described giving up on coping and on the refugee status claim. For example, a female participant gave up on coping and on the refugee status claim by attempting suicide. A male participant also gave up on the refugee status determination process by not responding to correspondences from his lawyer and INZ. Both participants stated that the stress from the process had become overbearing, making it difficult for them to cope. The female participant recalled the point when she gave up as occurring when she received a letter from INZ informing her that her claim for refugee status had been declined. Unlike these participants, another participant stated that she did not give up on her refugee status claim because her children were involved in the process.

> *I have never felt like giving up, ya because you know, I have children, it is not just me.* (Interviewee 4, Female, p. 45)

6.1.7 Venting

The items in the Brief COPE scale that measured 'venting' were

> *09. I've been saying things to let my unpleasant feelings escape.*
>
> *21. I've been expressing my negative feelings about the claim.*

Venting as described by the participants in this study can be construed in two themes: venting on self; and venting on others.

6.1.7.1 Venting on self

The participants in this group described saying unpleasant things to self. Three female participants narrated channelling their anger and frustration from the claim by disassociating themselves from others and sometimes crying in places like their bedrooms and bathrooms.

There were times that I would lock up myself in my bedroom and I would be in the room by myself and I would talk to myself and cry. (Interviewee 5, Female, p. 59)

Some of the female participants also recounted indulging in self-harm behaviours (for example, severely scratching the skin) as a way of expressing their negative emotions from the claim. The majority of male and female participants described self-talking as a way of venting their frustration from the claim.

6.1.7.2 Venting on others

Several of the participants described venting their anger and frustration from the claim on friends, family, co-workers, case officers including lawyers and therapeutic professionals. They recounted expressing their negative feelings about the refugee status claim by being grumpy or responding to others in an inappropriate manner or anger.

At times it can be stressful and I become so grumpy. (Interviewee 6, Female, p. 65)

A participant described expressing her frustration from the refugee status claim on her children.

They wanna play, they wanna have fun, but I am frustrated because immigration does not give me the answer that I was hoping for. So ya, I tend to scream a lot, and get angry. It is not good especially when I have children because sometimes I can take my anger on my children…, and sometimes they can't understand why mum is so upset today. (Interviewee 4, Female, p. 46)

6.1.8 Use of instrumental support

The items in the Brief COPE scale that measured 'use of instrumental support' were

10. I've been getting help and advice from other people.

23. I've been trying to get advice or help from other people about what to do.

Participants described receiving instrumental support from community organisations; and instrumental support from professionals, and peers.

6.1.8.1 Instrumental support from community organisations

The majority of the participants stated that they received help with accommodation from generous New Zealanders during the period of their refugee status claim. The helpers were mostly from their church communities. Others explained that they got charged only affordable rents. Some of the host families and friends from the church

also provided food and clothing to the participants, assisted with transportation within Auckland, and provided a computer and internet/telecommunications services in the house to facilitate researching and communications with families in the country of origin.

> *I was a little bit privilege to um have someone that was a little bit generous because he was a brother from a Christian background… He provided some assistance… We had some support of people who provided us with accommodation. We paid whenever we generated something. It wasn't like … we were in a rental property that we needed to pay weekly. So that's another de-stressing factor... And um the internet in there was free.* (Interviewee 7, Male, p.72)

These participants described their church communities as being helpful with motivating them to work, and exposure to job opportunities, as well as liaising with potential employers and providing character references. The church also gave hand-outs, and instrumental support in the form of involving them in social gatherings such as picnics and outings.

> *I have received a lot of help through the church. The job I am doing, the very first organisation I worked was through the church. I had a referral from the church.* (Interviewee 2, Male, p.27)

The participants identified the Asylum Seekers Support Trust (ASST) as helping with accommodation at the hostel for asylum seekers and advising through a social worker at the hostel on how to cope with the refugee status claim.

> *People have been helpful especially when we were at the hostel, because we were in an environment where all of us were asylum seekers and the manager there was really helpful in advising us.* (Interviewee 4, Female, p. 47)

Other community organisations such as the Framework Trust, Salvation Army, New Zealand Red Cross, and Society of Saint Vincent de Paul New Zealand were identified as being supportive. For example, a female explained that Framework Trust provided the funding she needed for swimming and yoga exercises while Salvation Army, New Zealand Red Cross and Society of Saint Vincent de Paul New Zealand supported her with hand-outs.

6.1.8.2 Instrumental support from professionals, and peers

The participants recounted receiving professional advice from lawyers, and support from healthcare professionals (psychologists including professional supervisors, and

social workers). In addition, they received advice from others who have had a lived experience of seeking asylum in New Zealand.

> *I met three Pakistanis guys that they just approved them, and they gave me some good insight of what is happening and how could I cope with the situation. And they redirected me to someone [a lawyer] that could help. And actually the lawyer was the person that brought the breakthrough.* (Interviewee 7, Male, p.74)

Besides receiving positive instrumental support, some of the participants had a negative experience with instrumental support.

> *The first lawyer I met made the situation seem very scary and he told me to go back to my country. Then someone advised me to go to the Mangere Community Law Centre. I went there and they gave me an Immigration adviser. She wanted me to move from that and do something else but um it needed a lot of finance. And she was just so negative on the side of asylum, saying they can send me [back] home and they can even send me to prison. So it affected me mentally, all those things.* (Interviewee 7, Male, p.78)

6.1.9 Positive reframing

The items in the Brief COPE scale that measured 'positive reframing' were

> *12. I've been trying to see the claim in a different light, to make it seem more positive.*
>
> *17. I've been looking for something good in what is happening.*

Positive reframing as described by the participants in this study can be classified into two themes; kept a positive mind, and struggled to keep a positive mind.

6.1.9.1 Kept a positive mind

The majority of participants described remaining positive regarding their refugee status claim despite the difficult nature of the process. Most of them stated they remained positive by looking onto and having faith in God that He would take them successfully through the challenging refugee status claim. Example of a challenging situation they experienced during the refugee status claim include when the processing officers were unconvinced or unmoved by the explanations they provided to support their claims. The participants narrated that they stayed more positive about their claim and did not let the interviewing officers' attitudes deter them from pursuing their claim to the end.

> *Despite the fact that it was obvious to me from the beginning of my refugee interview that the processing officer came into the interview with a doubtful and distrustful*

mind, I remained positive at all times during the interview and even afterwards. I did not let his attitude flattened me. (Interviewee 1, Male, p. 15)

A participant described staying positive by thinking during the challenging moments of the security that will come with raising her children in New Zealand should her claim for refugee status be successful. This helped her to keep a positive mind despite the stressful nature of the refugee status claim.

For me positive was that should we get the positive answer what life could be like in terms of safety and in terms of raising children here.... So where you are you must somehow have a positive um outlook to say things will get better. (Interviewee 4, Female, p. 47)

Another participant described the source of his positive mind during his refugee status claim as coming from the experiences of others who had gone through the refugee status process and had a successful outcome. He became positive as a result of the successful story of the others. He assured himself with the fact that, if the others can go through the refugee status determination process and are successful, then he can equally be successful.

I was blessed to meet the three guys so… when they told me that the three of them were approved ... It started giving me some positive thought about it. (Interviewee 7, Male, p. 78)

6.1.9.2 Struggling to keep a positive mind

This group of the participants described struggling to stay positive during the refugee status determination process. Unlike the participant above who had a positive influence from the success of others, another explained that the success of those made it difficult for her to stay positive. This she explained was because all the female asylum seekers who came to New Zealand almost at the same with her had been approved except for her.

Furthermore, a participant explained that he saw his claim in a positive light only in the initial stages of the claim, but he is not seeing his claim again in a positive light since the claim has dragged on for long (being more than five years). Therefore, although he still holds a positive mind that the claim is still possible to achieve, he does not feel positive in the way the claim is progressing.

I can say I was seeing it in a different light in the initial stages. But given the 5 to 6yrs that claim has been going on, it has dragged on for so long. Even though, I still see a

positive outcome, uh that is, I believe that the case will come out positive at the end, but the length of time that the case has taken, it has really affected my being and I don't always feel positive how it is going. (Interviewee 2, Male, p. 25)

The participants who had been on appeal with their claim also described struggling to stay positive with the appeal because they were still negatively affected by the initial unsuccessful attempt. Others described being negatively impacted by the news in 2016 within their community of an asylum seeker who committed suicide while traversing the refugee status determination process in New Zealand. These challenging events left them with a negative mind-set and difficulties staying positive.

I have been trying to have a positive outlook but I have just lost a friend of mine who killed himself going through the same process. So at times it can really hit me. In the meantime honestly I don't know. I always ask myself if I receive again another bad news, how am I going to cope, you know. I have been trying to, you know, stay positive even though it is not easy. I don't know what to believe because I try to believe positive before and the outcome was negative and that is where it can really hit someone hard, you know. (Interviewee 6, Female, p. 66)

6.1.10 Self-blame

The items in the Brief COPE scale that measured 'self-blame' were

13. I've been criticizing myself.

26. I've been blaming myself for things that happened.

Self-blame, as described by the participant can be classified in two themes: blamed self; and blamed others including spirituality and supernatural forces.

6.1.10.1 Blames self

All the participants interviewed in this study described blaming self to some extent for the challenging situation they found themselves in. Firstly, they blame self for not answering the questions well (or not performing well) during the refugee status interview, and for not getting it right with the facts about their refugee status claim.

After the interview I was criticising myself that I didn't respond to some of the questions in an appropriate manner. (Interviewee 1, Male, p. 16)

The participants whose claims for refugee status were declined (at least at the first instance) tend to self-blame more than the others who were successful in the first instance.

> *I criticised myself a lot especially when I was declined on the first occasion. I blamed myself that maybe the decline was because I didn't do well in my interview. Yes, I was asking myself a lot of questions but not getting the answers.* (Interviewee 5, Female, p. 60)

Additionally, they self-blame for the predicaments that happened in the country of origin to make them flee as refugees, and they blame self for not doing enough to avert such predicaments. They recounted living with guilt because of this.

> *You blame yourself that I could have done things differently back home, you know, maybe the situation could have been different.* (Interviewee 4, Female, p. 47*)*

6.1.10.2 Blames others including spirituality and supernatural forces

This group of participants attributed their circumstances and the problems they faced on others. For example, a participant blamed his friends and relations for the difficulties he experienced in the refugee status determination process.

> *I think sometimes I blame some of my friends here in New Zealand. I believe their presence had an effect on my claim in one way or the other.* (Interviewee 2, Male, p. 26)

Another participant associated her predicament on a transgression that might have been committed by her parents or it being the effect of a curse by someone on them. She believed the best way to get rid of the curse was by engaging in a self-cleansing ritual. This she did by washing herself in a waterfall at Piha.

> *I was thinking also that maybe there was a problem somewhere back home. Maybe it is from my father's side. Maybe they did something wrong in the past or someone has something against them because um things are difficult... Always had sad and bad news and maybe this was affecting me too and putting me in the difficult and struggling situations I found myself. So I went to the waterfall in Piha and washed myself from any bad luck that was coming from my father and maybe my mother's side too.* (Interviewee 5, Female, p. 60)

Some of the participants believed and blamed supernatural factors for having adverse effects on their claim for refugee status. They believed an evil spirit was sent by someone to stop them from progressing in life. Some thought the evil spirit was coming from the forces of nature, and the purpose of the spirit was to put them in difficulties and hinder their progress and make them unhappy.

> *I am conscious of the fact that life is spiritual and so sometimes I tend to associate my failures or challenges to some evil forces behind it who do not want me to be happy. They don't want me to succeed in anything I do.* (Interviewee 3, Female, p. 37)

Others blamed God for allowing the predicament to happen to them in the first place, and for not intervening to avert it.

> *Sometimes you do ask like uh you know, why God did allow this to happen, you know. Ya, if God is on my side why do people sometimes have to go through so much pain in life. Why God can't just stop other things before they even happen.* (Interviewee 4, Female, p. 48)

In addition, the participants blamed their case officers for conducting a difficult interview and for staying aloof to their plight.

> *It was rather the approach taken by the interviewing officer. He simply wanted things to come out from my mouth in a way he wanted to hear. He didn't take into consideration the fact that I was in a very difficult situation.* (Interviewee 1, Male, p. 16)

Another participant blamed her lawyer for not doing enough to support her through the refugee status determination process. All the participants blamed the authorities and the instrument of government in Africa for their predicaments.

> *Blaming it on you know, [the] African politics.* (Interviewee 4, Female, p. 48)

6.1.11 Planning

The items in the Brief COPE scale that measured 'planning' were

> *14. I've been trying to come up with a strategy about what to do.*
>
> *25. I've been thinking hard about what steps to take.*

Two themes emerged that reflect planning: strategising on doing something, and unable to strategise.

6.1.11.1 Strategise on doing something

A majority of the participants narrated considering judiciary review or other higher courts if their initial claim for refugee status and subsequent appeal with the IPT were declined.

> *I was determined that should the outcome be a decline, I will keep appealing till it gets to the highest possible level.* (Interviewee 1, Male, p. 16)

They also planned on remaining in New Zealand rather than returning to their country of origin. A participant stated that, in case all the attempts at appeal were unsuccessful, he would rather be detained in New Zealand than repatriated to his country of origin. Another participant said she was thinking about committing suicide if all appeals on her case were unsuccessful.

> *If it is a decline, I will appeal. If the appeal is unsuccessful, I [will] seek humanitarian consideration. If the humanitarian fails, then I don't know what next. Um maybe I will jump into the ocean or I will look for a transformer nearby and hug it* (Interviewee 3, Female, p. 38).

When I heard this participant idealise suicide, I checked with her whether I should be worried that she is planning to commit suicide. The participant responded that there was nothing to be concerned about.

Two other participants described their strategy to deal with the situation as helping others in the community, engaging community organisations and civil societies, as well as contacting international organisations that work with asylum seekers including the UNHCR to highlight their plight. They believed doing these would improve their situation.

> *I am always looking at working or volunteering for charitable organisations in my community. And I am always looking online to join any local and international organisations that support and help asylum seekers. Um I stay active in my community activities and I like helping others. I believe if I keep doing more of this community activities, someday I will find someone or an organisation that will also help me out of this difficult situation.* (Interviewee 2, Male, p. 26)

6.1.11.2 Unable to strategise

While the majority of participants seen above tend to have somewhat of a strategy to deal with the situation, a few of the participants saw the entire asylum process as having brought their life to a standstill. They described the process as having left them in a limbo such that they were unable to come up with a strategy on how to deal with it.

> *The whole asylum process sort of stops your life, you know. You can't really move forward until it is over.* (Interviewee 4, Female, p. 48)

They felt stuck in the process of the claim and felt it was hard to plan since they were not sure whether the outcome of the claim would be an approval or a decline.

It is hard to really plan when you don't know whether the outcome will be a decline or an approval (Interviewee 6, Female, p. 67)

6.1.12 Humour

The items in the Brief COPE scale that measured 'humour' were

18. I've been making jokes about it.

28. I've been making fun of the situation.

Two themes emerged from the use of humour as a coping strategy: use of humour; and no use of humour.

6.1.12.1 Use of humour

Two females interviewed in the study described using and finding humour an effective way of getting through the stress from the claim (at least momentarily). They laughed and joked about it with friends, and found this to be helpful.

Yes, I made jokes but jokes as a way, as a means to release the stress. When I crack jokes about it, it is like the load on me has become a bit lighter. Ya, it gives me a moment away from it. (Interviewee 3, Female, p. 38)

6.1.12.2 No use of humour

The majority of participants in the study described not using humour at all as a coping strategy. Essentially, all the male participants and a female interviewed in the study described not using humour (including even black humour) as a coping strategy. The refugee status determination process to them was critical and likened to life and death, and not something they would ordinarily laugh about.

I didn't take my case as a laughing matter or something to throw jokes about. It was matter of life or death … A joke as I see it; I didn't make fun of the situation. (Interviewee 1, Male, p. 17)

I don't know, maybe others they get, they can get to make jokes about it but I have never. (Interviewee 4, Female, p. 49)

6.1.13 Acceptance

The items in the Brief COPE scale that measured 'acceptance' were

20. I've been accepting the reality of the fact that it has happened.

24. I've been learning to live with it.

Two themes emerged from the use of acceptance: in acceptance, and not in acceptance.

6.1.13.1 In acceptance (see Section 6.1.3.2)

A majority of the participants described accepting the reality of their situation as asylum seekers in New Zealand. They described being bound to accept because they could not ordinarily go back to their country of origin. They also felt there was nothing else they could do but learn to live through the stressful process to be recognised as refugees in New Zealand. Furthermore, this group of participants described seeing the refugee status determination process as a temporary process, and described it as fate. The participants who were largely in acceptance were mostly those who had spent somewhat longer period of more than 12 months pursuing the refugee status claim. An example could be seen in this male participant who stated

> *I have been accepting the reality of the fact that I am going through this claim. It is now a reality because mine has taken so many years... It is now five to six years and has become a reality and a part of me…* (Interviewee 1, Male, p. 27)

A position also held by a female participant in the study who had taken over 20 months traversing the refugee status determination process.

> *I have accepted that, you know, we are asylum seekers. So I have learnt really to live with it.* (Interviewee 4, Female, p. 50)

6.1.13.2 Not in acceptance (see Section 6.1.3.1)

Participants reported being in denial of what had happened in their home country to make them flee as refugees. They recounted not being able to accept the fact that they were now seeking protection as refugees in New Zealand. The participants who were not in acceptance of their situation as asylum claimants were mostly those who had been in the process for less than 12 months. Besides those who had not accepted their situation, there was another group of participants who were in limbo and in confusion, not knowing whether they have accepted or not (see Section 6.1.11.2).

> *I can't really accept it because it is a situation where I am hoping and, you know, but when the outcome comes, it is something else… I don't know what to say, whether I have accepted it or not.* (Interviewee 6, Female, p. 68)

6.1.14 Religion

The items in the Brief COPE scale that measured 'religion' were

> *22. I've been trying to find comfort in my religion or spiritual beliefs.*
>
> *27. I've been praying or meditating about the claim.*

The participants' description of religion indicated that it is a fundamental coping strategy that cuts across several of the other coping strategies such as self-distraction, emotional support, instrumental support, and positive reframing One participant even referred to it as 'the rock' of her coping.

> *The thing that has really helped me cope is my religion. Definitely, that. That has been my rock, I would say.* (Interviewee 4, Female, p. 51)

Religion can be group into two themes: the source of comfort and strength; and the hub for self-distraction, emotional, instrumental and peer support.

6.1.14.1 The source of comfort and strength

All the participants interviewed described religion as being a comforter during their experience as refugees. They also described gaining much strength to traverse the refugee status determination process from phrases in the Bible.

> *I find comfort in my religion. Ya, I find comfort in my spiritual belief because that's the source of my strengths and with my spiritual belief, I am comforted by the fact that whatever I go through is for a time, and that it will pass, and whatever challenge I face, is there to make me stronger not to break me. Ya, it is a stepping stone for me not a drawback... Ya, so irrespective of what I am going through, God is still in control and I can make it.* (Interviewee 3, Female, p. 39)

Spirituality also played a dominant role in their coping process as they recounted always praying, meditating and having faith that God will take them successfully through the process; and that He would bring a positive outcome to their situation regardless of the challenges they face (see Section 6.1.9.1). Religion thus kept them hopeful and believing they can make it.

6.1.14.2 The hub for self-distraction, emotional, instrumental and peer support

As seen earlier under 'self-distraction', 'use of emotional support' and 'use of instrumental support', the participants described religion as a significant coping mechanism in several ways. The church community was primarily identified by

participants as an avenue where members provided comfort, consolation, encouragement and emotional support during the refugee status determination process (see Section 6.1.5.4).

Additionally, church members helped them to cope with the process by providing advice, financial assistance, accommodation and communications support, as well as motivation and support with finding employment (see Section 6.1.8.1). Furthermore, the church served as a resource for peer support. Lastly, it served as an avenue where participants distracted themselves from the stress from their refugee status claims by going for outings, picnics and other activities with church members (see Section 6.1.1.1).

In sum, in this first part of the qualitative results, the participants' description of the coping strategies assessed in the Brief COPE scale has been outlined (Table 23). It shows that each of the coping strategies evaluated in the Brief COPE scale was meaningful to the population in this study. Thus, within the context of the population in this study, it can be said that the Brief COPE scale is a suitable tool for assessing coping strategies for asylum seekers. The findings in this part highlight as well that the participants did not use humour substantially (or they did not find humour functional) within their context as asylum seekers. In addition, their notion of self-blame extends beyond the western notion of self-blame, to blaming others, spiritual and supernatural forces.

Table 23: Summary of coping strategies and corresponding themes

Coping strategy	Themes
Self-distraction	1) Use of religious activities for self-distraction. 2) Use of vocational activities for self-distraction. 3) Use of physical exercise for self-distraction. 4) Use of social activities for self-distraction. 5) Keeping busy at home to self-distract.
Active coping	1) Taking action to improve the outcome of the claim. 2) Not taking action to improve the outcome of the claim.
Denial	1) Living in denial. 2) Not in denial.
Substance use	1) Reliant on substance. 2) Not reliant on substance.
Use of emotional support	1) Emotional support from family. 2) Emotional support from professionals (therapists). 3) Emotional support from other asylum seekers (peer support). 4) Emotional support from church members.
Behavioural disengagement	1) Contemplative state of giving up. 2) Gave up on the coping and the claim.
Venting	1) Venting on self. 2) Venting on others.
Use of instrumental support	1) Instrument support from community organisations. 2) Instrumental support from professionals and peers.
Positive reframing	1) Kept a positive mind. 2) Struggling to keep a positive mind.
Self-blame	1) Blamed self. 2) Blamed others, spirituality and supernatural forces.
Planning	1) Strategising on doing something. 2) Unable to strategise.
Humour	1) Use of humour. 2) No use of humour.
Acceptance	1) In acceptance. 2) Not in acceptance.
Religion	1) The source of comfort and strength. 2) The hub for self-distraction, emotional, instrumental and peer support.

6.2 Part Two

In this part, themes are presented that relate to the participants' explanations for the significant differences in coping levels between the group that was still in process and the declined and the approved groups. Results suggested that the levels of coping among the asylum seekers who were still in process were significantly lower than those who had been declined, and those who had been approved in use of self-distraction, active coping, substance use, use of emotional support, use of instrumental support, positive reframing and planning. This section presents the themes from the participants' descriptions that explore these significant results.

6.2.1 Changes in stress levels and coping behaviours through the refugee status determination

A majority of the participants in the 'in process' group were still in the initial stage of their refugee status claim and had yet to attend the refugee status interview. Their description of the stress and coping from the refugee status determination was less dramatic than the participants who had already participated in the refugee interview. For example, when a participant was asked to identify a point in the refugee status determination that was very stressful, the participant described his experience of the refugee status interview as follows

> *The interviewing officer had so many questions about my situation. I was really distressed, I found myself in a difficult situation and I was uncomfortable.* (Interviewee 1, Male, p. 12)

And then he added

> *At first, I didn't bother, and um, I didn't listen to the stress until it was really heavy and starting to crush me. And this was really starting to happen immediately after I attended interview. Yes, it was, until I had to do something about it*. (Interviewee 1, Male, p. 13)

The participant then likened his interviewing experience to being caught up in the "lion's den" (p. 16).

Another female participant also reported that the stress she experienced from the claim escalated when she received a letter of decline from INZ.

> *I think it was much better at that time because that was my first claim but when it got declined that's when the stress starts piling up*. (Interviewee, Female, p. 65)

In sum, the participants described experiencing substantial levels of stress before the refugee status interview. However, the stress increased dramatically after they had attended the asylum interview. Similarly, the participants whose claims for refugee status were declined also experienced a dramatic increase in stress. Hence it was largely at the post-interview juncture and post-declined juncture that the participants actively engaged in more coping behaviours (be it adaptive or maladaptive coping strategies).

6.2.2 Emotional unawareness in early days of claim

The majority of participants 'in the process' group were still in the very early days of their claim and may not have realised that the refugee status claim was already taking a toll on their mental health. Also, the participants may have known that the refugee status determination process was stressful on them, but had not considered or thought well about ways of dealing with the stress. So they simply got on with life while traversing the refugee status determination process and did not listen to their body until things started getting out of hand. It was at this later stage that they realised they must find ways of coping with the stress.

> *Initially I thought it will be an easy and straightforward process but I soon learnt the hard way several months after that it was not easy emotionally especially as it was taking long and forever, you know. I think for most of the time I didn't listen to what my body was saying until it got to a point when I was feeling like giving up. That's when I had to seek help from friends, and from my external supervisor at work.* (Interviewee 2, Male, p. 24).

A female participant recalled that she only sought or got therapeutic help after her lawyer triggered the process of getting emotional support. Prior to the meetings with her lawyer, the participant had not realised that she was being overwhelmed by stress and that she needed help.

> *As I began meeting with the lawyer regarding my case, the lawyer saw some things in me and said I was not alright, and so she decided that I needed therapy. So she triggered the process for me to get help from the psychologist.* (Interviewee 3, Female, p. 35)

Another participant described that she only realised she needed help when she was suicidal. It was not until the participant started meeting the psychologist that she was able to take more active and positive steps to cope with the stress. The psychologist helped her to understand what was happening and taught her how to cope with it.

I got that information when I was already going through suicidal. Ya the psychologist intervened. (Interviewee 6, Female, p. 66)

6.2.3 False sense of resilience and mental preparedness

Some of the participants interviewed reported believing during the very early days of their claim that they were strong enough to go through the claim process without needing great coping strategies. As explained by this participant

I thought I could handle it. (Interviewee 1, Male, p.13)

And he added that

I have survived tougher situations in my country, you know, before I came to New Zealand…. In the first two or three or more weeks of my claim, I was having headaches and finding it difficult to concentrate but um I told myself I have seen it all back there and survived terrible situations. So this wasn't going to be anything more than just, you know… (Interviewee 1, Male, p. 13)

Another described her experience as follows

I was born in [....] and I also lived in [.....] for some time [names of both countries withheld by researcher to safeguard the participant's privacy]. The crime there was a lot. Especially where I was staying, I saw people being ambushed by gangs... And I also had some terrible experiences as a gay person in Africa. Gangs of men beat me up several times because I was gay. So finally when I got here, I just felt relieved and I thought I was safe. Hmm I didn't go for counselling and anything like that. Hmm I didn't even think I will be needing emotional help. I thought I was strong and fine. It only dawned on me when it took a different turn and hmm I wanted to kill myself. That's when the psychologist came in. (Interviewee 5, female, p. 58)

Many of the participants left their country of origin and embarked on the journey as refugees believing that they are well prepared mentally to deal with the situations they would face. The participants tended to rely on their survival instincts to travel all the way to a country as isolated from the rest the world as New Zealand. While in New Zealand many have continued to count on the mental preparedness and thus were reluctant in the early days of their claim to seek or utilise the emotional support systems that could help them to cope with the stress. Ultimately, they learned in the later stage of the claim (usually at the refugee status interview and beyond) that the process is much more mentally demanding than they had expected.

As the process went on, um I started realising that it was more intense than I had expected. (Interviewee 3, Female, p. 35)

6.2.4 False sense of safeness and security

Linked to false sense of resilience and mental preparedness is false sense of safeness and security. The participants relied on a false sense that they were safe at last, having come from some of the countries with arguably the worse human rights records in Sub-Saharan Africa compared to the safe standards in New Zealand. Additionally, having lived through and fled traumatic experiences, and perhaps put their lives at grave risk in the course of the voyage to New Zealand; the participants tended to have a false sense of security. They believed that they had already seen and survived the worse that could be thrown at them. So living in that false sense of being safe and secured, they believed they could cope naturally with the claim process now that they are finally in a western country where everything seems smooth. They held onto this false sense of safeness and security, and then began the refugee status determination process without seeking the much needed emotional or instrumental support until the emotions became very difficult to curtail as they progress through the refugee status interview.

6.2.5 Unfamiliar with the notion of professional therapy

The participants in the 'in process' group may have scored significantly lower on the use of emotional support than the declined and approved groups because some of the participants stated that in the initial days of the claim, they were not familiar with the notion of professional therapy. For example, a male participant explained that the idea of seeing someone in a paid role for emotional support was entirely new to him. He stated that he was not familiar with the concept that he could seek emotional support from someone in a paid role like a counsellor, psychotherapist, psychologist and others. The participant also added that he would have found it strange in the early days of his claim to use the services of a therapist. Describing his experience of the concept of professional (emotional and instrumental) support, the participant stated that

I think it was still a bit strange to me especially in those early days when I was still very new in the country and was still going through the process as an asylum seeker. But I think I am much familiar to it now after having lived here for years, but not then… I was not used to it. It was strange for me to just open up to people I just met in my life and tell them all I had been through in my home country. So as an African, I

found it difficult to use that emotional support despite that it might have been available… I think most ordinary New Zealanders would have easily used the Kiwi family or other professional therapies in the community, open up and freely talk about the details of their claim and life experiences thereby reducing in some way the stress they were encountering, but um I found it very difficult... (Interviewee 1, Male, p. 18)

Another added that

Therapy I have never done it because..., I don't know maybe for other people it works but I was just never ready to sit and start talking my story to someone. (Interviewee 4, Female, p. 44)

The participants stated however that they were familiar with seeking emotional support from within their community (that is, from family, friends, extended families and elders in the community). Unfortunately, being new as asylum seekers in New Zealand, this familiar network of support was not readily available to them upon arrival in the country.

6.2.6 Concealment of status as asylum seekers

Linked to the unfamiliarity with the role of professional, emotional support is the fact that the asylum seekers who were still traversing the refugee status process (and the majority of those in the initial stage of their claim) were strictly reserved or concerned that someone else would hear about the facts of their refugee status claim. As noted by a participant who was concerned that others in his community would hear about his refugee status claim. He decided to be reserved with his status as an asylum seeker and did not seek the helped he needed from the early days of the claim.

I have kept my refugee claim very confidential. (Interviewee 2, Male, p. 23)

This group of participants stated that being new in New Zealand they found it hard and uncomfortable to trust anyone they met for the first time, including even flatmates. Hence they preferred not to talk to anyone about their refugee status claim until they knew the person was trustworthy.

I found it very difficult talking my issues to them even when they had initiated the conversations. (Interviewee 1, Male, p. 18)

6.2.7 Not enough knowledge on instrumental support

The participants described lacking information during the asylum seeking process that could have helped them access instrumental support. This was a common phenomenon

for those who were in the early days of the refugee status determination process. A majority of them had spent very minimal lengths of time in the country before initiating their claims for refugee status. Some had to claim refugee status upon arrival at the Auckland International Airport. Others had been in the country for a few weeks to a few months before starting their claims for refugee status. Thus, the participants had very minimal or no knowledge of the services or persons in the community that could be of instrumental help to them.

> *Being new in New Zealand and not knowing people, not knowing my way around…* (Interviewee 3, Female, p. 33)

Furthermore, the participants narrated that they were not informed by the INZ of the relevant services in the community that could offer instrumental support except the information that was provided on how to contact lawyers in the legal aid system. They described not having enough or receiving confusing information on where to find employment and access healthcare services. For example, a participant described not being able to register at a primary healthcare service (General Practitioner - GP) because the administrator at the service thought she had to be a permanent resident of New Zealand before she can register. Even though the participant tried to explain that she was an asylum seeker in New Zealand, the administrator still did not understand who an asylum seeker was and whether or not they can access primary health care in New Zealand without having lived here for two years.

> *I remember once I had to register for a GP and when I got there this lady didn't even understand, you know, what I was talking about, and just like oh no you have to be here for like 2 years before you can register with this GP*. (Interviewee 4, Female, p. 52)

6.2.8 Inadequate familiar emotional support

A majority of the participants in the study did not have family members and friends with them upon arrival as asylums in New Zealand. Only two participants in the qualitative phase of this study (the interviews) had dependent children in New Zealand at the time of their refugee status determination process. Some other participants were in relationships and have dependent children, but their partners or the children were still in the country of origin. Thus, many of the participants did not leave their home countries together with their existing support networks. That is, they did not have

family members or friends with them in New Zealand who could readily support them emotionally.

> *But it is not easy in New Zealand especially when you come, you don't have any family, friends and nothing.* (Interviewee 4, Female, p. 45)

However, the asylum seekers who had been in New Zealand for longer periods, (most of whom were in the 'declined' or the 'approved' groups), tended to have built new networks of friendships and relationships in the country. These new networks supported them emotionally. In contrast, the asylum seekers who were just arriving in New Zealand (that is, most of those in the 'in process' group) had not built these supportive networks yet. It is not, therefore, surprising that the participants who were in the 'in process' group scored significantly low on the use of emotional support.

6.2.9 Dispirited by self-stigma

The participants described the public perception of asylum seekers and refugees as sometimes not friendly and not welcoming. They believed asylum seekers are being stigmatised because of their backgrounds as refugees. As a result they were uncomfortable and reluctant to approach people or public offices to seek help as asylum seekers who were still going through the process. They were shy and did not know how others would react to their demands as asylum seekers.

> *There is that sort of like stigma being an asylum seeker. It makes you very uncomfortable. Yes, definitely. Also things of like going to your GP, you know having to explain by yourself, no I am an asylum seeker. Ya, they said I must get a doctor, and register… It is very uncomfortable.* (Interviewee 4, Female, p. 52)

Table 24 is an outline of the themes that describe the statistically significant results observed between the 'in process' group and the other two groups (declined and approved). It is worth noting that these themes relate mainly to the participants' explication for the low scores in active coping, self-distraction, use of emotional support and use of instrumental support. The participants' account was however not sufficient (inconclusive) to explain the significant results observed in those who were in the early days of the claim (in process group) as they scored significantly lower in substance use than the other two groups (declined or approved).

It was also observed that in planning, those who were still in the early days of the claim (the in process group), scored significantly lower the other two groups (declined and approved). The participants' description of their experience of planning during the

refugee status determination process provided some clarification as to the significant results. They explained that they felt they were stuck (were in a limbo or at a standstill) in the process of the claim. Hence it was hard to plan since they were not sure whether the outcome of the claim would be an approval or a decline (see Section 6.1.11.2).

In addition, regarding positive reframing, the participants described starting the refugee status determination process on a reasonably positive mind-set and had to stay more positive in order to cope till the end of the process, especially after being challenged by the interviewing officers as to the veracity of their claim (see Section 6.1.9.1). They described having to maintain a positive mind-set in order to cope with a declined claim and to lodge an appeal, although sometimes during the appeal process they struggled to stay positive because of the impact of the initial decline.

Table 24: Outline of the themes explaining low levels of coping between the in process group, and declined or approved groups.

The period leading to the RSB interview and a decision by RSB.

The in process group recorded lower levels of coping than the declined or approved group in

1) Active coping
2) Self-distraction
3) Use of emotional support
4) Use of instrumental support
5) Substance use
6) Planning
7) Positive reframing

Explanations for low levels of copings by the in process group

1) The stress levels and use of coping strategies increased post the refugee interview and post a decline
2) Emotional unawareness in early days of the claim
3) False sense of resilience and mental preparedness
4) False sense of safeness and security
5) Unfamiliar with the notion of professional therapy
6) Concealment of status as asylum seekers
7) Not enough knowledge on instrumental support
8) Inadequate familiar emotional support
9) Dispirited by self-stigma

However, same levels of copings was recorded by the in process group and the declined/approved groups in

8) Religion
9) Acceptance
10) Venting
11) Denial
11) Self-blame
13) Behavioural disengagement
14) Humour

6.3 Part 3

This part presents four additional themes that have emerged from the analysis of the qualitative data. The themes are stress, re-traumatisation, stigma and stereotype, and hope.

6.3.1 Stress

Stress emerged as a fundamental theme from the participants' description of their coping. The entire refugee status determination was largely described as stressful by the participants. The participants narrated having many sleepless nights and going to bed in tears, and sometimes crying in the shower during the period the claim was being processed. For example, a male participant gave an account of his experience as follows

> *It was daunting. Even before I finally went for the interview, I was already having nightmares. I didn't know what to expect. I will spend hours and hours thinking about it and sometimes I simply could not sleep. I also had nightmares. Sometimes it was re-traumatising.* (Interviewee 1, Male, p. 19)

Similarly, a female participant described her account as follows

> *It is very stressful. Ya, very stressful sometimes I go to bed crying on my pillow, by myself.* (Interviewee 4, Female, p. 49)

The participants described experiencing anxiety, especially during the waiting period for a decision on the claim, as well as living in fears of looming deportation to the country of origin in the event that their claim was unsuccessful. It was also observed that the anxiety, fear, uncertainty and emotional distress tended to intensify in the period immediately leading up to the refugee status interview and afterwards.

Other sources of on-going stress during the refugee claim were separation from family and inability to return home in a family emergency like funerals. Problems obtaining employment and accessing health services, and barriers accessing social welfare, including difficulties finding accommodation in the wider Auckland region were also described as significant sources of stress.

6.3.2 Re-traumatisation

The participants described experiencing re-traumatisation from the refugee status claim. Principally, they described being re-traumatised by the asylum interview. The

participants interviewed in the qualitative phase of this study mentioned some accounts of premigration traumatic experiences that included having their lives threatened, being tortured and raped. They stated that the refugee status interview brought memories of some of these incidences.

> *It was very terrible. It was like going back to childhood experiences. Ya, old wounds reopened, and everything just came crashing back heavily on me and there was no easy way out… When they asked me those questions that made me go deeper and deeper like talking about um torture, rape, abuse,…, it was then that it finally caved in on me, especially by the end of the interview and after I got out of there, and I got to my place, um I just felt like ending it, yes overdosing on meds.* (Interviewee 3, Female, p.35)

In addition to the stressful circumstance experienced by the participants, some of the participants narrated living in guilt, sadness and anger triggered by the refugee status interview. They described the refugee status determination process as reopening "old wounds" in their life and they were "not able to sleep pass them" (Interviewee 3, Female, p. 32). Participants had difficulties concentrating and often suffered nightmares. Additionally, some of the participants stated that, during the refugee status interview, they tried to avoid talking about their premigration traumatic experiences but were interrogated by the interviewing officers and made to talk about them, and this re-traumatised them.

6.3.3 Stigma and stereotype

A majority of the participants stated that they did not feel comfortable seeking emotional and instrumental support because of the negative public stereotypes about asylum seekers. They narrated living with self-stigma as asylum seekers and being shy to ask for help from the New Zealand public. They also described being shy to disclose their status as asylum seekers to others because they believed the public had negative stigma and stereotypes about asylum seekers.

> *It was very scary to approach some people to say that I want to go through the process. I was just saying what if they say my claim is not true. That was always on my mind. People would say I am giving false information... And um I believe that from the perspective of our situation, they will always look at where we are coming from, [the] background that we're from and receive us from the negative side. So it also had a significant impact on me. And from that perspective I was thinking negative with regards to my case.* (Interviewee 7, Male, p. 73)

6.3.4 Hope.

Hope emerged as a vital theme from the participants' description of their coping. A majority of the participants recounted that the main thing that kept them going during the voyage to New Zealand and through the refugee status claim was the hope of a positive outcome and the hope of a better life in New Zealand.

> *So you gotta have hope, and I think human beings we move on, we do things, we take chances is because we are hopeful of something better.* (Interviewee 4, Female, p. 50)

Their hope was sustained by the successful stories of other former asylum seekers and religion was fundamental in keeping the hope alive.

> *I just hold on something, and I believe it was my belief system that kept me. The God that I believe in kept me alive.* (Interviewee 7, Male, p. 76).

Hope was described variously by the participants. For example, a participant described her hope in the process as follows

> *Even though it is long and exhausting but I was hopeful there is like uh, you know, light at the end of the tunnel.* (Interviewee 4, Female, p. 45)

Another recalled that hope as follows

> *There was some hope in me, but that hope was only like a candle in a dark room somewhere but I held on it.* (Interviewee 7, Male, p. 76)

Chapter summary

In sum, stress, re-traumatisation, stigma and stereotyping, and hope were four additional fundamental themes that emerged from the participants' subjective description of their coping experience. Overall, in this chapter, I have described the coping strategies assessed in Brief COPE scale from the participants' perspectives and experiences. I have also provided the participants' explanation for the differences observed between the group which was in process (mostly made of those who were still in the early days of their claim), and the approved/declined groups (mostly made of those who had been in the claim process somewhat longer). The next chapter will focus on the discussion, limitations, recommendations and conclusions of this study.

CHAPTER 7: DISCUSSION

In this chapter, I discuss the results of this study. I begin the chapter by presenting a summary of the results of the study. The results are then discussed and the implications for the asylum seekers, policy and services are discussed; and the limitations of the study described. The chapter ends with recommendations and conclusions.

7.1 Overview of the results

Although the primary focus of this study was to investigate the coping strategies of the Sub-Saharan African asylum seekers, the asylum seekers were also asked to rate the level of stress from the refugee status determination process. Perhaps, it would have been an untamed excitement assessing how the asylum seekers cope with stress from the refugee status determination process without also establishing whether or not the process is in fact stressful to them. The participants revealed that the refugee status determination process is an extremely stressful process.

Over 80 percent of the 31 asylum seekers in the quantitative phase reported their levels of stress from the process at extreme (recorded 10 on a scale of one to 10). Additionally, the descriptions of the experiences of coping provided by the seven participants interviewed in the qualitative phase of the study reflected that the process is burdened with stress, re-traumatisation, stigmatisation and stereotypes. These findings are not surprising given similar observations of the stressful nature of the refugee status determination process that have been reported in other studies with asylum seekers in New Zealand and overseas (Bloom & Udahemuka, 2014; Schock et al., 2015; Uprety et al., 1999).

Besides the direct stress from the refugee status determination process, the asylum seekers experienced significant stress from other socio-demographic factors such as separation from family members, difficulties obtaining employment, accessing healthcare services, social welfare and lack of housing. Other studies in New Zealand and overseas have reported fairly the same challenging experiences faced by asylum seekers (Bloom & Udahemuka 2014; Douglas, 2010; Essex, 2013; Mann & Fazil, 2006). However, this study found that hope for a better outcome and better life was vital

in helping the asylum seekers through the refugee status determination process in New Zealand. In addition, the asylum seekers tended to use more of the adaptive coping strategies than the maladaptive coping behaviours.

For the first time it is demonstrated that seekers in the early days of the claim (those in process) tend to cope differently from those who have been declined or approved. That is, those in process reported lower levels of coping than the declined and approved in self-distraction, active coping, substance use, emotional support, instrumental support, positive reframing and planning. These results are discussed further in Section 7.2 and Section 7.3.

In terms of the use of the individual coping strategies assessed in the Brief COPE scale, the study shows that religion is a fundamental coping strategy for Sub-Saharan Africans (see Section 6.1.14). The use of religion cuts across several of the other coping strategies such as self-distraction, emotional support, instrumental support and positive reframing. The results on religion are discussed in detail under Section 7.4.

Furthermore, this study suggests that the Brief COPE scale is generally an appropriate tool for assessing coping behaviours in asylum seekers from Sub-Saharan Africa, although there are some limitations. For example, there are differences between the Western worldview and African worldview in the conceptualisation of coping strategies such as humour and self-blame. Section 7.5 details the appropriateness of the Brief COPE scale in the Sub-Saharan African context.

Lastly, the participants' description of their experiences of venting and use of emotional support was, to some extent, counterproductive as discussed in Section 7.6. Contrary to the general categorisation of self-distraction as a maladaptive coping strategy (Meyer, 2001; Monzani et al., 2015), self-distraction was considered an adaptive coping strategy in this study. Self-distraction is discussed in detailed under Sections 7.2 and 7.7.

7.2 Adaptive and maladaptive coping strategies

This study indicates that the asylum seekers tend to use more of the adaptive coping behaviours than maladaptive coping behaviours. The coping strategies that were used most by the asylum seekers included planning, active coping, positive reframing, religion, self-distraction, acceptance, use of instrumental support and use of emotional support (refer to Table 21).

Regarding the reported utilisation, these coping strategies were the most common coping behaviours used by the participants. They are usually classified as adaptive coping behaviours, excepting self-distraction (generally classified as a maladaptive coping strategy) (Meyer, 2001; Monzani et al., 2015). In this study, I provide a new perspective on self-distraction as an adaptive coping. Other scholars have classified the coping strategies listed above as effective (Rohde et al. 1990) or positive (O'Brien & Leafman, 2012) coping.

It can said that, despite the stressful nature of the refugee status determination process and the limited resources available to the asylum seekers, they - Sub-Saharan African asylum seekers (at least those in this study) report using more of the adaptive coping behaviours than maladaptive coping behaviours. One might hypothesise that with the extreme stress from the refugee status determination process and the challenges they face with limited resources, asylum seekers would use more maladaptive coping behaviours such as venting, denial, substance use, behavioural disengagement and self-blame. This study demonstrates otherwise.

Nevertheless, the results of this study are not surprising. They confirm an assertion made by the UNHCR (1996) that refugees should not be seen as being entirely vulnerable and a burden on the host countries or people that will always depend solely on hand-outs. The UNHCR (1996) notes that, despite the traumas, psychological and physical health difficulties that refugees have lived through, they are a resilient people, and it is because of their ability to survive difficult situations that they are able to become refugees in the first place.

The implications of the statement above to New Zealand and other refugee host/destination countries are far reaching. They indicate that asylum seekers and refugees are people who, despite their vulnerabilities, are endowed with a lot of strengths, capabilities and resilience. Therefore, if asylum seekers are given appropriate interventions and opportunities, they could grow into becoming assets to the country. Instead, they are being pushed to the fringes of society and made to become arguably "one of the most silenced and at risk groups within society" (Pickering & Lambert, 2001, p. 219).

The results of this study are significant because it is the first to use the Brief COPE scale to explore the coping strategies of asylum seekers. Insights drawn from other studies that have used the Brief COPE scale in refugee (not asylum seeking) populations provide context for the findings of this study. The first was an honours

research thesis that investigated stressors, coping strategies, and meaning making of Liberian refugees living in a refugee camp in Ghana (Sarfo-Mensah, 2009). Results from the study indicated that the most frequently endorsed coping strategies were adaptive. They included religion, planning, positive reframing, acceptance, active coping, use of instrumental support and emotional support (Sarfo-Mensah, 2009). A similar report of use of mainly adaptive coping strategies was observed in a study that explored coping among Bhutanese refugees in Nepal (Chase et al., 2013).

Even though the results from this study seem promising as they indicate that the Sub-Saharan African asylum seekers use more of adaptive coping behaviours than maladaptive coping behaviours, the results are not entirely optimistic. The incidence and form of maladaptive coping behaviours are concerning. For example, the asylum seekers frequently used venting, substance use, denial, self-blame and behavioural disengagement (refer to Table 21). The frequent use of these strategies raises concerns as to the mental and emotional wellbeing of the asylum seekers in the communities (Carver et al., 1993).

In this regard, two male participants interviewed in this study narrated that they consumed alcohol regularly to cope with the stress from the refugee status determination. Likewise, two female participants narrated that they could not sleep even after taking antidepressants or 'sleep tablets'. Three participants recounted that the stress from the process had become enormous that they contemplated giving up on the claim and/or gave up on the claim by attempting suicide. A couple of the participants narrated an account of a friend who committed suicide in New Zealand in 2016 as failed asylum seeker. Another participant stated that she would sometimes direct her anger and frustration from the claim at her children by yelling at them. These are very concerning situations. Despite asylum seekers most frequently endorsing adaptive coping strategies, reports of the times where they have used and the way they used maladaptive coping strategies show beyond reasonable doubt that their mental and emotional health is vulnerable and they need help immediately.

One does not need to look far afield to see that the mental and emotional problems are prevalent among asylum seekers and refugees (Essex, 2013; Uprety et al., 1999), and there is already growing concern over the mental health of refugees in New Zealand (Mortensen, 2011). There have been concerns in the past on the need for emergency psychiatric teams to work with asylum seekers and refugees in New Zealand (Young & Mortensen 2003). In the same way, the Department of Labour (2004) observed in

another study that more than one-third of recently arrived asylum seekers in New Zealand reported experiencing emotional problems at their first six months in the country.

These studies were conducted more than 10 years ago but to date there is no current study in New Zealand on the prevalence of mental disorders and mental illness in asylum seekers. Studies overseas have likewise recognised high rates of psychiatric disorders among refugees and asylum seekers, including post-traumatic stress disorders (PTSD), depression, anxiety, somatization and substance abuse disorders (Al-Obaidi, West & Fox, 2015; Fazel, Wheeler & Danesh, 2005; Hollifield et al., 2009; Kirmayer et al., 2011; Pitman, 2010; Pumariega, Rothe & Pumariega, 2005; Summerfield, 2001).

Although it is almost inevitable that having had the traumatic experiences that most asylum seekers have had fleeing persecution, and that they are likely to need psychiatric care at some point in their life, their plight seems to be disregarded in New Zealand and off shore (Bloom & Udahemuka, 2014; Douglas, 2010; Essex, 2013; Mann & Fazil, 2006). The New Zealand government has passed increasingly deterrent and punitive legislation concerning asylum seekers; a trend preceded by the UK, Australia, and most recently the European Union (Bogen & Marlowe, 2017).

The New Zealand Immigration Act 2009 and Immigration Amendment Act 2013 represent the government response to international events and concerns of the new millennium (West-Newman, 2015). The legislations were used as a weapon to dissuade potential asylum seekers (and people smugglers) from choosing New Zealand as an attractive place for refuge (Bogen & Marlowe, 2017). West-Newman (2015) assert that as in other larger and more influential Western nations, policy and practice in New Zealand have been strongly driven by fear and shaped through ethnic stereotyping that reflects perceptions of threat from dangerous strangers, despite the absence of local empirical evidence to that effect.

Ironically, as legislation and policy are used to make things harder for asylum seekers, concerns over the mental health of asylum seekers and refugees continue to grow (Douglas, 2010; Essex, 2013; Mortensen, 2011; Pitman, 2010; Summerfield, 2001; Tribe, 2002). Studies have indicated that postmigration stressors exacerbate existing stress and worsen the mental well-being of the asylum seekers and refugees (Schock et al., 2015; Sinnerbrink et al., 1997). In addition to high exposure to conflict, torture and trauma before attempted migration, there is evidence to suggest mental health is

significantly poorer in refugee and asylum seeker populations after arrival in settlement countries (Essex, 2013; Uprety et al., 1999).

Even more challenging is the fact that there are inadequate numbers of culturally appropriate and trained professionals to deal with experiences unique to asylum-seekers and refugees (Bloom & Udahemuka, 2014; Uprety et al., 1999). The point of this argument is reflected in a study by the Department of Labour of New Zealand. The study, which described resettlement experiences of refugees over a broad range of areas including their arrival experiences, did not consider questions about the participant's experiences with mental health because mental health was deemed too sensitive, and there were inadequate mental health clinicians to provide interventions (Department of Labour, 2004).

There is a need therefore for services to be geared towards early interventions in the mental health of asylum seekers, instead of adopting tough and restraining policies that trigger or exacerbate existing mental health problems for the asylum seekers that most probably will be critical to deal with later on. The importance of early interventions in mental health cannot be overemphasised (Al-Obaidi et al., 2015; Bell, 2011; Weine, 2011). The initial medical screening for asylum seekers in New Zealand should include a culturally relevant mental health assessment component. Literature and studies in New Zealand and overseas in the field of mental health screening have stressed both the importance of using culturally specific approaches to the assessment of mental health (Al-Obaidi et al., 2015; Bolton 2001; Durie, 2004; Kingi, 2005; Mental Health Commission, 1998).

Intervening early not only reduces the burden of ill-health a person experiences but also decreases the damage to their life chances (Bell, 2011). Providing access to proper mental health assessment and care may contribute to better health and productivity for refugees in their new communities (Al-Obaidi et al., 2015). This is important given it has been argued by the refugee communities in New Zealand that refugees and their communities can experience complex and long-term challenges when their needs are not met early enough or are met insufficiently (Auckland Refugee Community Coalition, 2015).

7.3 Difference in levels of coping among the asylum seekers

Beside the results on adaptive and maladaptive coping strategies, the asylum seekers in the early days of the claim (the in process group) tended to cope differently from those who had been in the process longer (the declined or approved groups). In active coping, self-distraction, substance use, emotional support, instrumental support, planning and positive reframing, the newly arrived tend to use these coping strategies less than those who had been in the process longer.

This knowledge of the differences in the levels of coping among the asylum seekers is important as it sheds light into how asylum seekers cope as they traverse the refugee status determination process. It suggests that the stress asylum seekers experience, and coping strategies they use, fluctuate depending on where they are at in the journey of refugee status determination process. The asylum seeker may be stressed from the moment the initial claim for refugee status is lodged but the stress is likely to intensify at the time of the refugee status interview. The stress is also likely to intensify if the claim for refugee status is declined and then an appeal has to be lodged. Therefore the asylum seekers may tend towards different coping behaviours or different levels of coping depending on the level of stress they are encountering at the time.

It is important for practitioners to understand the nature of the refugee status determination process, the probable differences in levels of stress and the likely coping strategies that the asylum seekers use through the stages of the refugee status determination process, and intervene accordingly. The practitioner could take advantage of this knowledge and intervene much earlier with appropriate suggestions about coping with the different stages.

Several other explanations were gathered from the qualitative research to account for the differences in levels of coping. Some of the reasons were being new in Aotearoa New Zealand and uninformed about the avenues/benefits of professional, emotional support and instrument support services. There was the lack of information mostly at the initial stages of their claim at the RSB. These findings are not surprising given that studies in New Zealand have highlighted that asylum seekers lack information and access to resources at the time of their refugee status claim (Bloom & Udahemuka, 2014; Young & Mortensen, 2003). Similar findings have also been recorded overseas in Australia and the UK (Douglas, 2010; Essex, 2013; Mann, & Fazil, 2006).

It is observed as well that the asylum seekers who were still in the early stage of the claim, had arguably a false sense of mental preparedness and were unaware that the claim was already having a severe impact on their mental health. As a result it is not surprising that they tend to score less in, for example, use of emotional support, instrumental support and self-distraction. As newcomers, even if they had desired these forms of support, it would have been challenging familiarising with the Western way of life (Douglas, 2010; Mann, & Fazil, 2006; Young & Mortensen, 2003). Like the Sub-Saharan Africans of this study, most asylum seekers and refugees do not usually have family and friends with them and are from cultural backgrounds that are predominantly non-western (Mann & Fazil, 2006; Te Pou, 2009).

Given this backdrop, the newly arrived asylum seekers tended to conceal the fact that they are asylum seekers more than the others who had been in the process longer. One would not be too adventurous to contemplate that the stigmatising and discriminatory language, which occasionally headlines in the media and public discourse (Bogen & Marlowe, 2017; West-Newman, 2015; Sulaiman-Hill et al., 2011) may have amplified the need for the asylum seekers to be reserved in the communities. Asylum seekers and refugees may have lived in refugee camps and environments with close communal spaces; hence they could be afraid that if they tell someone about their traumatising experiences, everyone else in the community would hear about their problem (UNHCR, 1996).

To make matters worse, on the many occasions where issues concerning asylum seekers are covered in the press and political discourse, the attention given is most often negative (Bogen & Marlowe, 2017; West-Newman, 2015; Sulaiman-Hill et al., 2011). Paradoxically, researchers have been able to demonstrate that news stories have a significant influence on the formation of public attitudes toward asylum seekers and refugees (O'Doherty & Lecouteur, 2007; Sulaiman-Hill et al., 2011). Others have argued that the media and political discourse exacerbate public fears through discourse that labels asylum seekers as dangerous, dishonest, destitute and deviant (Bogen & Marlowe, 2017; Sulaiman-Hill et al., 2011).

Given the environment of stigmatisation, stereotyping, discrimination and arguably hostile public discourse against the asylum seekers, it is not surprising that those who might have had exposure to the negative discourse would want to conceal the fact that they are asylum seekers. While on the one hand, it is comprehensible why the asylum seekers would want to conceal their claim in community, on the other hand, it is

somewhat a concern when that secrecy becomes a stumbling block to help seeking behaviours. The implication of concealment of their status as asylum seeker could be that, as observed in Young and Mortensen's study (2003), they may only seek help in the community at a later stage where things are worse. A situation I refer to as an ambulance at the bottom of the cliff.

It should be noted that this commentary discusses how concealment of asylum seeking status could be preventing asylum seekers, especially the newly arrived, from seeking emotional and instrumental support or utilising self-distraction and resources in the communities in which they live. This should not nonetheless be mistaken to mean asylum seekers overtly conceal their status even to the professionals in the country. This is not the case. On the contrary, several studies have suggested that asylum seekers may dramatise and embellish emotional and traumatic experiences during interviews with immigration officers, lawyers, and concerned therapists, with the hope of attracting the empathy and a positive outcome (Schock et al., 2015; Sinnerbrink et al., 1997).

Accordingly, it can be said that asylum seekers practice tactful concealment of their status. They may disclose in the members in the community where they deem it is safe to do so. However, the question that is relevant to this discussion is - how could the environment in New Zealand be made more welcoming so that asylum seekers may feel free to seek help in the communities without the fear of being labelled or being judged. I argue that the negative stigmatising, stereotyping and discriminatory language (Bogen & Marlowe, 2017) about asylum seekers has to change to positive language.

In addition, there is the need for RSB officers, immigration lawyers and other professionals who are in the business of first contact with asylum seekers to encourage and support them to seek help with any mental distress in the very early days of the claim. It is important for these officials to inform the asylum seekers that in New Zealand a mental distress is not the result of a curse or witchcraft as is commonly perceived in Africa (Ezeabasili, 1977; Idemudia, 2003; Lambo, 1978; Tsala Tsala, 1997). Similar to other indigenous beliefs of mental distress (Mark & Lyons, 2010), the African traditional belief of a mental distress brings shame on the sufferer from their community, and this can deter helping seeking behaviours. The UNCHR (1996) recommends that staff working with refugees should build rapport and work in safe environments where confidentiality can be safeguarded.

In the context of New Zealand, Te Pou (2010) notes that, while the mental health needs of resettled refugees and new migrants are similar in some ways to those of any other

person using services, key differences exist in understandings, experiences of health systems, education, family and community, and in other social and personal areas. This means that mental health professionals may need to apply special attention and new skills if they are to help asylum seekers achieve a sense of well-being in a country and society where many cultural values and practices are new to them.

Te Pou recommends that the practitioners use holistic approach to assessing the health needs of refugees and asylum seekers and employ therapeutic approaches that are more culturally responsive. I support this recommendation and the following. A shift from the rigid diagnostic categories of pathology to considering the person 'as a whole' including their strengths, personal and cultural resources, and aspirations. It is also useful for practitioners working with refugees and asylum seekers to take a strengths-based approach (Rapp, 1998; Rapp & Goscha, 2011). Despite the traumatic experiences that could affect any ordinary person, and could lead to mental health problems, refugees have often learned how to survive and cope in intensely difficult situations. Healthcare practitioners could tap from this strength. A few studies on refugees and asylum seekers overseas have emphasised the need and benefits of strengths based and person centred approaches (Hartley et al., 2017; Marlowe, 2010; Raghallaigh & Gilligan, 2010; Shakespeare-Finch et al. 2014).

7.4 Religion as a fundamental coping strategy in Africans

Religion was found in this study as a fundamental coping strategy that cuts across several of the other coping strategies including self-distraction, emotional support, instrumental support, and positive reframing. Specifically, the participants registered a high score for religion (refer to Table 21). While describing the various coping strategies assessed in the Brief COPE scale, they made references to the material, emotional and spiritual help they received from the religious communities. This raises some questions including whether the high importance of religion reflects the sample composition. Perhaps, this sample comprised people who were members of church communities. Alternatively, religiosity may be a major factor for the Sub-Saharan African asylum seekers.

As to the first limb of the question, this study was advertised in several community organisations including a church in Auckland that has many African worshippers. A few people who have been worshippers at this church responded positively to the

advertisement and participated in the study. A few other participants were also recruited from other churches in Auckland through snowball sampling. This may explain why religion seems to be a dominant theme on the participants' description of what helped them cope through the refugee status determination process.

As to the second limb of the question, it is beyond the scope of this thesis to systematically review all the literature on the importance of religion in the Sub-Saharan Africa asylum seekers and refugees. However, some studies overseas have found that religion is particularly important to asylum seekers and refugees from Sub-Saharan Africa (Copping, Shakespeare-Finch & Paton, 2010; Marlowe, 2010; Sarfo-Mensah, 2009). Although there is a lack of literature on religious coping among African refugees and asylum seekers in New Zealand, insights can be drawn from the studies overseas.

Gladden (2013) conducted a literature review on the coping skills of East African refugees and found religiosity to be one of the highest coping mechanisms used by East African refugees in the USA while overcoming the many struggles they face. Adedoyin et al. (2016) also conducted a systematic review on the importance of religion and spirituality in coping with traumatic and mental issues among African refugees. They found that religious activities and membership of religious congregations show marked improvements in overcoming traumatic experiences among African refugees. They concluded that

> *Religiosity is the dominant sub-type of culture in most African culture, and it is not surprising that African refugees resort to religious activities during adversities. Religiosity is central to the value systems of most Africans, and a key ingredient in how Africans interact with people and their environment. Religiosity is also the way Africans maintain their overall well-being... African refugees use spirituality to heal both the physical body and the mind from post-traumatic experiences.* (Adedoyin et al., 2016, p 103)

These observations are congruent with the findings in this study. It can be said that religion is an important coping mechanism for the Sub-Saharan Africa asylum seekers in New Zealand. Not only does it help them to stay focused and to remain hopeful, but it also puts them in an environment where they can receive the material, emotional and spiritual support they may need. It can therefore be suggested from this finding that, in the initial stages of the refugee status claim, immigration lawyers and therapists working with asylum seekers in the community should inquire from the asylum seeker

and encourage the asylum seeker who has identified as coming from a religious background to connect with local church communities.

7.5 Appropriateness of the Brief COPE scale in Sub-Saharan African asylum seekers

The participants' descriptions of their experience of coping behaviours show that the strategies assessed in the Brief COPE scale are meaningful to asylum seekers from Sub-Saharan Africa. This finding endorses the Brief COPE scale as an appropriate tool for assessing coping behaviours in asylum seekers from Sub-Saharan Africa. Although the result is encouraging, observations were made from this study that suggests that the Brief COPE scale may need to be adapted to enhance its effectiveness in the chosen population. Chase et al. (2013) and Sarfo-Mensah (2009) have made related endorsements for the adaptation of the Brief COPE scale in studies with refugee populations.

The first observation that was noted from this study in the quantitative phase is that the assessment by the Brief COPE scale revealed humour as the least utilised coping strategy. The follow-up interview in the qualitative phase revealed as well that most of the participants did not find humour functional within their context as asylum seekers. Chase et al. (2013) made just about the same observations in their study with Bhutanese refugees in Nepal. The majority of the participants interviewed in this study considered the question on humour offensive in their context as asylum seekers. They considered the asylum seeking process a serious process to an extent that some of them even likened it to a matter of 'life and death'. Consequently, they proposed the following questions, as an adaption of the questions on humour - *'I've been using jokes as a way of getting through it'* and '*I've been using fun as a way of getting through the situation'*. The participants explained that the question as is in the Brief COPE scale - '*I've been making jokes about it*' and '*I've been making fun of the situation*', gives them the impression that they do not take their claim process serious.

Furthermore, in light of the current era of globalisation where social media is an important component of human social life, the participants suggested that chatting on Facebook, WhatsApp, IMO, Viber, internet navigation and others be added to the list of self-distractive activities in the Brief COPE scale. The Brief COPE scale was developed in 1997 at a time when social media was still unknown to most of the world. Future

researchers who intend to use the Brief COPE scale in asylum seekers and refugee populations and perhaps other populations could consider these recommendations on the conceptualisation of humour and self-distraction.

Additionally, it was found in this study that there is a difference in the way the concept of self-blame is perceived and conceptualised in Africa or at least in Sub-Saharan Africa. The Sub-Saharan African asylum seekers' perspective of 'self-blame' extends to others, spirituality and supernatural forces. Related observations have been made elsewhere in Africa in studies with refugees. Sarfo-Mensah (2009) found in the study with Liberian refugees that under self-blame, the participants' notion of self included others, a term she called "collective self blame". It was believed by some of the participants in the study that their country was war torn because they (Liberians) must have done something against God (Sarfo-Mensah, 2009, p. 40). The belief of ascribing blame on spirituality and supernatural forces for illnesses or difficult situations is not only an African way of life (Ezeabasili, 1977; Idemudia, 2003; Lambo, 1978) but is also practiced by other indigenous peoples in the world (Durie, 2004; Mark & Lyons, 2010).

This concept of ascribing blame on supernatural factors rather than oneself may help as well to explain why the participants in this study seemed to have found or described religion as the rock of their coping, that is, their primary coping mechanism. It is only logical that, if they have a belief system that says the causes of their difficulties as asylum seekers is a curse or a bewitchment by others or an evil spirit; then they will seek help from faith based and miracle healings or other tradition and spiritual forms of cleansings (Adedoyin et al., 2016; Gladden, 2013; Mark & Lyons, 2010).

Knowledge of this African belief system can be particularly instrumental to healthcare practitioners working with Sub-Saharan Africa asylum seekers in New Zealand. It could be used to help the person living with mental illness to make meaning of their illness and to design a treatment plan for the illnesses in a manner that is culturally responsive and appropriate to the Sub-Saharan African asylum seeker. In this light, Te Pou (2009) provides an outline of numerous culturally relevant therapeutic treatments and suggestions on how they could be adapted to asylum seekers, refugees and new migrants in New Zealand.

7.6 Coping strategies used to some extent in a counterproductive manner

The usage of venting by the participants in this study was somewhat counterproductive. Venting (mean=5.2, *SD*=1.7) was the most frequently reported maladaptive coping strategy in the quantitative phase. The follow-up qualitative interview revealed that some of the participants would often spend time in solitude, in showers and would cry about the difficulties they were facing in their refugee status claim. Others became grumpy, and a participant vented on her children.

Carver et al. (1989) observed that, while venting can be functional, for example, in a case where a brief period of mourning is used to accommodate the difficult emotion and progress made, it can impede adjustment if used for long periods. The results from this study suggest that the participants used venting recurrently and for long, consequently making the usage counterproductive. The general implications of endorsing venting and the other maladaptive coping behaviours have been discussed in Section 07.2.

Besides venting, the usage of emotional support by the participants in this study was to a certain degree counterproductive. A high score for use of emotional support was recorded in the quantitative phase and the participants' description of how they used emotional support indicated that they depended immensely on emotional support during the refugee status determination process. While emotional support is generally classified as an adaptive form of coping (O'Brien & Leafman, 2012; Meyer, 2001; Monzani et al., 2015) it can have negative implications if not used properly. Carver et al. (1989) described emotional support as a double-edged sword.

Emotional support is functional in many ways. For example, a person who is made insecure by a stressful transaction can be reassured by obtaining this sort of support. This can then foster a return to problem-focused coping (Carver et al., 1989). In the case of the participants in this study, they found it beneficial talking to someone perhaps a therapist, family or friends about the emotional challenges they faced during the claim process and after the discussion, they went back to focusing on other important things that could move them forward.

On the contrary, if the sources of sympathy are used more as outlets for the ventilation of one's feelings, it will lead to negative coping (Carver et al., 1989). In this study, the participants' description of their experiences of emotional support suggests that they

largely wanted emotional support as a means of ventilation. Evidence from studies in western populations indicates that using social-emotional support in this way may not always be very adaptive (Billings & Moos, 1984; Costanza, Derlega & Winstead, 1988).

If one takes the African worldview into consideration, then a clearer picture is seen as to why the participants in this study tend to use emotional support somewhat as a source of ventilation. Unlike the western nuclear family and independent communities (Kamwangamalu, 1999; Van der Walt, 1997), Africans live in large communities and extended families and with a high ratio of interdependence, oneness and sharing. A concept Gade (2012, p. 492) refers to as *ubuntu*, an adage ‘"I am what I am because of you". Under the concept of Ubuntu, Africans see others as being an important part to the solution to their problem. It is not surprising therefore that the asylum seekers have tended to used emotional support for ventilation. They see their problem as a collective problem, and expect others to share the burden of the problem and help with a solution. Knowledge of this cultural perspective can be useful to practitioners, particularly the therapists working with asylum seekers from Sub-Saharan Africa may need to be mindful of professional self-care and to work in a culturally responsive manner.

7.7 Self-distraction as an adaptive coping strategy

Contrarily to the general categorisation of self-distraction as a maladaptive coping strategy, it was reported, to a large extent, as an adaptive coping strategy in this study. Self-distraction is considered a maladaptive coping strategy because it involves changing one’s focus from the problem to something else (Carver et al., 1989). This is usually when the strategy is used for a long period of time (Meyer, 2001; Monzani et al., 2015; O’Brien & Leafman, 2012). However the use of the strategy for a brief period of time can be beneficial (O’Brien & Leafman, 2012). The results from the quantitative phase and qualitative phase of this study indicate that self-distractive activities were endorsed at length as was the case with studies elsewhere in refugee populations (Chase et al., 2013; Sarfo-Mensah, 2009). The following paragraphs discuss how this study provides a new perspective on the coping behaviour as an adaptive coping behaviour in asylum seekers.

The asylum seekers have to wait for long periods while their refugee status claim is being processed. In theory, it could take approximately a month from the time the

refugee status claim was lodged, for an interview to be held at the RSB. And there is no timeframe for the interview if the refugee status claim is declined and an appeal is lodged at the IPT by the asylum seeker (MBIE, 2015b). In practice, the participants in this study estimated that it took two months or more for the interview to be held at the RSB and about eight months for the interview at the IPT. Hence there is an estimated waiting time of two months for the interview at the RSB and eight months at the IPT.

There is another waiting time from the date the interview is held until the date the decision is delivered. Therefore, the asylum seeker may have long waiting times from the period when the claim was lodged, to being interviewed, and to a decision being made. During these waiting times, the stress and anxieties of living in a state of limbo and fear of deportation exacerbates (Bloom, & Udahemuka, 2014; Fazel, Wheeler, Danesh, 2005; Mares, Newman, Dudley & Gale, 2002; Pitman, 2010; Summerfield, 2001; Tribe, 2002; Uprety et al., 1999).

Given this backdrop, I argue therefore that the use of self-distractive activities during the waiting times, as reported by the participants in this study, is adaptive coping. During the waiting periods the asylum seekers cannot do much about their claim but wait on the processing officer to get back to them with either a date for the interview, or an interview report, or a decision. Perhaps the asylum seeker might be able to research and provide additional information during the waiting periods, but most asylum seekers go through the refugee status determination process with an immigration lawyer under the legal aid system in New Zealand (MBIE, 2015b). As a result, many of the asylum seekers may expect the lawyer to do or instruct the researching, and the asylum seekers may not even anticipate that they could do additional research beyond that requested by the lawyer. Assuming that all the required information has been provided to the RSB or IPT, the asylum seekers would have nothing else to do about their claim but wait for the outcome. The use of self-distractive activities during the waiting time may be beneficial to the asylum seeker.

Perhaps, the asylum seekers could engage in other activities that will enhance their determinants of health such as securing gainful employment instead of engaging in self-distraction during the refugee status determination process. Interestingly, the participants in study described using employment, to a certain degree, as a means to distract self from the stress from the claim. Some may not even have the right to work (no work permits) during the waiting times (Bloom et al., 2013). As observed in Bloom et al. (2013), others may have the work permits but cannot secure a job because of the

short duration of the work permits (within three months to one year) and they may not have the relevant New Zealand work experience. Hence during the long waiting periods, especially in cases where the asylum seeker is not entitled to work, service providers may need to encourage regular walks in parks or in other safe environments, and support with access to physical exercises such as a gym, swimming pool and cycling in safe places as this may help with physical and mental wellbeing.

Although I have suggested that the use of self-distraction in the short and long term could be beneficial to the asylum during waiting period, I am also cautious of the fact that in some cases it would not be beneficial for the asylum seeker to engage in self-distractive activities. This perhaps could be in cases where more information is still needed to establish their claim. Moreover, under Section 135 of the Immigration Act 2009, the responsibility to establish the refugee status claim is on the claimant (the asylum seeker). Consequently, a long term use of self-distraction in a situation where information is still needed to establish the refugee status claim may not be beneficial to the asylum seeker.

7.8 Limitations and strengths of the study

The limitations and strengths of this study are acknowledged in the ensuing discussion. Principally, the findings in this study may not be fully representative of the Sub-Saharan African asylum seekers in New Zealand.

The results from the quantitative phase present an indication of the coping strategies of asylum seekers from Sub-Saharan Africa in New Zealand but cannot be generalised or taken as conclusive of the coping strategies of this population. The aim of the sampling technique in the quantitative phase was to obtain a representative sample as far as possible. The study was advertised in community organisations in Auckland region that offer support services to asylum seekers. The majority of the participants in the study came only from three of the community organisations where the advertisement where posted, making the sampling more of a self-selected convenient sample. Moreover, the study was advertised only in Auckland and not all-over New Zealand where a representative sample would have been achieved. Consequently, the findings in the quantitative phase of this study are only a suggestion of the coping strategies of asylum seekers from Sub-Saharan Africa, and cannot be generalised to the population asylum seekers from this region.

Another limitation of the results from the quantitative phase of the study is the fact it was extremely difficult to locate and recruit a representative sample. As found in the literature review and the results of this study, asylum seekers regularly experience negative depictions in the media and political discourse. The inadvertent effect of the negative (arguably hostile) discourse has been that most asylum seekers live in concealment of their status as refugee status claimants and they are very sceptical talking to anyone including researchers in the community about their status. There is also intricacy in light of the fact that any information they may disclose to the public about their circumstances as asylum seekers could expose them to adverse people from their community. It could also uncover them to authorities in their home country and/or it could potentially affect the outcome of their case if it reaches the Refugee and Protection Officers in New Zealand. Therefore, this made it difficult to locate and recruit a representative sample for this study.

Furthermore, the results in the qualitative phase may not satisfactorily transfer to all the asylum seekers from Sub-Saharan Africa in New Zealand, except those who meet the demographic characteristics described in this study. Following the results from the quantitative phase, I used a purposive sampling method to select the participants for the interview in the qualitative phase. The participants were selected based on demographics such as country of origin, sub-region of origin in Sub-Saharan Africa, family situation, educational status and the stage at which they were in the refugee status claim. Asylum seekers living with psychiatric disabilities and those in detention facilities were not included in the study. Muslim women from Sub-Saharan African were also excluded from the qualitative interview. Consequently, the results from the qualitative phase may not have satisfactory transferability to all the asylum seekers from Sub-Saharan Africa in New Zealand, except to those who meet the demographic characteristics described in this study. However transferability is the province of the research reader and I have provided a detailed description of the participants and their context to support this.

There is the likelihood that the sample in this study was comprised mostly of peoples from religious backgrounds, thus the coping abilities of atheists may not have been covered comprehensively in the study. This is due largely to the fact that the study was advertised in various community organisations in Auckland (one of which is a church mostly attended by Africans). This may have accounted for the fact that religion played a significant role in the participants' coping abilities. It is likely, therefore, that the

present sample provides insights from a midrange of individuals seeking asylum in New Zealand.

In addition, caution must be taken with the interpretation of the results of the study. In the quantitative phase of the study, the participants reported experiencing extreme levels of stress. The results were constricted by the fact that the stress scale used in the study did not capture wide-ranging aspects of situational stress. Furthermore, the participants' description of stress in the qualitative phase was also intense. Researchers have noted however that report of stress from asylum seekers should be taken with caution as it is possible that some asylum seekers may accentuate their difficulties with the hope that publicity will rally sympathy to their plight (Schock et al., 2015; Sinnerbrink et al., 1997). The possibility therefore that the participants in this study were being biased cannot be discounted entirely, although the pattern of results of the study indicates that they were responding honestly to the questions.

Culture might have been a possible source of limitation in the carrying out of the research. It is likely that participant responses on relative utilisation of coping strategies in general, were influenced by a desire to cohere with social norms (Chase et al., 2013). Given that I am from the same cultural background as the participants, the participants might have withheld information on the coping behaviours that are generally seen as shameful in the African culture, for example, the smoking of cannabis by males or cigarettes by females or vice versa. It is also possible that the participants might have withheld information on maladaptive coping behaviours that they think could endanger their circumstances as asylum seekers in New Zealand. Chase et al. (2013) argues that this common challenge presents an even greater obstacle when conducting research in asylum seeking populations where privacy is very crucial to the research participants. That said, the nature of the data gathered in this study and the incidences of maladaptive coping behaviours reported by the participants, indicate that participants were honest in their response, thus credibility may not have been compromised significantly. It is possible as well that the findings reflect cultural beliefs and norms around preferred coping behaviour by the asylum seekers from Sub-Saharan Africa.

Besides culture, language might have been a limitation to the study. The Brief COPE scale was developed and first used in the USA in a community recovering after Hurricane Andrew (Carver, 1997), but was used in this study in a population from Africa. In view of its original setting, several scholars have cautioned researchers against using Western developed scales in non-western populations (Mann, & Fazil

2006; Shoeb et al., 2007). Moreover, in the context of this study, the Brief COPE scale was not translated or adapted. Given the diversity of languages in Sub-Saharan Africa region, it would have been unrealistic to translate the scale into the multiplicity of languages in Sub-Saharan Africa. Nonetheless, English is a dominant language in Sub-Saharan Africa and it was deemed reasonable to use the English version of the scale. The majority of participants in the study came from Nigeria, Cameroon, Zimbabwe and South Africa. English is an official language in these countries and the remaining few participants from the non-English speaking counties had reading and writing comprehension in English except two who needed assistance.

Another limitation of the study is the fact that the study participants are limited to Sub-Saharan Africa hence it excludes several asylum seekers (from Northern Africa and the rest of the world), whose experiences could have widen the knowledge on the experiences of asylum seekers in New Zealand. As this is only a master's thesis, besides language barriers between the researcher and asylum seekers from other continents of the world, time and budget constraints also contributed significantly in determining the appropriate design that would suit a study of this nature. A much broader study that would open the spectrum for all asylum seekers in New Zealand could be contemplated for a PhD thesis.

Lastly, given that I have had a lived experience of having gone through the refugee status determination process in New Zealand, there is a potential that my experience of the refugee status determination process coloured the way I interpreted the data in this study. However, I had a pre-understandings interview with my primary supervisor that helped me to be aware of existing biases and conceptual blinders that I had. Through the pre-understandings interview, I was able to identify some of my preconceptions. For example, I had assumed that the participants would be offended by the questions on humour because I did not think there was anything to laugh about a refugee status claim. I had also assumed that the participants' description of self-blame would extend beyond blaming self to others. Moreover, I had assumed that the participants would report the refugee status determination process as stressful. These assumptions were confirmed in the study.

Despite the limitations above, there were several aspects that strengthened the results of study. Among these is the fact that the decisions made in relation to the research design, methodology and methods were supported by literature. In addition, the commonality of cultural background and lived experience of the refugee status determination process

between the participants and the researcher may have normalised the relationship and made it easier for the participants to share their experiences and beliefs. Furthermore, the results of the study were strengthened by the fact that the interviews continued until saturation was reached. Lastly, the most important fact that has strengthened the trustworthiness and the rigour in the study has been the use of triangulation. The use of both the quantitative and qualitative research methods in the study has led to a broader and deeper understanding of the concepts of coping than would have been achieved if any one method was used alone.

7.9 Recommendations

In this section, I present the recommendations from this study. The recommendations are discussed under healthcare practitioners; immigration officers, lawyers and service providers in the community; policy makers; and researchers.

7.9.1 Recommendations for healthcare practitioners

Primarily, it is important for healthcare practitioners to understand the nature of the refugee status determination process, that is, the differences in levels of stress and the possible coping strategies that asylum seekers may tend to use as they traverse the different stages of the process, and then provide interventions accordingly. The practitioner could take advantage of their knowledge of the process as seen in this study, that the asylum seekers are likely to experience intensification in levels of stress and coping during the refugee status interview, and after a decline, and while lodging an appeal. The practitioner may then step in much earlier to provide suggestions or directions to the asylum seekers on how to cope with any of these experiences.

In addition, early interventions in the mental health needs of asylum seekers are needed. Despite the fact that most of the asylum seekers frequently endorsed adaptive coping strategies in this study, reports of the incidences where they have used and the way they used maladaptive coping strategies show clearly that their mental and emotional health is vulnerable and they need help immediately. This calls for early interventions in the mental health of asylum seekers. The importance of early interventions in mental health cannot be overstated. Intervening early not only reduces the burden of the illness or distress but also decreases the damage to their life chances and may contribute to better health and productivity for asylum seekers in their new communities. One possible way

of early intervention is that the initial medical screening for asylum seekers in New Zealand should include a culturally relevant mental health assessment component.

Another way of early intervention is in the form of a specialised service centre for asylum seekers in the community. Given the environment of lack and often confusing information provided to asylum seekers by members in their community and even some of the staff at essential service providers like WINZ, schools and GP services; there is a crucial need for a service centre (perhaps, a small bureau for asylum seekers in the community in Auckland). The said bureau for asylum seekers should be staffed by social worker(s) including at least a person with a lived experience of the RSD in New Zealand (for peer support). The office would be instrumental in supporting asylum seekers access services like health care, housing, employment, income support, driving and other relevant services in the community. Thus, RSB officers, immigration lawyers and other officials who are in the regular business of meeting newly arrived asylum seekers can link the asylum seekers to the said asylum bureau. This would surely serve to eliminate/reduce the lack of information or confusing information and the vulnerability that asylum seekers currently encounter in the community.

In addition, healthcare practitioners working with African asylum seekers could inquire from the asylum seekers to understand what their belief about the cause of their mental illness, distress, and difficulty is. Where it is established that the asylum seeker holds non-western perspectives, the practitioner could help the person to make meaning of their situation and design a treatment plan that is culturally responsive and appropriate to the person. For example, it may be useful for healthcare practitioners to understand the conceptualisation of self-blame by Africans, and how this extends to blaming others and spirituality. An African asylum seeker may attribute their mental illness, distress or difficulty to being bewitched, being cursed, being possessed by demons and so forth. Moreover, under the African adage - *ubuntu* -"I am what I am because of you", the practitioner may become a victim in the therapeutic relationship as the asylum seeker may instead use emotional support for ventilations. Accordingly, the practitioner may need to be more mindful of self-care in therapeutic relationship with an African asylum seeker.

7.9.2 Recommendation for immigration officers, lawyers and service providers in the community

The first recommendation for immigration officers, lawyers and services in the community is for persons in these roles to identify, encourage and support the asylum seeker to seek help with any mental distress in the very early days of the claim. Fundamentally, the Sub-Saharan African asylum seekers in New Zealand have cultural backgrounds where there are still myths about mental distress and illness. The myths could be interfering with help seeking behaviours, especially help seeking from the Western notion of psychiatry and psychotherapy. Accordingly, where an asylum seeker presents with early signs of a mental distress, the refugee and protection officers, immigration lawyers and other professionals who are in the business of first contact with asylum seekers should encourage and support them to seek help in the very early days of the claim. It may be important as well for the concerned officers to seize the opportunity (where possible) to help to dispel the myth about mental illness (where it exists), and encourage adherence to treatment plans.

The second recommendation relates to support with joining local religious communities. It was found in this study that Africans attach importance to religiosity and they benefit substantially from belonging to the religious communities. Therefore it can be recommended that, in the initial stages of the refugee status claim, immigration lawyers and service providers in the community should inquire from the asylum seeker if they have a religion. If the asylum seekers identifies as having a religion, the officers should encourage the asylum seeker to join their preferred religious group in their locality.

The third recommendation is for services in the community to support asylum seekers with self-distractive activities such as a gym, swimming pool, walks and cycling in safe places as this may help with physical and mental wellbeing during the waiting periods.

Another recommendation is that services providers for asylum seekers and refugees may also consider hiring former asylum seeker or peoples from refugee backgrounds in roles such as case workers, counsellors, social workers, and psychologists. The participants in this study overwhelmingly highlighted that it was beneficial to them talking or receiving emotional and instrument support from other former asylum seekers in New Zealand. Peer support could be an effective means of reaching these individuals and easing the challenges around stigma, stereotype and concealment.

The last recommendation is for Immigration New Zealand to provide information to asylum seekers at the initial stages of their claim that can connect them to communities from their countries of origin or by and large, the refugee communities in New Zealand. While Immigration New Zealand has a pamphlet that outlines the services that asylum seekers could access in New Zealand, this information does not include information about the refugee communities. The provision of such information could help the asylum seeker to connect with refugee community leaders and other dependable people from their communities that can support them through the refugee status determination process.

7.9.3 Recommendation for policy makers

The policy for asylum seekers was designed over two decades ago and it does not reflect the current realities of the New Zealand today. The introduction of the advanced passenger screening system in 2003 by Immigration has meant that New Zealand has not been flooded by asylum seekers. Since 2003 when the policy was introduced, New Zealand has received a constant average of 300 asylum claims per year to date. Other deterrent measures brought by the Immigration Act 2009, and the Immigration Amendment Act 2013 have continued to protect New Zealand borders against peoples who would otherwise be asylum seekers in New Zealand. Thus, it may be time that the refugee policy in New Zealand is revised to ensure that the few asylum seekers who are able to get to New Zealand receive equal entitlements as their counterparts - the quota refugees.

In addition, the use of negative and stigmatising language towards asylum seekers may further alienate them in society and increase their vulnerability. The environment of stigmatisation, discrimination and stereotyping inadvertently discourages help seeking behaviours among asylum seekers in the community. The political discourse from policy makers on asylum seekers in New Zealand needs to be positive and balanced against current realities so that asylum seekers may feel free to seek help in the communities without the fear of being labelled or judged.

7.9.4 Recommendation for researchers

Primarily, although the results of this study were encouraging as it shows that the Brief COPE scale is an appropriate tool for assessing coping in asylum seekers from Sub-Saharan Africa, observations were made from this study that suggests that the Brief

COPE scale may need to be adapted to enhance its effectiveness. Future researchers who intend to use the Brief COPE scale in asylum seekers and refugee populations and perhaps other populations could consider the following recommendations on the conceptualisation of humour and self-distraction. The asylum seekers interviewed in this study considered the question on humour offensive in their context as asylum seekers. Consequently, they proposed the following questions, as an adaption of the questions on humour - '*I've been using jokes as a way of getting through it*' and '*I've been using fun as a way of getting through the situation*'. They also suggested that chatting on Facebook, WhatsApp, IMO, Viber, internet navigation and others be added to the list of self-distractive activities in the Brief COPE scale. These recommendations may need to be further validated in a larger sample.

Furthermore, interested researchers in this field could consider a comprehensive study on the prevalence of mental illness and mental disorders in asylum seekers. The study by Uprety et al. (1999), which assessed the prevalence of mental distress/illness in asylum seekers, was conducted some 18 years ago. The only other study that made a brief observation on the prevalence of mental disorders in asylum seekers/convention refugees was conducted more than 10 years ago (Department of Labour, 2004). Both studies are reports, and most probably, were not independently peered-reviewed. To date, there is no current study in New Zealand on the prevalence of mental disorders and mental illness in asylum seekers. Therefore, a study of this nature is needed.

There should be inclusion in future studies on how the New Zealand mental health services are responding to asylum seekers.

Difficulties were encountered making associations between stress and coping behaviours in this study. The single-item stress scale used in this study did not capture broader features related to stress. Researchers interested to use the Brief COPE scale to explore associations between stress and coping skills could consider using a stress scale that captures wide-ranging aspects of situational stress such as the 'Perceived Stress Scale' (PSS-10) (Cohen, Kamarck & Mermelstein, 1983) or the 'Background Stress Inventory' (BSI) (Terrill, Gjerde & Garofalo, 2015).

Given that it is extremely difficult to recruit asylum seekers for the purpose of research, a community service such as the ASST (that runs the asylum seekers hostel in Auckland) could consider conducting a longitudinal study on asylum seekers. The study could involve data collection from asylum seekers on levels of stress, and levels of coping at the time they enter the hostel, and perhaps at the time they have attended the

refugee status interview, and finally when a decision has been reached on their case or upon exiting the service. This could help fill in the gap in literature on the mental health and coping strategies of asylum seekers in New Zealand.

Research could also focus exclusively on the qualitative experience of how asylum seekers cope with the refugee status determination process in New Zealand. Alternatively, it could be a study that investigates spirituality and religious coping among refugees and asylum seekers in New Zealand. Such a study could be broadened to include participants from many ethnic backgrounds. A qualitative study would give room for deeper accounts to be gathered and for culturally relevant coping concepts to emerge from the participants' expression of themselves in manners that they are familiar with.

Lastly, considering that the existing studies on asylum seekers in New Zealand have tended to focus on stress; and other studies on the same population offshore have focused generally on stress as well as the prevalence of mental disorders, it is recommended that scholars should include the strengths perspective into researching. An example of a research that could potentially fit well within the scope of strengths perspective or person-centred approach could be a study that explores the refugee status determination process from a therapeutic jurisprudence model.

7.10 Conclusion

This is the first New Zealand study to investigate the experience of asylum seekers from a more strengths-based perspective, unlike the other studies that have focused on challenges and the prevalence of mental distress in this population. It is also the first study internationally that has used the Brief COPE scale to explore the coping strategies of asylum seekers. The study focuses on factors that support asylum seekers as well as those that do not.

Results from the study indicate that the most frequently endorsed coping strategies by the asylum seeker are in the adaptive domain. Planning, active coping, positive reframing and religion are among the most common adaptive coping strategies used by the Sub-Saharan African asylum seekers. This negates the political and media discourse that mainly portrays asylum seekers as problems, dangers and liabilities to their host countries.

The study suggests as well that the stress asylum seekers experience and coping strategies they use fluctuate depending on where they are at in the journey of refugee status determination process. Asylum seekers may tend towards different coping strategies or different levels of coping depending on the level of stress they are encountering. For example, in self-distraction, emotional support and instrumental support, the asylum seekers who are new in the process, tend to use less of these coping strategies than those who have been in the process considerably longer. Importantly and more broadly, the study demonstrates the cultural validity of the Brief COPE scale for measuring the coping behaviours of asylum seekers from Sub-Saharan Africa.

The implications of findings of the study to New Zealand and other refugee destination countries are far reaching, despite its small scale. In spite of the traumatic experiences that many asylum seekers have lived through and the arduous processes that they have traversed to be recognised as refugees, they have learned to survive and cope with these profoundly difficult situations. Asylum seekers are endowed with strengths, capabilities and resilience. They could quickly grow into assets for their host countries if provided the interventions, opportunities and resources tailored to the stage of their application process in a timely way.

Practitioners can therefore use the Brief COPE scale to determine their strengths in the coping behaviours and tap into the coping strategies. New research could incorporate more of a strengths-based perspective to promote coping behaviours that are adaptive, and to encourage change in areas of maladaptive coping.

References

Adedoyin, A. C., Bobbie, C., Griffin, M., Adedoyin, O. O., Ahmad, M., Nobles, C., & Neeland, K. (2016). Religious coping strategies among traumatized African refugees in the United States: A Systematic Review. *Journal of the North American Association of Christians in Social Work*, 43(1), 95-107.

Aliseda, A. (2006). *Abductive reasoning: Logical investigation into the processes of discovery and evaluation*. Dordrecht, The Netherlands: Springer.

Al-Obaidi, A., West, B., & Fox, A. (2015). Incorporating preliminary mental health assessment in the initial healthcare for refugees in New Jersey. *Community Ment Health J*, 51, 567-574. doi: 10.1007/s10597-015-9862-8

Amnesty International. (2015). New Zealand says welcome to refugees - #RefugeesWelcomeNZ. Retrieved from https://www.amnesty.org.nz/new-zealand-says-welcome-refugees-refugeeswelcomenz

Anderson, N. B., Nordal, K. C., Breckler, S. J., Ballard, D., Bufka, L., Bossolo, L., … Palmiter, D. J. (2010). *Stress in America findings*. Washington, DC: American Psychological Association.

Andersson, E. K., Sjostrom-Strand, A., Willman, A., & Borglin, G. (2015). Registered nurses views of caring in coronary care - a deductive and inductive content analysis. *Journal of Clinical Nursing, 24, 3481-3493.*

Auckland Refugee Community Coalition. (2015). *ARCC annual report 2014-2015. Auckland, New Zealand*: Auckland Refugee Community Coalition.

Avison, W. R., & Turner, R. J. (1988). Stressful life events and depressive symptoms: Disaggregating the effects of acute stressors and chronic strains. *Journal of Health and Social Behavior*, 29, 253-264.

Bailey, C. A. (1996). *A guide to field research*. Thousand Oaks, CA: Pine Forge.

Barbour, R. (1999). The case for combining qualitative and quantitative approaches in health services research. *Journal of Health Services Research and Policy*, 4, 39-43.

Batchelor, T. (2015). The new iron curtains: Where the fences are going up across Europe to keep migrants out. Retrieved from http://www.express.co.uk/news/world/624488/Europe-border-fences-migrant-crisis

Baumstarck, K., Alessandrini, M., Hamidou, Z., Auquier, P., Leroy, T., & Boyer L. (2017). Assessment of coping: a new French four factor structure of the Brief COPE inventory. *Health and Quality of Life Outcomes*, 15 (8). doi: 10.1186/s12955-016-0581-9

Bazeley, P. (2006). The contribution of computer software to integrating qualitative and quantitative data analyses. *Research in the Schools*, 13(1), 64-74.

Beaglehole, A. (2013). *Refuge New Zealand: A nation's response to refugees and asylum seekers*. Dunedin, New Zealand: Otago University Press.

Beehive. (2015). New Zealand to take 750 more Syrian refugees. Retrieved 11 April 2016 from https://www.beehive.govt.nz/release/new-zealand-take-750-more-syrian-refugees

Bell, A. (2011). The importance of early intervention in mental health. *British Journal of Healthcare Management*, 17(7), 272-275.

Billings, A. G., & Moos, R. H. (1981). The role of coping responses and social resources in attenuating the impact of stressful life events. *Journal of Behavioral Medicine*, 4, 131-157

Billings, A. G., & Moos, R. H. (1984). Coping, stress, and social resources among adults with unipolar depression. *Journal of Personality and Social Psychology*, 46, 877-891.

Bloch, A., & Schuster, L. (2002). Asylum and welfare: Contemporary debates. *Critical Social Policy*, 22, 393-414.

Bloom, A. & Udahemuka, M. (2014). 'Going through the doors of pain': Asylum seeker and Convention refugee experiences in Aotearoa New Zealand. *Kōtuitui: New Zealand Journal of Social Sciences Online*, 9(2), 70-81. doi: 10.1080/1177083X.2014.939664

Bloom, A., O'Donovan, T., & Udahemuka, M. (2013). *'Marking time': Experiences of successful asylum seekers in Aotearoa New Zealand*. Wellington, New Zealand: ChangeMakers Refugee Forum/New Zealand National Refugee Network.

Bogen, R., & Marlowe, J. (2017). Asylum discourse in New Zealand: Moral panic and a culture of indifference. *Australian Social Work*, 70 (1), 104-115, doi: 10.1080/0312407X.2015.1076869

Bolger, N. (1990). Coping as a personality process: A prospective study. *Journal of Personality and Social Psychology*, 59, 525-537.

Bolton, P. (2001). Cross-cultural validity and reliability testing of a standard psychiatric assessment instrument without a gold standard. *Journal of Nervous and Mental Disease*, 189(4), 238-242.

Bonnett, G. (2016). Former refugee's plea to increase quota. Retrieved from http://www.radionz.co.nz/news/national/296611/former-refugee's-plea-to-increase-quota

Breznitz, S. (Ed.). (1983). *The denial of stress.* New York, NY: International Universities Press.

Briskman, L., & Cemlyn, S. (2005). Reclaiming humanity for asylum-seekers: A social work response. *International Social Work*, 48(6), 714-724.

Brookers Ltd. (2010). *Brookers immigration law handbook*. Wellington, New Zealand: Brookers Ltd.

Bryman, A. (1984). The debate about quantitative and qualitative research: A question of method or epistemology? *British Journal of Sociology*, 35(1), 75-92.

Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse Education Today*, 11, 461-466.

Burns, N. & Grove, S. K. (2005). *The practice of nursing research: Conduct, critique & utilization*. St Louis, MO: Elsevier Saunders.

Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioral Medicine*, 4, 92-100.

Carver, C. S., Pozo, C., Harris, S. D., Noriega, V., Scheier, M. F., Robinson, D. S., …. & Clark, K. C. (1993). How coping mediates the effect of optimism on distress: A study of women with early stage breast cancer. *Journal of Personality and Social Psychology*, 65, 375-390.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, 56, 267-283.

Chase, L. E., Welton-Mitchell, C., Bhattarai, S. (2013). Solving Tension: Coping among Bhutanese refugees in Nepal. *International Journal of Migration, Health and Social Care*, 9(2), 71-83.

Chinn, P. L. & Kramer, M. K. (1999). *Theory and nursing a systematic approach*. St Louis. MO: Mosby Year Book.

Cohen, J. W. (1988). *Statistical power analysis for the behavioural sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *J. Health Soc. Behav.* 24, 385-396.

Cole, S. (2000). Ethics and the Treaty of Waitangi. Retrieved from http://www.nathaniel.org.nz/component/content/article/13-bioethical-issues/what-is-bioethics/53-ethics-and-the-treaty-of-waitangi

Collins, B. (2016). Community groups to sponsor refugees. Retrieved from http://www.radionz.co.nz/news/national/306309/community-groups-to-sponsor-refugees

Connor, K. M., Vaishnavi, S., Davidson, J. R. T., Sheehan, D. V., & Sheehan K. H. (2007). Perceived stress in anxiety disorders and the general population: A study of the Sheehan stress vulnerability scale. *Psychiatry Research*, 151, 249-254.

Cook, T., & Campbell, D. T. (1997). *Quasi-experimentation: Design and analysis issues for field settings*. Chicago, IL: Rand McNally.

Cooper, C., Katona, C., & Livingston, G. (2008). Validity and reliability of the Brief COPE in carers of people with dementia: The LASER-AD study. *The Journal of Nervous and Mental Disease*, 196, 838-843.

Copping, A., Shakespeare-Finch, J., & Paton, D. (2010) Towards a culturally appropriate mental health system: Sudanese-Australians' experiences with trauma. *Journal of Pacific Rim Psychology*, 4(1), 53-60.

Coughlan, M. & Cronin, P. (2017). *Doing a literature review in nursing, health and social care* (2nd ed.). Thousand Oaks, CA: Sage.

Costanza, R. S., Derlega, V. J., & Winstead, B. A. (1988). Positive and negative forms of social support: Effects of conversational topics on coping with stress among same-sex friends. *Journal of Experimental Social Psychology*, 24, 182-193.

Crabtree, B. F., & Miller, W. L. (Eds.). (1992). *Doing qualitative research: Research methods for primary care*. Newbury Park, CA: Sage.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative and mixed methods*. Thousand Oaks, CA: Sage.

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell. J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Creswell, J. W., & Garrett, A. L. (2008). The movement of mixed methods research and the role of educators. *South African Journal of Education*. 20, 321-333.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousands Oaks, CA: Sage.

Creswell, J. W., Plano Clark, V. L., Gutmann, M., & Hanson, W. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209-240). Thousand Oaks, CA: Sage.

Creswell, J. W., & Maietta, R. C. (2002). Qualitative research. In D. C. Miller & N. J. Salkind (Eds.), *Handbook of social research* (pp. 143-184). Thousand Oaks, CA: Sage.

Crocket, K., Agee, M., & Cornforth, S. (2011). *Ethics in Practice: A guide for counsellors*. Wellington, New Zealand: Dunmore Publishing Ltd.

Dale, J. R., Williams, S. M., & Bowyer, V. (2012). What is the effect of peer support on diabetes outcomes in adults? A systematic review. *Diabetic Medicine*, *29*(11), 1361-1377.

Dalzie, L. (2003). Extending New Zealand's borders off-shore. Retrieved from https://www.beehive.govt.nz/release/extending-new-zealand%E2%80%99s-borders-shore

DAPAANZ (2005). *Code of Ethics*. Wellington, New Zealand: Drug and Alcohol Practitioners

Association of Aoteoroa New Zealand.

Davis, J. H. (2017). Trump orders Mexican border wall to be built and plans to block Syrian refugees. Retrieved from https://www.nytimes.com/2017/01/25/us/politics/refugees-immigrants-wall-trump.html

Delongis, A., Folkman, S., & Lazarus, R. S. (1988). The impact of daily stress on health and mood: psychological and social resources as mediators. *Journal of Personality and Social Psychology*, 54, 486-495.

Department of Labour. (2012). *Refugee status applications accepted and decided*. Wellington, New Zealand: Department of Labour.

Department of Labour. (2011). *Migration trends and outlook 2010-2011*. Wellington, New Zealand: Department of Labour.

Department of Labour. (2006). *Migrant and refugees streams: A guide to understanding how migrants and refugees enter New Zealand*. Wellington, New Zealand: Department of Labour.

Department of Labour. (2004). *Refugee voices, a journey towards resettlement*. Wellington, New Zealand: Department of Labour.

DePoy, E., & Gitlin, L. N. (1994). *Introduction to research: Multiple strategies for health and human services*. St. Louis, MO: Mosby.

Derogatis, L. R. (1987). The Derogatis Stress Profile (DSP): quantification of psychological stress. *Advances in Psychosomatic Medicine*, 17, 30-54.

Diamond, J. (2017). Trump orders construction of border wall, boosts deportation force. Retrieved from http://edition.cnn.com/2017/01/25/politics/donald-trump-build-wall-immigration-executive-orders/

Dong, A., Lovallo, D., & Mounarath, R. (2015). The effect of abductive reasoning on concept selection decisions. *Design Studies*, 37, 37-58.

Doron, J., Stephan, Y., Maiano, C., & Le Scanff, C. (2011). Motivational Predictors of Coping With Academic Examination. *The Journal of Social Psychology*, 151(1), 87–104.

Douglas, A. (2010). Identities in transition: living as an asylum seeker. *Advances in Psychiatric Treatment*, 16, 238-244, doi:10.1192/apt.bp.108.006080

Dulock, H. L. (1993). Research design: Descriptive Research. *Journal of Paediatric Oncology Nursing*. doi: 10.1177/104345429301000406.

Durie, M. H. (2004). Understanding health and illness: research at the interface between science and indigenous knowledge. *International Journal of Epidemiology*, 33, 1138–1143. doi:10.1093/ije/dyh250

Edwards, A. (2015). *UNHCR viewpoint: 'Refugee' or 'migrant' - Which is right?* Geneva, Switzerland: UNHCR.

Endler, N. S., Kantor, L., & Parker, J. D. A. (1994). State-trait coping, state-trait anxiety and academic performance. *Personality and Individual Differences*, 16(5), 663-670. doi:10.1016/0191-8869(94)90208-9

Essential Humanities. (2016, April 16). History of Sub-Saharan Africa. Retrieved from http://www.essential-humanities.net/world-history/sub-saharan-africa/

Essex, R. (3013). Asylum seeker health and bridging visas: history repeating. *Australian and New Zealand Journal of Public Health*, 37(6), 506-508. doi: 10.1111/1753-6405.12142

Eurostat Statistics Explained. (2016). Asylum statistics. Retrieved from http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics

Ezeabasili, N. (1977). *African science, myth or reality*? New York, NY: Vantage Press.

Fay, B. (1987). *Critical social science*. Ithaca, NY: Cornell University Press.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet*, 365, 1309-14.

Feldt, R. C. (2008). Development of a brief measure of college stress: The college student stress scale. *Psychological Reports*, 102, 855-860. doi: 10.2466/pr0.102.3.855-860

Feldt, R. C., & Updegraff, C. (2013). Gender invariance of the college student stress scale. *Psychological Reports*, 113, 2, 486-489. doi 10.2466/03.PR0.113x23z0

Fink, G. (2016). *Stress: concepts, cognition, emotion, and behavior*. London, England: Academic Press.

Fink, G. (2009). Stress: definition and history. *Elsevier Ltd*, 549-555. Retrieved from http://www.georgefink.com/wp-content/uploads/2012/03/Stress-Definition-History-Fink_2009_Encyclopedia-of-Neuroscience.pdf

Folger, R., & Stein, C. (2016). Abduction 101: Reasoning processes to aid discovery. *Human Resource Management Review*. doi: org/10.1016/j.hrmr.2016.08.007

Folkman, S., & Lazarus, R. (1985). If it changes it must be a process: study of emotion and coping during three stages of a college examination. *J Pers Soc Psychol*, 48, 150-170.

Folkman, S., & Lazarus, R. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, 21(3), 219-239.

Foss, C., & Ellefsen, B. (2002). The value of combining qualitative and quantitative approaches in nursing research by means of a method triangulation. *Journal of Advanced Nursing*, 40, 242-248.

Friedman, U. (2016). A world of walls: Donald Trump's proposal for the U.S.-Mexico border isn't outdated. It's a sign of the times. Retrieved from https://www.theatlantic.com/international/archive/2016/05/donald-trump-wall-mexico/483156/

Frydenberg, E., & Lewis, R. (1996). *Coping scale for adults*. Melbourne, Victoria: Australian Council for Educational Research.

Gade, C. B. N. (2012). What is Ubuntu? Different interpretations among South Africans of African descent. *S. Afr. J, Philos*. 31(3), 484-503.

Gale, P. (2004). The refugee crisis and fear. *Journal of Sociology*, 40(4), 321-340.

Gastel, B., & Robert, A. D. (2016). *How to write and publish a scientific paper* (8th ed.). Santa Barbara, CA: Greenwood.

Gelkopf, M., & Sigal, M. (1995). It is not enough to have them laugh: Hostility, anger, and humor-coping in schizophrenic patients. Humor*: International Journal of Humor Research*, 8, 273-284.

Gelo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. *Integr Psych Behav*, 42, 266-290. dol 10.1007/s12124-008-9078-3

Giddings, L. S., & Grant, B. M. (2007). A Trojan Horse for positivism? A critique of mixed methods research. *Advances in Nursing Science*, 30(1), 52-60.

Gladden, J. (2013). Coping skills of East African refugees: A literature review. *Refugee Survey Quarterly*, 31(3), 177-196. doi:10.1093/rsq/hds009.

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: a paradigm framework for novice researcher. *Contemporary Nurse* 13: 10-28.

Greene, J. C., & Caracelli, V. J. (Eds.). (1997). *Advances in mixed-method evaluation: The challenges and benefits of integrating diverse paradigms*. San Francisco, CA: Jossey-Bass.

Griensven, H. V., Moore, A. P., & Hall, V. (2014). Mixed methods research: The best of both worlds? *Manual Therapy*, 19. pp. 367-371

Gruner, A., & Searle, S. (2011). *New Zealand's refugee sector: Perspectives and developments, 1987-2010 quota refugees ten years on series*. Wellington, New Zealand: Department of Labour.

Guba, E. G. (Ed.). (1990). *The paradigm dialog*. London, England: Sage.

Guba, E. G., & Lincoln, Y. S. (1998). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research*: *Theories and issues* (pp. 185-193). London, England: Sage.

Hamberg, K., Johansson, E., Lindgren, G., & Westman, G. (1994). Scientific rigour in qualitative research-examples from a study of women's health in family practice. *Oxford University Press,* 11(2), 176-181.

Hartley, L. Fleay, C., & Tye, M. E (2017). Exploring physical activity engagement and barriers for asylum seekers in Australia coping with prolonged uncertainty and no right to work. *Health and Social Care in the Community*, 25(3), 1190-1198. doi: 10.1111/hsc.12419

Hastings. (2012). *Immigration and Protection Tribunal: Second annual report 2011/2012*. Auckland, New Zealand: Immigration and Protection Tribunal.

Hastings. (2011). *Immigration and Protection Tribunal: First annual report 2010/2011*. Auckland, New Zealand: Immigration and Protection Tribunal.

Hathaway, J. C. (2005). *The rights of refugees under international law*. Cambridge, England: Cambridge University Press.

Helewa, A., & Walker, J. M. (2000). *Critical evaluation of research in physical rehabilitation: toward evidence-based practice*. Philadelphia: Saunders.

Heron, J., & Reason, P. (1997). A participatory inquiry paradigm. *Qualitative Inquiry,* 3, 274-294.

Holahan, C. J., & Moos, R. H. (1987). Risk, resilience, and psychological distress: A longitudinal analysis with adults and children. *Journal of Abnormal Psychology,* 96, 3-13.

Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., et al. (2002). Measuring trauma and health status in refugees: A critical review. *American Medical Association*, 288(5), 611-621.

Holloway, I. (1997). *Basic concepts for qualitative research*. Oxford, England: Blackwell Science.

Hopkins W. G. (2000). Quantitative research design. *Sportscience* 4(1). Retrieved from http://www.sportsci.org/jour/0001/wghdesign.html

Howell, K. E. (2013). *Introduction to the philosophy of methodology*. London, England: Sage Publications.

Horesh, N., Klomek, A. B., & Apter, A. (2008). Stressful life events and major depressive disorders. *Psychiatry Research*, 160, 192-199.

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15, 1277-1288. doi:10.1177/1049732305276687

Human Rights Commission (2010). *Human rights in New Zealand 2010.* Auckland, New Zealand: Human Rights Commission.

Hunter, A., & Brewer, J. (2003). Multimethod research in sociology. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 577-594). Thousand Oaks, CA: Sage.

Hwang, K. (1979). Coping with residential crowding in a Chinese urban society: The interplay of high-density dwelling and interpersonal values. *Acta Psychologica Taiwanica*, 21(2), 117-133.

Idemudia, E. S. (2003). Mental health and psychotherapy 'through' the eyes of culture: Lessons for African psychotherapy. *TRANS. Internet-Zeitschrift für Kulturwissenschaften*, No. 15/2003. Retrieved from http://www.inst.at/trans/15Nr/02_7/idemudia15.htm

Immigration New Zealand. (2016, April 10). The refugee and protection unit. Retrieved from http://www.immigration.govt.nz/migrant/general/generalinformation/refugee-

protection/

Immigration New Zealand. (2016a). *The refugee and protection unit: Refugee Quota Branch (RQB) statistics*. Auckland, New Zealand: Ministry of Business, Innovation & Employment.

Immigration New Zealand. (2016c). *The refugee and protection unit: Refugee Quota Branch (RQB) arrival statistics*. Auckland, New Zealand: Ministry of Business, Innovation & Employment.

Immigration New Zealand. (2016d). *The refugee and protection unit: Refugee Status Branch (RSB) statistics*. Auckland, New Zealand: Ministry of Business, Innovation & Employment.

Immigration New Zealand. (2015). *Immigration New Zealand Operational Manual Residence*. Wellington, New Zealand: Immigration New Zealand.

Immigration New Zealand. (2015a). *Claiming refugee and protection status in New Zealand.* Wellington, New Zealand: Ministry of Business Innovation & Employment.

Immigration New Zealand. (2014a, May 17). Refugee resttlement factsheet. Retrieved from http://www.immigration.govt.nz/migrant/general/generalinformation/media/refugeefactsheet.htm

Immigration New Zealand. (2012). Refugee status applications accepted and decided. Retrieved from http://www.immigration.govt.nz/NR/rdonlyres/FCDA531E-8691-4DE0-807B-DD2484DDA329/0/RF1RefugeeStatusAppsAcceptedAndDecided02Aug2010.pdf

Immigration and Protection Tribunal. (2016, April 15). Immigration and Protection Tribunal. Retrieved from http://www.justice.govt.nz/tribunals/immigration-protection-tribunal

Ivankova, N. V., Creswell, J. W., & Sheldon L. S. (2006). Using mixed-methods sequential explanatory design: From theory to practice field methods. *Sage Journals*, 18: 3-20. doi: 10.1177/1525822X05282260

Jayasinghe, U. (2006). Women as members of a particular social group: Some flexible judicial developments. *Alternative Law Journal*, 79. 20; 31(2)

Johnson, C. (2006). Writing narrative literature reviews for peer-reviewed journals: secrets of the trade. *Journal of chiropractic medicine,* doi:10.1016/S0899-3467(07)60142-6

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, 1; 112. doi: 10.1177/1558689806298224

Johnson, R. B., & Onwuegbuzie, A. J. (2004). *Mixed methods research:* A research paradigm whose time has come. *Educational Researcher*, 33(7), 14-26.

Jones, A. & Bugge, C. (2006). Improving understanding and rigour through triangulation: an exemplar based on patient participation in interaction. *Methodological issues in nursing research*, 612-621. doi: 10.1111/j.1365-2648.2006.03953.x

Kamwangamalu, N. M. (1999). Ubuntu in South Africa: a sociolinguistic perspective to a pan-African concept. *Critical Arts*, 13(2), 24-41, doi: 10.1080/02560049985310111

Kapsou, M., Panayiotou, G., Kokkinos, C. M., & Demetriou, A. G. (2010). Dimensionality of coping: an empirical contribution to the construct validation of the Brief COPE with a Greek-speaking sample. *Journal of Health Psychology*, 15(2), 215-29.

Kemmis, S., & Wilkinson, M. (1998). Participatory action research and the study of practice. In B. Atweh, S. Kemmis, & P. Weeks (Eds.), *Action research in practice: Partnerships for social justice in education* (pp. 21-36). New York: Routledge.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., et al. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal*, 183(12), 959-967. doi:10.1503/cmaj.090292.

Kingi, K. R. (2005). *Cultural interventions and the treatment of Māori mental health consumers*. Wellington, New Zealand: Auckland University Conference Centre.

Koch, T. (2006). Establishing rigour in qualitative research: the decision trail. *Journal of Advance Nursing,* 53(1), 91-103.

Kopp, M. S., Thege, B. K., Balog, P., Stauder, A., Salavecz, G., Rózsa, S., … Adams, S. (2010). Measures of stress in epidemiological research. Journal of Psychosomatic Research, 69, 211-225.

Krueger, R. A. (2000). *Focus groups: a practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage.

Kuhn, T. S. (1970). *The structure of scientific revolutions*. Chicago, IL: The University of Chicago Press.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.

Lamb, C., & Smith, M. (2002). Problems refugees face when accessing health services. *New South Wales Public Health Bulletin,* 13(7), 161-163.

Lambo, T. A. (1978). Psychotherapy in Africa. *Human Nature,* 1(3), 32-39.

Langford, C. P. H., Bowsher, J., Maloney, J. P., & Lillis, P. P. (1997). Social support: a conceptual analysis. *Journal of advanced nursing*, *25*(1), 95-100.

Lazarus, R. S. (1966). *Psychological stress and the coping process*. New York, NY: McGraw-Hill.

Lee, C., Suchday, S., & Wylie-Rosett, J. (2012). Perceived social support, coping styles, and Chinese immigrants' cardiovascular responses to stress. *Int J Behav Med, 19(2),* 174-185.

Letourneau, N. & Allen, M. (1999). Post-positivistic critical multiplism: a beginning dialogue. *Journal of Advanced Nursing,* 30(3), 623-630.

Locke, K. (2011). Keith Locke on the Tamil asylum seekers - general debate speech. Retrieved from https://home.greens.org.nz/speeches/keith-locke-tamil-asylum-seekers-general-debate-speech.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In Y. S. Lincoln & E. G. Guba (Eds.), *Handbook of qualitative research* (pp. 163 -188). Thousand Oaks, CA: Sage.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lipscomb, M. (2012). Abductive reasoning and qualitative research. *Nursing Philosophy*, 13, 244-256

Little, A. (2016). Labour joins double the quota campaign. Retrieved from http://www.labour.org.nz/labour_joins_double_the_quota_campaign

Lycke, H. (2011). A formal explication of the search for explanations: the adaptive logics approach to abductive reasoning. *Oxford University Press*, 20 (2). doi:10.1093/jigpal/jzq053

Magobe, B. D. N., Beukes, S., & Muller, A. (2011). A Scoring clinical competencies of learners: A quantitative descriptive study. *Health S A*, 16.1.

Magyar. (2016). Understanding migration and asylum in the European Union. Retrieved from https://www.opensocietyfoundations.org/explainers/understanding-migration-and-asylum-european-union

Malloch, M., & Stanley, E. (2005). The detention of asylum seekers in the UK: Representing risk, managing the dangerous. *Punishment & Society*, 7(1), 53-71.

Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Ontario, CA: Althouse.

Mann, C. M., & Fazil, Q. (2006). Mental illness in asylum seekers and refugees. *Primary Care*

Mental Health, 4, 57-66.

Manning D. & James, E. (2011). Refugees and those in need of protection. In M. Bedggood & K. Gledhill (Eds.), *Law into action: Economic, social and cultural rights in Aotearoa New Zealand* (pp 221-241). Wellington, New Zealand: Thomson Reuters.

Mares, S., Newman, L., Dudley, M., & Gale, F. (2002). Seeking refuge, losing hope: parents and children in immigration detention. *Australasian Psychiatry*, 10, 91. doi: 10.1046/j.1440-1665.2002.00414.x

Mark, G. T., & Lyons, A. C. (2010). Maori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science & Medicine*, 70, 1756-1764.

Marlowe, J. (2010). Beyond the discourse of trauma: Shifting the focus on Sudanese refugees. *Journal of Refugee Studies*, 23, 183-198.

Marlowe, J. & Elliott, S. (2014). Global trends and refugee settlement in New Zealand, Kōtuitui: *New Zealand Journal of Social Sciences Online*, 9(2), 43-49, doi: 10.1080/1177083X.2014.953186

Matthews, K. A., Siegel, J. M., Kuller, L. H., Thompson, M., & Varat, M. (1983). Determinants of decisions to seek medical treatment by patients with acute myocardial infarction symptoms. *Journal of Personality and Social Psychology*, 44, 1144-1156.

MBIE. (2016). *Refugee Status Branch (RSB) Statistics*. Auckland, New Zealand: INZ/MBIE

MBIE. (2015). *Migration Trends and Outlook 2014/15*. Wellington, New Zealand: Ministry of Business Innovation & Employment.

MBIE. (2015b). *Claiming refugee and protection status in New Zealand*. Wellington, New Zealand: Ministry of Business Innovation & Employment.

McCrae, R. R. (1984). Situational determinants of coping responses: Loss, threat, and challenge. *Journal of Personality and Social Psychology*, 46, 919-928.

McCrae, R. R., & Costa, P. T. Jr. (1986). Personality, coping, and coping effectiveness in adult sample. *Journal of Personality*, 54, 385-405.

Mental Health Commission. (2012). *Blueprint II: How things need to be.* Wellington, New Zealand: Mental Health Commission.

Mental Health Commission. (1998). *Blueprint for Mental Health Services in New Zealand: How things need to be.* Wellington, New Zealand: Mental Health Commission.

Mertens, D. M. (2013). What does a transformative lens bring to credible evidence in mixed methods evaluations? In D. M. Mertens & S. Hesse-Biber (Eds.), *Mixed methods and credibility of evidence in evaluation. New Directions for Evaluation*, 138, 27-35.

Mertens, D. M. (2010). Transformative Mixed Methods Research. *Qualitative Inquiry* 16(6) 469-474. doi: 10.1177/1077800410364612

Mertens, D. M. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of Mixed Methods Research*, 1, 212-225.

Mertens, D. M. (2003). Mixed methods and the politics of human research: The transformative-emancipatory perspective. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in the social & behavioural sciences* (pp. 135-164). Thousand Oaks, CA: Sage.

Mertens, D. M. (1998). *Research methods in education and psychology. Integrating diversity with quantitative and qualitative approaches*. Thousand Oaks, CA: Sage.

Meyer, B. (2001). Coping with severe mental illness: Relations of the Brief COPE with symptoms, functioning, and well-being. *Journal of Psychopathology and Behavioral Assessment*, 23, 265-277.

Miller, M. A., & Rahe, R. H. (1997). Life changes scaling for the 1990s. *Journal of Psychosomatic Research*, 43, 279-292.

Miller, S., & Gatta, J. (2006). The use of mixed methods models and designs in the human sciences: Problems and prospects. *Quality & Quantity*, 40(4), 595-610.

Ministry of Health. (2006). *Mental health nursing framework and its future: A discussion framework*. Wellington, New Zealand: Ministry of Health.

Minister of Health. (2005). *Te Tāhuhu - Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan*. Wellington, New Zealand: Ministry of Health.

Miyazaki, Y., Bodenhorn, N., Zalaquett, C., & Kok-Mun, N. (2008). Factorial structure of brief cope for international students attending U.S. colleges. *College Student Journal*, Vol 42, Issue 3, 795-807.

Moir, J. (2016). Government allies put pressure on National to lift the refugee quota. Retrieved from http://www.stuff.co.nz/national/politics/78404029/Labour-to-announce-policy-to-double-New-Zealands-refugee-quota

Monzani, D., Steca, P., Greco, P., D'Addorio, M., Capelletti, E., & Pancani L. (2015). The situational version of the Brief COPE: Dimensionality and relationships with goal-related variables. *Europe's Journal of Psychology*, Vol. 11(2), doi:10.5964/ejop.v11i2.935

Morse, J. M. (2003). Principles of mixed methods and multimethod research design. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 189-208). Thousand Oaks, CA: Sage.

Mortensen, A. (2011). Public health system responsiveness to refugee and groups in New Zealand: Activation from the bottom up. *Social Policy Journal of New Zealand*. Issue 37.

Mullen, B., & Suls, J. (1982). The effectiveness of attention and rejection as coping styles: A meta-analysis of temporal differences. *Journal of Psychosomatic Research*, 26, 43-49.

Neumann, K. (2016). The current refugee crisis: What's new? *New Zealand International Review*, 41(4), 10-12.

Newman, I., Ridenour, C. S., Newman, C., & DeMarco, G. M. P. (2003). A typology of research purposes and its relationship to mixed methods. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 189-208). Thousand Oaks, CA: Sage.

New World Encyclopedia. (2015). Sub Saharan Africa. Retrieved 16 April 2016 from http://www.newworldencyclopedia.org/entry/Sub-Saharan_Africa

Oakley Browne, M., Wells, J., Scott, K., (2006). *Te Rau Hinengaro: The New Zealand mental health survey*. Wellington, New Zealand: Ministry of Health

O'Brien, L. & Leafman, J. (2012). Level of stress and common coping strategies among physician assistant students. *The Journal of Physician Assistant Education*, 23(4):25-29.

O'Doherty, K., & A. Lecouteur. (2007). "Asylum seekers", "boat people" and "illegal immigrants" Social categorisation in the media. *Australian Journal of Psychology*, 59(1), 1-12.

OECD.Stat. (2016, April 19). Population. Retrieved 19 April 2016 from http://stats.oecd.org/Index.aspx?DatasetCode=POP_FIVE_HIST

O'Hagan, M. (2001). *Recovery competencies for New Zealand mental health workers*. Wellington, New Zealand: Mental Health Commission.

Onwuegbuzie, A. J., & Leech, N. L. (2005). On becoming a pragmatic researcher: The importance of combining quantitative and qualitative research methodologies. *International Journal of Social Research Methodology*, 8:5, 375-387. doi:10.1080/13645570500402447

Oppenheim, A. N. (2000). *Questionnaire design, interviewing and attitude measurement*. London, England: Bloomsbury Academic.

Pallant, J. (2013). *SPSS Survival manual: A step by step guide to data analysis using IBM SPSS* (5th ed.). New South Wales, Australia: Allen & Unwin.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Paukert, A. L., LeMaire, A., & Cully, J. A. (2009). Predictors of depressive symptoms in older veterans with heart failure. *Aging & Mental Health,* 13(4), 601-610. doi:10.1080/13607860802459823

Pearlin, L. I., & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior, 19, 2-21.*

Peirce, C. S. (1998). Pragmatism as the logic of abduction (Lecture VII - Harvard Series). In N. Houser (Ed.), *The essential Peirce: Selected philosophical writings - Volume 2* (pp. 226-241). Indianapolis, IN: Indiana University Press.

Pickering, S. (2001). Common sense and original deviancy: News discourses and asylum seekers in Australia. *Journal of Refugee Studies*, 14(2), 170-186.

Pickering, S., & Lambert, C. (2001). Immigration detention centres, human rights and criminology in Australia. *Current Issues in Criminal Justice*, 3(2), 219-223.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne - Psychological Journal*, 20(1), 7-14. doi: 10.14691/CPPJ.20.1.7

Pitman, A. (2010). Asylum application process: the psychiatric patient's experience. *Psychiatric Bulletin*, 34, 344-348. doi: 10.1192/pb.bp.109.024968

Polit, D. F., & Hungler, B. P. (1999*). Nursing research: Principles and methods* (6th ed.). Philadelphia. PA: JB Lippincott.

Price, S. (2004). Terrorism by media: Coverage of the Ahmed Zaoui affair. *Pacific Journalism Review*, 10 (1).

Pugh, M. (2004). Drowning not waving: Boat people and humanitarianism at sea. *Journal of Refugee Studies*, 17(1), 50-69.

Pumariega, A. J., Rothe, E., & Pumariega, J. B. (2005). Mental health of immigrants and refugees. *Community Mental Health Journal*, 41(5), 581-597. doi: 10.1007/s10597-005-6363-1

Raghallaigh, M. N. & Gilligan, R. (2010). Active survival in the lives of unaccompanied minors: coping strategies, resilience, and the relevance of religion. *Child and Family Social Work*, 15, 226-237. doi: 10.1111/j.1365-2206.2009.00663.x

Rapp, C. A. (1998). *The strengths model: Case management with people suffering from severe and persistent mental illness*. New York, NY: Oxford University Press.

Rapp, C. A., & Goscha, R. J. (2011). *The strengths model: A recovery-oriented approach to mental health services*. New York, NY: Oxford University Press.

Refugee Council of Australia. (2016). *Recent changes in Australian refugee policy*. New South Wales, Australia: Refugee Council of Australia.

Refugee Health and Screening Service. (2016, April 10). Refugees and asylum seekers in New Zealand. Retrieved from http://www.refugeehealth.govt.nz/about-us/refugees-and-asylum-seekers-in-new-zealand

Reilly, A. (2013). Fact check: Are Australia's refugee acceptance rates high compared with other nations?. Retrieved from http://theconversation.com/factcheck-are-australias-refugee-acceptance-rates-high-compared-with-other-nations-17151

Richardson, S. H. M. (2014). *Stress*. London, England: John Murray Learning.

Rim, Y. (1993). Coping styles, schizotypy and the opposite directions effect. *Personality and Individual Differences*, 14, 741-745.

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *The British Journal of Psychiatry*, 194(4), 306-312.

Robson, C. (1993). *Real world research. A resource for social scientists and practitioner-*

researchers. Oxford, England: Blackwell Publishers.

Roche, D. (2016). Govt can show heart by doubling our refugee quota now. Retrieved from https://www.greens.org.nz/news/article/govt-can-show-heart-doubling-our-refugee-quota-now

Rohde, P., Lewinsohn, P. M., Tilson, M., & Seeley, J. R. (1990). Dimensionality of coping and its relation to depression. *Journal of Personality and Social Psychology*, 58, 499-511.

Rose, K. E., & Webb, C. (1997). Triangulation of data collection: practicalities and problems in a study of informal carers of terminally ill cancer patients. *NT Research*, 2, 108-116.

Rosenfarb, I. S., Ventura, J., Nuechterlein, K. H., Goldstein, M. J., Snyder, K. S., & Hwang, S. (1999). Expressed emotion, appraisal, and coping by patients with recent onset schizophrenia. *Scandinavian Journal of Behaviour Therapy*, 28, 3-8.

Rossman, G. B., & Wilson, B. L. (1985). Numbers and words: Combing quantitative and qualitative methods in a single large-scale evaluation study. *Evaluation Reviews*, 9(5), 627-643.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23, 334-340.

Sandelowski, M. (1986). The problem of rigour in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.

Sandstrom, B., Willman, A., Svensson, B., & Borglin, G. (2015). Perceptions of national guidelines and their (non) implementation in mental healthcare: a deductive and inductive content analysis. *Implementation Science*, 10(43). doi:10.1186/s13012-015-0234-0

Sales, R. (2002). The deserving and the undeserving? Refugees, asylum seekers and welfare in Britain. *Critical Social Policy*, 22(3), 456-478.

Sanjuán, P., Molero, F., Fuster, M. J., & Nouvilas, E. (2013). Coping with HIV related stigma and well-being. *Journal of Happiness Studies*, 14(2), 709-722. doi:10.1007/s10902-012-9350-6

Sarason, I. G., Johnson, J. H., & Siegel, J. M. (1978). Assessing the impact of life changes: development of the life experiences survey. *Journal of Consulting and Clinical Psychology*, 46, 932-946.

Sarfo-Mensah, A. G. (2009*). Coping methods and meaning making of Liberian refugees in the Buduburam refugee camp of Ghana*. Honors scholar thesis, Storrs, C T: University of Connecticut.

Schock, K., Rosner, R., & Knaevelsrud, C. (2015). Impact of asylum interviews on the mental health of traumatized asylum seekers. *European Journal of Psychotraumatology*, 6: 26286. doi.org/10.3402/ejpt.v6.26286

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms*. Thousand Oaks, CA: Sage.

Scott, A., & Doughty, C. (2012). Care, empowerment and self-determination in the practice of peer support. *Disability & Society*, 27:7, 1011-1024. doi:10.1080/09687599.2012.695578

Seedhouse, D. (2009). *Ethics: the heart of health care*. Chichester, England: Wiley-Blackwell.

Shakespeare-Finch, J, Schweitzer, R., King, J., & Brough, M. (2014). Distress, coping, and posttraumatic growth in refugees from Burma. *Journal of Immigrant & Refugee Studies*, 12:311-330. doi: 10.1080/15562948.2013.844876

Sheehan, D. V., Raj, A. B., & Sheehan, H. K. (1990). Is buspirone effective for panic disorder? *Journal of Clinical Psychopharmacology*, 10, 3-11.

Shek, D. T., & Cheung, C. (1990). Locus of coping in a sample of Chinese working parents: Reliance on self or seeking help from others. *Social Behavior and Personality*, 18(2), 327-345.

Selo, S., & Kyngas, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing* 62(1), 107-115. doi: 10.1111/j.1365-2648.2007.04569.x

Selye, H. (1975). Confusion and controversy in the stress field. *J Hum Stress*, 1, 37-44.

Selye, H. (1936). A syndrome produced by diverse nocuous agents. *Nature*, 138:32.

Serido, J., Almeida, D. M., & Wethington, E. (2004). Chronic stressors and daily hassles: Unique and interactive relationships with psychological distress. *Journal of Health and Social Behavior*, 45(1), 17-33.

Shoeb, M., Weinstein, H., & Mollica, R. (2007). The Harvard trauma questionnaire: Adapting a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Iraqi refugees. *International Journal of Social Psychiatry*, Vol. 53, 447-63.

Sikarwar, H. S., & Gurjar. K. S. (2014). Stress vulnerability comparison among selected disciplines. *Annual Refereed & Peer Reviewed Journal*, vol. 2, no.1, January-December.

Silove, D., Austin, P., & Steel, Z. (2007). No refuge from terror: The impact of detention on the mental health of trauma-affected refugees seeking asylum in Australia. *Transcultural Psychiatry* 44: 359-393.

Sinnerbrink, I., Silove, D., Field, A., Steel, Z., & Manicavasagar, V. (1997). Compounding of premigration trauma and postmigration stress in asylum seekers. *The Journal of Psychology*, 131 (5), 463-470.

Small, D. (2004). Ahmed Zaoui: New Zealand's very own political prisoner. Retrieved from http://www.converge.org.nz/watchdog/07/10.htm

Smith, D. (2017). Trump signs order to begin Mexico border wall in immigration crackdown. Retrieved from https://www.theguardian.com/us-news/2017/jan/25/donald-trump-sign-mexico-border-executive-order

Smith, R. (1993). Potentials for empowerment in critical education research. *Australian Educational Researcher*, 20(2), 75-93.

Snell, D. L., Siegert, R. J., Hay-Smith, E. J. C., & Surgenor, L. J. (2011). Factor structure of the Brief COPE in people with mild traumatic brain injury. *Journal of Head Trauma and Rehabilitation*, 26, 468-477.

Smythe, L., & Giddings, L. S. (2007). From experience to definition: Addressing the question 'What is qualitative research?' *Nursing Praxis in New Zealand*, 23(1), 37-57.

Sokol, R., & Fisher, E. (2016). Peer support for the hardly reached: A systematic review. *AJPH RESEARCH*, vol 106, no. 7.

Spiller, P. (2016). *Immigration and Protection Tribunal: Annual report 2015/2016*. Auckland, New Zealand: Immigration and Protection Tribunal.

Spiller, P. (2015). *Immigration and Protection Tribunal: Annual report 2014/2015*. Auckland, New Zealand: Immigration and Protection Tribunal.

Spiller, P. (2014). *Immigration and Protection Tribunal: Annual report 2013/2014*. Auckland, New Zealand: Immigration and Protection Tribunal.

Statistics New Zealand. (2012). *Ethnicity and crowding: A detailed examination of crowding among ethnic groups in New Zealand 1986-2006*. Wellington, New Zealand: Statistics New Zealand.

Stein, N. R., Schorr, Y., Litz, B. T., King, L. A., King, D. W., Solomon, Z., & Horesh, D. (2013). Development and validation of the coping with terror scale. *Assessment*, 20(5), 597-609. doi:10.1177/1073191111411668

Stone, A. A., & Neale, J. M. (1984). New measure of daily coping: Development and preliminary results. *Journal of Personality and Social Psychology*, 46, 892-906.

Streubert, H. J., & Carpenter, D. R. (1999). *Qualitative research in nursing: Advancing the humanistic imperative* (2nd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Sukamolson, S. (2016, October 20). Fundamentals of quantitative research. Retrieved from http://www.culi.chula.ac.th/Research/e-Journal/bod/Suphat%20Sukamolson.pdf

Sulaiman-Hill, C. M. R., Thompson, S. C., Afsar, R., & Hodliffe, T. (2011). Changing images of refugees: A comparative analysis of Australian and New Zealand print media 1998-2008. *Journal of Immigrant & Refugee Studies*, 9:4, 345-366, doi: 10.1080/15562948.2011.616794

Summerfield, D. (2001). Asylum-seekers, refugees and mental health services in the UK. *Psychiatr Bull*, 25, 161-3.

Sweetman, D., Badiee, M., & Creswell, J. W. (2010). Use of the transformative framework in mixed methods studies. *Qualitative Inquiry* 16(6), 441-454. doi: 10.1177/1077800410364610

Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: Sage.

Tashakkori, A., & Teddie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA: Sage.

Taylor, S., & Stanton, A. (2007). Coping resources, coping processes, and mental health. *Ann Rev Clin Psychol*, 3, 377-401.

Te Pou. (2010). *Therapies for refugees, asylum seekers and new migrants: Best and promising practice guide for mental health and addiction services*. Auckland, New Zealand: Te Pou o te Whakaaro Nui.

Te Pou. (2009). *National guidelines for the professional supervision of mental health and addiction nurses*. Auckland, New Zealand: Te Pou o te Whakaaro Nui.

Terrill, A. L., Gjerde, J. M., & Garofalo, J. P. (2015). Background stress inventory: Developing a measure of understudied stress. *Stress and Health*, 31, 290-298, doi: 10.1002/smi.2554

The Library of Congress. (2017, February 22). List of Sub-Saharan African countries. Retrieved from https://www.loc.gov/rr/amed/guide/afr-countrylist.html

The New York Times. (2015). Australia's brutal treatment of migrants. Retrieved from https://www.nytimes.com/2015/09/03/opinion/australias-brutal-treatment-of-migrants.html?_r=0

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing*, 16, 151-155. doi: 10.1111/j.1744-6155.2011.00283.x

Tobin, D. L., Holroyd, K. A., Reynolds, R. V., & Wigal, J. K. (1989). The hierarchical factor structure of the coping strategies inventory. *Cognit Ther Res*, 13(4), 343-361.

Toki, V. (2009). Therapeutic jurisprudence and mental health courts for Maori. *International Journal of Law and Psychiatry*. 33, 440-447.

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). Others: The role of family, friends and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation*, 9(1), 17-37.

Tribe, R. (2002). Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment*, 8, 240-247. doi: 10.1192/apt.8.4.240

Trochim, W. (2000). *The research methods knowledge base* (2nd ed.). Cincinnati, OH: Atomic Dog Publishing.

Tsa-Tsala. (1997). Beliefs and disease in Cameroon. In S. N. Madu, P. K. Baguma & A. Pritz (Eds.), *Psychotherapy in Africa: First investigation*. Vienna. Austria: World Council for Psychotherapy.

TVNZ. (2007). Timeline in the Ahmed Zaoui case. Retrieved from http://tvnz.co.nz/content/1223429/2591764.xhtml

United Nations Economic Commission for Africa. (2017, February 22). Subregional Offices. Retrieved from http://www.uneca.org/pages/subregional-offices

United Nations General Assembly. (2016). *Draft outcome document of the high-level plenary meeting of the General Assembly on addressing large movements of refugees and migrants*. New York, NY: United Nations General Assembly.

United Nations General Assembly. (1994). *Note on international protection (submitted by the High Commissioner) A/AC.96/830*. NY, New York: United Nations General Assembly.

UNHCR. (2016a, April 10). Asylum seekers. Retrieved from http://www.unhcr.org/pages/49c3646c137.html.

UNHCR. (2016b, April 11). Migrant definition. Retrieved from https://emergency.unhcr.org/entry/44938/migrant-definition

UNCHR. (2016c). *Global forced displacement in 2015*. Geneva, Switzerland: UNHCR.

UNHCR. (2015a). *UNHCR global trends: Forced displacement in 2014*. Geneva, Switzerland: UNHCR.

UNHCR. (2015b, April 7). *2015 likely to break records for forced displacement* - study. Retrieved from http://www.unhcr.org/5672c2576.html

UNHCR. (2015c, April 7). Worldwide displacement hits all-time high as war and persecution increase. Retrieved from http://www.unhcr.org/558193896.html

UNHCR. (2015d). *UNHCR asylum trends 2014: Levels and trends in industrialized countries*. Geneva, Switzerland: UNHCR.

UNHCR. (2015e). *UNHCR refugee resettlement: Trends 2015*. Geneva, Switzerland: UNHCR.

UNHCR. (2015f). *UNHCR Mid-year trends 2015: Trends 2015*. Geneva, Switzerland: UNHCR.

UNHCR. (2013). *Asylum trends 2013: Levels and trends in industrialized countries*. Geneva, Switzerland: United Nations High Commissioner for Refugees.

UNHCR. (2005). *Refugee status determination*. Geneva, Switzerland: UNHCR.

UNHCR. (1996). *Mental health of refugees*. Geneva, Switzerland: UNHCR/WHO.

UNMISS. (2017, February 22). UNMISS Background. Retrieved 16 April 2016 from http://www.un.org/en/peacekeeping/missions/unmiss/background.shtml

Uprety, K., Basnwet, U., & Rimal, D. (1999). *A study on the needs of asylum-seekers/refugees for early intervention*. Auckland, New Zealand: Auckland Refugee Council Inc.

Van der Walt, B. J. (1997). *Afrocentric or Eurocentric? Our task in a multicultural South Africa*. Potchefstroom, South Africa: Potchefstroom University for Christian Higher Education.

Wahass, S., & Kent, G. (1997). Coping with auditory hallucinations: A cross-cultural comparison between Western (British) and non-Western (Saudi Arabian) patients. *Journal of Nervous and Mental Disease*, 185, 664-668.

Weine, S. M. (2011). Developing preventive mental health interventions for refugee families in resettlement. *Family Process*, 50(3), 410-430

Welman, J. C., & Kruger, S. J. (1999). *Research methodology for the business and administrative sciences*. Johannesburg, South Africa: International Thompson.

West-Newman, C. L. (2015). Changing attitudes: What if refugee lawyers and Māori wrote New Zealand's asylum seeker and refugee policy? *New Zealand Sociology*, 30(2), 10-25.

Witztum, E., Briskin, S., & Lerner, V. (1999). The use of humor with chronic schizophrenic patients. *Journal of Contemporary Psychotherapy*, 29, 223-234.

Woodhouse, M. (2016). Govt announces increase to refugee quota. https://www.beehive.govt.nz/release/govt-announces-increase-refugee-quota

Woodhouse, M. (2015). New Zealand to take 750 more Syrian refugees. Retrieved from

https://www.beehive.govt.nz/release/new-zealand-take-750-more-syrian-refugees

Wrosch, C., Amir, E., & Miller, G. E. (2011). Goal adjustment capacities, coping, and subjective well-being: The sample case of caregiving for a family member with mental illness. *Journal of Personality and Social Psychology*, 100(5), 934-946. doi:10.1037/a0022873

Young, C., & Koopsen, C. (2005). *Spirituality, health and healing: An integrative approach*. NJ, New Jersey: Slack Incorporated.

Young, N., & Mortensen, A. (2003). Refugees and asylum seekers: Implications for ED care in Auckland, New Zealand. *J Emerg Nurs*, 29, 337-41. doi:10.1067/men.2003.104

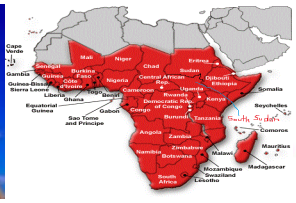
Yusoff, N., Low, W. L., & Yip, C. H. (2010). Reliability and validity of the Brief COPE scale (English version) among women with breast cancer undergoing treatment of adjuvant chemotherapy: A Malaysian study. *Med J Malaysia*, Vol, 65, No 1/03.

Yusoff, N. S. B. (2010). A multicenter study on validity of the 30-items Brief COPE in identifying coping strategies among medical students. *International Medical Journal*, 17, 249-253.

Appendices

Appendix A: Poster

Research Participants Needed




Are you an asylum seeker former asylum seeker? Whether or not you were successful with your Refugee Status Claim?

We are researching how asylum seekers cope with stress from the Refugee Status Claim (asylum process) in New Zealand. You can help by telling us what you did to cope with this stress.

There are two stages involve in this research:

The first stage is

- to complete a survey. The survey will have questions on some of the strategies you might have used to cope with stress.

and the second stage is

- to undergo a brief interview with the researcher. The interview will check what the coping strategies mean to you and how you have used them.

We will appreciate your time and thank you for participating in the research with a Paknsave gift voucher of $25:00 for participating in the first stage of the research, and another Paknsave gift voucher of $25:00 for participating in the second stage of the research.

To participate in this research, you have to be or have been an asylum seeker in New Zealand; have come from Africa; and be aged 18 years or over; and can read, write or speak English language or Pidgin English.

For more information:
Call or text 0220715506
Email hrf6679@autuni.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 18 May 2016 AUTEC Reference number 16/119

Appendix B: Brief COPE scale

Brief COPE scale

Instructions:

The following questions are about ways you used to cope with the stress you personally experienced when you went through your claim for refugee status (the claim) in New Zealand. Each question says something about a particular way of coping. We want to know to what extent you did what the question says. Please use the response choices provided by each statement and circle the number that best describes your personal experience from the claim. Try to rate each question separately in your mind from the others. Make your answers as true FOR YOU as you can.

		I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1	I've been turning to work or other activities to take my mind off the claim.	1	2	3	4
2	I've been concentrating my efforts on doing something about the situation I'm in.	1	2	3	4
3	I've been saying to myself "this isn't real.".	1	2	3	4
4	I've been using alcohol or other drugs to make myself feel better about the claim.	1	2	3	4
5	I've been getting emotional support from others.	1	2	3	4
6	I've been giving up trying to deal with the claim.	1	2	3	4
7	I've been taking action to try to make the situation better.	1	2	3	4

		I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
8	I've been refusing to believe that it has happened.	1	2	3	4
9	I've been saying things to let my unpleasant feelings escape.	1	2	3	4
10	I've been getting help and advice from other people.	1	2	3	4
11	I've been using alcohol or other drugs to help me get through the claim.	1	2	3	4
12	I've been trying to see the claim in a different light, to make it seem more positive.	1	2	3	4
13	I've been criticizing myself.	1	2	3	4
14	I've been trying to come up with a strategy about what to do.	1	2	3	4
15	I've been getting comfort and understanding from someone.	1	2	3	4
16	I've been giving up the attempt to cope.	1	2	3	4
17	I've been looking for something good in what is happening.	1	2	3	4
18	I've been making jokes about it.	1	2	3	4

		I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
19	I've been doing something to think about it less such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	1	2	3	4
20	I've been accepting the reality of the fact that it has happened.	1	2	3	4
21	I've been expressing my negative feelings about the claim.	1	2	3	4
22	I've been trying to find comfort in my religion or spiritual beliefs.	1	2	3	4
23	I've been trying to get advice or help from other people about what to do.	1	2	3	4
24	I've been learning to live with it.	1	2	3	4
25	I've been thinking hard about what steps to take.	1	2	3	4
26	I've been blaming myself for things that happened.	1	2	3	4
27	I've been praying or meditating about the claim.	1	2	3	4
28	I've been making fun of the situation.	1	2	3	4

We would like to ask you to answer a few general questions about yourself:

Please **tick** the correct answer **or fill** in the space provided.

1. Are you (Please tick)	□ Male	□ Female
2. What is your age group?	□ 18 – 24yrs □ 35 – 44yrs □ 55 – 64yrs	□ 25 – 34yrs □ 45 – 54yrs □ 65 and above
3. What is your country of origin?	_____	
4. What is the highest level of education you have completed?	□ None at all □ Secondary school	□ Primary School □ Tertiary
5. What is your marital status?	□ Single □ Married □ Living as married	□ Separated □ Divorced □ Widowed
6. What is your current employment status?	□ Full-time work □ Part-time work □ Unemployed	□ Student □ Retired □ Other _____
7. What is the status of your claim?	□ Approved	□ Declined □ In process
8. What is the duration of your claim?	□ 1 – 6 months □ 13 – 18 months □ 24 months and above	□ 7 – 12 months □ 19 – 24 months
9. Are you living with a mental illness?	□ Yes	□ No

10) We would like to invite you to take part in the next phase of this study, which is an interview that will help explain and add your understanding and meanings to the information we have collected from you in this questionnaire. The interview will last about an hour and will take place in July 2016. Do you consent to us contacting you for the interview part of this research? □ Yes □ No

11) Have you attended at least an interview with an Officer of the Refugee Status Branch (RSB) in New Zealand? Also, answer yes to this question if your case went on appeal and you were interviewed at the level of the Immigration and Protection Tribunal (IPT) or both.

□ Yes □ No

12) On a scale of **1** to **10**, with **1** being 'NOT STRESSFUL' at all, and **10** being 'EXTREMELY STRESSFUL', how do you rate the stress you personally experienced from the claim in New Zealand? Please circle the number that best describes your personal experience of stress from the claim.

Not stressful				**moderate stress**					**extremely stressful**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Thank You

Appendix C: Indicative Qualitative Questions

Indicative Qualitative Questions

Self-distraction

We will begin the interview with Q1 and Q19 in the questionnaire in your hand: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Active coping

Let's now look at Q2 same as Q7: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Denial

Q3 same as Q8: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Substance use

Q4 same as Q11: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

What about prescription medications, do you rely on any at this time of your claim?

The point I am picking from here is that you needed the prescription medications to help you to sleep and to eat as well. I wonder if you also had to use prescript medications for these purposes in your home country!

Did you find using the medications helpful?

Use of emotional support

Q5 same as Q15: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

How often would you say you are seeing you psychologist for emotional support.

When you are with the psychologist, what are the sorts of things you tell her?

How do you express yourself to her?

Are there other people in the community who have supported you emotionally in this journey?

Behaviour disengagement

Q6 same as Q16: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Something that I am picking up from this conversation is it seems as well like for you it was not so much your claim in itself that was stressful and hurting to you but the fact that it led to this digging into your past, was something terrible for you ....?

When did you start feeling like giving up?

It seems there are is a lot of things that you would have preferred to deal with them at the surface but you did know that in an asylum claim you would be made to go deeper?

When it started weighing heavily on you and the thoughts of suicide started coming, when did you finally decide that it is time you get help?

Venting

Q9 same as Q21: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Use of instrumental support

Q10 same as Q23: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Positive reframing

Q12 same as Q17: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Self-blame

Q13 same as Q26: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Tell more about the blaming thing, how it meant to you, I am interested.

Planning

Q14 same as Q25: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Humour

Q18 same as Q28: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Acceptance

Q20 same as Q24: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Religion

Q22 same as Q27: Looking at these 2 questions, what was it like for you? What does it mean to you? How did you use it?

Looking back at your asylum claim, what would you say is the most useful thing that is helping you cope with the process?

Are there ways of coping that you used during the time of you claim that you think has not been captured or included in this form?

Is there anything you think could be added or removed from the questions?

Appendix D: Ethics Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

18 May 2016

Grace Wong
Faculty of Health and Environmental Sciences

Dear Grace

Re Ethics Application: **16/119 A mixed methods inquiry into the coping strategies of asylum seekers and Convention refugees from Sub-Saharan Africa.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 16 May 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 16 May 2019;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 16 May 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Bernard Sama Nde hrf6679@autuni.ac.nz, Nick Garrett

Appendix E: Approval of Amendment to Ethics

AUTEC Secretariat
Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

20 July 2016

Grace Wong
Faculty of Health and Environmental Sciences
Dear Grace

Re: Ethics Application: **16/119 A mixed methods inquiry into the coping strategies of asylum seekers and Convention refugees from Sub-Saharan Africa.**

Thank you for your request for approval of an amendment to your ethics application.

A change to the inclusion criteria allowing the researcher to capture and include data from 'incidental participants' if consent is obtained is approved.

I remind you that as part of the ethics approval process, you are required to submit the following to the Auckland University of Technology Ethics Committee (AUTEC):

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 16 May 2019;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 16 May 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Bernard Nde, Nick Garrett

Appendix F: Support Letter from NZRCS

Auckland Service Centre
PO Box 97014
Manukau
Auckland 2163
33 Lambie Drive
Manukau
Auckland 2104
Phone 09 262 0694
Fax 09 262 0976
www.redcross.org.nz

NEW ZEALAND
RED CROSS

18th March 2016

Dear Sir or Madam

Re: Bernard Sama – Consultation re research with Asylum seekers and refugee

I am writing to inform you that I met with Bernard Sama to discuss his research into strategies used by asylum seekers from Sub Saharan Africa to cope with stress from their refugee claims.

In meeting with Bernard I was impressed by his insights, self-knowledge and research into this area. I believe that he is has a sound understanding of the cultural differences, including beliefs, values and practices with this particular group. As he is himself from this region I believe that he has good cultural insights and will therefore be at an advantage in researching the group.

If you need any further information please do not get in contact with me.

Your sincerely

Celia Brandon
Client Services Team Leader
Refugee Services Programme
Auckland

Appendix G: Support Letter from KMGC

King's Mercy Global Church
114 Wiri Station Road
Wiri, Manukau
Auckland 2104
Tel: 0210 524 297

07 March 2016

Bernard Sama Nde
(MHSc student at)

AUT University - North Shore Campus
School of Public Health & Psychosocial Studies
90 Akoranga Drive, Northcote
Auckland 0627

Dear Bernard,

We are writing in support of your proposed research "*A mixed methods inquiry into the coping strategies of asylum seekers from Sub Saharan Africa*", submitted to the School of Public Health and Psychosocial Studies at AUT University. Given the limited resources available to asylum seekers, there is a need for their coping behaviours to be studied so we can understand how to continue to support them.

We are pleased to serve as a community resource for this project. We will assist the project by (1) providing a platform for cultural and spiritual issues, and (2) announcing the study to potential participants.

King's Mercy Global Church (KMGC) is dedicated to promoting the wellbeing of people in the community and your proposed research is congruent with our desire for all new immigrants to develop their full capacities in New Zealand.

We hope that your research proposal receives a favourable outcome.

Sincerely,

Apostle Prince Chikezie
King's Mercy Global Church
0210524297

Participant Information Sheet

Date Information Sheet Produced:

12 May 2016

Project Title

A mixed methods inquiry into the coping strategies of asylum seekers and Convention refugees

An Invitation

I am Bernard Sama, a former asylum seeker, and now a student at AUT University completing a thesis for a Masters of Health Science (MHSc). I am interested in exploring how asylum seekers cope with stress from the Refugee Status Claim (the asylum process) in New Zealand. I would like to invite you to be part of this research. Before you make up your mind whether or not you should participate in the research, it would be good to talk to someone you feel comfortable talking with, or inquire more about the research by contacting either my research supervisor or me on the contact details provided at the end of this Information Sheet. Your participation in the study will be voluntary but will be highly valued. Even after deciding to participate in the study, you will still be able to withdraw from it should you change your mind at the later date before the 29 July 2016.

What is the purpose of this research?

The goal of this study is to explain how asylum seekers cope with stress from the asylum process in New Zealand. The process of applying for asylum is stressful to many people. Unfortunately, there are limited knowledge, research, and resources to support asylum seekers to cope with this stress. We would, therefore, like to know what you did to cope with the stress. Your experience will help us get a better understanding of the coping strategies of asylum seekers. Your contributions will be helpful to organisations that work with asylum seekers.

How was I identified and why am I being invited to participate in this research?

You have not been identified specifically to take part in this study. Rather we are inviting you to participate in the study because of your experience as an asylum seeker in New Zealand. We believe your experience of the asylum process can help us to understand how people cope with the asylum process.

What will happen in this research?

The study is structured in two stages:

Stage 1

In Stage 1, you will be required to complete a survey. The survey will take place between 23 May and 30 June 2016. The survey will ask questions about coping strategies. The aim of the survey is to see if you have used any of the coping strategies during your claim for asylum in New Zealand. The survey (questionnaire) is included in this information pack. You are not obliged to answer every question in the survey. If you do not wish to answer any of the questions, or you feel uncomfortable doing so, you are free not to. Also, there will be a few other general (demographic) questions and an invitation for you to participate in Stage 2 of the research.

Stage 2

In Stage 2 of the research, you will have a brief interview with the researcher. The interview will be about your experience of the coping strategies assessed in the survey. The interview will take place between the 1 July and 17 July 2016. It will be held in a safe and comfortable place at any of the AUT University campuses or any other place in the community that is safe for you. The interview will be recorded, and only you and the researcher will be present at the interview location except that you may choose to bring a support person with you. During the interview, if you feel uncomfortable answering any questions, you will not be obliged to answer.

What are the discomforts and risks?

Because this research will focus on how you cope with stress from your asylum process in New Zealand, there is the chance that some of the questions in the survey and/or the interview might make you feel uncomfortable rethinking some of the experiences you went through during your asylum claim.

How will these discomforts and risks be alleviated?

Should you feel distressed during the research, you can stop, withdraw or ask to be removed from the research. Also, we can support you to get counselling from the 'AUT Health, Counselling and Wellbeing service'. They can be contacted directly by phone or at the City or North Shore Campuses. Their telephone number is 921 9992 (that is, Room WB219 in the City Campus) or 921 9998 (that is, Room AS104 of the North Shore Campus). Please inform the receptionist that you are a research participant for Bernard Sama's Masters thesis.

How will my privacy be protected?

We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept confidential. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is, and the recording and information will be stored in a secured place in a locked office at AUT University. It will not be shared with or given to anyone except the research supervisors, and the AUT Health, Counselling and Wellbeing Service should there be need to do so because of any distress that you might have experienced as a result of your participation in the research.

What are the costs of participating in this research?

The study is structured into 2 phases. The first phase (completion of the questionnaire) will take approximately 30 minutes of your time. Then the second phase (interviews) will take approximately 1 hour of your time. Therefore, in total, it should take about 1 hour 30 minutes to participate in the entire study. The only other cost will be the time it will take you to walk, or cost of petrol, or cost of public transport to any safe place you might prefer other than your home; for example, AUT University campus (the City, North Shore or Manukau Campus).

You will not be provided any incentive to take part in the study. However we will give you a koha (a PaknSave Gift voucher worth $25.00) to thank you for your time and travel expense to participate in the first phase of the research; and another $25.00 Paknsave Gift voucher to thank you for your time and travel expenses to participate in the second phase of the research.

What opportunity do I have to consider this invitation?

You have a week from the date you receive this information to think whether or not you would like to participate in this research.

How do I agree to participate in this research?

You can agree to take part in this study by completing the Consent Form. The Consent Form is also included in this information pack. If you still have some questions about the research, you can text, phone, email or arrange to see Bernard Sama before completing the Consent Form. Once you have completed the Consent Form and mailed, emailed or handed it to Bernard Sama, the next step for you to do is to complete and return the survey (questionnaire) which is also included in this information pack.

Will I receive feedback on the results of this research?

Yes, you will receive feedback on the results of this research if you wish. However, no information that you will provide us in the research will be attributed to you by name. We may also publish the results of the study so other interested parties may learn from it, but the publication will be anonymous.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Grace Wong, grace.wong@aut.ac.nz , 09 921 9999 ext 7501

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Bernard Sama, hrf6679@autuni.ac.nz , 0220715506

Project Supervisor Contact Details:

Dr. Grace Wong, grace.wong@aut.ac.nz , 09 921 9999 ext 7501

Approved by the Auckland University of Technology Ethics Committee on 18 May 2016. AUTEC Reference Number 16/119

Consent Form

Project title: ***A mixed methods inquiry into the coping strategies of asylum seekers and Convention refugees from Sub-Saharan Africa***

Project Supervisor: ***Grace Wong (PhD)***

Researcher: ***Bernard Sama***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 12 May 2016.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details:

.....

.....

.....

.....

Date: .....

Approved by the Auckland University of Technology Ethics Committee on 18 May 2016 AUTEC Reference Number 16/119

Note: The Participant should retain a copy of this form.

Appendix J: Memorandum from AUT Counselling

Memorandum

To	Bernard Sarna
From	Paul Wedge
cc	
Subject	AUT Counselling services for research participants
Date	1 March 2016

Dear Bernard

As the Head of Counselling of AUT Health Counselling and Wellbeing, I would like to confirm that our counselling service is able to offer confidential counselling support for the participants in your AUT research project entitled:

"A mixed methods enquiry into the coping strategies of asylum seekers from Sub Saharan Africa"

The free counselling, for participants who require it, will be provided by our professional counsellors for a maximum of three sessions, and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and counselling on our website http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Current AUT students also have access to our counsellors and online counselling as part of our normal service delivery.

Yours sincerely

Paul Wedge
Head of Counselling

From the office of: Paul Wedge, Head of Counselling,
AUT Health, Counselling and Wellbeing
e: paul.wedge@aut.ac.nz | t: 09 921 9999 xtn 6065