Exploring Migration Experiences and Mental Health among Refugees and Asylum-seekers in Durban, South Africa: Guidelines for Mental Health Promotion Interventions

Submitted in fulfilment of the requirement for the degree

Doctor of Philosophy (Health Promotion)

By

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DECLARATION

I hereby declare that this thesis, Exploring Migration experiences and Mental Health among Refugees and Asylum-seekers in Durban, South Africa: Guidelines for Mental Health Promotion Interventions is my own original work. All citations, references and borrowed texts have been duly acknowledged. This research has not previously been submitted to any other institution for degree or examination purposes.

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January 2020

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Dedication

I dedicate this work to my mother, **Abeba Ghebresema'ati Weldesilase,** who has given everything she can in her life to me, to become the person I am today.

Acknowledgement

With heartfelt gratitude and appreciation, I thank my supervisor Professor Anna Meyer-Weitz, for her unselfish guidance, constructive criticism and enormous kindness and professionalism that taught me a lot academically and personally and kept me grounded throughout this research journey. Thank you, Anna, you have also been a mother while I am away from home.

Special thanks also to Refugee Social Services, particularly to the director Mrs Yasmin Rajah for the permission and your cooperation during data collection and opening your doors to use for interviews.

I would also like to thank every family member and friends who always understood and encouraged my academic pursuits and keep me on their prayers. Your words are not without fruit.

Abstract

Background: Refugees and asylum seekers flee war, state violence, persecution and economic hardships. They tend to be very poor, vulnerable and are often excluded from the health and socio-economic activities of the hosting communities. In these contexts, refugees and asylum-seekers are found to be among high-risk groups for mental health problems, especially those that resettle in Low-and-Middle Income Countries. Further, mental health issues of refugees are worsening in light of the sustained conflict and forced migration the world is witnessing. For a long time now, the need for mental health promotion among refugees has been a public health concern. However, it seems there has been limited research undertaken in Africa, particularly in South Africa regarding the migration experiences and mental health of refugees. This study therefore aimed to explore refugees' and asylum-seekers' migration experiences particularly the stressors, psychological problems and coping strategies at pre-, transit-, and post-migration stages. Understanding migration experiences provides an essential background for developing mental health intervention guidelines to promote psychological wellbeing among refugees.

Methodology: The study utilised a sequential exploratory mixed-method strategy that allows first qualitative data collection and analysis followed by a second phase of quantitative data collection and analysis that builds on the results of the first qualitative phase. The main purpose of utilising this design was to initially explore the migration experiences of refugees and to understand their explanations and descriptions of migration and mental health experiences qualitatively. Then the quantitative phase aimed at expanding the initial qualitative results using a much larger sample. Based on a descriptive phenomenological method, qualitative data was collected from 14 purposefully selected participants using face-to-face interviews. The data was analysed using the five steps phenomenological descriptive analysis. A cross-sectional survey was utilised to collect data from 195 conveniently sampled respondents. A survey questionnaire was used to collect data and it included demographic questions and the following measures: Refugees Stress Scale (RSS), Post- Migration Living Difficulties Questionnaire (PMLD), Refugees' Defenceless Scale (RDS), Connor-Davidson Resilience Scale (CD-RS), General Health Questionnaire (GHQ - 28) and Post-Traumatic Stress Disorder Checklist - civilian version (PCL -5). The data was analysed using the Statistical Package for the Social Science (SPSS version 25). Techniques of exploratory factor analysis, independent samples t-tests, ANOVA, Pearson-moment correlation coefficient and regression models were used to analyse the quantitative data.

Results: The qualitative results revealed that throughout migration refugees have experienced life-threatening events and gross violation of human rights emanating from state-organized-violence, conflict and xenophobic violence or criminal attacks. Further, refugees also suffered from economic hardships mostly due to lack of employment opportunities, not knowing where they were going, travelling alone, lack of basic necessities, persecution and lack of security. As a result, their mental health experiences attest emotional and psychological distress resulting from the immediate stressors and lingering migration stressors. The participants described experiencing symptoms of PTSD, anxiety and depression throughout the migration process and beyond. The psychological distress of refugees who fled recently and experienced traumatic events have been further stressed by the lack of basic necessities in South Africa, is notably worrisome. Refugees were dealing with very negative experiences using different coping mechanisms, mainly, faith and religiosity, escaping danger, using hopeful thoughts and relying on some social support. The quantitative results revealed threats to life, forced separation from family, not having a clear vision about ones' future, limited freedom and police or military follow-ups or beating as most common pre-migration stressors. The post-migration stressors are mainly insecurity and vulnerability that includes xenophobic threats, lack of job opportunity/ unemployment, worries about their children, discrimination, separation from family, unable to return to their original home in an emergency time and fear of repatriation. Regarding psychological distress, anxiety and insomnia are found as the most prevalent symptoms of distress, followed by social dysfunction, somatic complaints and depression. About one third of the participants are experiencing major symptoms of PTSD.

Conclusion: The prevalence of psychological distress is relatively lower in this study when compared to other studies among African refugees, however, refugees who fled recently from traumatic experiences are found to be notably stressed with major PTSD symptoms. Further, lack of basic needs, minimal financial income and insecurity are found to be determinants of mental health of refugees. Mental health promotion interventions for refugees should consider their primary needs, health inclusive of mental health screening at entry and to follow-up by addressing their psychological problems through both individual and community-based psychosocial interventions to enable refugees to take better control of their health and wellbeing within an supportive and enabling environment.

Acronym

ACMS - African Centre for Migration and Society

ACCORD – African Centre for the Constructive Resolution of Disputes

APA – American Psychological Association

CBT - Cognitive Behavioural Therapy

CDC - Centre for Disease Control

CD-RS - Connor-Davidson Resilience Scale

CW – Corruption Watch

DALY - Disability-Adjusted Life Years

DHA – Department of Home Affairs

DRC - Democratic Republic of Congo

DSM - Diagnostic and Statistical Manual of Mental Disorders

GHQ - General Health Questionnaire

IMO – International Migration organization

IRC - International Rescue Committee

ITT - Intergroup threat theory

KMO - Kaiser-Meyer-Olkin

LHR - Lawyers for Human Rights

LMICs - Low- and Middle-Income countries

NET - Narrative Exposure Therapy

NGO - Non-governmental Organization

OAU - Organization of African Unity

PCA - Principal Components Analysis

PCL - Post-Traumatic Stress Disorder Checklist

PMLD - Post- Migration Living Difficulties Questionnaire

PLWHA - People Living With HIV/AIDS

PTG - Post-Traumatic Growth

PTSD - Post-Traumatic Stress Disorder

RDS - Refugee Defencelessness Scale

RRO – Refugee Reception Office

RSS – Refugees Social Services

RSS - Refugees Stress Scale

AS – South Africa

StatsSA – Statistics of South Africa

UNECE – United Nations Economic Commission for Europe

UNDP – United Nations Human Development

UNICEF - United Nations International Children's Fund

WHO - World Health Organization

Key Terms Definitions

Asylum-seeker - "*… a person who is seeking recognition as a refugee in the Republic*" (Section 1(V) of the *Refugee Act of 1998 of South Africa*).

Coping - a "*constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person*" (Lazarus & Folkman, 1984, p. 141).

Ecological environment - is "*… as a set of nested structures, each inside the other like a set of Russian dolls. Moving from the innermost level to the outside*" (Bronfenbrenner, 1994, p. 39).

Health - "*…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO, 2001b, p.1).

Health promotion – according the Ottawa Charter Health promotion is *"a process of enabling people to increase control over their health and its determinants, and improve their health"* (WHO, 1986).

Mental health - ''*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*'' (WHO, 2005, p. 2).

Mixed methods - "*… a research design (or methodology) in which the researcher collects, analyses, and mixes (integrates or connects) both quantitative and qualitative data in a single study or a multiphase program of inquiry*" (Johnson, Onwuegbuzie, & Turner, 2007; p.119).

Phenomenology - "*a science, a system of scientific disciplines... above all denotes a method and an attitude of mind…*" (Husserl, 1964; p. 18-19).

Psychological distress - "*a set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. In some cases, however, psychological distress may indicate the beginning of major depressive disorder, anxiety disorder, schizophrenia, somatization disorder, or a variety of other clinical conditions. It is thought to be what is assessed by many putative self-report measures of depression and anxiety"* (https://dictionary.apa.org/psychological-distress).

Psychological disorder – "*a psychological dysfunction within an individual that is associated with distress or impairment in function and a response to this which deviate from the person's culture"* (Barlow & Durand, 2005; cited by Austin et al., 2014, p. 6).

Refugee – according to *Section 3(a) Refugees Act no. 130* of 1998 of South Africa a refugee is a person who: "*Owing to a well-founded fear of being persecuted by reason of his or her race, tribe, religion,*

nationality, political opinion or membership of a particular social group, is outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country, or, not having a nationality and being outside the country of his or her former habitual residence is unable or, owing to such fear, unwilling to return to it."

Resilience **-** is the ability of a person to successfully adapt to or recover from stressful and traumatic experiences (Crawford, Wright, Masten, 2005).

Xenophobia – is defined as a hatred of or prejudice against someone considered as an outsider or foreigner to a community, and an irrational fear of someone that is a stranger or a person with a different culture (Harris, 2002; Nyamnjoh, 2006).

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Chapter One

Introduction

1.1 Background of the Study

The World Health Organization (WHO, 2013) states that there are excessively high rates of morbidity and mortality among people with mental health problems. *The Mental Health Act* (WHO, 2013) mentioned that there is a 40 to 60 per cent greater chance of premature death among persons with major depression and schizophrenia than in the general population, mostly due to major neglect of Physical health problems (e.g. cancers, cardiovascular diseases, diabetes, and HIV infections) leading in some cases to suicide in this group. The De Hert report found that there are a 30 year premature death rate for people with severe mental health conditions including depression, schizophrenia and a bipolar mood disorder (De Hert et al., 2011). More recently, the WHO (2018), reported that every 40 seconds someone commits suicide in the world and severe depression is the leading factor for 800,000 suicides annually. Of these three quarters are from Low- and Middle-Income countries (LMICs, Patel, 2015). Furthermore, mental health disorders contribute to a high global burden of disease (Whiteford et al., 2013). Mental and substance abuse disorders accounted for 183.9 million Disability-Adjusted Life Years (DALYs) or 7.4 per cent of the total disease burden in 2010. Overall, mental and substance abuse disorders were the fifth leading disorder category of global DALYs of which depressive disorders, anxiety disorder, alcohol and other drug use disorders accounted for most DALY cases (Whiteford et al., 2013). The economic burden associated with mental disorders exceeded the economic burden of each of the major categories of non-communicable diseases, i.e. diabetes, cardiovascular diseases, chronic respiratory diseases, and cancer (Bloom et al., 2011).

Furthermore, there is an increase in psychological distress in the general population, where more mental health conditions have been detected in vulnerable groups by comparison with those found in the general population. Saxena et al., (2006), for example, indicated that depression affected over 450 million people. However, according to the WHO report it increased to 615 million people by 2013. The majority of these are poor people from developing countries (WHO, 2016). People from developing countries and other vulnerable groups such as the poor, people living with HIV/AIDS (PLWHA), people who have experienced combat and who were displaced due to war experience higher psychological distresses. For example, Lund et al. (2010), systematically reviewed epidemiological literature that included 115 studies from 36 LMICs that showed a strong association between common

mental disorders (including depression, anxiety and somatoform disorders) and different indicators of poverty. The common mental disorders showed a consistent and strong correlation with indicators such as level of education, food insecurity, housing, social class, socio-economic status and financial stress. Furthermore, the review reported that community-based studies found up to 79 per cent positive association between a range of poverty measures and common mental disorders (Lund et al., 2010).

South Africa is one of the Upper and Low- and Middle-Income Countries that experiences a high incidence of mental health disorders (Bloom et al., 2011; Bruckner et al., 2011; Lopez et al., 2006). In a representative national survey, namely the *South African Stress and Health (SASH) study* it was reported that 16.5 per cent of adults had experienced a mood, anxiety or substance use disorder (Williams et al., 2007). Bradshaw, Norman, and Schneider (2007) stated that neuropsychiatric disorders ranked third after HIV/AIDS and other infectious diseases in their contribution to the overall burden of disease in South Africa. Further, a high economic loss was reported by Lund, Myer, Stein, Williams, and Flisher (2013), who stated that lost earnings among adults with severe depression and anxiety disorders during the previous 12 months amounted to ZAR28.8 billion (equal to 2.2 per cent of the GDP in 2002). Compared to direct spending of the nation on mental health care for adults, that was approximately ZAR472 million, this loss of earnings might not be as insignificant as it might, at first sight, appear to be. The researchers concluded that for South Africa, it costs more not to treat mental illness than it does to treat it (Lund et al., 2013). There are also the social costs of mental illness that include but are not limited to disrupted families and negative reports on social media networks dealing with stigma, discrimination, loss of future opportunities, marginalization and decreased quality of life.

People displaced due to war, particularly refugees and asylum seekers, tend to be very poor, vulnerable and are often excluded from the general community. This exposes them to major socioeconomic stress that cumulatively contributes to poor mental health on top of their traumatic experiences caused by flight from their countries of origin (Feijen, 2009; Ryan, Dooley & Benson, 2008; Simmelink & Shannon, 2012; UNHCR, 2008).

In this 21st century, Syria is the most affected country by war. Since the war started in 2011 more than half a million Syrians are dead, and the UNHCR (2017) global trends on forced displacement reported

that more than 6.3 million Syrians had been forced to leave their homes. The Syrians were scattered over 125 countries where they sought refuge with 3.4 million hosted by Turkey, followed by 992,100 by Lebanon (UNHCR, 2017). Furthermore, Syrian refugees showed greater deterioration in mental health when the Balkan countries, the European Union and Turkey closed their borders to stem the influx (Farhat et al., 2018). These refugees suffered institutional abuse characterized by lack of proper protection, an uncertain future, and the humiliation of waiting in lines for basic services and the constant fear of deportation and separation from family. Among Syrians who have been stranded without a definite future, transit and post-migration stressors are found as a source of pain and suffering together with the past war experiences (Farhat et al., 2018). These resulted in a continuous experience of trauma and living in the state of emergency due to lack of protection and mental health care (Eleftherakos et al., 2018). Similarly, Doctors without Borders, reported that closure of the borders and stranded refugees are strongly associated with systematic and organized violence against the refugees perpetrated by state authorities (Arsenijevic et al., 2017; Farhat et al., 2018). Among Syrians stranded in Greece, 75 to 92 per cent of participants tested positive for anxiety disorder, which warranted referral for mental health. Other symptoms include difficulty with adjustment, acute reactions, depression, psychotic disorders, Post Traumatic Stress Disorder (PTSD) and behavioural problems (Farhat et al., 2018). A higher level of psychological distress was also reported by the German Chamber of Psychotherapists (Munz, 2015). This indicated that at least half of the refugees in Germany are mentally ill. The refugees suffer mostly PTSD (40 to 50%) or depression (50%). The report also mentioned that PTSD and depression frequently occur together. The study revealed that refugees with PTSD are often suicidal, and 40 per cent of them had plans to take their own lives or had even tried to kill themselves (Munz, 2015).

Several studies reported that forced migration experiences of refugees resulted in psychological distresses mainly PTSD, depression and anxiety (Abebe, Lien & Hjelde, 2014; Hynie, 2018; Kartal & Kiropoulos, 2016; Leong, Park & Kalibatseva, 2013; Miller & Rasmussen, 2010). There are also large studies that explain the association between significant traumatic events, daily stressors, and less than satisfactory social support with psychological complaints such as PTSD, depressive symptoms and psychosomatic disorder in refugees (Abebe et al., 2014; Aichberger et al., 2015; Hynie, 2018; Kartal & Kiropoulos, 2016). It is noteworthy that the issue is becoming ever more urgent in light of the sustained conflict and forced migration that our world is witnessing in every corner of the globe (Perera

et al., 2013; UNHCR, 2017). As indicated above, Syrian refugees in particular but, globally, all refugees and asylum-seekers are found to be among the high-risk groups for mental health problems, especially those resettled in LMICs, in which all African countries including South Africa belong.

Africa is one of the major refugees producing continents due to persistent war and organized violence. Several countries in Africa, even though they are at the lowest level of the socio-economics ladder, hosted high numbers of refugees and asylum-seekers (UNHCR, 2017). In South Africa, the Department of Home Affairs (DHA) reported that it had granted refugee status to 119, 600 migrants and asylum-seeker permits for 1 061 812 migrants (DHA, 2017).

Even though there are limited studies on forced migration and mental health in Africa, evidence shows high levels of mental health problems. Mostly, a high level of emotional distress with high levels of posttraumatic stress, anxiety and depression and social difficulties was found among refugees by comparison with other immigrants and hosting communities in Africa (Akinyemi, Owoaje, Ige, & Popoola, 2012; Akinyemi, Atilola, & Soyannwo, 2015; Idemudia, Williams, Madu, & Wyatt, 2013). For example, a comparative study among African refugees in Nigeria (Akinyemi et al., 2012) reported higher mental health problems, i.e. they were three times more likely than non-refugees to suffer these problems. The most common mental health problems among the refugees were depression (45.3%), followed by obsession (34%), PTSD (34%), mania (25.9%), alcohol abuse (19%) and suicidal inclination (11%) (Akinyemi et al., 2012). The study reported significant disparities in the mental health status between the refugees and non-refugees in Nigeria after ten years of living in exile including higher suicidal tendency (27.3%) among the refugees compared to that in the local community estimated to be at 7.3 per cent (Akinyemi et al., 2015). A disturbingly high rate of depression symptoms (92%) and PTSD symptoms (71%) was also reported among female refugees from the Democratic Republic of Congo and Somalia in Uganda (Morof, Mangeni, Blanton, Cardozo & Tomczyk, 2014). A recent study by Maharaj, Tomita, Thela, Mhlongo, and Burns (2017) reported a significant level of anxiety (49.4%) and depressive symptoms (54.6 %) among refugees in Durban, South Africa.

In addition, in South Africa, xenophobic violence has been one of the most intractable post-migration difficulties that affect refugee livelihoods and exacerbates their mental health problems (Crush, 2008;

Gordon, 2015; McConnell, 2008; Mothibi, Roelofse & Tshivhase, 2015). Furthermore, studies among refugees in South Africa indicated significant psychological distress associated with food insecurity (not eating enough and eating less), discrimination, unemployment and exploitation (Bloch, 2010; Idemudia et al., 2014; Maharaj et al., 2016).

Another important aspect of refugees' migration experience is coping strategies and resilience. Many refugees tend to overcome difficulties under abnormal situations by showing extra resilience and adaptive ability, while others do not. Studies so far have found, particularly with African refugees, faith and religiosity, cognitive processing, meaning-making, and resilience as common strategies of positive coping (Khawaja et al., 2008; Vázquez, Cervellón, Pérez-Sales, Vidales, & Gaborit, 2005). These include refugees' attitudes toward their internal resources, such as taking a positive approach, identifying strengths, determination to cope and self-perceptions of being a survivor rather than a victim seem to contribute to positive adaptation (Cherewick et al., 2015; Goodman, 2004; Ziain, Antiss, Antoniou, Baghurst, & Sawyer, 2011), and they also show Post Traumatic Growth. Refugees in South Africa also use different coping strategies to avoid xenophobic attacks and other post-migration stressors such as escaping (hiding) from identity, psychological and social withdrawal, living in overcrowded inner-city areas and embracing self and informal employment (Mujawamariya, 2013). Resilience is related to low psychological distress; however, a low level of resilience is associated with the presence of depressive symptoms or other emotional or behavioural problems (Schweitzer, Greenslade, & Kagee, 2007; Siriwardhana & Stewart, 2013; Ziaian et al., 2011).

1.2. Rationale for the study

Despite the growing burden of mental illness and the resultant level of suffering for individuals and society, efforts to address it are unsatisfactory (Atilola, 2014; Silove, Ventevoget & Rees, 2017). This is particularly true in developing countries due to low budgetary resources (Becker & Kleinman, 2013; Saxena et al., 2007), the presence of competing and conflicting health system needs, scarcity of mental health personnel, and the stigma involved in seeking psychiatric help (Silove et al., 2017; Verhaeghe & Bruynooghe, 2007). Additionally, mental disorders continue to be driven into the shadows by stigma, prejudice and fear.

The WHO acknowledged mental health as one of the important features of health when it defines this as "… *a state of complete mental, physical, and social well-being, and not merely the absence of*

disease or infirmity" (WHO, 2001, p.1). Based on a positive psychological view, mental health was equated with the well-being of an individual who *"... realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*" (WHO, 2001, p.1). Despite the above sentiments, mental health has not been given the attention it deserves, and it is neglected in the mainstream of health care systems, especially in the LMICs (Becker & Kleinman, 2013; Faydi et al., 2011; Omer et al., 2010). Mental health is considered one of the lowest health priorities in LMICs, and it is estimated that four out of five people with mental illness in these countries receive no effective treatment (Kohn, Saxena, Levav, & Saraceno, 2004; WHO-mhGAP, 2008, WHO, 2011). The WHO's Mental Health Action Plan (2013) similarly reported that 76 to 85 per cent of people with severe mental disorders receive no treatment for their disorders in LMICs, while in the high-income countries the rates are between 35 and 50 per cent. This is called a 'treatment gap' - the gap between the number of people with mental disorders who require treatment, and those who receive it. This gap is estimated to be, for example, 75 per cent in South Africa (Williams et al., 2007) and over 90 per cent in Ethiopia (Alem, Kebede, Fekadu, Shibre, Fekadu, Beyero, 2009). Further, in South Africa, it was indicated common mental health disorders (CMDs) remain largely undetected and untreated in the primary healthcare (Peterson & Lund, 2006; Petersen & Lund, 2011). Then, the WHO theme '*no health without mental health'*, seems not to have been realised. The health systems have not adequately responded to the burden of mental disorders; as a consequence, the gap between the need for treatment and its provision is large across the world (WHO, 2013).

Earlier, Ingleby (2005) stated that mental health care is a priority for refugees once basic necessities are met. In line with this statement, Dr Dietrich Munz, the president of the German Chamber of Psychotherapies said that refugees need not only basic necessities but medical care too, however, "… *almost no mentally ill refugee receives an adequate supply*" (Munz, 2015). The consequences of untreated mental illness include suffering, diminished quality of life and disability (Kebede et al., 2005), and lead to human rights abuses, stigma, and discrimination (Thornicroft et al., 2009), as well as poverty (Lund et al., 2010), poor physical health and premature mortality (Teferra et al., 2011). It could also be argued that, as Saraceno, Levav, and Kohn's (2005) social drift hypothesis outlined, people with poor mental health are at increased risk of staying impoverished because of stigma, unemployment, reduced productivity and increased health expense.

South Africa adheres to an urban settlement policy, where asylum-seekers are allowed to integrate, anywhere, from the first day of arrival (Belvedere, 2007; Kavuro, 2015). This means that there is no immediate basic needs and health care support for newcomers unless someone accommodates them. Therefore, there are many who suffer from a lack of basic needs, and the mental health needs of asylum-seekers and refugees are largely neglected. Thus, research that explores the migration stressors and mental health outcomes of refugees and asylum-seekers are imperative in understanding the mental health needs of African refugees and asylum-seekers in South Africa. Therefore, this study intended to develop guidelines for mental health interventions that promote the psychological well-being of refugees and asylum-seekers. Migration stressors and mental health experiences of refugees and asylum-seekers are different throughout their journey for sanctuary and resettlement. There is a norm, in forced migration studies, that categorizes refugees' experiences into three migration stages; namely pre-migration, transit-migration and post-migration (Bhugra & Jones, 2001; Khawaja et al., 2008; Lindert & Schinina, 2011). This study also adhered to this approach in exploring and understanding refugees' migration stage and related mental health experiences as well as coping mechanisms and resilience.

1.3 Purpose Statement of the Study

Globally, refugees are among the most vulnerable people and at high risk of encountering mental health problems, particularly those that resettle in LMICs. However, there has been limited research conducted in South Africa regarding forced migration and the mental health stressors experienced in pre-, transit- and post-migration. The existing literature is limited in many ways, for example, qualitative studies focused on migration stressors included samples from Zimbabwe only (Idemudia et al., 2013), and another one by Smit and Rugunanan (2014) explored African women migration experiences and distress. Further, the quantitative studies were cross-sectional either examined the prevalence of psychological distress (Mhlongo et al., 2018; Thela et al., 2017) or partially investigated post-migration stressors (Maharaj et al., 2016). In addition, there seems there is nothing known about refugees' and asylum-seekers' resilience and coping mechanisms to mitigate the impact of their mental health distress. The prevalence and patterns of psychological distress among refugees in South Africa is also not adequately documented. Therefore, the purpose of this study is to explore and understand refugees' and asylum-seekers' migration experiences and mental health outcomes, and the coping strategies they use in order to develop guidelines for mental health interventions to promote

psychological wellbeing among refugees and asylum-seekers in South Africa. The terms refugees and asylum-seekers are defined in detail in the second chapter, however, from here after the term refugees is used to refer to both refugees and asylum-seekers unless there is a need to distinguish between them.

1.4 Aim and Objectives of the Study

The aim of this study is to explore refugees' three stages of migration experiences and related mental health distresses and coping mechanisms with the aim of developing guidelines for mental health promotion interventions to support psychological well-being among refugees. To this end, an exploratory mixed-method study (Creswell, 2009) was used in which the qualitative study explored the participants pre-migration, transit migration and post-migration experiences and their related psychological impacts. The quantitative cross-sectional survey study examined the pre and post-migration stressors, resilience and mental health problems.

Research Objectives of the qualitative study

- To explore the lived experiences, during the pre-migration, transit-migration and post-migration, of African refugees in Durban, South Africa;
- To understand the psychological distress experienced, during the pre-migration, transit-migration and post-migration, of African refugees in Durban, South Africa; and
- To explore the coping mechanisms used, as well as the nature of the resilience displayed by African refugees to overcome the challenges, they encountered at different migration stages.

Research objectives of the quantitative study

- To determine the prevalence of the most common psychological distresses among African refugees in Durban South Africa.
- To investigate the association between refugees' migration stressors and psychological distresses.
- To examine the resilience level and associated factors among African refugee in Durban, South Africa.

1.5 Ethical Consideration

In research protecting the dignity, integrity and safety of research participants is always a priority (Kirigia, Wambeba, & Baba-Moussa, 2005; Wassenaar & Mamotte, 2012). The psychological society

of South Africa (PsySSA) instructs practitioners and researchers to preserve and protect the fundamental human rights of participants in the research (PsySSA, 2007). Further, the PsySSA has outlined principles of research which researchers have to subscribe to. These are competence, integrity, professional and scientific responsibility, respect for people's human rights and dignity, concern for others' welfare and social responsibility. In line with the above recommendation, this study sought and was granted ethical clearance by the Humanities and Social Sciences Research Committee of the University of KwaZulu-Natal (Protocol reference number is HSS/2072/016D). Hence, the study accordingly adhered to these ethical principles. Participation in the study was totally voluntary because participants were informed that they could withdraw from the study at any time without negative consequence, if they felt discomfort or if they objected in any way to any aspect of the study. Potential participants were informed about the nature and purpose of the study, and they were also given assurance of anonymity. Their names would not be mentioned, and the information that they shared would remain confidential. The participants were also informed that, should they experience any distress or emotional disturbance during the interview process, they may stop the interview and seek psychological support. A prior arrangement had been made with the counsellor at Refugees Social Services (RSS) to provide support to the participants should they require such support. Then, after they were given these assurances and after verbally agreeing to participate, they all signed Informed Consent forms. These transparent procedures in approaching and collecting data from participants are further detailed in the methodology chapter in the data collection section. See Appendix 1 and 3 for the Ethical approval from the HSSRC and a copy of the Informed Consent form signed by the participants.

1.6 Overview of the Chapters

Chapter One: Introduction

The background to the study and rationale are presented with reference to the nature of the research design, aims and objectives. Then, the chapter addressed the ethical principles followed in selecting and collecting data from participants, and an overview of the chapters is provided.

Chapter Two: Literature Review

This chapter presented a wide range of literature regarding forced migration and mental health. Starting with an overview of global migration, it moved on to addressing the issue of forced migration in Africa,

and it looked at the Refugee Policy and Asylum-seeking processes in South Africa. Then refugee experiences and stressors at different stages are addressed. Mental health was discussed from the perspectives of health promotion, and an attempt was made to outline the determinants of refugees' mental health. Then the literature dealt with major psychological distresses, which are PTSD, anxiety and depression. Then it proceeds to refugees' coping mechanisms, resilience and post-traumatic growth. Lastly, the chapter addressed the literature on mental health promotion interventions among refugees and outlined the arguments between two main intervention approaches, namely, the multi-model and trauma-focused approaches.

Chapter Three: Migration Stressors and Mental Health of African Refugees: A scoping review

This chapter is a continuation of the literature review; it systematically reviewed previous studies among African refugees in Africa. The review included 18 studies completed between 1998 and 2018 that explored refugees' traumatic and migration experiences and mental health outcomes at the three stages of migration as well as the prevalence of psychological distresses, traumatic events, coping strategies and resilience. The review addressed the traumatic experiences and common stressors, the prevalence of psychological distress, disparities of prevalence between refugees and the local population and the lived experiences of refugees. The chapter ended with a discussion of the findings, methodological challenges and limitations of the study.

Chapter Four: Theoretical Framework – Bioecological Theory

This chapter is dedicated to the theoretical framework - Bronfenbrenner's (1917 – 2005), bioecological theory. The first section addressed the importance of declaring a theory that informed the research study and the intervention guidelines. It then proceeded to address the evolution of the theory during the 30 years of its development and expansion. Then the four components of the theory are outlined. Lastly, the relevance and application of the theory in this study was addressed.

Chapter Five: Methodology

In this chapter, the design of the mixed methods approach that involved collecting, analyzing and discussing both qualitative and quantitative data sequentially, is addressed. First, the mixed-method and its relevance to this study was presented. Then the descriptive phenomenological method developed by Edmond Hussler (1859-1938), is addressed followed by the descriptive phenomenological psychological design (Giorgi, 2005). The sampling procedures and participants'

selection for data collection are addressed, followed by the step-by-step data analysis methods, and their philosophical implications were also outlined. In the second section, the cross-sectional quantitative design and its relevance to this study was discussed in detail. Then the guidelines adhered in adapting the instruments used in collecting data for this study was discussed, followed by sampling procedure and measurements used. Lastly, the chapter addressed the participant selection and data collection procedures followed by data analysis.

Chapter Six: Results of Qualitative Study

Firstly, the socio-demographic information of the participants was presented. Then the pre-migration experiences of refugees were presented under four themes of stressors, followed by experiences of psychological distresses and coping mechanism employed. Similarly, refugees' description of the transit-migration experiences; stressors, psychological distresses and a coping mechanism was presented. At the post-migration stage, the refugees' expectation and realities of the South Africa experience were outlined. Then the post-migration stressors presented under seven themes, followed by mental health experiences as well as coping strategies were discussed. The chapter closed by presenting various recommendations made by the refugees regarding their needs, particularly for mental health care.

Chapter Seven: Discussion of Qualitative Analysis Results

In the chapter, the findings are presented and discussed with the integration of the relevant literature in the field. A discussion on pre-migration experiences showed the consistency of the findings with previous literature regarding civil war and state-organized violence as common stressors. The experiences of psychological distress include symptoms of PTSD, mainly re-experiencing the traumatic events and anxiety shows congruency with other findings. Similarly, the findings of transit and post-migration stressors, psychological distress and coping mechanism are discussed in relation to the relevant literature, and further interpretation is also made.

Chapter Eight: Quantitative Survey Results

The chapter first outlined the results from the socio-demographic information of the respondents. Then the results of the factorial analysis for each measurement presented was followed by the description of the scales and sub-scales. This is followed by results from the frequency analysis, including prevalent pre-migration and post-migration stressors, major psychological distress symptoms and resilience.

Then correlation analysis undertaken among all the scales and sub-scales results from chi-square tests and mean tests (t-tests) are presented. Finally, the results of the multivariate regression analysis on the predicting ability of factors to psychological distress are presented.

Chapter Nine: Quantitative Results Discussion

In this chapter results of the quantitative study are discussed and compared with results reflected in the relevant literature, and further interpretation and critical reflections are also made. From the demographic information of the participants, a sense of the refugee communities' characteristics is made. Then the results from the factorial analysis are compared with other relevant studies in the field and examined for information regarding the participants. Similarly, the descriptive information of the measures is checked for further information about the participants. Then, the results from the correlation analysis, t-tests and regression model outcomes are discussed.

Chapter Ten: Conclusion and Guidelines for intervention

This chapter includes three sections. The first section addresses the key findings in relation to the theoretical framework of the study and presents a conclusion based on the findings. In the second section, suitable guidelines for mental health promotion interventions are outlined. Lastly, limitations of the study are outlined, and recommendations for policymakers and further studies are made.

Chapter Two

Literature Review

2.1 Introduction

Forced migration is a rampant phenomenon that has etched itself into the history of nations. The first two decades of the 21st century has recorded the highest displacement of people. Mass media and research often focus on the causes of the displacement of migrants and the socioeconomic implications of post-migration settlement. However, the experiences of refugees and asylum-seekers have never fully been told. It is ironic that a large proportion of research in refugees' migration and psychological experiences is undertaken in the developed world whilst the developing world is the producer and host of the largest number of refugees and asylum-seekers in the world (UNHCR, 2017).

Mental health concerns have grown exponentially in recent years, and efforts are increasing to break the silence of the public and to create more awareness of a mental illness that drastically impacts on wellbeing. The implications of mental health reach beyond the medical dimension, affecting a wide range of interconnected systems, having an impact on, and being impacted by, the social, cultural and economic spheres (WHO, 2012), making it an important area to explore, particularly in vulnerable populations like refugees.

In this chapter, the statistics regarding refugees globally and then specifically in Africa, will be presented to provide insight into the extent of displacement involved, followed by the typology of refugees. The relevant literature and discussion of stressors and challenges that refugees confront at the different stages of migration, i.e. pre-migration, transit-migration and post-migration, will be presented. These stressors have been found to induce psychological problems, and therefore a wide range of literature overview will be given on the mental health outcomes of migration experiences with particular focus on Post-Traumatic Stress Disorder (PTSD), depression and anxiety as these seem common psychological stressors experienced by refugees. This is followed by a discussion of the coping mechanisms employed by refugees, including reference to resilience and Post-Traumatic Growth. The section is concluded with reference to literature pertaining to interventions designed to ameliorate psychological distress.

The review is based on a thorough search of published articles, books, editors, unpublished masters, or PhD dissertations. The most common words used to identify the relevant studies are combination;

refugees, asylum-seekers, forced migrants/displaced, trauma, traumatic experiences, mental health/distress/problem, psychological distress/problem/ mental illness, anxiety, depression, PTSD. The databases, including sciences direct, PsycINFO, Medlin, EBSCO host, and PubMed, and reference list of the relevant articles was searched for more studies. Further, books from libraries, and digital libraries and research spaces of institutions were also searched to find materials.

2.2. Global migration

Migration is a phenomenon that has been shaping and reshaping human history. Migration is also mentioned as a 'key factor' in Human Development of UN (Klugman, 2009). There are several typologies and theories of migration, all of them involve the movement of people from place to place internally, and across borders, however, the movement differs in terms of cause and purpose. In this study the focus is on forced migration across borders; hence it involves coercion factors, including threats to life and livelihood, whether arising from natural or man-made causes, causing many to cross their national borders as the only viable alternative (IMO, 2017; UNHCR, 2003).

In recent years the world has seen an unprecedented increase in the number of displaced people on a global scale. The UNHCR (2017) estimates that the number globally of forcibly displaced people has now reached a record amount of 68.5 million (1 person in every 110 is displaced) because of persecution, conflict, organised violence, and natural disasters (UNHCR, 2017). The number of people who were forcefully displaced increased by 2.9 million in 2017 only. From the total number of people forcibly displaced 25.4 million are refugees - a number not recorded since 1992, 3.1 million are asylum-seekers who are still awaiting responses to their asylum application, and the rest of the 40 million are internally displaced. In 2017 it was recorded that 16.2 million people were newly displaced, and out of this 4.4 million are newly displaced refugees and asylum-seekers. Furthermore, the UNHCR report showed that, in 2017, every day, an average of 44, 000 people were forced to flee their homes. However, only 102, 800 were admitted for resettlement in other countries. Two thirds (68 %) of the world's refugees came from five countries, Syria, (6.3 million), Afghanistan (2.6 million), South Sudan (2.4 million), Myanmar (1.2 million) and Somalia (close to 1 million). Another disturbing fact is that 16.9 million of the world's refugees are hosted by developing countries, which is beyond their economic capacity (UNHCR, 2017). Developing countries hosted a large number of refugees relative to their populations. For example, in Lebanon 1 in 6 people is a refugee, Jordan (1 in 14), Turkey (1 in

23), however, Turkey hosted the largest number of refugees (3.5 million) followed by Pakistan (1.4 million), Uganda (1.4 million), Lebanon and Iran both close to one million each (UNHCR, 2017).

Therefore, the developing countries are the most affected by the global migration crisis; for example, 85% of the world refugees are granted protection in these countries. The developing countries hosted 6.3 million refugees under UNHCR (UNHCR, 2017). The largest portion of this number is to be found in the East and in the horn of Africa (4.3 million), while a fraction, 197, 700, are hosted by southern African countries, where South Africa is located. The number of refugees in Africa has also shown an increase in 2017. In sub-Saharan Africa alone, the number increased by 1.1 million as a result of civil war in South Sudan, where one million South Sudanese fled mostly to Sudan and Uganda. In Africa, South Sudan and Somalia are the largest refugee-producing countries, followed by Sudan and DRC. Most of the refugees from these countries are hosted by Uganda, Sudan, Ethiopia, Kenya and the DRC. South Africa hosted 27, 000 refugees from Somalia and 26, 000 from the DRC. South Africa also hosts other African and non-African refugees. According to South African Statistics, in 2014, there were over 65,500 refugees and 230,000 asylum seekers in South Africa. The South African Statistics report of 2014 further states that Gauteng, which is the hub of the South African economy and Pretoria Refugee Reception Office are the nucleus of asylum processing centres (StatsSA, 2014). However, Landau, Segatti, and Misago (2011) pointed out it is always problematic to obtain the correct information about the exact number of refugees in South Africa.

It is noteworthy to mention that Africa hosts the largest number of refugees as well as contributes largely to the increasing number of displaced people and migration. The continent is marred by war, ethnic and tribal conflict, state oppression, violations of human rights, economic difficulties, civil unrest and poverty (Perera et al., 2013; Shannon, Vinson, Wieling, Cook & Letts, 2014; Lindert et al., 2009). Refugees flee from those difficult conditions to other places for sanctuary, yet problems of social exclusion, acculturation, language barriers, discrimination, unemployment, and xenophobia are rife in host countries (Aragona, Pucci, Mazzetti & Geraci, 2012; Chu, Keller & Rasmussen, 2012; Idemudia et al., 2013, Soloman & Kosaka, 2013).

But, how is a refugee or an asylum-seeker identified and how do countries and institutions process refugee claim for those people who cross their borders? Most countries adopted refugee policies based on the *UN 1951 Refugee Convention* and the *UN 1967 Protocol.*

2.3. Refugee Policy and Asylum-seeking Process in South Africa

The terms 'asylum seeker' and 'refugee' are often used interchangeably even though they are different. The international laws that govern forced migration of people are the *UN 1951 Refugee Convention* and the *UN 1967 Protocol* that improved some provisions of the convention. The Organization of African Unity (OAU, 1969) also constituted a law that governs forced movement on the continent – the *1969 Refugee Convention*.

South Africa is a signatory to the above-mentioned UN and African Union (AU, the then OAU) conventions through its *1998 Refugee Act*, which has been amended several times, with the recent one being the *Amended Refugee Act of 2017*. The act provides for conditions under which asylum-seekers may qualify for refugee status or be rejected. It provided for the establishment of a Refugee Reception Office, Refugee Standing Committee and Refugee Appeal Board to manage the asylum process. The Constitution and the Acts relating to refugees are based on the UN's *Refugee Convention (1951)* and the *Protocol (1967)* that stipulated that a person has an unchallengeable right to ask for asylum in a signatory country if; the individual has "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" (UN, 1967). Then once the person becomes legal refugee protection from being forcefully returning to the home country has to be provided, as this could endanger the refugee's life. In addition, the host country's responsibility for the refugee is to provide basic humans rights and suitable living conditions. These rights include the right to work, basic health care services, and freedom of association and movement.

Section 3(a) Refugees Act no. 130 of 1998 of South Africa states that a person will qualify for refugee status if that person:

> "*Owing to a well-founded fear of being persecuted by reason of his or her race, tribe, religion, nationality, political opinion or membership of a particular social group, is outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country, or, not having a nationality and being outside the country of his or her former habitual residence is unable or, owing to such fear, unwilling to return to it*." (*Refugee Act, 1998*)

Section 1(V) of the Refugee Act of 1998 of South Africa defines an asylum-seeker as "*… a person who is seeking recognition as a refugee in the Republic*" (Refugee Act, 1998).

In South Africa, an Asylum-seekers must claim asylum from the Status Determination Office Centre, within five days of entry into the Republic at any Refugee Reception Office (*RRO, Refugee Amended*

Act, 2017). The applicant must also provide necessary information to the officer to support the claim for asylum. An asylum-seeker whose application could not be adjudicated is issued an *asylum-seeker permit, section 22* that allows the asylum-seekers to stay in South Africa while a final decision with regard to the application is pending (*Department of Home Affairs [DHA], 2017*). *A section 22 permit* allows the holder to work and study in South Africa. If asylum-seekers are deemed to qualify as a refugee (based on the above definition) they can be granted a section *24 permit, Refugee Status*, valid for 2 or 4 years, renewed at the expiry date. The permit allows the person, now a refugee, to work and study in South Africa. Refugees are also allowed full legal protection, entitled to seek employment, and they receive basic healthcare and primary education and the same rights as South African citizens *(Refugees Act, 1998*). During this entire process, no fees are required to be paid (for interviews and the issuing or renewal of any permits), it is explicitly stated that the services provided to asylum seekers and refugees are free of charge (DHA, 2017).

The South African refugee system is known as a no-camp, urban settlement, where refugees are permitted to resettle by themselves anywhere. There is no subsistence or welfare support provided for asylum seekers during and after the time their application is processed (either from UNHCR or the South African government). In South Africa, refugees are mostly located in the major metro cities; Johannesburg, Pretoria, Durban, Cape Town and Port Elizabeth. The reason could be to stay closer to the RROs, where they have to renew their documents (Belverere, 2007). There are 1, 061 812 asylum-seekers whose asylum claims have not yet been adjudicated and they have to renew their permits every six months. The number of refugees with legal refugees' status is reported to be 119,600 (DHA, 2017).

However, the reality of refugees' asylum process is the opposite. Once commended as one of the most advanced and progressive systems of refugee protection, the South African refugee regime has declined beyond recognition. Increasingly restrictive policies paired with chronic processing delays and endemic corruption and mismanagement in the DHA have twisted the post-1994 system into one ridden with violations of both the South African Constitution and AU and UN conventions (Amit, 2012, Corruption Watch [CW], 2016). Several studies recorded that the asylum-seeking process is unlawful, dehumanising and refugees often become victims of corrupt officers and mediators (CW, 2016). It is widely documented also that refugees are experiencing difficulties and discrimination even to access DHA for application and renewal, as well as to find jobs (CW, 2016; Kuvaro, 2015; Rugunanan & Smit, 2015; Sutton, Vigneswaran & Wels, 2011). The conduct of officials at RROs

against asylum-seekers can be summarised by what Vigneswaran (2008), concluded in his study *"... officials were not simply failing to do their jobs but were collectively going out of their way to repel, hinder, and undermine asylum seekers' capacity to receive fairly adjudicated claims*".

Further, there are reports that state that, when refugees are employed, they are underpaid, and they also have difficulties in accessing public service health care, housing and banking (Belvedere, 2007; CW, 2016; Rugunanan & Smit, 2015; Sutton, Vigneswaran & Wels, 2011). Their rights are only on paper and rarely implemented (Belvedere, 2007; Kuvaro, 2015).

Refugees are different in many ways from other migrants who travel voluntarily from place to place. Hence they mostly seek humanitarian attention. Nevertheless, they are also generally known as migrants. The study of migration has a long history, and researchers have been trying to understand the phenomenon of migration from different perspectives; from the pushing and the pulling factors. Several explanations and types of migration have developed in order to simplify and to better understand the phenomenon. In the following section, theories of migration, particularly of refugees, is presented to clarify the borderlines between different categories and explanations of these concepts. However, in this study, both refugees and asylum-seekers will be referred to as refugees as this study is interested in experiences of forced migrants.

2.4. The Phenomenon of Migration: Refugee Theory

Migration as a phenomenon can be categorized broadly as voluntary or forced migration. However, several researchers identified different types of migration, for example, Jennissen (2004), identified four types of migration, namely: Labour migration, Return migration, Chain migration and Asylum migration. Similarly, Bell, Alves, de Oliveira and Zuin (2010) categorised international migration into three groups: Labour migration, Forced migration and International retirement migration. Recently, other concepts have emerged, such as political, economic and environment migration (Wickramasinghe & Wimalaratana, 2016).

Migration is facilitated by several factors. The network theory states that the different factors that facilitate migration include geographical proximity of the country of migration, availability of social networks, cultural and historical factors (De Haas, 2010). These factors amount to a migration network which is defined as a "*set of interpersonal ties that connects migrants with relatives, friends or fellow countrymen at home who convey information, provide financial backups, and facilitate employment*

opportunities and accommodation in various supportive ways" (Arango, 2000, p. 291). Earlier migrants are vital in influencing the selection and decision of subsequent migrants' destination. Migration networks are also known for decreasing migration costs and risks (De Haas, 2010). In this 21st century, the range of options and a speedier flow of information have made migration easier to occur around the world. Even though it is not yet established, forced migration that produces refugees is also facilitated by some of the above factors. A theoretical explanation is needed to understand the concept of refugee and forced displacement.

2.4.1 Refugee Theory by Egon F. Kunz (1981)

A renowned refugee theory was developed by Kunz (1981) based on the relationship of refugees to their people at home, displacement and host country conditions. He states that people differ in their identification with their surroundings, and every wave of refugees is different in its social relationship to the people at home. Furthermore, he argued that most of the post-migration difficulties could be traced back to refugees' emotional ties, dependence and identification with the population in their home country. Based on this argument, he devised different typologies of refugees.

Regardless of their migration causes Kunz placed refugees, according to their social relationships with the population in their homeland, in categories labelled: *majority-identified, event-alienated and self-alienated*. The ***Majority identified*** refugees reject the government or the event, not the nation, and they firmly believe that the majority of the population have the same sentiments that they have. The ***Event alienated*** refugee may originally have had the desire to be identified with the nation of origin, but events of discrimination embittered their attitude towards their former fellow citizens, and they feel rejected. This group of people could be in a religious or racial minority. Their common characteristics are that they have lost hope of making it in the new country and wish to return to their home country. The third group of refugees are ***Self-alienated***. They do not want to be identified with the nation because of their individual ideological and philosophical beliefs. However, they might still be attached to and identify with their country of origin.

Kunz (1981, p. 43) developed other categories of refugee, based on refugees' "attitudes towards displacement" or conditions of their flight from their homeland. Two other categories; namely *reactive-fate groups and purpose groups,* can be sub-categorized as self-fulfilling and Revolutionary activist groups. The ***reactive-fate*** refugees flee mainly in reaction to a situation they perceive to be intolerable and dangerous, mostly, war, conflicts and violence. This is the majority-identified group

and in some instance, can include the event-alienated group. Kunz (1981) explained their nature of flight as being reluctant and forced to move without a plan for a solution. The **purpose groups** are sometimes confused as to whether they are voluntary migrants or refugees. The ***self-fulfilling group*** "*comprise[s] persons [who] became alienated by their insistence on the overriding importance [of] certain facet[s] of belief, dogma, or by their passionate pursuit of society which derives its framework from minority ideologies with those currently in the home*" (Kunz, 1981, p. 45). They can be considered as refugees if their ideologies are in conflict with those that are dominant in the home nation, whether they flee due to harassment and persecution, or not. The ***revolutionary activists*** are usually self-alienated people who are ready to change the government or situation and the life of their people at home. The determined revolutionaries are distinguished by being ideologically different from the mainstream.

Furthermore, Kunz (1981) discussed host country factors and how refugees identify with them. He argued that newly arrived refugees bring with them the memories and thoughts of their pre-migration (home) and transit. As time goes on, they become less and less captives of their own thoughts and memories of their home and engage in discovering their surroundings to find a '*niche*' that is consistent with their backgrounds but also important to their progress in the host country. Host country-related factors that are crucial for refugee integration are *cultural compatibility, population policy and social attitudes*. ***Cultural compatibility*** includes language, values and practices, and if they find themselves among strange people with a different language, values and practices, they are exposed to psychological distresses, including isolation and withdrawal from interaction. However, if they found people compatible with their culture, they easily integrate. The second factor is the ***population policy*** of the host countries; some under-populated countries. '*Augmentative societies*' valued migrants to support their numerical growth and economic capacity. But, in most instance, these countries exploit refugees for their own gain. In doing so, they select the healthy and the young while refusing the old and the ill (Kuzn, 1981, p. 48). Other sufficiently populated countries are less likely to receive refugees. However, they are tolerant, and when they do offer refuge, they do so without imposing their cultural practices. Finally, Kunz categorized host population into two depending on their ***receptive attitudes*** toward the newcomers in a monistic and pluralistic society. A ***monistic*** society is less favourable to people who are culturally different, whilst ***pluralistic societies*** are more open to multi-ethnicity and to multi-cultural practices.

Based on the typologies of Kunz, most of the refugees in South Africa can be regarded as *majority-identified and reactive-fate* refugees because their flight is a reaction to war, organized violence or the abuse of human rights that caused the loss of loved ones and that endangered their lives. However, they still identified themselves with the population in their home country and opposed to the government, or to the root cause, that uprooted them, and which made them flee. Some of the refugees could be *event-alienated* who escaped perhaps from racial, religious and sex orientation-based discrimination. As Kunz (1981) argues, event-aliened refugees might not have a desire to return to their home country, unless there are significant socio-political reforms.

The migration experiences of refugees begin in their home countries with the push factors. The journey for sanctuary and resettlement does not have a set form and might not end in a lifetime for many. Refugees experience different forms of stressors through their journey; therefore, several studies have been trying to understand the journey by categorizing it into stages of migration. However, there is no clear cut of time and place for these stages.

2.5 Migration Experiences of Refugees and Stages of Migration

Many studies of forced migration and psychological/mental health discuss refugees' migration experiences in terms of the aforementioned three stages (Bhugra & Jones, 2001; Khawaja et al., 2008; Lindert & Schinina, 2011). Even though there is no consensus regarding the definition and exact nature of the stages, it is a widely used approach. ***The pre-migration stage*** covers experiences before refugees physically relocate to another country while they are still in their country of origin (Wessels, 2014). ***The transit-migration stage*** is when a refugee travels across countries for a period of time while seeking a place for asylum and permanent resettlement. Staying in another country for a period of time can also be transit for some. Neighbouring countries and refugee camps are the most common transit places whilst travelling to another country can be regarded as a transit experience. ***The post-migration stage*** is where refugees find asylum for possible resettlement but might relocate even after an extended period of time. As mentioned above, there is no clear-cut division between the three stages of migration, particularly the transit migration phase that could take many years depending on the destination and for some, the current post-migration stage might become a transit stage if they further migrate and resettle in another country for different reasons. The sole purpose of using stages of migration in this study is to explore and understand refugees' experiences; stressors (difficulties), psychological and coping experiences of refugees in an ordered way. Hence, the stages of migration

and the experiences of refugees' in each stage are discussed below in more detail in an attempt to explore the migration stressors of African refugees and the mental health outcomes of those experiences. Table one is adopted from Lindert and Schinina (2011). The table summarises the experiences of refugees in the three stages.

Table 1

Pre-, transit- and post-migration stressors associated with psychological Distresses

Pre-migration stressors	*Transit Migration stressors*	*Post-migration stressors*
Direct violence and oppression E.g. Combat experiences, torture, wartime rape, death or disappearance of friends and family members, lack of freedom of speech, faith and future, state oppression and restriction	**Direct violence** E.g. Violence during migration (e.g. rape), kidnapping and torture, combats	**Direct violence** E.g. discrimination, xenophobic attacks, gang violence
Poor living Conditions E.g. lack of food and water, poor or no access to health care, lack of job opportunity and slavery	**Poor living conditions** E.g. lack of food and water, poor or no access to health care and housing, insecure environment	**Poor living conditions** E.g. in detention centres or refugee camps
Humiliation, exclusion, discrimination E.g. Exclusion from the infrastructure of the home country, loss of persons, possessions, culture	**Humiliation, exclusion, discrimination** E.g. Exclusion from basic services, being vulnerable to abuse	**Humiliation, exclusion, discrimination** E.g. Exclusion from the infrastructure of the host country: living in an unstable and insecure environment that is hostile towards foreigners, discrimination and racism, language and culture barriers, restricted work permits, poor or no access to health care

Note. Adapted from Mental health of refugees and asylum-seekers (p. 174), by J. Lindert and G. Schinina, 2011, Migration and health in the European Union, 169-181.

2.5.1 Pre-migration Stressors

Refugees mostly flee from their home countries due to war, violence, intergroup conflict (tribal or between rebels), state oppression, political and religious persecution and socioeconomic hardships (Lindert & Schinina, 2011). The war and related violence are the most common pre-migration stressors and are traumatising and dehumanising experiences that force people to flee and look for sanctuary as

the last resort to save their lives. In Africa, especially, consecutive civil wars have killed and injured hundreds of thousands of people and destroyed the livelihoods of communities. Ethnic cleansing has left millions displaced internally, forcing migration across borders (Abraham, Lien & Hanssen, 2017; Nakash, Langer, Nagar, Shohan, Lurie & Davidocitch, 2015; WHO, 2008). For example, the WHO (2008) reported that the civil war in Darfur, South Sudan has killed an estimated 300,000 people, and displaced 2.5 million people from their homes. The people flee persecution and mass murder of civilian populations perpetrated by the government and armed militia groups of Sudan (Nakash et al., 2015). Recently, more than one million South Sudanese fled mostly to Sudan and Uganda due to civil war (UNHCR, 2017). More than half a million Eritreans left their home country due to the oppressive regime known for its serious violations of human rights; religious and political persecution, disappearances of citizens and use of torture (Abraham, Lien & Hanssen, 2017; Nakash et al., 2015; UNHRC, 2017). Somalia has been the largest refugee-producing African country over a long time. Somalis have been fleeing their country for nearly three decades since the state collapsed in 1991, becoming a playing field for civil war. More than 1.1 million Somalis are living as refugees across the world (Kroll, Yusuf & Fujiwara, 2011; Molsa, Hjeelde & Tiilikainen, 2010; UNHCR, 2016; WHO, 2010).

The crisis in the Democratic Republic of Congo is complicated in nature with violent conflict among different rebel groups and the government (UNHCR, 2017), mostly instigated by western countries that compete for the Congo's natural resources. Due to the complex, violent conflict and its consequences, between 1998 and 2004, there were 3.9 million dead as reported by the *International Rescue Committee* (IRC, 2007). In the previous year, the UNHCR indicated that 4.5 million Congolese were internally displaced and over 735,000 DRC refugees were dispersed in sub-Saharan African countries (UNHCR, 2018). For Zimbabweans, the main reason for their migration is the collapsed economy of the country, in addition to systematic political repression that was preceded by wide-spread unemployment and poverty. It was reported that around 3.4 million Zimbabweans have migrated and the bulk of them migrated to South Africa (Madebwe & Madebwe, 2017; Zinyama, 2002).

The pre-emigration experiences of refugees are widely researched. For example, refugees from South Sudan, who resettled in Australia, shared life-threatening experiences including losing loved ones, violence and threats to their lives, and lack of basic necessities for daily living were the main push factors (Khawaja et al., 2008). Idemudia, Williams and Wyatt (2013) explored the reasons for

migration among homeless Zimbabweans in South Africa. They found the lack of basic resources and employment, lack of health care and medication, politically motivated civil unrest and violence as the main stressors pushing Zimbabweans to migrate to South Africa. There are similar findings across many studies among African refugees in Africa and outside the continent (Karunakara et al., 2004; Neuner, Schauer, Karunakara, Klaschik, Robert & Elbert, 2004; Rasmussen et al., 2010; Schweitzer et al., 2006; Smit & Rugunanan, 2015).

2.5.2 Transit Migration Stressors

The phrase 'transit migration' appeared in the literature in the early 1990s, when migrants and refugees travelled long distances for extended periods of time (days to months) and crossed several countries to reach Europe (Duvell, 2012). However, even though the concept 'transit migration' has been used since then, there is no commonly used definition for it. The UN Economic Commission for Europe (UN/ECE, 1993, p. 7) has defined 'transit migration' as "*migration in one country with the intention of seeking the possibility there to migrate to another country as the country of final destination*". Transit migrants are also defined as strangers "*who stay in the country for some period of time while seeking to migrate permanently to another country*" (IPU, 2005, p. 4). Those countries that migrants cross are called transit countries (Duvell, 2012). Sometimes, transit migration is also identified with concepts such as illegal/irregular migration, human smuggling and trafficking and other crimes. Most of the time, transit migrations are prompted by the attraction of stable and rich countries as the ultimate destination of migrants. The socio-economic and legal opportunities in the first county of arrival also play a role in the decision making of settlement (Duvell, 2012).

Travelling across borders for the poor migrants is a stressor and takes a long time as they lack finance for their journey. They also walk long distances to avoid detection and because of financial reasons. 'Porous borders' and slack entry controls are common factors that facilitate transit migration (Duvell, 2010). In most instances, transit-migration is characterized by prolonged periods in refugee camps with poor resources and endemic violence (Akinyemi et al., 2012). Goodman (2004) found that violence, hunger and disease in the refugee camps, death and attacks or hostility from local communities were the main stressors experienced by South Sudanese boys who stayed in refugee camps in Ethiopia and Uganda. Similar stressing experiences were reported by Nakash et al., (2014) among Eritrean and Sudanese asylum-seekers in Israel. The asylum-seekers crossed the Sinai desert to reach Israel, and most of them were victims of violence or witnessed violence (like beating and shooting). In the study,

particularly men from Eritrea were found to experience physical violence, while women experienced more sexual violence (Nakash et al., 2014). This was supported by Idemudia et al. (2013), who reported that physical harassment and sex for survival are the stressors Zimbabwean women experienced in their transit to South Africa.

In some countries, refugees are kept in detention centres with harsh conditions that lead to a sense of powerlessness and hopelessness (Coffey, Kaplan, Sampson, Tucci, 2010; Porter & Haslam, 2005; Zwi & Marse, 2015). However, these migrants integrate into the host communities, in the same country or other countries with their unresolved socioeconomic and psychological problems (Fazel & Silvo, 2006; Idemudia et al., 2013; Silove & Mares, 2018). They then reach a stage that is called post-migration and encounter other stressors that impact their mental health negatively.

2.5.3 Post-migration Stressors

Globally, refugees experience multiple sources of social oppression in host countries, including, xenophobia, racism, sexism, and discrimination in socioeconomic spheres: poverty and unemployment (Yakusho, 2012). Societal prejudices against refugees advance the idea that they are poor, uneducated, and desperate to live in the host country. Several studies have used different theories to unpack and to understand the post-migration experiences of refugees in relation to hosting communities as a complex phenomenon. The 'structuration theory' (Gidden, 1984) and the 'Intergroup threat theory' (Stephan & Stephan, 1996) are discussed below, briefly, to shed light on the post-migration experiences of refugees. There are studies that found post-migration stressors as the most stressing experiences, more so than past experiences, impacting psychological problems among refugees (Miller, 2012; Rasmussen et al., 2010; Smit & Rugunanan, 2015).

The structuration theory developed by Anthony Giddens (1984) helps to explore the social practices developed across time and space. The theory seeks to understand the interaction between the structures of society and human agency. The structural elements are dominant discourses of the society influenced by the culture, while the human agency represents the ability of someone to perform an action. The structural forces affect human behaviour through implicit and explicit norms and rules. In other words, they determine ways of acting, and that is regarded as approved behaviour in a particular society (Healey, 2006). Giddens (1984, p.3) describes human beings as "*purposive agents, who both have reasons for his or her activities and is able, if asked, to elaborate discursively upon these reasons"*. There are variations in structural forces within and between societies; therefore, people who

migrate to another society with different cultures, always have difficulties in understanding the structures of the hosting community.

Structures also influence the way people function, and there are both limiting and facilitating factors. They are produced or changed at the time of interaction and manifest their presence then or not at all. Furthermore, the structures do not exist independently but are continually reconstructed by individuals' experiences. Human agents rationalize their actions depending on the vast knowledge they accumulated through monitoring their actions. Therefore, agents are empowered to perform an action. However, they are not independent of the socio-cultural, psychological and material factors around them.

Several studies found that social structures are the main post-migration challenges experienced by refugees. The social structures could be institutionalized in the form of policy or social practices of the host community. This includes the policy of the country pertaining to refugees; the documentation required, language barriers, restricted public services, social norms and systems that are open to some or closed to others (Belvedere, 2007; Smit & Rugunanan, 2015; Sutton, Vigneswaran & Wels, 2011). For example, it has been reported that because of the structures within hosting countries, refugees have been exposed to poor health services, housing and exploitation at work (Murray, 2010). This is true in South African, where the policy of labour prioritizes local South Africans, and it restricts refugees from accessing employment opportunities (Kavuro, 2015).

In South Africa, the refugee policy and asylum-seeking processes create a chain of difficulties for refugees, e.g. due to a lack of proper documents they are unemployable, and they lack access to public services, i.e. hospitals, education, housing and banking (Kavuro, 2015; Smit & Rugunanan, 2015). Particularly, those who are provided with an asylum-seeker permit (*Section 22 of Refugee Act 1998*), experience huge difficulties accessing public services like housing, banking and health, as their documentation is a six-month permit which is not recognized by most public and private institutions (Belvedere, 2007; Landua, 2006; Vigneswaran, 2008). The permit is subject to renewal every six months, and this could be one reason why institutions do not wish to recognize it.

Furthermore, another structural barrier is corruption that seems to be entrenched in South African institutions, and this has a profound impact on refugees obtaining documentation. *The Corruption Watch* (CW, 2016) revealed consistent exploitative experiences of refugees and asylum-seekers across

many levels of role players in the DHA. This was also confirmed by Rugunanan and Smit (2015) who undertook a qualitative study of Congolese and Burundians' experiences in South Africa. The results of the study highlighted inaccessibility and exploitation as the main obstacles when trying to secure documentation. Queuing and waiting for documentation were also framed as a form of imposed regulation and dehumanisation by other researchers (Belvedere, 2007; Sutton, Vigneswaran & Wels, 2011). Despite a constant effort by refugees to gain access to Home Affairs, they have to return frequently due to the long queues or unreasonable restrictions at the gate for entry to the building (Sutton, Vigneswaran & Wels, 2011). Accessing the DHA is becoming worse after the amendment of international migration policy. Refugees felt their rights are only recognised on paper and that these rights are not translated into practices (Belvedere, 2007). Furthermore, no measures have been taken to hold the Department accountable (Landua, 2006; Vigneswaran, 2008). Similarly, in 2015, the *Lawyers for Human Rights (LHR)* and the *African Centre for Migration and Society (ACMS)* reported the findings from a survey of 928 asylum-seekers. The report stated that there was endemic corruption, extortion, deliberate delays and serial abuse at almost all stages of the process (LHR, 2015).

Healey (2006), who applied the structuration theory to understand the post-migration difficulties among refugee in England, found that structural forces, such as the English language and documents posed barriers for interaction and employment. However, there was a difference among individuals who overcame the language barrier, by studying the English Language with a purpose to fit in and to interact with people around them, as distinct from those who only studied the language to satisfy a routine requirement (Healey, 2006).

Post-migration structural stressors such as low socio-economic living conditions, a lack of housing and employment, discrimination, and lack of health care and related acculturation stressors were shown to have negative effects on mental health outcomes (Asgary et al., 2012; Milner, Page & LaMontagne, 2014). This is discussed further in detail in the next section.

Intergroup threat theory (ITT)

Stephan and Stephan (1996) developed the *Intergroup Threat Theory,* which is used in social and psychological studies to understand the interrelationship between social groups and the reasons for increasing anxiety and prejudice towards out-groups. The theory helps to unpack the impact of the hosting society's perceived threats that lead to prejudice against other social groups. Stephan and Stephan (1996), state that intergroup conflict, status differences, the strength of identification within a

group, knowledge of the out-group and the nature of the contact between the groups are the variables that determine feelings of threat. In other words, ITT states that increased prejudice and feelings of being threatened develop when there is intergroup conflict, difference in status, if a hosting group's knowledge about the other group is limited and people who strongly identified themselves with their group are seen to be threats to others. However, if they have consistent positive contact, the conflict between the two groups is limited (Stephan & Stephan, 1996; Stephan, Stephan, & Gudykunst, 1999).

Several studies used the ITT and other similar theories to explain the interrelationship between migrants and the hosting community in general, and xenophobia in South Africa in particular (Laher, 2010, Mawadza & Crush, 2010; Moyo, Nshimbi & Gumbo, 2018).

Xenophobia

Harris (2002) defined xenophobia as hatred of or prejudice against someone considered as an outsider or foreigner to a community. It is also defined as an irrational fear of someone that is a stranger or a person with a different culture (Nyamnjoh, 2006). Many studies concluded that for many non-South Africans, xenophobia is a daily experience and a structural impediment (Crush, 2008; Harris, 2002; McConnell, 2008; Mothibi, Roelofse & Tshivhase, 2015; Neocosmos, 2010). On a daily basis, refugees are subjected to constant insults, harassment and discrimination by locals and in public institutions. For example, the *Centre for Disease Control* (CDC, 2013) reported that refugees were not provided with HIV Counselling and Testing services, even if they have access to the services in theory. Crush and Tawodzera (2014), reported that refugees experienced discrimination based on documentation and language and negative attitudes from health care workers, and this was supported by a study undertaken among Congolese refugees in Durban (Zihindula, Asante, Meyer-Weitz & Akintola, 2016).

Mostly, xenophobia, in South Africa, is characterized by violent attacks, physical violence (brutal beating and killings), looting and destruction of proprieties, and verbal abuse (Crush, 2008; Gordon; 2015). For example, the commonly used insulting word is '*makwerekwere*' (a local language slur that means foreigner) accompanied with "go back to your country". The frequent attacks mostly target African migrants, and so there is a racial dimension to this phenomenon (Gordon, 2015; Matsinhe, 2011; Zegeye, 2009). This was substantiated by a national representative survey that found that for South Africans, African migrants are the most undesired group of migrants by comparison with Asians and others (Gordon, 2015).

The largest recorded occurrence of xenophobic violence in recent history happened in Alexandra Township in May 2008 and spread through the nation like wildfire. In that month, more than 80 people, including South Africans, were killed brutally and businesses of migrants were looted and destroyed amounting in monetary value to more than one billion rand, and tens of thousands were displaced from their locations (McConnell, 2008; Neocosmos, 2010; Wilkinson, 2014).

According to Kunz (1981), South Africans, as a hosting society, in their attitude towards refugees, can be described as monistic. There is more recent evidence that shows a wide range of unwelcoming and antagonistic behaviour towards refugees, and mainly towards African migrant communities (Gordon, 2015; Matsinhe, 2011; Neocosmos, 2010).

Laher (2010) applied the ITT and unpacked how African migrants are negatively perceived in South African communities. The study revealed that South Africans' perceptions of migrants are that they are taking away employment and resources. The negative representation of migrants in the media increased the prejudice against migrants. Furthermore, she argued that the threat over scarce resources eventually leads to violence. Similarly, Moyo, Nshimbi and Gumbo (2018) used the '***threatening other***' concept of Michlic (2006) to explain the xenophobic violence against African migrants. They argued that African migrants are seen as a threat and as problematic by local South Africans. Therefore, they have to be "*eliminated and excluded*" from South Africa (Moyo et al., 2018, p. 95). A longitudinal study by Schippers (2015) reveals that there are specific xenophobic attitudes among the local population towards foreigners. The study also revealed that South Africans were becoming more intolerant towards foreigners, and their levels of distrust were rising (Schippers, 2015). The source of these negative attitudes is often attributed to stereotypes as well as to the local population perceiving the foreigners as a threat to jobs, to national identity and a threat to individual rights (Soloman & Kosaka, 2013). The notion that refugees are taking advantage of the land they find themselves in at the expense of the local population is one of the key underlying factors of xenophobic attitudes (Mcknight, 2008).

A qualitative study conducted by Tshishonga (2015) revealed that even when migrants attempted to start their own informal businesses to generate an income, they meet hostility and xenophobic attacks. South African participants in the study felt that foreigners were responsible for stealing their business, and they showed a stereotype of foreigners' as involved in drug activity. However, in the same study, the refugees reported that they had not found much difference between economic opportunities in

South Africa compared to those that they enjoyed in their home countries. They complain that they are suffering from a lack of basic necessities. Furthermore, they are experiencing exploitation and coercion due to their documentation problem in South Africa (Tshishonga, 2015).

Mothibi et al. (2015) used the scapegoat theory of Marger (1991, 94), which states that people experience frustration when efforts to achieve the desired goal are not successful. Unable to find a way to achieve their goals, they vent their frustration out on others who are weaker than themselves. In South Africa, the majority-black communities live in poverty and blame non-South Africans for taking away their jobs and competing for the scarce resources and for the increasing crime rate. However, there is also a wide agreement that South Africans are unhappy about the extent of the economic transformation and about its slow rate of progress (Gibson, 2012; Neocosmos, 2010).

The widely used explanation for the xenophobic phenomenon in South Africa is economic deprivation and scarce resources (Fauvelle-Aymar & Segatti, 2011; Miller, 2012). However, recently scholars are suggesting that the political discourse based on "*citizenship rights around political indigeneity*" (Gordon, 2015, p. 505) offered an alternative to the inadequacy of the aforementioned explanation (Landau, 2010). This can be confirmed from the provisions of the *Health Promotion Policy and Strategy 2015-2019 (DH, 2014)*. The Department of Health targets only South Africans, and it does not have any provision for refugees.

The experiences of post-migration are very challenging and inevitably stressful with resulting loss of family, identity, community, and culture (Idemudia et al., 2014; Morof et al., 2014; Nickerson, Bryant, Steel, Silove & Brooks, 2010; Pamaray, 2014). Furthermore, the poor socioeconomic status resulting from unemployment, the language difficulties they face, shifts in gender roles and acculturation in the new country, exposes refugees to immense psychological problems (Bhugra & Gupta, 2010; Idemudia, Williams & Wyatt, 2013; Idemudia, 2014; Leong, Park & Kalibatseva, 2013). A growing amount of research suggests that refugees are more prone to psychological distresses than the general population, specifically depression, anxiety and PTSD, but not limited to these (Asgary, Charpentier & Burnett, 2012; Bhugra, 2011; Fazel, Wheeler & Danesh, 2005; Rasmussen, Smith & Keller, 2007).

2.6 Mental Health versus Psychological Distresses of Refugees

Generally, studies that researched refugees' traumatic and migration experiences and mental health outcomes have been using the concepts mental health, psychological distress and mental disorder

interchangeably. These concepts have been used to refer to depression, anxiety (sometimes different kinds of anxiety), social dysfunction, insomnia, PTSD, suicidal behaviour, adjustment difficulties, isolation and withdrawal (Akinyemi, Owoaje, Ige & Popoola, 2013; Akinyemi, Atilola & Soyannwo, 2015; Bolton et al., 2007; Payton, 2009). Studies in this field are characterised by a lack of clarity and definition of the concepts. In most instances, studies explored psychological distress or mental health problems using mental health as an umbrella word, but it is not necessarily about mental health per se but can also include positive mental growth. As Payton (2009) has explained it, there is an overlap, and researchers often use one concept as a proxy for another one.

> *"On one end of the spectrum, we need only to study one of the three constructs because each serves as a proxy for the others. For instance, research on psychological distress is equally researched on mental health and disorder. On the other end of the spectrum, any attempt to synthesize these constructs is reductionistic* (sic.) *and neglects important variation. Research on disorders, for instance, should not be taken to reveal important insights into mental health and thus the overwhelming majority of research in the sociology of mental health, in fact, tells us very little about mental health."* (Payton, 2009, p. 217).

Payton (2009) stated that mental health, psychological distress and mental disorders are contested concepts which are still used interchangeably in this field of research. Furthermore, in his seminal article Payton (2009) reviewed studies in the field to establish the relationship between these three concepts used in the sociology of mental health and tested three hypotheses combining the variables using Confirmatory Factor Analysis. He addressed the relationship between the variables from three perspectives (Payton, 2009).

He named the first perspective, the ***modal perspective***, that sees mental health and mental disorder in a single continuum, and, as a result, researchers have been conflating the concepts. In this perspective, a mental disorder is the main concept, while mental health is explained by the relative presence or absence of a mental disorder. This means that, based on the modal perspective, research into mental disorders does not tell a researcher much about mental health. The modal perspective largely ignores the factor of psychological distress. The second perspective is a ***positive psychology perspective.*** This perspective rejects the inadequate explanation of mental health as the absence of a mental disorder, and therefore, seeks to study mental health as separate and distinct but as a related construct to mental disorder. Ryff's (1989) conceptualization of mental health is a prominent positive psychological approach that consists of six dimensions of mental health; self-acceptance, purpose in life, autonomy,

positive relations, environmental mastery and personal growth. The third perspective is ***Mirowsky and Ross's (2002)*** approach that emphasizes psychological distress as the main concept and defines this as an experience of emotional pain that includes two major symptoms, namely depression and anxiety. Both depression and anxiety consist of two major symptoms; mood (characterised by feelings of sadness and apprehension) and malaise (physical state of restlessness and illness) (Mirowsky & Ross, 1989). Furthermore, Mirowsky (2007) explained mental disorder as a concept used by professionals and companies that render services and that sell drugs. He strongly disagreed with this view and stated that viewing disorders as 'unusual distress' prevent the studies from understanding the fundamental process of human suffering (Mirowsky, 2007). This perspective sees mental health as an absence of distress and distress as the opposite of mental health.

Payton's (2009), CFA showed that there is no continuum relationship between any two of the three concepts, but that they are found to be distinct from each other. However, he concluded that even though studies claimed that they are distinct concepts, they cannot be entirely independent. Yet there is no conclusive understanding of their relationship; whether one is independent of the other or not. (Payton, 2009).

This study aimed at exploring psychological experiences of refugees, and it is therefore about psychological distress/problems as much as it is about mental health – aspects of importance include resilience and Post-Traumatic Growth (PTG). Therefore, in the context of this study, as outlined above, psychological distress cannot be discussed without discussing mental health or vice versa as people can share negative and/or positive mental health experiences at the same time. However, the study did not focus on psychological disorders, per se, as clinical tools are not used. There is also an issue of assessment, only very few studies used structured clinical screening tools, as most studies used self-reporting through questionnaires to diagnose mental health issues, and calculated scores were used to distinguish the status of mental health. The severity of mental health is determined by the higher scores. This traditional way of assessment supports the perspective of a continuum where a person is assessed based on their scores and their placement on the continuum of mental health or distress. In this study, psychological distress/ problems and mental health/problems are used interchangeably. However, it is imperative to define those terms in order to make sense of them and their inter-relationship.

Definitions

The widely used definitions of mental health from the WHO and APA are used.

- ***Mental health*** - is ‘‘*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*’’ (WHO, 2005, p. 2).

- ***Psychological distress “****a set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. In some cases, however, psychological distress may indicate the beginning of major depressive disorder, anxiety disorder, schizophrenia, somatization disorder, or a variety of other clinical conditions. It is thought to be what is assessed by many putative self-report measures of depression and anxiety”* (Psychological Distress, 2018. https://dictionary.apa.org/psychological-distress).

- ***Psychological disorder – “****a psychological dysfunction within an individual that is associated with distress or impairment in function and a response to this which deviates from the person’s culture”* (Barlow & Durand, 2005; cited by Austin, 2014, p. 6). Further, psychological or mental disorders have to meet, usually, diagnostic criteria such as DSM or ICD, and this might distinguish them from psychological distress.

2.7 Health Promotion Perspective of Mental Health

This study intended to develop guidelines for interventions to promote mental health among refugees in South Africa. Therefore, it is an interest to the study to incorporate health promotion perspective generally, and in particular a mental health promotion perspective. The definition of health by the WHO is a foundation of the mental health focus in health promotion. When the WHO defined health as “…*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*” (WHO, 2001b, p.1), mental health is viewed as an integral part of health, a state of well-being, while the notion that it is not only the absence of illness, further underlines its close relationship to physical and social health (WHO, 2005). Concurring with the WHO’s view, health promotion sees health from an ecological perspective, that emphasizes “*the social, institutional and cultural context of people-environment relations*” (Stokols, 1992 as cited by Green, Richard & Potvin, 1998, p. 270). In other words, health is a product of the interaction between individuals and the systems around them, including family, community, culture, and physical and socio-economic environment. Therefore, mental health can be promoted best when these systems are conducive for health, including sound socioeconomic conditions (Green, Richard & Potvin, 1998). The reverse is true, where mental health is negatively impacted by the quality of the system.

Even though numerous studies concurred with the statement of "*there is no health without mental health*", the broader definition of health has not yet been a focus of studies of mental health among refugees. It is known that mental health is closely related to physical health and behaviour (Desjarlais, Eisenberg, Good & Kleinman, 1995). There is also evidence that demonstrated the intimate association of mental health with educational performance, employment and low levels of crime (Barry & Jenkins, 2007; Friedli, 2009; Herrman, Saxena & Moodie, 2005). Furthermore, Patel, Swartz and Cohen (2005) confirmed the contribution of mental health to human, social and economic development to the advancement of individuals and groups in the achievement of their potential and to the facilitation of prosperity and quality of life (Jane-Llopis et al., 2011).

In this regard, understanding health determinants are very important for developing mental health promotion interventions as the effectiveness of an intervention depends on successfully influencing or changing the health-related determinants (Nutbeam, 2000). Refugees' mental health might be determined by traumatic experiences and violence (physical and sexual), separation from loved ones and communities, poor socioeconomic status (unemployment, poverty, housing and security problems and lack of social support), acculturation processes including migration policy and asylum processes, to mention only the main factors. Most of these factors can be influenced positively to promote the mental health of refugees. The impact of traumatic experiences can be influenced and reduced, and there is evidence to suggest that post-migration living stressors are far more influential on mental health and negatively affecting mental health outcomes of refugees than the traumatic experiences they endured previously (Miller & Rasmussen, 2010; Rasmussen et al., 2010; Smit & Rugunanan, 2015). Besides reducing and preventing psychological distress, the *Ottawa Charter of Health Promotion* declared that the aim of health promotion is "*enabling people to increase control over, and to improve, their health*" (Patvin & Jones, 2011). This implies that refugees can achieve a state of mental health by strengthening their resilience and coping mechanisms to face environmental challenges and as a way of increasing the control of their health.

2.8 Determinants of the Mental Health of Refugees

There are multiple and interacting psychological, biological and socioeconomic factors that determine mental health or psychological distress (WHO, 2005). Generally, mental and physical health and social and economic conditions are closely interrelated in determining the general health of any given population. Migration, on its own, is a major life-changing experience which can be a source of

significant stress leading to mental health problems if not handled well (David & Nadal, 2013; Goff, Zarin, & Goodman; Koning, 2011). Migration has been shown to be a major risk factor for psychological distress and mental disorders (Nwoye, 2009). Even relocating to a different geographical place and climatic changes in the environment have been found to affect mental health (Winbush & Selby, 2015). Refugees are mostly forced to migrate from their home of origin, and they have to abandon their loved ones and belongings, and, in addition, they face traumatic and life-threatening experiences. These multiple difficulties have a major impact on the status of their mental health. Thus, they have a higher risk of psychological distress at various stages of their settlement in a new country. An initial euphoric stage might be followed by increasing living difficulties that can crush their mental health integrity (Rasmussen et al., 2010; Winbush & Selby, 2015). In the following section, the main refugees' mental health determinants will be discussed briefly.

2.8.1 Traumatic Experiences and Violence

Refugees who are forced to flee from war-affected places, have, almost all, experienced and/or witness traumatic and violent events. A wide variety of traumatic and violent experiences of refugees are documented including war-related experiences of combat involving child soldiers, of being besieged, the horror of ethnic or tribal wars, attacks by militia or rebels, experiencing or witnessing a rape, witnessing killing and violence against others, torture, police brutality and organized state violence (Fox & Tang, 2000; Idemudia, 2014; Onyut et al., 2009; Rassmussen et al., 2010). They might also experience some kind of violence in their flight; war-related violence, kidnapping by smugglers who torture them for ransom, losing loved ones along the way, conflict and attacks in the refugee camps (Abraham et al., 2018; Akinyemi et al., 2012; de Jong et al., 2000; Nakash et al., 2014; Onyut et al., 2009; Rassmussen et al., 2010). In post-migration, traumatic experience during xenophobic attacks was associated with high rates of PTSD among refugees in South Africa (Womersley, Shroufi, Severy, & Cutsem 2016).

The Dose-effect model explains the direct relationship between the extent of war exposure (or organized violence) and the degree of PTSD. In other words, it explains the prediction power of organized violence experienced on the extent of PTSD's symptoms (Miller & Rasmussen, 2010). There is extensive literature that reported the high prevalence of PTSD, including depression and anxiety, among refugees from war and conflict areas (Crager, Chu, Link & Rasmussen, 2013; Porter & Haslam, 2005; Steel et al., 2009). In a large review that considered 181 studies among refugees and

war-related displaced people, PTSD was strongly predicted by torture experiences, while depression was predicted by the number of traumatic events encountered (Steel et al., 2009).

2.8.2 Separation from the Immediate Community

Particularly in African culture, a family is extended to community, and there is a bond between the social and natural environment. The attachment shows one's identity and the meaning of one's existence. Therefore, being forcefully removed from one's home and having to flee from roots and social support and a familiar environment is very distressing (Porter & Haslam, 2005; Nickerson, Bryant, Steel, Silove & Brooks, 2010). The loss of social support networks, the relationships and the meanings attached to the results in refugees becoming vulnerable and alone with their loss of communality (Erikson, 1976), that can lead to the feeling of rootlessness and alienation from both home and the hosting community. Being forced to leave your family behind, little opportunity for preparation can result in the sense of helplessness and lack of agency in having to leave with little or no sense of what lies ahead (Schweitzer et al., 2006).

A study among Iraqi refugees in Australia by Nickerson et al. (2010) found higher mental health-related disabilities, PTSD and depression among the refugees who were separated from their immediate family members rather than those who were not. Worrying about families who were left behind in the home country, where there is still ongoing war, increases the psychological distress of refugees (Nickerson et al., 2010). Similarly, Porter and Haslam (2005) reported worse mental health outcomes among refugees whose countries are engaged in continuous war, and PSTD and depression were significantly predicted by a ranking of the home country with the extent of political terror (Steel et al., 2009).

2.8.3 Daily Stressor and Socioeconomic Hardships

Understanding the role of daily stressors in psychological distress will help to inform appropriate psychosocial interventions. Daily stressors include the realities of refugee camps characterized by overcrowding, inadequate basic necessities like water, shelter and food, poor sanitation as well as a lack of privacy and security (Akinyemi et al., 2012; de Jong et al., 2000; Rassmussen et al., 2010). Other daily post-migration stressors relate to being a refugee in a new country and socioeconomic discrimination and disadvantages (Idemudia et al., 2014; Morof et al., 2014).

Stressful life events are traumatic and can easily cause disturbing emotional instabilities in a person's mental health and the entire quality of their life (Nwoye, 2009). Individuals escaping difficult circumstances and arriving in a new country, may find that being hopeful and optimistic about establishing a new life, may very soon change to experiences of considerable stress and emotional hardship if they are faced with multiple challenges associated with being a refugee in the new country (Nickerson et al., 2010). It was found that psychological distress among South Sudanese refugees in Chad is strongly related to post-migration socioeconomic daily stressors that include the lack of basic needs and insecurity rather than war-related trauma (Rasmussen et al., 2010). Similarly, Chaaban et al. (2010) found that Palestinian families with housing difficulties were twice as prone to mental health problems compared to those Palestinian refugees without housing problems. Porter and Haslam (2005), found in their meta-analysis of 59 studies that refugees who had secure private accommodation had better mental health outcomes compared to those who were in temporary shelters and institutions.

Refugees in South Africa are subjected to gross exploitation because they represent a resource that is quite susceptible to exploitation as they take jobs that most local people are loath to take up (Adjai & Lazaridis, 2013; Smit & Rugunanan, 2014). These jobs usually involve physical labour with low wages, and in many instances, they work in notably sub-standard conditions in plantations and in other corporate facilities (Vachon, 2013) or in South Africa informal work arrangements such as car guard (looking after other's car when parked). Hazardous work conditions always have a negative impact on their mental health (Manik, 2014).

The reality of unemployment has been shown to have negative effects on mental health, and it even increases the risk of suicide (Milner, Page & LaMontagne, 2014). According to Paul and Moser (2009), the risk of psychological problems such as distress, depression and anxiety amongst those who are unemployed is further increased when the country has weak unemployment protection systems. Similarly, refugees in South Africa are often not protected from unemployment and face exploitation (Adjai & Lazaridis, 2013; Smit & Rugunanan, 2014).

2.8.4 Migration Policies and Asylum Processes

Even though the *UN convention (1951*) and the *1967 UN Protocol* clearly states the rights of Asylum-seekers and refugees, different countries depend on their national policies to regulate and restrict migration. It is well-documented that refugees are victims of harsh migration policies that expose them to risky mental health problems (Eleftherakos et al., 2018; Farhat et al., 2018). Prolonged asylum-

seeking processes, living for a long time in unconducive detention centres, and suspension of asylum status determination triggers past traumatic experiences (Eleftherakos et al., 2018; Farhat et al., 2018), and these have been strongly associated with psychological distress among unaccompanied adolescents and adults (Coffey, Kaplan, Sampson & Tucci, 2010; Jakobsen, Demott & Trond Heir, 2014; Zwi & Marse, 2015). The lack and delay of proper documentation are often accompanied by unemployment, housing problems and a lack of basic services, that exacerbates the acculturation processes.

In some countries, refugees and asylum seekers are kept in detention centres with harsh conditions that lead to a sense of powerlessness and hopelessness (Eleftherakos et al., 2018; Zwi & Marse, 2015). Hence, this sense of powerlessness can aggravate depression leading to other mental health problems (Coffey et al., 2010; Porter & Haslam, 2005; Zwi & Marse, 2015). There are strong associations between the length of stay in detention and severity of mental disorders, especially for individuals with prior exposure to traumatic events (Silove & Mares, 2018). For example; Fazel and Silvo (2006), and Steel and Silvo (2001) have reported on their study in Australia that detention activates past traumatic experiences, and these become most difficult to bear and stressful among long-term detainees. To date, a few policy-level mandates have incorporated, explicit measures, to detect or prevent psychological morbidity in detention centres (Idemudia, 2011; Silove & Mares, 2018).

In South Africa, refugees are systematically prevented from exercising their rights, for example, to compete for employment and to access some public services (Bloch, 2010; Landau, 2006) and the South African labour policy prioritizes South Africans and systematically blocks others from competing (Belvedere, 2007; Matsinhe, 2011). What becomes apparent is that with or without the necessary permits, refugees are caught in a cycle of hopelessness due to a lack of opportunities (Belvedere, 2007) and are vulnerable to exploitation (Bloch, 2010).

2.8.5 Acculturation

The experience of moving from one cultural environment to another can produce a cultural shock. Winbush and Selby (2015) describe culture shock as an extremely emotional experience in which migrants experience behavioural confusion and disoriented cognitive functioning. Refugees are forced to adapt and to change from a secure and familiar identity to that which is insecure (Sawicky, 2011). Cultural shock can cause behavioural uncertainty and impaired cognitive function. The grief and loss experienced, the stress about the changing environment and the demands of settling into a new culture,

such as working, learning and socializing in a second language all result in elevated levels of anxiety (Bhugra, 2010). A steady conversion takes place which leaves refugees with a higher degree of identity susceptibility, and this vulnerability could lead to anxiety and depression when coping becomes difficult (Winbush & Selby, 2015).

Berry (1990) stated four outcomes where migrants could acculturate with respect to adapting to hosting communities and new cultures. These are ***assimilation, separation, marginalization and integration***, and are discussed briefly in the stress and coping section hereunder.

Nwoye (2009), argued that refugees hold preconceived ideas about the host country that life would be far much better when they arrived in the host country, only to find out that there are disparities between their preconceived ideas and the actual reality. This conflict of experiences results in destabilization, depression, cognitive discord and confusion. These develop from the efforts to adapt to a new environment and the demands from work and family (Jackson, 2014).

In South Africa, although English is a shared language and the most spoken language followed by isiZulu – a local language predominant in KwaZulu-Natal, refugees have difficulties in communicating in the local languages and in English (Winbush & Selby, 2015). Having to learn, work and socialize in a second language can be mentally and emotionally tiring (Sawicky, 2011). The loss of opportunity to express oneself adds to the overall feeling of alienation and stress. The inability of refugees to use their first language presents complications for them and people in the host country who assist them (Sawicky, 2011).

The manner in which psychological symptoms manifest is a big concern. Slobodin and De Jong (2015) argue that during the post-migration stage, factors of language proficiency and cultural differences may influence the manifestation of symptoms and could further obstruct accessing health care. Furthermore, socio-cultural differences and a general lack of awareness of mental health issues among refugees and the host society increases the rate of mental health illnesses experienced by refugees (Delbar, Tzadok, Mergi, Erel, Haim, & Romem, 2010). These phenomena could become worse, particularly among African refugees, with little knowledge of western perspectives on mental health.

Regarding the general African population and mental health awareness, studies have revealed that there is a low level of mental health literacy, particularly in identifying psychological problems using

western symptomology. Atilola (2014) systematically reviewed studies that explored the level of sub-Saharan communities' mental health literacy which is defined as "*the possession of knowledge and skills about mental disorders which aid their recognition, management and prevention*" (Atilola, 2014, p. 94). Most of the reviewed studies reported that the respondents were unable to identify psychiatric syndromes correctly and that most of them believe in supernatural and ultra-human explanations of distresses and preferred alternate mental health services like those provided by traditional healers or priests. However, Atilola (2014) argues that the studies could not be conclusive as they used vignettes based on western concepts for multi-cultural and multi-ethnical societies of sub-Saharan Africa. So, there are also studies that found difficulties of accessing mental health services mainly due to cultural differences and language difficulties (Maier, Schmidt, & Mueller, 2010; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). This also applies to African refugees when accessing mental health services, in South Africa and in other countries, which are based on western perspectives.

Regarding the host countries' factors, there are several studies that reported refugees' post-migration difficulties of integrating into the hosting communities, particularly in the first few years (Jackson, 2014; Nwoye, 2009; Sawicky, 2011). However, opposite to what Kunz outlined, not all refugees adapt the post-migration stressors easily, and consequently, this affects their mental health. For example, as stated above, language and cultural practices are the major post-migration stressors for many. Several studies reported that refugees have been isolated and have withdrawn from social interaction as they could not speak the local language and experienced a mismatch of the cultural practices and values (Bhugra, 2010; Sawicky, 2011; Winbush & Selby, 2015).

2.9 Major Psychological Distress among Refugees

Several studies have reported that PTSD, depression and anxiety are the most common psychological problems experienced by refugees with studies also showing higher mental health problems among refugee than in the general population (Bogic, Njoku & Priebe, 2015; Crager, Chu, Link & Rasmussen, 2012; Porter & Haslam, 2005; Steel et al., 2009). An earlier, systematic review reported lower prevalence rates of PTSD and depression among refugees. The widely cited systematic review by Fazel, Wheeler and Danesh, (2005) reported a 5 per cent rate of depression and a 9 per cent rate of PTSD among 7000 refugees resettled in Western countries. Furthermore, they reported that the lower prevalence of psychological distress was reported by rigorously conducted studies (Fazel, Wheeler & Danesh, 2005). A meta-analysis by Porter and Haslam (2005) included 56 publications from 1959-

2002, with a total sample of 67, 294 of which 22, 221 were refugees and 45, 073 were comparison non-refugees (internally displaced and returnees). The result showed that refugees had higher mental health distress with a medium-size effect (.041). The mental health outcomes were worse among refugees who were older, had a higher educational and pre-displacement socioeconomic status and which were female (Porter & Haslam, 2005).

Many studies also revealed that the prevalence of psychological distress is exponentially higher among refugees than in the general population. Steel et al. (2009) have completed the largest review among refugees and other war-displaced populations across the world. The review included 181 surveys with a total sample of 81,866 from 40 countries (Steel et al., 2009). They reported a similar prevalence of 30 per cent of the population for both PTSD and depression. Steel et al. (2009) also reported considerable heterogeneity in prevalence among the surveys. Consistently, methodologically rigorous studies reported a lower prevalence of PTSD, estimated PTSD at 15 per cent. PTSD was strongly predicted by torture experiences, while depression by the number of traumatic events (Steel et al., 2009).

Recently, Bogic, Njoku, and Priebe (2015) examined psychological distress among war refugees who had been resettled for more than five years in different parts of the world. The systematic review included 29 studies with a total sample of 16, 010 (where 22 per cent were from sub-Saharan Africa). They reported a 2.3 to 80 per cent prevalence of depression, PTSD (4.4% – 86%) and anxiety (20.3% – 88%). The wider range of prevalence rate was related to the quality of methodology, language of assessment; where studies with higher quality and use of native language for assessment reported lower prevalence (Bogic et al., 2015). However, with the high-quality studies only, the prevalence of depression among refugees is 14 times, and PSTD 15 times higher than in the general population. Prevalence was also related to the country of origin, and where they resettled, for example, lower prevalence of depression (2.3%) was found among Southeast Asians in Canada and a higher rate (80 %) among Cambodians in the USA. Furthermore, the study also revealed that pre-migration traumatic experiences and post-migration living difficulties were frequently correlated with the three psychological problems mentioned (Bogic et al., 2015).

Most studies used a self-report questionnaire using a western-based instrument to assess psychological distresses. The most commonly used instruments are; GHQ, Hopkins Symptom Checklist-25 (HSCL-25), the Harvard Trauma Questionnaire (HTQ) and the Post-traumatic Stress Diagnostic Scale (PDS)

developed by Foa (1995). For example, Bogic et al. (2015) has reported that from the 29 articles they reviewed about 80 per cent of them used a self-reporting questionnaire developed using the western paradigm, even though more than 86 per cent of the samples were from non-western cultures (Bogic et al., 2015). There is a high suspicion of a lack of sensitivity in the use of these instruments with multi-cultural refugees.

As discussed above, research studies have clearly outlined the prevalence of psychological distress among refugees. The mental health and psychological distress studies among diverse cultural populations seemed to be influenced primarily by the mismatch between the cultural and contextual concepts and symptoms of psychological problems. Almost, all studies in this regard are limited by using or adapting Western frameworks. However, several studies did attempt to identify African language and cultural concepts to identify mental health issues (Molsa, Hjeelde & Tiilikainen, 2010; Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014; Reggi, 2014, UNHCR, 2016). The UNHCR publication '*Cultural, context and mental health of Somali refugee*s' stated that there are similarities and differences between psychiatric terminologies and Somalis' traditional concepts regarding mental health and distress. For example, Molsa et al. (2010), examined traditional Somali conception and practices related to mental health problems and healing. The authors interviewed refugees Somali elders and traditional healers in Finland and found contradictions between the western-based biomedical explanations of psychological distress that were understood by the Somali refugees as spiritual and social problems. For the Somalis, generally, psychological distress is expressed as an "*illness of the mind*" (Molsa et al., 2010, p. 283) that largely gives a religious explanation for causation and treatment. However, the study also noted that mental health conceptualizations are changing with impacts of post-migration challenges and by the newly encountered health services (Molsa et al., 2010). With a sample of Congolese and Somali women refugees in the USA, severe emotional distress was acknowledged as a mental illness, while other forms of psychological distress were acknowledged as outcomes of daily stressors (Piwowarczyk et al., 2014). Furthermore, Piwowarczyk and colleagues (2014), reported that a lack of or differences in understanding of the western view of mental health illness and treatment, together with stigma and fear of disclosing personal information, posed major barriers for mental health care. However, they also stated that participants' acknowledged war and violence contribution to psychological distress, besides the common spiritual explanations (Piwowarczyk et al., 2014). Therefore, there is a need for culturally appropriate mental health instruments; otherwise, the existing western instruments must be adapted to cultural contexts, and

findings must be interpreted with high caution. The literature on the three major psychological distresses among refugees is examined next.

2.9.1 Post-Traumatic Stress Disorder (PTSD)

Refugees who are forced to migrate from war and conflict zones reported high psychological distress and disorders, mainly, post-traumatic stress disorder (PTSD) which results from experiencing or witnessing life-endangering traumatic events and it incorporates symptoms of intrusive memories of the traumatic experiences, avoidance behaviour, and general hyper-arousal and decreased functioning (Lacroix & Sabbah, 2011; Weine, 2001). The PTSD symptoms of survivors increased with the severity of the traumatic experiences and the number of traumatic events experienced or witnessed. This is called the dose-effect theory of PTSD – with a high dose of traumatic events, a high incidence of PTSD symptoms is expected.

A meta-analysis by Steel et al. (2009) investigated the prevalence of PTSD amongst a number of refugee groups. The results of the analysis revealed that African refugees, specifically, seemed to display the highest prevalence of PTSD when compared to all other refugee groups. In a study comparing PTSD and major depressive disorders between refugees and voluntary migrants, Crager et al. (2012), demonstrated that refugees appeared to display a higher prevalence of these disorders than their counterparts who had voluntarily left their country of origin. Studies among African refugees have also reported a PTSD prevalence of between 25 and 71 per cent (Karunakara et al., 2004; Kolassa et al., 2010; Neuner et al., 2004; Onyut et al., 2004; Onyut et al., 2009; Ssenyonga, Owens & Olema, 2013).

Longitudinal studies among recently resettled refugees conducted by Mollica et al., (2001) and Roth, Ekblad and Agren, (2006) have shown that PTSD reaction may continue and even increase over time. However, systematic reviews and meta-analyses have shown that with prolonged migration time there is reducing risk of mental health problems among refugees (Fazel et al., 2005; Porter & Haslam, 2005; Steel et al., 2009).

It should be noted that most forced migrants are from war-affected poor countries and these countries, most often, are characterized by poverty, insecurity and violence (physical and sexual) that might contribute to the development of PTSD (Neuner et al., 2004; Ssenyonga, Owens & Olema, 2013).

2.9.2 Depression

In the *Diagnostic and Statistical Manual of Mental Disorders* 5th edition (DSM-5) depression is categorized as a separate mood disorder, however, early in DSM- IV-TR, depression along with bipolar disorder were in the same category of mood disorders (Austin et al., 2014). The mood disorder is characterized by feelings of depression and/or elation where the person displays a feeling of depression and mania for extended periods of time resulting in impaired functioning (Austin et al., 2014). Depression is usually accompanied by somatic manifestations and practical complaints, such as headaches, loss of appetite, crying, insomnia, abdominal pain, general body aches, social isolation, feeling hot, hair loss, trouble interacting, concentrating, lack of energy and interest in taking care of family and children and staying at home (DSM- 5, 2013).

Depression is one of the major psychological distress conditions that is widely reported among refugees. A systematic review by Bogic et al. (2015) has reported a prevalence of depression ranging from 2.3 to 80 per cent among refugees. In the review, depression was found to be associated with poor post-migration socio-economic difficulties, including the lack of financial income, poor host language proficiency, and lack of social support. A research study by Tekin et al. (2016) also reported high rates of major depression (39.5%) and comorbid PTSD and major depression (26.4%) among Iraqi female refugees in Turkey.

2.9.3 Anxiety

The American Psychological Association (APA) defines anxiety as an emotion characterized by feelings of tension, troubled thoughts and physical changes like increased blood pressure (APA, 2019). The common symptoms of anxiety disorders include frequent disturbing thoughts or concerns, avoidance of events or situations out of fear or worry, that they could prompt physiological symptoms such as sweating, trembling, dizziness or a rapid heartbeat. The DSM-5 distinguished three categories of Anxiety which were earlier commonly known as generalized anxiety disorder, panic disorder and phobias, obsessive-compulsive disorder and stress-related disorders (Austin et al., 2014).

Often studies among refugees use a general instrument of anxiety that does not differentiate between different anxiety disorders (Birman & Tran, 2008; Craig, Sossou, Schnak, & Essex, 2008; Gerritsen et al., 2006; Stige & Sveaasstorture, 2010). However, a recent systematic review by Bogic et al. (2015), among war refugees, reported that 20 studies out of 29 investigated specific anxiety disorder, and

reported the prevalence of PTSD in 20 studies, general anxiety disorder (5 studies), panic disorder (4 studies), obsessive-compulsive disorder (4 studies) and agoraphobia (2 studies). The systematic review reported a prevalence of unspecified anxiety with an incidence of between 20.3 and 88 per cent among Southeast Asian refugees resettled in USA (Bogic et al., 2015).

A meta-analysis of 35 articles published between 1990 – 2007 among labour migrants and refugees (20 of the studies included only refugees) by Lindert et al. (2009) shows the combined prevalence of anxiety (40 %) among refugees. The review also reported that the prevalence of anxiety is higher among refugees than labour migrants. Similarly, a cross-sectional study among Iraqi refugees in Jordan indicated that more than half of the sample suffered from high anxiety levels, while 42.8 per cent reported high stress. The study also found a high level of anxiety significantly predicted for those living with a low-level quality of life (Al-Smadi, Tawalbeh, Gammoh, Ashour, Alshraifeen & Gougazeh, 2017).

While traumatic events and distressing contexts make refugees vulnerable for mental distress, many display high levels of resilience and find ways to cope and even experience post-traumatic growth, and this will be addressed below.

2.12 Coping, Resilience and Post-Traumatic Growth (PTG)

At times of adversity, people react differently to similar experiences. An extensive body of literature exists regarding people's responses or behavioural changes when encountering adversities (Berry, 1997; Goodman, 2004; Halcon et al., 2004; Kuo, 2014; Lazarus & Folkman, 1984; Schweitzer, Greenslade & Kagee, 2007). Researchers have identified those reactions as coping strategies, resilience and more recently as Post-Traumatic Growth (PTG). There is no universally agreed-upon definition and clear-cut distinction between coping and resilience in particular. Sometimes the terms are used interchangeably, and their definitions also overlap. These concepts; coping, resilience and PTG are widely applied in refugee studies.

2.10.1 Coping Theory – Stress and Coping

In order to cope with the various challenges and difficulties in their flight and migration, refugees often use different coping strategies in an effort to survive and to overcome the condition. The prominent psychological theory of stress and coping by Lazarus and Folkman (1984), can be used to explore refugees' response to stressors. They defined coping as a "*constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing*

or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). In other words, coping is a response to stressors, and stress is a condition, or an experience considered by an individual to be beyond their capacity to manage and which endangers their wellbeing (Lazarus & Folkman, 1884). Therefore, personal appraisal of a situation or condition is key to measure coping. Personal appraisal refers to the various ways' individuals seek to modify adverse aspects of their life in order to minimize the internal threat of stressors. Individuals experience similar stressors, their physical and psychological reaction to those stressors could be divergent. According to this theory, the difference in reaction is attributable first to the level of perceived threat (the primary appraisal) and secondly to the presence or absence of personal resources to respond to the stressors (Lazarus & Folkman, 1984).

Lazarus and Folkman (1984) indicated that there are two types of coping strategies: problem-focused and emotion-focused coping. Problem-focused coping involves eliminating stressors completely, while emotion-focused coping entails controlling and moderating emotions that are related to experiences of stress (Lazarus & Folkman, 1984). In this regard, coping is effective if stress is accurately appraised, and specific behavioural and cognitive strategies are used to manage, reduce or tolerate stressful events.

At a later stage, Folkman and her colleague (Folkman, 1997; Folkman & Moskowitz, 2000) investigated the co-occurrence of positive and negative psychological states during a stressful condition. Her study with HIV/AIDS caregivers (Folkman, 1997) found that people experience positive emotions despite the highly stressful situation they were in, i.e. in the midst of caregiving to a dying partner and at the bereavement stage. Then she modified the stress and coping theory – previously focused on the managing of stress (Lazarus & Folkman, 1984) - to consider the account of positive emotions. She then identified three coping mechanisms; positive reappraisal, problem-focused coping and creating a positive event. The underlining theme of these is making a positive meaning out of the situation, and positive meanings are highly associated with a positive psychological state (Folkman, 1997). The positive re-appraisal is a cognitive process where individuals focus on the good aspects of the things that are happening. The problem-focused coping focuses on managing the causes of the distress and often works in situations where the individual has control over the situation. Creating positive events entails creating positive psychological meanings from ordinary events such as remembering positive events during a stressful time. These help people to experience positive emotions and psychological wellbeing (Folkman, 1997; Folkman & Moskowitz, 2000).

Movement of people to another cultural environment is a major change that makes the experiences of stress and coping salient (Lazarus & Folkman, 1984). The refugee is in forced transit from one culture to another culture from the time they leave home. Confronting another culture is a persistent stressor that they struggle to adapt to, even after long years in the post-migration phase. Grounded on the psychological theory of Stress and Coping (Lazarus & Folkman, 1984), Berry (1997) stated that acculturation or cultural adaption is an unavoidable process that occurs in response to the need to manage and cope with stressors attendant upon migration and that occurs through continuous interaction with the new culture. Similarly, Redfield, Linton and Herskovits (1936) defined acculturation as a phenomenon that occurs: "*when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups*" (p. 149). For refugees who are going through cultural transition and change, there is an intertwined association between coping strategies and acculturation. Therefore, the coping strategy an individual exerts is indicative of his or her acculturation or adaption to the new culture, or vice versa acculturation impacts upon the individual's coping behaviour or response to stressors (Kou, 2014).

According to Berry (2006), an individual's adaptation to a new culture can happen in two ways, the first way is called '*cultural learning*' and requires a person to learn particular cultural skills that would be used as entry into the hosting culture—for example, teaching refugees language and general rules of social behaviour. The second way is called '*stress, coping and adaption*'. These two ways are used by individuals in response to stressors resulting from contact with the new culture, and they take account of the characteristics of the individual and the situation that can enable or hinder adaption to the new culture.

Berry (1997, 2006) claims that there are four acculturation strategies that represent the coping strategies individuals adopt to manage their relationship with hosting communities or cultural groups. The ***well-integrated*** migrants are those who adopt the host community's culture and still practice their home culture. There are others who are ***assimilated*** into the host community and who detached themselves from their home culture. The ***separated*** migrants are those who practice their home culture and refuse to practice the way of living in the host community. The ***marginalized*** are at both extremes, not practising their home county's culture and resisting the adoption of the new way of living. However, these conditions are highly influenced by complex factors such as discrimination and socio-

economic restrictions and disadvantages, lack of family and social support, adoption processes and cultural shock, conflict of values, priorities and meaning (Patel & Stein, 2007).

The theory also states that individual-level factors and group-level factors that happened before and during acculturation can influence the outcome of the adoption processes. At the individual or psychological level, the moderating variables for a person prior to acculturation include demographics information, migration motivation, expectation and personality characteristic. During acculturation, the moderating factors include; acculturation phases and strategies, coping strategy and resources, social support and attitude (Berry, 1997). Therefore, coping is a salient factor in managing psychological distress during acculturation. It also leads to the final adoption of the hosting culture. Finally, Berry (2006) outlined three types of adaptation. Firstly, it requires a *behavioural shift* from the refugees to adopt the dominant culture. Secondly, it is a failure to cope and to acculturate that leads to *psychological distress* in the form of marginalization and separation. Thirdly, there is *acculturation stress* that refers to sources of stress characterized by negative behavioural and emotional responses as a result of acculturation experiences (Berry, 1997)

It is important to understand that refugees also have to cope with their past traumatic experiences and separation from their families. Studies that examined African refugees' coping mechanism have been reporting different strategies of coping. The most common coping mechanisms are faith-based responses and religiosity; cognitive reframing to gain a new perspective on their situation; and the use of social networks if available (Goodman, 2004; Halcón et al., 2004; Schweitzer, Greenslade & Kagee, 2007).

Adedoyin et al. (2016) conducted a systematic review of the literature to determine the coping strategies employed by African refugees settled in the USA. The results revealed a tendency to employ faith as the main coping strategy, and this increased their propensity to overcome traumatic experiences and acculturation stressors and to have the added benefit of gaining a sense of empowerment. Moreover, it was found that religiosity was the preferred coping mechanism utilized by African refugees to overcome psychological distress associated with trauma, and religiosity also improved social relations as many attended religious gatherings and were able to create a network of support (Adedoyin et al., 2016). This was supported by the qualitative study findings of Khawaja, White, Schweitzer and Greenslade (2008) that revealed religiosity as the prominent coping strategy used among Sudanese refugees. They also used social networks and cognitive structuring as coping

strategies. The use of social networks offered emotional support which many participants felt had dissipated since arriving in an alien country, while the cognitive strategies have elements of reframing; many participants reported a fixation on the future and the focus on the opportunities of education and employment which were now made available to them (Khawaja et al., 2008).

Goodman's (2004), qualitative study on coping mechanism among the 'Young boys of South Sudan' resettled in the USA, is a seminal and good example of coping studies involving war refugees. The young unaccompanied boys fled their homes as young as three or four years old, in masses, during the 1980s when their families were killed, and their villages were burnt down by the Sudanese militia. They have witnessed killings of parents, family members, friends, experienced extreme hunger and disease in refugee camps in Ethiopia and Uganda for more than ten years. With such enormous traumatic experience and hardship, there was a remarkable lack of psychopathology and dysfunction among the boys (Zutt, 1994). Goodman (2004), found collective and the common self-suppression and distraction, making meaning and emerging from hopelessness to hope as main themes of coping mechanism among the adolescents. By ***collective and common-self,*** this means that the boys relied on sharing of experiences leading to the feeling that they were not alone in their suffering. Responsibility for others and an obligation to help others comforts them. They were also ***suppressing their traumatic memories and emotions*** and distracting themselves from thinking about how they could change the difficult reality. Goodman (2004) also commented on how their suppression was reflected in the interviews when they were narrating their traumatic experiences without emotional attachment. The third coping mechanism was ***meaning-making*** – they attributed their condition to 'God's will' rather than questioning why they suffered so much. Lastly, ***feeling hopeful*** made them regard themselves as people with a future when they resettled, whereas before that they could not. The study supported the earlier study findings among the Sudanese children while they were at a refugee camp in Uganda (Paardekooper, Jong & Hermans, 1999). The study by Paardekooper and his colleagues reported the similar coping mechanism by the refugee children who found out how to use an emotional-inhibiting mechanism like 'keeping-quite' and 'blaming oneself' and in emotion-focused activities like spending time with others. This was different from local Ugandan children who used "yelling, crying and getting mad" as a coping mechanism (Paardekooper et al., 1999, p. 531). Both the studies of Goodman (2004) and Paardekooper et al. (1999) also reported wishful thinking, distracting thoughts by keeping busy with others and praying as a common coping mechanism among the Sudanese refugees.

2.10.2 Resilience

The factors for deteriorating mental health of refugees are multidimensional and interactive as discussed above. However, refugees' psychological reaction to migration stressors varies depending on different factors. There are some who show resilience and overcome stressors without many psychological problems. Several studies also showed better psychological health among refugee with strong resilience (Schweitzer et al., 2007; Siriwardhana & Stewart, 2013; Siriwardhana, Ali, Roberts & Stewart, 2014; Ziaian et al., 2012). Resilience has been used interchangeably as a coping mechanism even though some literature successfully differentiates it.

Resilience is a widely used concept; however, there is also wider criticism on definitional ambiguity and operationalizing the concept for measurement has been difficult (Davydov, Stewart, Ritchie & Chaudieu, 2010). In their critical article on resilience Davydov et al. (2010) showed how the concept had been used in different forms as an individual trait, a phenomenon caused by other factors and as a durable personal coping resource reserved for buffering during adversity. However, the widely used definition of individual resilience is the ability of a person to successfully adapt to or recover from stressful and traumatic experiences (Crawford, Wright, & Masten, 2006).

Furthermore, Ungar (2008) argued that there is an overlap among the different explanations of resilience whether or not it is from a developmental outcome perspective, a set of competencies or from a coping strategy point of view. However, the common factor among them is that the views agree that resilience occurs during adversity. Further, the explanations also shared the view that resilience is influenced by an individual's environment, and the positive outcome is determined by the interaction between the person and the social ecology (Ungar, 2008). For this purpose, Ungar proposed a definition of resilience that captures the individuals and their social-ecological aspects and how both explain the processes and outcome of resilience. He defines resilience as the *"… capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful way*s" (Ungar, 2008, p.255), in the situation of significant hardship. In other words, resilience is a process of navigation and negotiation for health resources. From their research on the *International Resilience Program* with children and youth across different cultures and contexts, Ungar and his colleagues developed four propositions that support the ecologically focused definition of resilience (Ungar & Liebenberg, 2005; Ungar, 2008). The first

proposition states that resilience "*has global as well as culturally and contextually specific aspects*" (Ungar, 2008, p.226). Secondly, depending on the particular culture and context, those aspects of resilience impose different degrees of influence on the person. The third mentions that individual aspects that contribute to the resilience of the person are interrelated and reflect the culture and context of the individual. The final proposition states that resilience aspects group together as a result of resolving the clashes between the individual and his or her cultural context.

When it comes to refugees, resilience in most forced migration studies is conceptualized as a multidimensional construct that includes personal strength and skills together with social environments and a supportive family network (Lenette, Brough, & Cox, 2013; Newbold, Chung, & Hong, 2013), rather than a multifaceted collection of purely personal attributes such as self-esteem or hardiness (Connor & Davidson, 2003). Resilience is seen as a dynamic process that alters according to the cultural, developmental and historical context of individuals, varying across age and gender (Connor & Davidson, 2003). Concurring with this, resilience is identified as a "*multi-dimensional characteristic that varies with context, time, age, gender and cultural origin, as well as within an individual subject to different life circumstances*" (Connor & Davidson, 2003, p. 76).

Siriwardhana et al. (2014), reviewed qualitative (N = 10) and quantitative (N = 23) studies on resilience and its impact on mental health among refugee and internally conflict-displaced people. The study found that perceived and available social support, a sense of coherence, social networks, coping strategies, individual qualities, religious belief systems and culture as "*critical nature of resilience*" were all important factors (Siriwardhana et al., 2014, p. 10). Most importantly, they found that an increased level of resilience and a lower level of psychological problems was associated with strong family and social support. Post-migration living difficulties, separation from family and prolonged displacement are found to negatively impact on resilience. From the findings, the authors also conceptualized a theoretical framework for resilience - mental health interaction. The framework outlines key factors that positively impact on both resilience and mental health. The ***'supportive'*** – factors include a sense of coherence, strong family and social support and networks, religion and belief systems, and personal qualities. On the other hand, there were factors that negatively impact on resilience and mental health. These are referred to as '***undermining***' factors that include levels of acculturation, daily stressors, broken families and social networks, gender and continuous displacement (Siriwardhana et al., 2014, p. 11). The framework states that there is an interdependent

relationship between resilience and mental health, and framed resilience as a result of a "*supportive environment with sufficient resources that aide individuals to overcome adversity*" (Siriwardhana et al., 2014, p.11).

A study among adolescent multicultural refugees in Australia found that in adolescents with higher resilience (measured using CD-RISA), females scored higher resilience levels, showed lesser depression symptoms and behavioural problems (measured using Children Depression symptoms) (Ziaian et al., 2012). Ziaian and his colleagues (2012), also found no relationship between earlier trauma experience and resilience; however, children who had stayed in Australia for more than five years showed higher resilience.

Refugee women from DRC, Burundi, and Zimbabwe showed resilience and hope for the future despite their poor post-migration conditions (Smit & Rugunanan, 2015). Even though it was difficult for the women to bounce back, the authors explained their resilience as "*survival with impairment*," doing what they can do to keep their family together (p.197). This was also demonstrated by persistent asking and look for assistance from individuals or organizations. Another way of managing their emotions and making meaning for their existence is their faith and the presence of God in their life. They also expressed their wishful-hope that their suffering might bring a better future for their children (Smit & Rugunanan, 2015).

2.10.3 Post-Traumatic Growth (PTG)

Gaining positive psychological outcomes in some way from traumatic experiences is called Post-Traumatic Growth (PTG) (Kilic, Magruder & Koryurek, 2015; Tedeschi & Calhoun, 1995). The positive psychological developments following traumatic experiences could entail higher levels of spirituality, better developed social skills, a greater appreciation for life and increased maturity after experiencing traumatic events. Kilic et al. (2015), stated that resilience and PTG are closely related concepts but must be distinguished in that resilience entails returning to the original level of functioning while PTG refers to gaining an advanced level of functioning after traumatic experiences. Similarly, Tedeschi and Calhoun's (1995) model of PTG refers to a positive psychological change that people experience after they have faced traumatic experiences. The positive change is achieved through a process of struggle and the strength that they gained through this process that is more than what they had prior to the difficulties. Tedeschi and Calhoun (1995) initially categorized growth into three general domains, namely, changes in perception of self, changes in the nature and experiences of

relationships with others and change in the philosophy of life. They later developed an instrument of PTG that produced five factors, namely; personal strength, new possibilities, improved relationships, change in life philosophy and spiritual change as outlined below (Calhoun & Tedeschi, 2006):

Personal strength – when individuals overcome trauma, they become more confident and capable of dealing with other challenges. They develop true knowledge of the self and understand the impact of traumatic events in life. They become more open, empathetic, mature, creative and humble. ***New possibilities –*** the 'victims' change priorities and appreciate life because they were spared from danger. Therefore, they begin to enjoy simple things and appreciate even small things and prioritize activities. ***Improved relationships*** entail a perceived improvement in the relationship with family, friends and others. They become intimate and open for support and use the support as a result of the difficulties they experienced. ***Changes in life philosophy (appreciating life)*** – this refers to the realization of one's vulnerability, and individuals become more aware of the purpose of life and to better appreciate it. ***Spiritual change*** comes about when individuals seek religious/spiritual explanations regarding their experiences, followed by a growth in religious beliefs. They may even change their spiritual practices, e.g. engage more in prayer, become more grateful to God, and experience a strengthening of faith.

Furthermore, Calhoun and Tedeschi (2006) emphasised that growth is an outcome of a process. When someone experiences trauma, it distorts their worldview and disturbs their ability to deal with emotions. In an attempt to deal with the difficulties, the individual repeatedly engages cognitively with these difficulties to reduce stress, a process called ***rumination***. In other words, rumination is a process of frequent reiteration and rethinking of the traumatic event until it becomes a habit, and in this process, an individual reappraises the experience and finds meaning in it. The PTG is predicted by "*personal pre-trauma characteristics, self-disclosure, fundamental schemas, beliefs and goals… rumination, more deliberate schema change, narrative development, and enduring distress*" (Calhoun & Tedeschi, 2004, p.7). It must be noted that positive psychological changes or growth does not entail the disappearance of psychological distress (Calhoun & Tedeschi, 2004), as the growth and distress can co-exist. However, the positive psychological growth prevails over the suffering.

A recent study by Abraham et al. (2018) explored resilience and PTG among Eritrean women in refugee centres in Norway. The refugee women fled political oppression and gross human rights' violation and reached Europe after an arduous journey through the Sahara Desert and the Mediterranean Sea. The researchers found that participants normalised the psychological distress they

experienced, e.g. lack of sleep, negative feelings, difficulty to concentrate and lack of appetite. They perceived the distresses as normal reactions to their difficulties and showed confidence that they would overcome them overtime when they resettled. Knowing Eritrean peers that overcame the issues, being able to identify with proxy families from the home country and 'borrowing networks' are the factors that gave them hope and positivity. Most of the participants declared that they had grown personally despite their challenges and preferred to stay optimistic about their future despite post-migration challenges because they had faith in God who helped them to overcome their past traumatic experiences (Abraham et al., 2018). The study demonstrated the manifestation of PTG among these traumatised refugees as theorized by Calhoun and Tedeschi (2006).

In the PTG study by Kilic et al. (2015), among 203 Iraqi students in Turkey who experienced war-related stressors, the relationships between types of trauma and PGT were examined. They categorised war-related adversities into three groups namely trauma to self (wounds, rape, torture, witnessing execution), trauma to loved ones (loved ones tortured, jailed or killed) and adversity (houses raided, woken up by blasts, harassed by soldiers). The participants experienced high rates of traumatic events, like being held at gunpoint and witnessing killings. In the study, trauma to self was negatively correlated with PTG, which means that PTG was restricted by self-trauma, the more trauma to self the less likelihood of PTG experiences. However, trauma to loved ones and adversity was not related to PTG. These findings were similar to those of Calhoun and Tedeschi (2006) in that PTG and distress were identified as separate dimensions and asserted that PTG does not necessarily stop the psychological distress of survivors. Kilic et al. (2015) concluded that war trauma could lead to positive growth experiences; however, the correlation between PTG and war-related adversities is not consistent.

It is important to note that positive psychological resource such as cognitive reframing or cognitive structuring (involves appraising and finding positive meaning to go on), resilience and emerging from hopelessness to hope are common coping strategies among refugees as discussed above (Goodman, 2004; Khawaja et al., 2008; Siriwardhana et al., 2014; Ziaian et al., 2012; Smit & Rugunanan, 2015). Some refugees have also shown PTG (Abraham et al., 2018; Kilic et al., 2015) that is explained through a strong positive inner resource such as a change in life's philosophy becoming more optimism about one-self, gaining self-confidence, determination on the action and hopeful for the result. These inner resources collectively are known in psychology, particularly in positive psychology, as Psychological

Capital (PsychCap). PsychCap is defined as "an individual's positive psychological state of development' (Luthans, Avolio, Avey & Norman, 2007, p. 542). The PsychCap construct optimism, hopeful thinking, resilience and confidence to execute an action (self-efficacy) have been found to closely related with mental health among refugees (Abraham et al., 2018; Goodman, 2004; Siriwardhana & Stewart, 2013; Siriwardhana et al., 2014; Ziaian et al., 2012). PsychCap is a core positive inner resource developed from those positive constructs. Further, there is a similarity between PsychCap constructs and PTG explanation and manifestation, and both are processes of growth rather than a fixed trait. In PTG person with traumatic experiences frequently reiterate and rethink of the traumatic event and reappraises the experience to find meaning (rumination, Calhoun & Tedeschi, 2006). PsychCap is also a process that develops through gratitude, courage, forgiveness (Luthans et al., 2007.

However, PsychCap as a core construct has not been explored among forcefully displaced refugees to examine the role of the construct as a coping mechanism and to promote the mental wellbeing of the group.

2.11 Mental Health Promotion Intervention among Refugees

Growing evidence shows poorer mental health among refugees than the general population of the host country (Asgary, Charpentier & Burnett, 2012; Rasmussen, Smith & Keller, 2007). The need for adequate treatment and screening facilities was further emphasized by Dunlavy (2010), who found a strong relationship between post-migration stress and mental health distress such as depression, anxiety, and PTSD. Several studies underlined that there is a lack of adequate and timely mental health treatment and support for refugees with detrimental consequences (Laufer, Pogachova & Zilber, 2013). Furthermore, the lack of timely attention to the psychological problems of refugees exacerbates the difficult adoption and integration process (David & Nadal, 2013). This predisposition may be further complicated by placing this population in contexts where mental health care is not easily accessible and of a hostile nature when it is available (Burns, 2011). It should be noted that the mental health services available in the Western world are underutilized for several reasons, mostly, because the services are not responsive to refugee needs and because of the stigma associated with seeking mental health services as well as problems experienced due to limited language proficiency (Weine et al., 2000) as discussed earlier.

Mental health interventions among refugees have been mainly trauma and individually focused showing mixed results in reducing the psychological distress including PTSD among this group (Goodkind et al., 2014; Miller & Rasmussen, 2010). The interventions lack comprehensive and inclusive strategies to alleviate post-migration difficulties (Slobodin & de Jong, 2015), despite the fact that both qualitative and quantitative studies showed a strong relationship between post-migration stressors and psychological distress including PTSD (Fernando et al., 2010; Rasmussen et al., 2010; Tempany, 2009).

Slobodin and de Jong (2015) critically reviewed the literature on mental health intervention, particularly for PTSD among refugees. The review aims to rationalize the development of culturally sensitive and evidence-based interventions. The commonly used interventions to ameliorate PTSD are Trauma-focused interventions, group therapy, multidisciplinary interventions, and pharmacological treatments (Slobodin & de Jong, 2015). The most researched and commonly used intervention strategies are Cognitive Behavioral Therapy (CBT) and Narrative Exposure Therapy (NET). They also reported that both interventions successfully integrate cultural practices and attitudes into the standard protocols and that they had been found to be suitable for some groups of refugees. This was supported by a systematic review that reported CBT and NET as being applicable and productive interventions among refugees (Nickerson, Bryant, Silove & Steel, 2011; Palic & Elklit, 2011). However, there is strong criticism of strategies focusing only on traumatic experiences, instead of focusing on the broader experiences of forced migration with an in-depth understanding of cultural techniques (Nickerson et al., 2010; Palic & Elklit, 2011; Slobodin & de Jong, 2015).

However, mental health intervention research is very limited among African refugees in Africa. The most referenced intervention is a randomized control study by Neuner et al., (2004); a trauma-focused intervention among South Sudanese war refugees, diagnosed with PTSD, in Uganda. The intervention compared the effectiveness of three intervention conditions, psycho-educational, supportive counselling, and Narrative Exposure Therapy (NET). In the ***psychoeducation*** (N = 12, one session) intervention, a control group were given education on the symptoms caused by traumatic experiences, and this aimed to normalize the reactions. The ***supportive counselling*** (N = 14, 4 sessions + psychoeducation) intervention aimed at discovering and strengthening the individual's values, culture and social factors and at installing a sense of a hopeful future. Participants developed a detailed

biography of themselves in ***NET*** *(N = 17,* 4 sessions + psycho-education*)*, which they refine during frequent discussions with the therapist where they are encouraged to re-experience the memory of the trauma and to discuss the emotional, cognitive and behavioural reactions to it. It is believed that over time the person will get used to the emotional reactions when reliving them, and that is when the narrative therapy stops (Neuner et al., 2004). At a 4-month follow-up after post-test, the three groups showed worsening of PTSD symptoms, attributed to the cutting of rations in the refugee camp, including receiving less food. However, the NET and Supportive Counselling treatment groups showed a better improvement after a one-year follow-up, with the NET group showing a significantly better outcome compared to the other two groups. At a year follow-up test, more than 70 per cent of the participants were not identified as suffering from PTSD. However, still half of the NET group diagnosed for severe psychological disturbance, while this was 91 and 77 per cent for psychological education and Supportive counselling groups, respectively. This outcome was attributed to the limitation of short-term intervention among refugees in a desperate situation (Neuner et al., 2004).

Another example of a study in an African context was by Bolton et al. (2007) in which the effectiveness of a randomized control study among war-affected Ugandan adolescents living in two camps for internally displaced people was undertaken. The study aimed to evaluate the effectiveness of two interventions that aimed to ameliorate mental health and to reduce psychosocial problems, which were locally defined syndromes, resulting from war and displacement. The interventions are therapy-based (Interpersonal Psychotherapy for Groups [IPT-G]) and an activity-based intervention (Creative Play [CT]) (Bolton et al., 2007). The results showed a decline in post-intervention scores of depressions for the three groups, including the control group. However, the decline in the IPT-G was significantly larger than in the waiting-control group. Neither of the designs were effective in improving locally defined anxiety and conduct problems among the boys or the girls. The study concluded that IPT-G was only effective at improving depression symptoms (Bolton et al., 2007).

The mixed results of trauma-focused interventions mainly based on psychotherapeutic strategies, are consistent. Most interventions that rely on Western psychotherapeutic approaches even among culturally diverse refugee groups were mainly ineffective, but those that tried to accommodate cultural backgrounds of participants had better results (Murray, Davidson, & Schweitzer, 2010). A review by Murray et al. (2010) included 22 mental health intervention studies among refugees in post-migration resettlements. These included interventions that evaluated treatment among children, family and adults

using various intervention techniques including; CBT, Eye-Movement Desensitization and Reprocessing (EMDR), family-based empowering and learning groups, Pharmacotherapy, Testimonial therapies and individual psychotherapy. They found CBT to be the most commonly used intervention and the most effective in reducing traumatic experiences and post-migration stressors. Expressive therapy used in the family and community-based interventions produced a moderately positive effect. The interventions among refugees from the same cultural background were more effective than the same interventions among heterogamous groups (Murray et al., 2010). More than half of the studies reviewed attempted to include particular cultural elements in their intervention. However, those using CBT and exposure therapy still rely on western approaches (Murray et al., 2010).

In the literature of mental health promotion intervention, there are two streams of intervention; ones that only focus on traumatic experiences and others that include socioeconomic stressors in post-migration. Nickerson et al. (2011) reviewed the efficacy of the two approaches, and they named them 'trauma-focused' and 'multi-model' approaches. In addition to the psychological support, the ***multi-model*** approach includes a wide range of interventions including resettlements support (advocacy, assistance in documentation, family reunion, housing and access to social services) and medical care. Using the ***trauma-focused*** intervention, a control group reported a decrease in the symptoms of PTSD. But a larger decrease was recorded in the treatment group. The interventions also contributed to a reduction in depression and anxiety symptoms. Other studies that focused on trauma but did not include a control group also reported a significant reduction in PTSD and depression (Nickerson et al., 2010). The multi-model approaches used psychosocial intervention to address multiple difficulties of refugees, who were visiting treatment centres, in addition to PTSD. However, the studies used in this approach did not report a significant reduction in PTSD or in other psychological distress. This was attributed to the possible severe mental health disorders of the refugees visiting treatment centres (Nickerson et al., 2010).

An outstanding six-month community based multi-method intervention, known as the *Refugee's Wellbeing Program (RWP*) was developed by Goodkind in 2005 and successfully implemented among Hmong adult refugees. The intervention was adopted by Goodkind et al. (2014) for African refugees, from DRC, Burundi, Rwanda, and Eritrea, who resided in the USA for less than 16 months. The thorough literature review that underpinned the intervention found a strong correlation between

psychological distress and post-migration stressors such as a lack of language proficiency, lack of social support and loss of valuable social roles (Goodkind et al., 2014). The intervention, designed to be culturally appropriate and to strengthen the refugees' cultural values, occurred in a non-stigmatised environment. Groups comprised of local students and refugees were created for learning opportunities, to increase environmental mastery, to develop advocacy skills in order to improve refugees' access to resources, to improve refugees' knowledge to increase social value and, lastly, to decrease the social isolation of refugees. The researchers reported that the adopted RWP for African migrants had similar positive outcomes as the original programme. Participants' experienced an increase in their English proficiency, enculturation, social support and a general increase in their quality of life with a significant decrease in psychological distress. The intervention also helped refugees to feel safe and more welcome in the US as the programme built trust and thus reduced their perceptions of racism and also helped them to focus on their new lives. The study underlined the importance of addressing the psychosocial and economic determinants of psychological wellbeing.

In light of the discussion above, it is clear that the two approaches, namely the trauma-focused and a multi-modal approach to refugee mental health, have been given much attention. However, after an extensive review of different studies, Miller and Rasmussen (2010), highlighted the shortcomings of the two models and proposed guidelines for an integrated sequential approach to mental health interventions for refugees and war-affected populations. What Miller and Rasmussen (2010) called a 'psychosocial approach' is similar to what Nickerson et al. (2010) called a 'multi-model approach. For the advocates of the ***trauma-focused*** model, also known as the "*dose-effect*", (Miller and Rasmussen, 2010, p.10), direct experiences of war or violence are the factor that explains the severity of psychological distresses or mental health in a conflict or post-conflict context. The advocates of trauma-focused model advance interventions that aimed to alleviate traumatic experiences, and they believe that this kind of intervention improves psychological health and the individual's ability to deal with ongoing stressors. For the ***psychosocial advocates*** – social and material stressors caused by or worsened by war or traumatic experience determine the psychological distress of communities. In the war-affected context or post-migration, displaced persons and refugees encounter difficulties like poverty, displacement into impoverished and crowded refugee camps, unemployment, separation from family and losing social supporting networks and other deprivations. Basically, for proponents of the psychosocial model, the mediation role for these 'stressful conditions' is more important than an

explanation of the severity of psychological distress and intervention. They believe changing those stressors will alleviate psychological health and enhance the coping ability of the individual (Miller & Rasmussen, 2010).

However, Miller and Rasmussen (2010), argued that both models overlooked the contribution of the other. They criticized the trauma-focused model for over-emphasizing the traumatic experiences and failing to recognize the role of daily stressful factors in explaining the rates of psychological distress among refugees. The shortcoming of the psychosocial model was that it solely targeted daily stressors undermining the role of traumatic experiences and ignored the mental health needs of severely traumatised groups (Miller & Rasmussen, 2010). In the integrated model (see figure 1 below) they proposed to add daily stressors not related to war, as direct predictors of psychological distress including PTSD. They argued that adding these stressors increased the explanation power of the model and minimised the direct impact of traumatic events.

Based on the integrated model that reconciled and recognised the contribution of both daily stressors and traumatic or violence-related experiences, Miller and Rasmussen (2010) highlighted the need for a thorough investigation of important contextual daily stressors before designing an intervention, as a first step. Then, in the second step addressing the daily stressors before providing particular treatment for psychological trauma or distress. They argued that dealing with social and material needs would make it easy to identify people with specific psychological needs. In the third step, the psychological intervention aimed at alleviating multiple forms of psychological distress, including PTDS, resulting from war or violence-related experiences. Lastly, they stated that practitioners have to take note that not only war-related experiences contribute to experiences of trauma.

Miller and Rasmussen's (2010) model concurred with the earlier study of Bolton and Betancourt's (2004), on mental health in post-war Afghans. The study suggested satisfying social and material needs that would help to identify the special psychological needs of people whose psychological distress could not be reduced through the reduction of daily stressors.

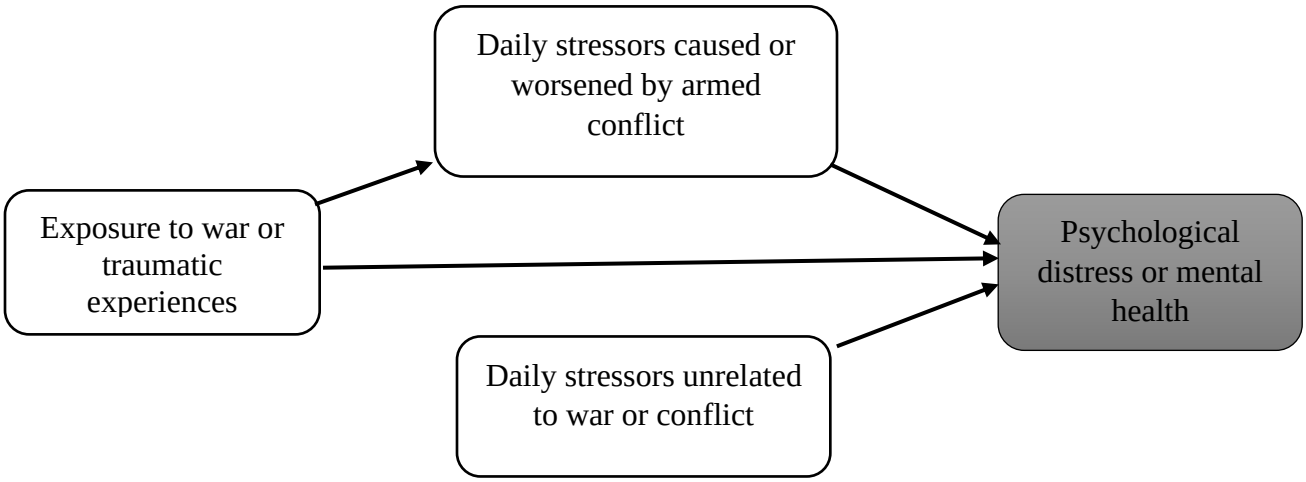

Figure 1: Note. Adapted from Integrated model of mental health outcomes among refugees and war-affected populations by Miller K. E and Rasmussen, A, 2010, *Social science & medicine*, 70(1), p. 9.

It is clear that the effectiveness of a mental health promotion intervention depends on how it is informed by cultural backgrounds and daily socio-economic stressors of refugees before addressing PTSD or other major psychological distress factors. This is, in line with the above, reviewed literature and the suggestion of a Transcultural Psychosocial Organization (Eisenbruch, de Jong & Put, 2004). This Transcultural Psychosocial Organization (TPO) developed a multidisciplinary, community-oriented and culturally sensitive mental health intervention to address the psychosocial problems of refugees and victims of organized violence (Eisenbruch, de Jong & Put, 2004). The authors outlined a 9-step protocol that they have termed a 'culturally competent psychosocial intervention'. In the protocol, they have underlined the participation of the beneficiaries in determining the priorities and using a culturally-based diagnostic method. The interventions are based on traditional, local and western healing systems. The TPO was used among South Sudanese refugees in Uganda and for internally war-displaced Cambodians (Eisenbruch, de Jong & Put, 2004).

2.12. Chapter Summary

The chapter presented extensive literature on refugees and mental health, starting with the global migration crisis and then narrowed the focus to encompass refugees in South Africa. The refugee theory (Kunz, 1981) was applied to explain the forced migration phenomenon. Then, refugee experiences and stressors at three stages of migration were outlined. In discussing mental health, first, its definition was clarified, and then mental health was explained using the perspective of health

promotion and an attempt was made to outline the determinants of refugees' mental health. Following this, the major psychological distresses, PTSD, anxiety and depression were presented. Then coping strategies, resilience and post-traumatic growth among refugees was discussed. Lastly, the chapter addressed the mental health promotion intervention among refugees and outlined the arguments between the two main intervention approaches, namely, the multi-model and trauma-focused approaches.

Chapter Three

Migration Stressors and Mental Health of African Refugees: A scoping review

3.1 Introduction

This chapter focuses particularly on the literature pertaining to mental health among African refugees in Africa. Apart from the research limitations pertaining to African refugees on the continent, mental health is also a much-neglected research topic in Africa. Atilola (2014) pointed out that mental health services and literacy among the general population in Africa is generally poor.

In light of the above, it is not surprising that mental health research among refugees is very scarce. Consequently, there is not a sufficient knowledge base upon which to anchor an understanding of the mental health needs of refugees and insights to inform the designing of appropriate interventions. There are, however, some studies in the literature, mostly from cross-sectional quantitative studies. Therefore, it is imperative to explore the current literature on mental health among African refugees in Africa. In this section, research studies that examined traumatic and migration experiences and mental health issues among refugees to understand the prevalence of psychological distress are reviewed. The importance of this review to the study is; firstly, to contextualise this study within culturally relevant studies from the continent, and secondly, to examine closely and to compare the level of psychological distress and migration stressors in order to develop appropriate guidelines for mental health interventions.

3.2 Studies Included in the Review

In this review, studies are included that explore refugees' traumatic and migration experiences and mental health outcomes at pre-, transit- and post-migration stages, examined the prevalence of psychological distress, coping strategies used and resilience. Further inclusion criteria are:

i) Studies completed in African countries among African refugees. It could be in refugee camps, urban areas, studies that included local population for comparison purposes are also included;
ii) Studies that examined at least one psychological distress.
iii) Peer-reviewed qualitative or quantitative or mixed methods studies; and
iv) Studies published from 1998 to 2018. Unpublished masters or PhD theses or conference papers are not included.

A total of 18 studies are included in this review. The studies are presented in three groups as per the research design, i.e. Quantitative, cross-sectional studies aimed at investigating the prevalence of traumatic experiences and psychological distress; quantitative studies that compared refugees' migration and psychological experiences with the hosting community to examine the psychological outcomes of migration experiences; and qualitative studies aimed at understanding refugees' experiences (See table 2 below). Therefore, presenting the review in three groups helps to achieve three main objectives; first understanding the prevalence of migration stressors and psychological distress, secondly, comparing the migration experiences and mental health outcomes with the host community who are not affected by migration stressors such as war and violence. Thirdly, qualitatively understanding the migration and mental health experiences of refugees. At the end of the review, a discussion on the methodological challenges and limitations of the studies is presented.

3.3 Quantitative Cross-sectional Studies: Migration stressors and Psychological distress

A total of 10 cross-sectional survey studies published between 2000 and 2018 were included. The studies involved, mainly, refugees from South Sudan, DRC, Rwanda, Burundi, Somali, Liberia, Sierra-Leone, Zimbabwe and others who comprised only a small percentage of the samples drawn. The studies examined refugees' pre- and post-migration experiences, traumatic events, refugee camp stressors, gender-based violence and the prevalence of psychological distress in particularly PTSD.

3.3.1 Pre-migration stressors among African refugees

Most of the refugees were from countries affected by civil war, war-related violence and socioeconomic difficulties. The most prevalent pre-migration traumatic events experienced by the participants include the murder of family members or friends, being close to death themselves, being in a combat situation, being kidnapped, suffering serious injuries, being forcefully separated from family, imprisonment, and being subjected to rape and sexual violence (Fox & Tang, 2000; Onyut et al., 2009; Rassmussen et al., 2010). For example, Somali and Rwandan refugees in Uganda reported that they witnessed dead or mutilated bodies (73.5%); injury with a weapon (67.37%), experienced shelling or bombing attacks (69.3%), experienced the burning of their house (60.2 %), witnessed or experienced crossfire or sniper attacks (60.3%), witnessed beatings or torture (59.1%), witnessed combat (50.9%), witnessed killing or murder (50.9%) and experienced harassment by armed personnel (48.7%) (Onyut et al., 2009). Furthermore, the study by Rassmussen et al., (2010), among South Sudanese refugees in Chad, found that 77 per cent of the participants personally experienced traumatic

events that included beatings, being chased from their homes and bombing, while more than 83 per cent of them also witnessed people being shot, chased and bombed. However, among Zimbabweans, the main pre-migration stressors were threats to their livelihood, e.g. trouble to get a job, have nothing to eat or to buy, hunger, threats to life, the death of a family member and economic hardship (Idemudia et al., 2014).

3.3.2 Transit- and Post-migration Stressors

These studies involved refugees residing in refugee camps that were characterized by poor living conditions and a wide variety of infectious diseases (Akinyemi et al., 2012; de Jong et al., 2000; Onyut et al., 2009; Rassmussen et al., 2010). Most of the time refugee camps are used as a transit point to further migration. Most refugees reported having lived in the refugee camps between 4 – 8 years (Akinyemi et al., 2012; Onyut et al., 2009). The study was undertaken by Onyut et al. (2009) among Somali and Rwandan refugees in the Ugandan refugee camp found the refugees to be under-nourished and about 94 per cent of them reported to be dependent on the UNHCR for food aid. They also reported eating little over one meal a day; only 5 per cent reported a variety in meals, e.g. inclusion of fish and meat in their food and experienced at least four separate physical illness episodes in the past month (Onyut et al., 2009). High safety concerns (97 %) and lack of basic needs (food and firewood) and money were reported as stressors among the refugees in a camp in Chad (Rassmussen et al., 2010).

Another study concerned refugees who resettled in urban areas in the host countries. The major post-migration stressors reported include poverty, unemployment, having no place to live, forced to leave family members and trouble with documentation (Idemudia et al., 2014; Thela, Tomita, Maharaj, Mhlongo & Burns, 2017). A study among female refugees from eight African countries in Durban, South Africa, reported lifetime traumatic events; unexpected death of someone close to them (72.26%), physical assault (52.87%), combat trauma (49.68%) and sexual trauma (4.2%) The participants also reported an unemployment rate of more than 50 % (Mhlongo et al., 2018). A disturbing prevalence of gender-based violence was also found among Somali and DRC women who lived in urban areas in Uganda (Morof et al., 2014). They reported a high rate of physical violence (76.2%), sexual violence (63.3%), forced sex (48.8%) and attempted sex (58.3%).

Table 2

*Description of the Articles reviewed***.**

	Quantitative Studies		Qualitative Studies
Study characteristics	**Cross-sectional (N = 10)**	**Comparative (N = 5)**	**Qualitative (N = 3)**
Hosting country			
South Africa	12, 16, 17, 18		9, 15
Uganda	6, 10, 13	1, 4, 5	
Nigeria		8, 14	11
Tanzania	2		
Chad	7		
Gambia	3		
Country of origin			
South Sudan	7	1, 4, 5	
Somali	6, 13		
Burundi	2,		15
Rwanda	2, 6		
DRC	10, 13,		15
Zimbabwean	12,		9, 15
Liberia		8	11
Sierra-Leon	3	8	11
Africans (more than three origin countries)	16, 17, 18	14	
Non-refugees (Uganda & Nigerian, South Sudan)		1, 4, 5, 8	
Population			
Refugees	2, 3, 6, 7, 9, 10, 12, 13, 16 - 18		
Refugees and Local		1, 4, 5, 8, 14	
Sample Size			
Less than 100	3,		9, 11, 15
100 – 200	12, 17		2
201 – 400	1, 16, 18		
More than 400	2, 6, 7, 10, 13	4, 5, 8, 14	
Sample Selection			
Convenient sampling (non-probability)	12, 16, 17, 18		9
Random sampling (Probability)	2, 3, 6, 7, 10, 13	4, 8, 14	
Purposive sampling			11

Note. A*rticles are numbered in table 3 chronologically on the date of publication*.

3.3.3 Prevalence and stressors associated Psychological Distress

Regarding psychological distress, there is a discrepancy in the prevalence of psychological distress reported in the studies. The challenge seems to be that the studies have reported either prevalence or the severity of psychological distress using different criteria across the studies. The prevalence of PTSD ranges from the lower rate of 24.9 per cent scored among African refugees in South African

(Thela et al., 2017) to a high prevalence of 71.1 per cent among Somali and DRC women in Uganda (Morof et al., 2014). Further, Somali and Rwandans refugee in Uganda scored a prevalence of 37.8 per cent for PTSD (Onyut et al., 2009), while, the study by Ssenyonga et al. (2013) in Uganda among refugees from the DRC, reported a high prevalence of PTSD (61.7%).

De Jong et al. (2000), reported that more than 50 per cent of the Rwandan and Burundians in a refugee camp in Tanzania were in serious mental health condition. The study particularly intended to identify refugees with serious cases for intervention and used stringent cut-off criteria, otherwise, the rate was between 26 and 74 per cent (95% CI) (de Jong et al., 2000). Overwhelmingly, the highest prevalence of depression (92% - with lower cut-off 1.75) was reported again among female refugees from Somalia and the DRC in Uganda (Morof et al., 2014), however, using stringent cut-off criteria of 2.65 the prevalence decreases to 54 per cent. Similarly, Fox and Tang (2000) who used the Hopkins Symptom Checklist-25, reported a high prevalence of anxiety (80 %, M = 2.49) and depression (85.5 %, M = 2.40) among Liberians and Sierra-Leonean refugees in the Gambia. Comparatively, using the same instrument, lower rates were scored among African refugees in South Africa with the prevalence of anxiety and depression at 49.4 per cent and depression at 54.6 per cent (Thela et al., 2017). This gap in the prevalence of psychological distress among refugees could be attributed to the context, i.e. refugee camps and urban areas of the hosting country. This shows the likelihood of context influencing the mental health of refugees. Another possible explanation, for the discrepancy in the mental health prevalence, could be the use of different instruments or using different cut-off measures for psychological distress.

Psychological distress of refugees is associated with pre-migration traumatic experiences and the deplorable refugee camp living condition (de Jong et al., 2000) and it is also attributed to persistent traumatic experiences even in the camp (Onyut et al., 2009). However, the studies have been inconsistent regarding the prediction of psychological distress, particularly PTSD. For example (Morof et al., 2014) and Ssenyonga et al., (2013) found traumatic experiences to account, mostly, for PTSD, and concurred with dose-effect theory. Similarly, Neuner et al. (2004) examined the dose-effect theory, using the data collected from South Sudan refugees and non-refugees, and local Ugandans. They found a linear correlation between the numbers of traumatic experiences and the increasing prevalence of PTSD. It means an increased number of traumatic events predicted increased prevalence of PTSD cases. Neuner et al. (2004), also indicated that various traumatic events explained a various number of

PTSD cases and the strong association between collective trauma and re-experiencing and avoidance symptoms of PTSD. Consistently, recent experiences and witnessing of traumatic events were found to be predictors of PTSD, where witnessing traumatic events was found to be a stronger predictor of PTSD than experiencing these (Karunakara1 et al., 2004). Karunakara1 et al. (2004) attributed that to the insecure refugees' environment and increased anxiety developed from the perception that something traumatic might well happen to them. This could well be the reason why witnessing traumatic events is such a strong predictor of PTSD.

Findings by Rassmussen et al. (2010) however, contradict those of the dose-effect theory, where the correlation between psychological symptoms and war-related traumatic experiences was small (range 0.19 - 0.20), while psychological distress and displacement stressors association were large (range 0.19 – 0.31) with large effect size. This means, above traumatic experiences, the post-migration refugee camp conditions (safety and basic needs) were found to be significant contributors to psychological distress. Similarly, the study by Maharaj et al. (2016) also found a significant association between the high prevalence of food insecurity and psychological distress (anxiety and depression) among African refugees in Durban.

However, Idemudia et al. (2014) found that collectively the Pre-migration stressors (threat to life, sexual abuse, and poverty) and post-migration stressors (sexual abuse, poverty) and psychological distress symptoms (Anxiety and Insomnia, and Social dysfunction) explain 41.2 per cent of the total variance of PTSD. The most significant predictors of PTSD, in order, are total stress, post-migration poverty, sexual abuse and social dysfunction (Idemudia et al., 2014). Other risk factors that were found to be associated with PTSD include being a female and experienced gender-based violence and having a low level of education (Morof et al., 2014; Ssenyonga et al., 2013).

Experiences of discrimination were also related to higher psychological distress, while separation from family was associated with a high risk of depression and PTSD symptoms (Thela et al., 2017), but not anxiety among African refugees in South Africa. In the study, participants who have lived in South Africa for less than a year showed higher rates of psychological distress. The authors concluded that refugees who came recently to the country at the age of 35 and older and have a history of family separation are at high risk of psychological distress (Thela et al., 2017).

The difference in prevalence across demographic characteristics was also reflected in some of the studies. Onyut et al. (2009) found that more men were distressed than women, and a higher prevalence

of PTSD was found among the Somali (48.1%) compared to their Rwandan counterparts (32%). The Somali were found to have experienced more lifetime traumatic events and traumatic events in the past year than the Rwandan refugees. However, Rwandan men scored a higher number of lifetime traumatic experiences, PTSD and depression (Onyut et al., 2009). Rassmussen et al. (2010) also reported that men showed higher depression symptoms than women in a sample of South Sudan refugees in Chad. However, Idemundia et al. (2014) reported no difference in pre- and post-migration stressors between men and women refugees from Zimbabwe, who migrated mostly due to the deplorable economic conditions mixed with state-organized violence. There was also no gender difference in the four sub-scales of GHQ (anxiety and insomnia, depression, social dysfunction and somatoform). They have also found only poor mental health, measured using GHQ, as a significant predictor of PTSD for women (Idemundia et al., 2014).

From the cross-sectional studies, two sampled only women refugees in the urban area. The study by Morof et al. (2014) among Congolese and Somali women refugees in Kampala, Uganda, found an extremely high lifetime prevalence of gender-based violence, depression and PTSD, as outlined above. PTSD was significantly correlated with a lifetime history of any violence (physical and sexual, at $p < 0.001$). Logistic regression analysis also indicated a 7.2-fold higher odds of PTSD symptoms for women with a lifetime history of physical violence and 3.8 fold higher odds of PTSD for women with a lifetime history of sexual violence. Similarly, the study among refugee women from eight African countries by (Mhlongo, Tomita, Thela, Maharaj, & Burns, 2018) found an association between higher traumatic experiences and higher risk post-traumatic symptoms. Furthermore, the study reported that the sexually traumatic experiences of the women were also strongly related to greater PTSD (Mhlongo et al., 2018).

3.4 Comparative studies: Migration Stressors and Mental health of refugees and local communities

Five articles included in the review involved refugees and host communities aimed at comparing refugees' war-related traumatic and refugee camp experiences and subsequent mental health outcomes within a population that is not affected by war, displacement or camp stressors. The comparative studies highlight the effect of traumatic experiences and poor refugee camp conditions on the psychological wellbeing of refugees. However, the five articles included here used three sets of data; obtained from children in South Sudan and Uganda (Paardekooper et al., 1999), from South Sudan

refugees in Uganda and war-affected South Sudanese non-refugees, and Ugandans (Karunakara et al., 2004; Neuner et al., 2004) and data obtained from refugees from Sierra-Leoneans and Liberians, and Nigerians as host communities (Akinyemi, Owoaje, Ige & Popoola, 2012; Akinyemi, Atilola & Soyannwo, 2015).

The study by Paardekooper et al. (1999) examined the psychosocial effects of war and consequent flight. The data was collected from South Sudan children, who fled the war and who were in Ugandan refugee camps and Ugandan children from the host community. The refugee children (N = 123, age = 7-12yrs) were compared with 80 Ugandan children of a similar age and cultural background but who did not experience war. The researchers found that these Sudanese refugee children had been exposed to a great number of experiences of trauma (torture, sexual abuse and separation from family) and daily stressors (lack of food, clothes and school material). The South Sudanese refugees were very often suffering from headaches, were nervous for no actual reason, behaved aggressively and ran away from home. Furthermore, they had more sleeping problems, traumatic memories, psychosomatic complaints, depressive symptoms and suicidal thoughts than the Ugandan children (Paardekooper et al., 1999). The study also examined coping mechanisms between the two groups. Common coping strategies used by the refugee children were wishful thinking and praying, as well as an emotional-inhibiting mechanism like 'keeping quiet' and 'blaming oneself' and /or used an emotion-focused strategy like spending time with others. However, the Ugandan children used shouting, crying and angry outbursts as ways of coping (Paardekooper et al., 1999).

Karunakara1 et al. (2004) on the other hand compared three groups, i.e. South Sudanese refugees (who fled the civil war to Uganda), South Soudan nationals who were living in the conflict zone in South Sudan and Ugandans who were living in a non-conflict environment. The study investigated the relationship between traumatic experiences and symptoms of PTSD among the three groups (Karunakara1 et al., 2004). The prevalence of past traumatic experiences, and within the last year, was significantly higher among the refugees than the non-refugees South Sudanese and Ugandans. The prevalence of PTSD symptoms among the refugees was more than 50 per cent, which was significantly different from Sudanese non-refugees (44 %, $p < 0.05$) and the Ugandans (21 %; $p < 0.001$). Furthermore, the study found that female refugees were significantly more likely to suffer PTSD symptoms than their male counterparts. These findings clearly showed the effects of war on mental health.

Karunakara1 et al. (2004) also reported that individual, household and migration variables explained 31 per cent of the variance for developing PTSD symptoms. The study reported a significant socio-economic difference among the groups, with the refugees more likely to be unemployed and to have insufficient food. The study also revealed that having an income and education emerged as protective factors from PTSD symptoms (Karunakara1 et al., 2004). Furthermore, PTSD symptoms were found to develop with increased witnessing of past traumatic events and within the last year. From the three groups, the refugees have experienced more traumatic experiences including robberies, extortion, beating and torture in the refugee camp under the security of UNHCR and Uganda government, while the South Sudan non-refugees who stayed in Sudan had a safer year.

Another comparative study by Akinyemi et al. (2012) found high mental health disparity between refugees and the local people in Nigeria. The study took place in Oru-Ijebu, Ogun State, south-western Nigeria, where the mental health disparities between the refugees (mainly from Liberia and Sierra-Leon) and local communities were examined. The refugees were found to be in poorer socioeconomic conditions without formal education compared to the local people. Refugees' overall quality of life and community quality of life was significantly lower from the local community. The major psychological distress reported among the refugees includes depression (45.3%), obsession (34%), PTSD (34%), mania (25.9%), alcohol abuse (19%) and suicidal ideation (11%). Refugees were also found to be three times more likely to have poor psychological/ mental health than the local community. The researchers reported that being a refugee was a singular factor for mental health difference between the communities. In another article, but using the same population, Akinyemi et al., (2015), reported a statistically significant higher prevalence of suicidal ideation among refugees (27.3 %) compared to the local communities (17.3 %). Even though they found social status and quality of life significantly poorer among the refugees, poor quality of life was the single predictor of suicidal ideation. These comparative studies showed, clearly, that refugees' mental health problems are much greater than the hosting communities as they are consistently exposed to migration stressors.

3.5 Qualitative studies: Lived experiences of African Refugees

Recently, researchers used qualitative studies to better understand the migration and psychological lived experiences of African refugees. Since 2013 three qualitative studies were published (Akinyemi, Owoaje, & Cadmus, 2014; Idemudia et al., 2013; Smit & Rugunanan, 2014). The studies included refugees from Sierra-Leone and Liberia hosted in Nigeria (Akinyemi et al., 2014), Zimbabweans in

South Africa (Idemudia et al., 2013) and Congolese, Burundians and Rwandese refugees in South Africa (Smit & Rugunanan, 2015).

Idemudia et al. (2013) explored the experiences of migration among homeless Zimbabwean refugees in Limpopo, South Africa. In the study, 20 refugees participated in two gender-based focus groups. The pre-migration stressors shared by the refugees include a lack of basic living needs, unemployment, and a lack of health services and politically motivated human rights abuses as the main pre-migration stressors that forced them to leave their homes. In their short-distance transit to South Africa, they experienced and/or witnessed physical violence, and threats, women particularly were forced to engage in 'survival sex' for food and water and to get assistance to cross the border (Idemudia et al., 2013). Regarding their experiences in South Africa, the participants shared their frustrations with the lack of economic opportunity to provide food and housing for themselves, and they found themselves in a similar situation as in Zimbabwe. In addition, they also experienced coercion when they do found employment and discrimination, particularly exploitation in terms of earning similar wages and payment for their work compared to local South Africans. The researchers stated that even though the participants openly described their experiences, most of them failed to acknowledge the psychological and emotional impacts of their difficult experiences. The researchers also found it difficult to discuss psychological distresses with the group. When the participants asked how they cope with daily stressors, they described different means including sex work, stealing and a few doing piecework/jobs (instant jobs for instant payment) like cleaning streets, washing dishes in restaurants, being a house servant and working on farms as labourers. For them, coping is equivalent to surviving on a daily basis. The homeless refugees did not mention any psychological or spiritual coping mechanisms (Idemudia et al., 2013).

In another study, in South Africa by Smit and Rugunanan (2014), the focus was on female refugees who fled the civil war in the DRC and Burundi, and Zimbabweans who fled deplorable economic conditions and politically motivated violence. The women had at least one child (1 – 5 children) and lived in the inner city of Johannesburg and Pretoria. The mothers' psychological distress included anxiety, fear, sadness, distress and frustration, which were found to be mostly related to their current post-migration stressors and near-future vision. The women were found to be in constant fear and distress due to insecure living conditions and lack of financial income to provide for themselves and their children. They were particularly worried about the wellbeing of their children and physical threats

such as crime and xenophobic violence. Secondly, the women shared their frustrating experiences with their attempts to obtain documents from the DHA, long over-night queues and the bribing of corrupt officials. For Congolese and Burundians not securing employment, and thus an income, was a source of distress. However, for Zimbabweans, as they can speak fluent English, they secured jobs but not those jobs that matched their professional backgrounds. Most of the women were disillusioned by the lack of safety and the deplorable conditions in South Africa and felt depressed for not being able to support their family. They also showed a sense of loss and sadness due to separation and losing ties with their families. A Congolese woman expressed her frustration for not being able to support her family financially. As she explained "*We are all like patients … in the same hospital. Who will help whom?* (Smit & Rugunanan, 2014; p.196), this showed their distress by not fulfilling what is expected of them.

Smit and Rugunanan (2014), explored the resilience of the women. The refugee women showed resilience and hope for the future despite their poor post-migration conditions. Smit and Rugunanan (2014) stated that even though it was difficult for the women to bounce back, their resilience, however, was seen as "*survival with impairment*," (p. 197), doing what they can do to keep their family together. This was also demonstrated by persistently asking and looking for assistance from individuals or organizations. Another way of coping was to make meaning from their existence based on their faith (thankful for being alive) and the presence of God in their lives. They also expressed their wishful-hope that their suffering might bring a better future for their children (Smit & Rugunanan, 2014).

Lastly, Akinyemi et al. (2014) explored refugees' experiences and understanding of mental health and quality of life among Liberia and Sierra-Leonean refugees in Nigeria. In the focus group discussions, the participants explained that they had a poor quality of life and mental health and described their poor quality of life as a major determinant of mental health. The poor post-migration quality of life emerged as a major explanation for their poor mental health outcomes and is consistent with the above two qualitative studies (Idemudia et al., 2013; Smit & Rugunanan, 2014). Their life was characterised by unemployment, poverty, unconducive living environment (poor housing and security), poor family structure and relationships, and discrimination in finding employment. Women described themselves as being more prone to mental health problems due to weighty family responsibilities and emotional vulnerability, men reported similar issues but mainly due to them failing to fulfil their role as breadwinners (Akinyemi et al., 2014).

3.6 Discussion

The participants in the studies reviewed represent African countries that were highly affected by civil wars in the past two decades: South Sudan; Somalia; the DRC**;** Burundi; Rwanda; Liberia and Sierra-Leone; while Zimbabwe has been known for economic deprivation and marred by organised violence. The results suggested that civil wars and organised violence are the main pre-migration stressors forcing African refugees to flee their countries to secure their life. The studies also showed various war, and violence-related traumatic experiences associated with psychological distresses, mostly PTSD symptoms, depression, and anxiety. However, deplorable refugee camp conditions and daily stressors also strongly explained poor mental health outcomes. The studies included in this review showed mixed findings that are consistent with the on-going global argument between the proponents of traumatic experiences and those of post-migration stressors as a major explanation for poor mental health outcomes. Most of the studies showed an increased prevalence of psychological distress, particularly PTSD, positively associated with an increased number of traumatic experiences.

The three qualitative studies involved refugees in different contexts; a refugee in a camp, homeless refugees in urban areas and refugees who live in inner metropolitan cities. The common finding is, however, is that they are all living in deplorable conditions characterized by poverty and insecurity that largely contributed to their poor mental health. The qualitative studies supported the post-migration daily stressors as being the main determinants of psychological distress.

Table 3

Forced Migration and Mental Health of African Refugees: Studies included in the review

	AUTHORS	HOST	PARTICIPANTS	DESIGN	INSTRUMENTS	FINDINGS
1	Paardekooper et al. (1999)	Uganda	Sudanese children (n = 123) in refugee camp and Ugandans (n = 80) Age = 7 -12	Quantitative **(**Comparative study) Cross-sectional snowball Sampling	• Trauma Event scale • Daily Stressors • KidCope (for coping) • Social support • Mental Health Assessment tool	Significantly more PTSD, DS and psychosomatic complaints. **Trauma** – refugees 28% tortured, 9% cent - sexually abused and 25.5% separated from family **Coping** - The refugees used an emotional-inhibiting mechanism like 'keeping-quiet' and 'blaming oneself' and emotion-focused (spending time with others. Ugandan children who used "yelling, crying and getting mad".
2	de Jong et al. (2000)	Tanzania	Rwandese and Burundians in a refugee camp (n = 854)	Quantitative Cross-sectional Random sampling & non-coping clients	• GHQ	GHQ-mean score is 13.6 (SD 8.0) in the random sample, and 19.4 (SD 4.3) in the non-coping sample. Approximately 50% of serious mental health problem (between 26 and 74% (95% CI).
3	Fox and Tang (2000)	Gambia	Sierra-Leone (n = 55)	Quantitative Probability sampling	• Harvard Trauma Questionnaire • Hopkins Symptom Checklist-25	**PTSD** - 49.1% critical symptoms (used critical cut-off 2.5, M = 2.56), **Anxiety** – 80% (cut-off 1.7, M = 2.49) **Depression** - 85.5% (M = 2.40).
4	Karunakara et al. (2004)	Uganda	South Sudanese Refugee (n = 1240), South Sudanese non-refugees (n = 664), and Ugandans (n = 1419) (Total = 3323)	Quantitative (**Comparative study** - Multi-stage sampling	• Checklist - migration and security histories • Post-traumatic Stress Diagnostic Scale (PDS) • Checklist for war & non-war related traumatic events	Refugees experienced significantly higher Traumatic events than their counterparts. PTSD - Refugee (more than 50%); Sudan non-refugees (44%), and the Ugandans (21%).

5	Neuner et al. (2004)	Uganda	South Sudanese Refugee in Uganda, South Sudanese and Ugandans (n = 3179)	Quantitative (**Comparative study)** multi-stage sampling	• Developed a Checklist for war & non-war related traumatic events, • Posttraumatic Stress Diagnostic Scale	Prevalence of PTSD - Sudanese refugees (50.5%), Sudanese nationals (44.6%), Ugandan (23.2%).
6	Onyut et al. (2009)	Uganda	1422 refugees from Somali (n = 516) and Rwanda (n = 906)	Quantitative Used two methods, for Somali – everyone in the camp above 12 years of age, for Rwandese cluster sampling	• Developed a 34 item Event Checklist, • PDS, • Hopkins Symptom Checklist 25	PTSD (37.8%) Most traumatic experiences; witnessing dead or mutilated bodies (73.5%), shelling or bombing attack (69.3%), witnessing injury with a weapon (67.37%), experiencing crossfire or sniper attacks (60.3%) and 6.02 % experienced burning of own house.
7	Rasmussen et al. (2010)	Chad	South Sudanese, Darfur Refugees in refugee camp (n = 848)	Quantitative Exploratory Simple random sampling	• Displacement stressors (developed via rapid ethnography) • PTSD checklist • Brief Symptom Inventory • World Health Organization's Disability Ass. Schedule • Assessment Schedule-Version II	Correlation between basic needs and safety concerns and psychological distress. Basic needs and safety concerns were more strongly correlated with Measures of distress than were war-related traumatic events.
8	Akinyemi et al. (2012)	Nigeria	Liberians and Sierra-Leoneans refugees (n = 444) in former refugee camp & Nigerians (n = 527)	Quantitative **Comparative study** Cross-Sectional Cluster sampling	• Mini-International Neuropsychiatric Interview (MINI) • WHO Quality of Life (WHOQOL) • Community Quality of Life	**Refugees** - 3X more likely than non-refugees to have poor mental health, **Psychological distress among refugees** - Depression (45.3%), obsession (34%), PTSD (34%), Mania (25.9%), Alcohol abuse (19%) and Suicidal ideation (11%)

9	Idemudia et al. (2013)	South Africa	Homeless Zimbabwean refugees (n = 20)	**Qualitative** Convenient sample, approached through NGOs and invitations	• Focus groups with semi-structured focus group interview guide	**Pre-migration** - lack of basic needs & unemployment, human right abuse **Transit-migration** - physical violence & involved in 'survival sex. **Post-migration** - lack of economic opportunity, discrimination, exploitation & coercion
10	Ssenyonga et al. (2013)	Uganda,	Congolese refugees in a camp (n = 426)	Quantitative Random sampling	• Post-traumatic Growth Inventory • CD-RISC and • PDS	High rate of PTSD (61.7%); Females = 58.6 per cent and male = 41.4 per cent Female gender, low education level, and trauma significantly predicted PTSD.
11	Akinyemi et al. (2014)	Nigeria	Liberians and sierra-Leoneans (n = 32)	**Qualitative** Purposive sampling	• Focus group discussion	Poor quality of life as a major determinant of poor mental health. Women - due to heavy responsibility and emotional sensitivity, Men - due to failure to fulfil their role as breadwinners
12	Idemudia et al. (2014)	South Africa	Homeless Zimbabweans in South Africa (n = 125)	Quantitative CRS Convenient sampling	• Pre- and post-migration difficulties checklists, • GHQ-28 • PTSD Checklist (Civilian Version (PCL).	Pre-migration factors (Threat to life, sex abuse, and poverty) and post-migration (sex abuse, poverty) and psychological distress symptoms (Anxiety and Insomnia, and Social dysfunction) have explained 41.2 per cent of the total variance on PTSD. Total stress, post-migration poverty and sexual abuse, social dysfunction as the main predictors.
13	Morof et al. (2014)	Uganda	Women from DRC and Somalia in an urban settlement (n = 117)	Quantitative CRS Stratified Random sampling	• Hopkins Symptom Checklist – 25 • Harvard Trauma Questionnaire	Physical violence (76.2%), Sexual violence (63.3%), Forced sex (48.8%), Attempted sex (58.3%) Depression (92%) and PTSD symptoms (71%)
14	Akinyemi et al. (2015).	Nigeria	African refugees (n = 444) and Nigerians (n = 527)	Quantitative **Comparative study**	• WHO Quality of Life (QOL),	Refugees scored higher suicidal ideation (27.3%) than the Local (7.3%).

				CRS - Cluster sampling	• Mini-International Neuropsychiatric Interview [MINI]	
15	Smit and Rugunanan (2014)	South Africa	Qualitative comparative study women from DRC, Burundians and Zimbabweans (total = 60)	**Qualitativ**e Not explicit	• Focus group (30 women from DRC and Burundi). • Interviews (4) Burundians, (6) Congolese and Zimbabweans (20).	Very low emotional distress and wellbeing characterised by depression, anxiety, sadness, fear and frustration
16	Maharaj et al. (2016)	South Africa	African Refugees (n = 335) (Above 95 per cent from Congo, Zimbabwe and Burundi	Quantitative Cross-sectional convenient Sampling	• Food insecurity tool • Hopkins Symptoms checklist-25	Not having enough food (23.1%) Eating less (54.3 %) Anxiety (49.4%) and Depression (54.6 %) Not enough & eating less significantly associated with anxiety and depression
17	Mhlongo et al. (2018)	South Africa	157 refugees from Zimbabwe, DRC, Rwanda, Burundi, Uganda, Ghana, Malawi and Mozambique	Quantitative Cross-sectional Convenient Sampling	• Harvard Trauma • Questionnaire (HTQ), • Life Events Checklist (LEC)	Most common traumatic experiences [unexpected death of someone close (72.26%), physical assault (52.87%), combat trauma (49.68%) and sexual trauma (24.20%)] have a strong association with PTSD
18	Thela et al. (2017)	South Africa	Africa 335 refugees from 8 African countries	Quantitative Cross-sectional Convenient Sampling	• Hopkins Symptom Checklist-25 • (HSCL-25), Harvard Trauma Questionaire-30	Anxiety (49.4%), depression (54.6%) and PTS symptoms (24.9%) Recent comers at an older age (35 & above), experiences of discrimination are more at risk of Psychological distress.

3.6 Methodological Challenges and Limitation

The researchers mostly used self-developed checklists to measure pre- and post-migration experiences, for example, the checklist for war and non-war traumatic events (Karunakara et al., 2004; Neuner et al., 2004; Onyut et al., 2009) and the Pre- and Post-Migration Difficulties Checklist (Idemunia et al., 2013). However, for assessing psychological distress, most of them used instruments developed in western cultures such as the Harvard Traumatic Questionnaire (Fox & Tang, 2000; Morof et al., 2014), Stress Diagnostic Scale (Karunakara et al., 2004) and PTS Diagnostic Survey (Idemunia et al., 2014; Onyut et al., 2009; Rasmussen et al., 2010). Another instrument was the General Health Questionnaire (GHQ) (de Jang, 2000; Idemunia et al., 2014) and the Hopkins Checklist (Fox & Tang, 2000; Morof et al., 2014; Onyut et al., 2009). These are multi-cultural instruments widely used to measure psychological distress across cultures. Only one study (Ssenyonga, Owens & Olema, 2013) attempted to examine resilience and Post-Traumatic Growth using the Conner-Davidson Resilience Scale (Connor & Davidson, 2003) and Post-Traumatic Growth Inventory (Calhoun & Tedeschi, 2006) respectively.

The most challenging part with the quantitative studies using instruments developed in western cultures is that they might not be sensitive to African perspectives of mental health. For example, Bogic et al. (2015) has reported that from the 29 articles they reviewed about 80 per cent of them used self-reported questionnaires developed in line with western models even though more than 86 per cent of the samples were from non-western cultures (Bogic et al., 2015). There is a high suspicion of the insensitivity of these instruments when used with multi-cultural refugees. In this regard, several studies argue that there is a difference between African perceptions of mental health and western symptomology of psychological distress (Delbar et al., 2010; Slobodin & De Jong, 2015). For example, the UNHCR publication *Culture, context and mental health of Somali refugees* stated that there are differences between psychiatric terminologies and Somalis' traditional concepts regarding mental health and distress (UNHCR, 2016). Similarly, Molsa et al. (2010) found a difference in traditional Somali conception and practices related to mental health problems and healing.

This seems to remain a key challenge for most studies in this field. Therefore, it is clear that there is a great need to develop measurement instruments based on African perceptions of psychological distress or to adapt the existing instruments for use among Africans in the African context.

In addition, different instruments are used to measure the same psychological distress, for example, the *Hopkins Symptoms Checklist* and the *General Health Questionnaire*, are commonly used to measure depression and anxiety. However, studies also have adopted different cut-off points on the scales. As a result, the results are inconsistent across studies and this also makes it difficult to compare the results.

Relevant to these limitations is that the above studies are used to investigating PTSD in particular, but also to investigate depression and anxiety. Only Akinyemi et al. (2012) reported other psychological distresses (obsession, mania, alcohol abuse and suicidal ideation) among refugees in Nigeria. Other psychological distress and mental disorders have not yet been explored. This might be due to the lack of exploratory studies with a deeper insight into the different mental health issues of refugees. But almost no attempt has been made to understand the coping mechanisms used and PTG of African refugees in the continent

Further, the quantitative studies are mainly cross-sectional. The surveys conducted in the refugee camps used probability sampling to select participants. It can be said that representation was attempted, and the list of refugees in the camp made this possible. However, in urban areas, researchers used convenience sampling, as no list could be found. However, the cross-sectional nature of the data undermines the credibility of the findings. The main problem with data collected using the cross-sectional design is that it can be biased due to different personal and situational conditions at the time of collection, particularly in a refugee camp where the conditions are stressing. Collecting data on more than one occasion would have yielded better information. However, there is no longitudinal or mixed methods study to remedy the shortcoming of collecting data once at a particular time. Refugees are highly mobile people; still, short-term longitudinal studies would have been manageable as most of the studies reported refugees to have lived in the camps between 4 to 8 years.

Regarding, the qualitative studies, two studies (Akinyemi et al., 2014; Idemudia et al., 2013) used focus group discussions to generate information, which might have compromised the disclosing of personal experiences. However, Smit and Rugunanan (2014) applied the focus group method and conducted one-on-one interviews so that one approach can compensate for the weakness in the other. Therefore, this study used a mixed-method design in order to fill this methodological gap that exists in the reviewed studies.

The major limitation of this review is the inclusion of different articles that made use of the same data sets to answer different research questions. This stems directly from the fact that an inadequate number of studies are available that address migration experiences and mental health outcomes among refugees. Therefore, the information from similar samples is limited and does not provide an adequate overview of these aspects. In addition, refugees are not a homogeneous group and different aspects, e.g. cultural orientations and practices are likely to influence refugees' coping strategies and in turn, the impact of migration experiences on their mental health.

3.7 Chapter summary

The chapter reviewed research articles that examined migration stressors, traumatic experiences and psychological distress among African refugees. In this review, 18 manuscripts were included, ten cross-sectional quantitative studies, five comparative quantitative and three qualitative studies. The major traumatic experiences are as a result of war and violence. Consequently, a high rate of PTSD was found among the refugees. Refugees also lived in extremely poor conditions in refugee camps that exposed them to further traumatic incidences, including violence. The studies supported both arguments, i.e. traumatic experiences and post-migration stressors, including poor refugee camp living conditions and insecure and impoverished urban settlements, as the main determinants of mental health. There is a discrepancy in the reporting of psychological conditions, and thus the extent of psychological distress largely attributed to the use of different measurements and cut-off criteria. In conclusion, the scarcity of studies pertaining to the mental health of refugees and the methodological limitations are highlighted in this review.

Chapter Four

Theoretical Framework – Bioecological Theory

4.1. Introduction

In this chapter, the bioecological theory of Bronfenbrenner is presented in terms of its historical evolution and the four concepts of the model: Process-Person-Context-Time, followed by the use of theory in mental health promotion among refugees. First, a brief discussion on the importance of theory to scientific study is presented.

4.2. Importance of a Theory in a Research Study

The role of a theory in a scientific study is very important in understanding particularly the multi-dimensional and interdependent societal issues that influence our daily activity and health. Metaphorically, a theory can be seen as a prism through which not only insight can develop, but connections among phenomena can be explained. The main purpose of a theory in a study is, according to Tudge, Mokrova, Hatfield and Karnik (2009), to provide a framework for research to gain insight from the phenomena. Furthermore, in a qualitative study theory is used to communicate the findings, while in quantitative research, the theory provides an explanation of findings and associations among the variables of the study (Tudge et al., 2009, p. 198). Neuman (1997) concurs with the above statement and outlines the main use of theory as providing basic concepts, and it directs us to the important questions. It suggests ways for us to make sense of research data and also connects the new study with literature and knowledge in the same field. Furthermore, Tudge et al., (2009) explained a theory as "*a representation of reality … providing researchers with a common scientific language and guiding empirical studies in such a way as to allow findings from different studies to be evaluated with a common rubric"* (p. 198). Thus, an empirical study also seems to test the accuracy and congruency of a theory, mostly in deductive studies, besides generating new information (Goldhaber, 2000; Neuman, 1997). Several scholars are of the opinion that in a study, there must be a tight connection between the methods used, the analysis applied and the theory of the study (Goldhaber, 2000; Guba & Lincoln; 1994; Tudge, 2008). Thus, in the section below the theoretical framework for this study, the bioecological theory is discussed in detail.

4.3. The Bioecological Perspective of Bronfenbrenner (1975 - 2005)

This study used Bronfenbrenner's bioecological theory as a theoretical framework to understand the migration and mental health experiences of African refugees in Durban, South Africa. The theory is also utilized in developing guidelines for mental health promotion interventions for this group of refugees. Bronfenbrenner (1917 – 2005), is known as a "*reflective and self-critical*" theorist, who engaged for three decades in developing, reassessing and noting the change of the bioecological theory (Tudge, 2009, p. 199). Bronfenbrenner bioecological theory was first introduced in the 1970s in response to what the author stated as *"the restricted"* views of most studies that were being conducted by developmental psychologists (Bronfenbrenner, 1994, p. 37). In the 1970s, Bronfenbrenner named the emerging theory as "the *ecological approach or ecological model*", and he meant by ecological approach ''*how environments change, and the implications of this change for the human beings who live and grow in these environments*'' (Bronfenbrenner, 1975, p. 439). He explained the ecology of human development as "*a scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts within which the settings are embedded* (Bronfenbrenner, 1979b, p. 21).

He was arguing that human development could only be understood ecologically by examining the interrelations between the developing person and the changing ecological systems and criticized other studies that did not use this approach as being out of context (Bronfenbrenner, 1979). However, his theory evolved after the 1970s of a more contextual perspective toward human development to the stage where the individual's role on his/her development is considered and emphasized as much as the context. Tudge et al. (2009), reviewed the theory's continued state of development since its conception until the death of the author, Uri Bronfenbrenner, in 2005. Through this extended period, it moved from a predominant focus on the contextual factors to its mature stage of the proximal process (Rosa & Tudge, 2013). Rosa and Tudge (2013, p. 244) stated that the theory had shown a major change of development *"... between its inception and its final state*". Thus, in using the theory, they warned, that the researchers should have to be clear and they should state upfront which version of the theory they are applying, instead of referring to the theory in general, when they used only a partial or old version of it (Rosa & Tudeg, 2013). Tudeg et al.

(2009), for example, analysed 25 research publications that claimed to be based on the Bronfenbrenner's ecological/bioecological theory or approach. However, only four articles were found to be using the fully mature form of the theory. The authors concluded that, even though there is no problem using the older version or some segments or concepts of the theory, researchers need to communicate this explicitly to the reader to avoid what they termed 'theoretical confusion'. They further argued that if studies failed to represent the theory appropriately, it is possible that two kinds of damage can result. One is a misrepresentation of a theory that misleads readers on the constructs of the theory. And secondly, researchers would be restricted in the testing of the theory; hence important contributions and improvements to the theory would be missed (Tudge et al., 2009).

The '*developed form*' of the theory, which this study incorporated, explains how the proximal processes and personal characteristics, contexts and historical time mutually influence the outcomes and behaviour. These processes thus became the central aspect of the theory, rather than earlier versions that largely focus on contextual influences on the developing person (Rosa & Tudge, 2013, p. 243). The '*developed form'* of the theory clearly outlined the interrelations in the Process-Person-Context-Time (PPCT) model (Tudge et al., 2009).

In understanding the migration experiences and mental health outcomes of refugees, the theory gives an insight into ways in which the war-related traumatic events or events that encourage forced migration, affect the outcome of mental health. Based on the theory, the mental health of an individual is an outcome of a process of reciprocal interaction with the event (which can be seen as time) and with individual characteristics of the refugee, and the environment (the remote and immediate context where he/she lives). The personal characteristics of a refugee could range from primary characteristics that stimulate initial interaction like age and gender; to cognitive and emotional characteristics like intelligence, skill, social support; temperament and motivation of the individual. The proximal processes are thus progressively reciprocal in the interaction of the individual with people and things in the immediate environment, and the context includes the extended sphere of influence ranging from the microsystem, i.e. family support to the macrosystem, i.e. cultural values and associated meanings. In the following section, the four components of the theory are discussed, as explained by Bronfenbrenner in the developmental study. The model is displayed in figure 2.

4.3.1 Process

At the later stage of the theory's development, from the 1980s, Bronfenbrenner explained human development as a process. He referred to the '*process*' as an explanation of the connection between some aspect of the context or some aspect of the individual and an outcome of interest. The proximal process features in two propositions that specify the defining properties of the theory. The first proposition states "… *throughout the life course, human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects and symbols in its immediate environment"* (Bronfenbrenner & Morries, 2006, p. 797). He called the process a "*Proximal Process*" and to be effective, he stated, it depends on how often the interaction occurs … "*must be for [an] extended period of time and on a fair[ly] regular basis*".

The second proposition identifies the four sources of these dynamic forces (Bronfenbrenner & Morries, 2006, p. 798), stated as "th*e form, power, content, and direction of the proximal processes effecting development vary systematically as a joint function of the characteristics of the* ***developing person***, ***the environment****—both immediate and more remote— in which the processes are taking place, the* ***nature of the developmental*** *outcomes under consideration, and the* ***social continuities and changes*** *occurring over time through the life course and the historical period during which the person has lived".*

Based on the above propositions, the mental health of a refugee is thus an outcome of the complex reciprocal interactions between the progressively developing individual (him-self/herself), and people, things and symbols around him/her. For this complex interaction or the '*proximal process*' to impact on the mental health - either positively or negatively – depends on the duration and whether it is happening on a regular basis or not. The difference on mental health outcomes among individuals, even among refugees who experienced these kinds of traumatic experiences, is a consequential result of the systematic variation in proximal process that resulted from a joint interaction of the individual characteristics, of the environment, nature of the development outcome (could be the accumulation of experiences) and events in time (war, traumatic events or economic depression).

4.3.2 Person

Bronfenbrenner emphasized the personal characteristics of the individual that are viewed prominently in social situations (Bronfenbrenner, 2005). However, he also did not undermine the importance of the biological and genetic aspects of human development. He divided personal characteristics into three categories, known as forces, resources and demand characteristics.

The Force characteristics: the characteristics of the person are mostly influenced by behavioural dispositions that either sustain or prevent the proximal processes. Bronfenbrenner and Morris (2006; p. 810) distinguished these dispositional characteristics as ***developmental generative*** and ***developmental destructive***. The former characteristic involves active orientations such as curiosity, a tendency to initiate and engage in activities, alone or with others, responsiveness to initiatives by others, and readiness to defer immediate gratification to pursue long-term goals. The developmental destructive characteristics include impulsiveness, explosiveness, distractibility, inability to defer gratification, and difficulties in maintaining control on the one hand and on the other hand there could be apathy, inattentiveness, unresponsiveness, a lack of interest in the surroundings and feelings of insecurity, to mention but a few. Individuals with these kinds of characteristics find it difficult to interact in proximal processes that require complex reciprocal interactions. Thus, individuals play different roles in how they interact with their environment, depending on the force characteristics. The individuals who respond or play an active role in changing the environment applying generative characteristics are highly likely to accommodate changes (stressors) and adapt. They are, as a result, less vulnerable to mental health problems. However, those with destructive characteristics are either ineffective or passive (less responsive) to changes and are highly likely to be exposed to psychological distress.

Resources characteristics are personal characteristics that "… *constitute biopsychological liabilities and assets that influence the capacity of the organism to engage effectively in proximal processes*" (Bronfenbrenner & Morris, 2006, p. 812). The assets are known as sources of a progressively complex interaction that extended the domains in which proximal processes can do their constructive work. These are knowledge, skills, abilities, intelligence, and experiences. In the liability category are conditions that limit or disrupt the functional integrity of the organism. Some obvious examples include genetic defects, low birth weight, physical handicaps, severe and persistent illness, or damage to brain function through accidents or degenerative processes. Among

refugees, skills, social abilities and educational background are positively associated with mental health, while persistent physical illness increases the likelihood of psychological distress.

Demand characteristics are characteristics used as an immediate stimulus for initial social interaction, for example, age, gender, skin colour and physical appearance. The characteristics are distinguished from the others by their ability to invite or discourage social interaction that can promote or interrupt psychological growth. These characteristics are known to influence initial interactions due to the expectations formed immediately on contact (Bronfenbrenner & Morris, 2006). From the demand characteristic, the effect of gender on mental health is well studied, even though there are inconsistent findings. Some studies have reported that women are more at risk for PTSD (Karunakara1 et al., 2004; Morof et al., 2014). However, Rassmussen et al. (2010) and Onyut et al. (2009) found that more men were distressed than women. Further, Idemundia et al. (2014) reported no difference in general psychological distress between men and women Zimbabwean refugee in South Africa.

4.3.3 Context

The environment, or context, involves four interrelated systems that conceptualize the environment from the person's perspectives. In the model, the ecological environment is conceived "… *as a set of nested structures, each inside the other like a set of Russian dolls. Moving from the innermost level to the outside*" (Bronfenbrenner, 1994, p. 39). The structures are the microsystem, the mesosystem, the exosystem and the macrosystem. The **microsystem** is the most immediate environment such as family, school, or peer group and workplace, in which the person spends a good deal of time engaging in activities and interactions. In this setting, activities take place in face-to-face interactions (Bronfenbrenner, 1979b). For refugees, direct experience of violence, torture, losing family members or friends, lack of the ability to satisfy basic needs, and language difficulties are microsystemic factors that can influence their mental health negatively. On the other hand, strong family support, individual therapy, acquiring skills, and safety can also ameliorate psychological distress.

The **Mesosystem** refers to the interrelationship between two or more microsystems in which the person actively participates or various settings that surround the individual or in which the individual is directly involved. For example, interactions between family demands and workplace

stressors (Bronfenbrenner, 1979b). In this situation, losing familial community and the kin support system impacts on mental health negatively. However, rebuilding those structures, facilitating interaction of refugees with the new social environment or building a support system can positively influence mental health. The third circle of the ecosystem is the **exosystem.** This refers to interactions between two or more settings within the larger social system of the immediate environment, in which the person is not situated or actively involved but is influenced indirectly by those forces and events—for example, a child's relation between the home and the parents' workplace. Influential factors involved here include employment of spouse or parent and access to public service; either way, they influence the mental health of refugees. **Macrosystems** refers to cultural beliefs and values that include but are not limited to belief systems, bodies of knowledge, material resources, customs, and lifestyles that influence both the microsystem and the exosystem. The influence of the macrosystem on other ecological settings, as Bronfenbrenner (1979a), stated, can be traced back to or reflected in how the lower systems (e.g., family, school) function. Because of those predominant belief systems or ideologies, people from the same societal or socioeconomic background tend to have similar daily experiences. Migration and integration combine as macrosystem factors that can influence the daily life and mental health of refugees. For example, a policy that allows integration of asylum-seekers with close family or communities from the same cultural background, and a migration policy that assist refugees in accessing health care, education and other services while their asylum process is ongoing. Furthermore, at a macro level, to avoid discrimination and conflict among refugees and locals, media campaigns can be used to raise awareness in the wider community or at a national level.

4.3.4 Time

Time included in the PPCT model is an extension of the earlier concept that Bronfenbrenner termed as chronosystems. The model emphasizes the importance of time on the developing person and encompasses change over time in the characteristics of the person and of the environment (Bronfenbrenner, 1997a). Bronfenbrenner (1999, p.20) stated that ''*The individual's own developmental life course is seen as embedded in and powerfully shaped by conditions and events occurring during the historical period through which the person lives*''. In his late publication, co-authored with Morris, the concept of time is modified as having three levels: microtime, mesotime and macrotime (Bronfenbrenner & Morris, 2006). Microtime refers to ''*continuity versus discontinuity in ongoing episodes of proximal process*,'' while mesotime refers to the occurrence

of these episodes across wider time frames such as days and weeks, and macrotime ‘‘*focuses on the changing expectations and events in the larger society, both within and across generations*’’ (Bronfenbrenner & Morris, 2006, p. 796). The war and violence-related traumatic events that forced refugees to flee from their home countries are the events and conditions denoted in the time component. Continued exposure to stressors (war) for an extended period of time is highly traumatic and mentally devastating.

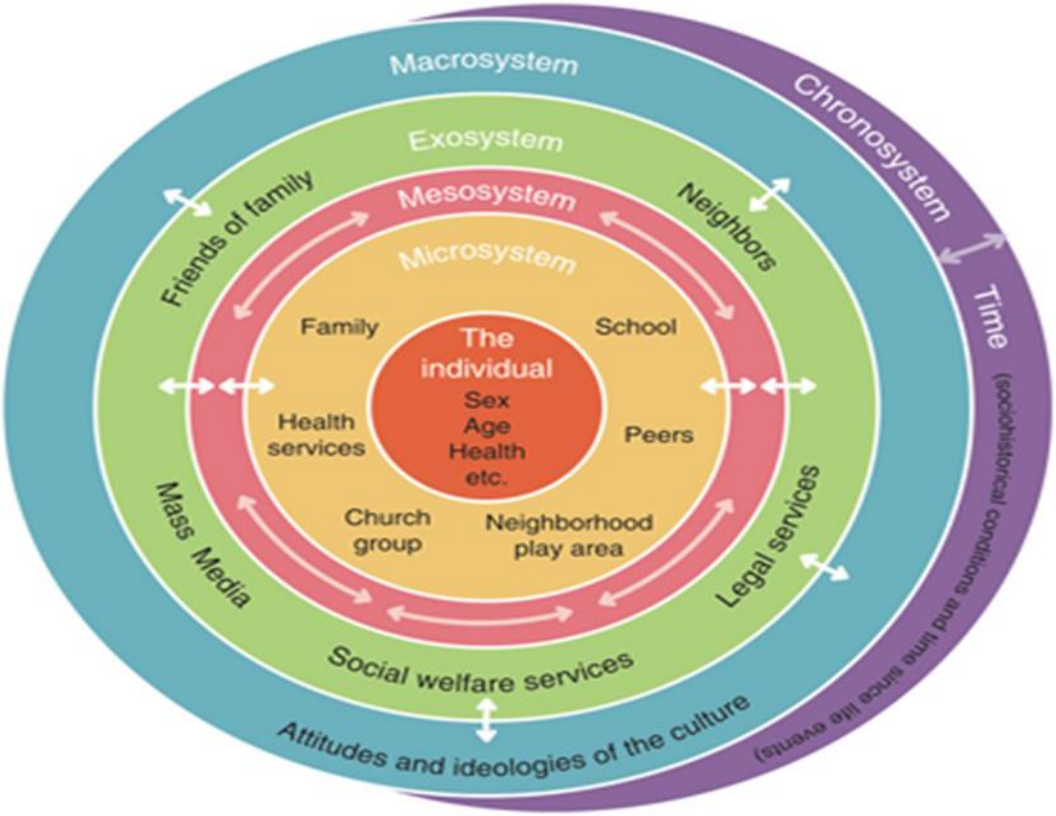

Figure 2: Bioecological Model (Bronfenbrenner, 1999)

4.4 Application of the Bioecological Theory

Originally placed within the field of early childhood development, the bioecological theory has been used by researchers across various disciplinary interests to analyze peoples’ relationships between and within particular contexts. For example, in recent years, the ecological systems theory has been widely used across disciplines such as in sport psychology (Krebs, 2009), social

marketing communications (Dibb et al., 2013) and workplace wellbeing (Bone, 2015). Furthermore, it has also been used in analyzing the resilience of victims to natural disasters (Boon, Cottrell, King, Stevenson, & Millar, 2012), and Betancourt, Meyers-Ohki, Charrow, and Tol (2013) used the theory in a review aimed at providing an overview of psychosocial and mental health interventions intended to address mental health needs of children affected by war. The review included 40 peer-review studies where most of them were school -focused interventions (Betancourt et al., 2013).

Bioecologically the mental health experiences of refugees can be explained as an outcome of the reciprocal interaction among the components of the theory. As outlined above, the major life-changing events, in a lifetime, could be war and violence-related or other major socioeconomic events that encourage forced migration that consequently affects mental health. These major life-time events impact on the refugees' mental health in any or all of the three stages of migration outlined earlier. The persistent occurrence of such evens or change over a wider time duration, and interaction with the personal characteristics and contextual factors (the proximal processes), may explain the increasing and decreasing severity of psychological distresses among refugees.

On the other hand, the effectiveness of a mental health intervention that intends to promote mental health among the refugee communities would need to consider various factors that would ensure the synergy of the bioecological components. In this regard, the theory is used to understand factors that contribute to the mental health promotion among groups of individuals. For example, understanding individual enabling characteristics, recognizing and enhancing existing family networks (microsystem) and integrating and maximizing the potential of community structures such as church and supporting networks (mesosystem) and advocating for favourable migration and integration (macrosystem) policy that would help to enhance mental health among individuals. Furthermore, in a post-migration context, understanding the events (stressors) that could affect the mental health and identifying alternative solutions, e.g. to a xenophobic event.

Most studies on forced migration and mental health among refugees focus on the traumatic events or generally forced migration-inducing events to explain the mental health outcome of refugees. The other components of the bioecological model are rarely considered in understanding the psychological distress among refugees. The personal characteristic can play a central role in

determining mental health outcomes. Generative characteristic such as the tendency to initiate and engage in activities alone or with others and responsiveness to initiatives by others are enablers for positive mental health outcomes, while destructive characteristics such as difficulties in maintaining control and being inattentive, unresponsive, lack of interest in the surroundings could expose individuals to psychological distress. The personal characteristics also include assets such as skills, abilities, intelligence and liability such as severe and persistent illness, or brain damage that may facilitate or limit mental health, and age, gender and race also play a role in mental health. Similarly, there is an influence of contextual factors in mental health. For example, the influence of family, social networks and support, host communities' attitudes and reactions, discrimination and violence, unemployment, language difficulties and migration policy as well as a lack of access to public services including health services are all important contextual factors.

This study used the theory to understand the migration experiences of African refugees. Similarly, it was used in developing guidelines for mental health promotion intervention. Therefore, it helps to understand the personal characteristic, contextual supporting and restricting factors and their reciprocal interaction in explaining the outcomes. The theory also magnifies the importance of the components of the bioecological theory by including the interaction between personal and contextual factors in conjunction with the events in the explaining of mental health outcomes. An intervention can enhance personal characteristics and contextual factors to strengthen refugees' interaction in the proximal processes or directly minimize the effects of stressors or reduce them. The mental health of a refugee can be promoted by increasing their ability to cope by developing better coping mechanisms and resilience, to affect the proximal process for their own advantage positively.

From the perspective of health promotion, mental health is an integral part of health, a state of well-being that includes physical and socioeconomic health (WHO, 2005). Similarly, health promotion as a discipline and model sees health from an ecological perspective that advances the social, institutional and cultural context of people-environment relations for the betterment of mental health. In other words, health is a product of the interaction between individuals and the systems around them, including family, community, culture, and physical and socio-economic

environment. Therefore, the mental health of refugees can be promoted best when these ecosystems are optimal and enabling for health and socioeconomic growth.

4.5 Chapter Summary

This chapter presented the bioecological theoretical framework by Bronfenbrenner (1917 – 2005), as the theoretical basis for this study. The importance of a theory in a research study is outlined first, followed by the development of this particular theory over 30 years of research. A critical discussion of the usage and misrepresentation of the theory by studies using partial or older versions of it was presented. Then the main components of the theory, namely, the proximal processes, personal characteristics, contexts and events in time were outlined. The discussion also addressed the two propositions of proximal processes, the personal characteristics categories, known as forces, resources and demand characteristics, and also the four structures or systems of the context (environment), namely; microsystems, mesosystems, ecosystems and macrosystem were outlined. Lastly, the application of the theory to this study was indicated.

Chapter Five

Methodology

5.1 Introduction

In this chapter, an outline of the methodology used for the study will be presented. The first aspect that will be presented is the study design and rationale for using a mixed-method design, i.e. a sequential exploratory mixed-method design. First, the qualitative study, namely a descriptive phenomenological study, is argued for, followed by sampling strategy and data collection procedures. Then the philosophical argument behind the step-by-step descriptive phenomenological analysis for psychology adopted by Giorgi (2005) is presented. This is followed by the approach to the instruments adaptation method, and the steps followed were presented in detail. In the quantitative method, a cross-sectional design is used. The relevance of the design is presented, followed by sampling, the instruments used and the data collection procedure. Lastly, the analysis techniques applied are discussed.

5.2. Mixed Methods

Social science research is a complex area that involves multiple factors such as biological, personal, interpersonal, psychological, sociological and political perspectives that are likely to play a role in influencing a phenomenon (Creswell, Klassen, Plano-Clark, & Smith, 2011; Sommer Harrits, 2011). This study broadly addresses forced migration and mental health that involves multiple factors. To unpack those multi-determinants, a mixed-methods approach that employs rigorous qualitative research in exploring subjective meanings and understandings of constructs and rigorous quantitative research examining extent and frequency of constructs is, therefore, most suitable in this case (Creswell et al., 2011). Johnson, Onwuegbuzie, and Turner (2007) reviewed 19 definitions of mixed methods by prominent researchers in the field, Creswell's definition is used for the purpose of this study:

> *"... a research design (or methodology) in which the researcher collects, analyses, and mixes (integrates or connects) both quantitative and qualitative data in a single study or a multiphase program of inquiry"* (Johnson et al., 2007; p.119).

Furthermore, a mixed-method research design emphasises a pragmatic approach to the problems under investigation and uses all approaches available to derive knowledge and understanding of

the problem (Creswell, 2009). Hence, in this study, a mixed-method approach is used for the purpose of triangulation (to compensate for some limitations in the qualitative method by including elements of the quantitative method) and to complement the information by elaborating and clarifying the results from one method with the results from the other method (Gray, 2014; Johnson et al., 2007).

Therefore, in this study, the combination of the strengths of each method is explored to understand the migration and mental health experiences as well as the coping mechanisms employed, and resilience displayed by African refugees in South Africa. Hence, a sequential exploratory mixed-method strategy was employed that requires firstly a qualitative data collection and analysis phase followed by a second phase of quantitative data collection and analysis that builds on the results of the first qualitative phase (Creswell, 2009). It should be noted that the sequential exploratory mixed-method design is often used when relatively little or nothing is known about the study phenomenon (Gray, 2014). As the migration and mental health experiences of refugees in South Africa has not received the attention it deserves, the main purpose of utilising this design was initially to explore the migration experiences of refugees and to understand their explanations and descriptions of mental health experiences qualitatively. Qualitative data collection was followed by analysis that also informed the next quantitative phase aimed at expanding the initial qualitative results using a much larger sample as outlined in Creswell et al. (2011). Thus, this study combined elements of both approaches for understanding and for substantiating study outcomes in terms of both depth and breadth (Johnson et al. 2007). The integration of data occurred when the analysis from the initial qualitative phase informed the data collection of the second quantitative phase of research. In this research, an instrument for measuring defencelessness of refugees was developed from the qualitative data analysis. Furthermore, results were also integrated to draw a conclusion. A more detailed discussion of the qualitative and quantitative designs used for the study is presented below.

5.3 Qualitative Study

Qualitative methods (inductively) allow for the exploration of previously unknown processes and provide explanations of why and how phenomena occur, and the range of their effects (Pasick et al., 2009). Nieuwenhuis (2007) refers to qualitative research as research that attempts to collect rich descriptive data to understand a particular phenomenon or context from which the

phenomenon arises. The focus is thus, on individuals or groups, and on a deeper understanding of their world and constructions of their experiences and the different meaning attached to these experiences (Nieuwenhuis, 2007). In this study, a phenomenological design is used to describe the lived experiences of migration and mental health issues; meanings and essence of migration experiences among African refugees (Moustaka, 1994).

5.3.1 The Descriptive-Phenomenological Method

A descriptive phenomenological approach was used in this study to understand and analyse the research problem. The philosophical foundation of phenomenology as a method of qualitative inquire is based on the philosopher and founder of the approach, namely Edmond Husserl (1859-1938; Creswell & Tashakkori, 2007; Giorgi, 2008). Husserl designed the phenomenological method for philosophy in studying conscious phenomena in a rigorous and systematically scientific way (Georgi, 2008). Husserl argued that the focus of philosophy is on human consciousness and human existence, and he proposed consciousness as the point of departure for phenomenology (Georgi, 2005). Husserl reasoned that anything that has to be dealt with in the world is through consciousness which for Husserl (1977), synthesizes experience through its intentional acts toward objects that are both sensorial and purely mental in origin. To understand the consciousness in its purest form, despite its nonphysical characteristics, he designed a method he called the *phenomenological reduction*. This implies that past knowledge concerning the phenomenon of interest should be put aside, and secondly, what is presented to consciousness should be seen without the automatic positing of existence that also normally takes place (Georgi, 2005, 2010).

Husserl's' method of phenomenology is best known through the concept of *"ephoche"* (Husserl, 1998), which means *"bracketing or suspension"* that is a methodological practice in phenomenological qualitative inquiries. Husserl (1965, p. 18-19), defined phenomenology as

> "*..a science, a system of scientific disciplines. But it is also and above all denotes a method and an attitude of mind…*"

Davidson (2003, p. 96), explained the importance of *epoche* or bracketing as a method

> "*…to understand experience on its own terms we must understand it in its own terms, and for this purpose, we place in phenomenological ''brackets'' our usual notions of causality.*"

When using the ephoche in a phenomenological study, it does not mean one has to forget totally previous knowledge about the phenomena, however, in order to see the phenomena at hand in a new dimension the researcher has to bracket or suspend previous knowledge and views that underpin existing attitudes (Englander, 2016). Phenomenological reduction helps the researcher to explore the pure existence of the object and to refrain from saying that it exists in the way that it presents itself to us. Husserl strongly recommends firstly to investigate the phenomena presented thoroughly before relating the experiences to other previous relevant experiences and knowledge gained in other ways (Giorgi, 2005). In other words, a researcher must concentrate on what is given about the phenomenon, and the explanation about the phenomena has to be based on what is given.

5.3.1.1 The Descriptive Phenomenological Method in Psychology

Even though most phenomenologists argue that their method is based on Husserl's philosophy of phenomenology, there are substantial differences among the different approaches used by researchers (Colaizzi, 1978; Creswell, 2007; Giorgi, 2008; Giorgi, Giorgi & Morley, 2017). This study employed the descriptive-phenomenological-psychological method adopted by Giorgi specifically for psychology from the Husserlian philosophy (Georgi, 2005, 2008, 2010).

In his book, Georgi (1985) explained the necessity of shifting phenomenological philosophy to phenomenological psychology as

> "*phenomenology to be helpful to psychology, must not remain just a philosophy; it must be expressed in a way that makes it proximately helpful to psychological praxis, and that would be the meaning of phenomenological psychology as a human science rather than phenomenological psychology as a subfield of philosophy*" (Giorgi, 1985, p. 46-47).

In this regard Broome (2011, p. 6) stated that phenomenology, as a method of inquiry for psychology, includes "irreal or non-physical" objects in its analyses, is

> "*… the investigation of consciousness through the examination of its actions upon objects that it takes without positing the origins of the objects*".

In other words, phenomenological psychology, according to Drummond (2010, p. 159),

> ''*. . . is a descriptive science that takes as its subject matter the intentional directedness of consciousness to the world*.''

Concurring with the philosophy of Husserl, Giorgi (2010) argued that '*phenomenological reduction*' is the first assumption one has to consider when embarking on descriptive phenomenological psychology as study design. Consistent with Husserl's philosophy, Giorgi's phenomenological reduction means firstly that the researcher has to resist

> "*… positing as existing whatever object or state of affairs is present.*"

But considers what is given

> "*... as something that is present to the consciousness and refrains from saying that it actually is the way it presents itself*" (Giorgi, 2010, p. 4).

In other words, phenomenological reduction refers to the action by the researcher to suspend any judgment on the phenomena being studied, i.e. to 'bracket' their own assumption/s about the phenomena being studied. Secondly, the researcher has to refrain from using the 'non-given' existing knowledge, attitudes or perception to account for whatever phenomenon is being studied (Giorgi, 2010). Therefore, Giorgi underlined that phenomenological reduction in a psychological study is of paramount importance. He further argued that any analysis that does not adopt phenomenological reduction could not be considered as phenomenology (2009, p. 98). In order to contextualise the method in psychology, Giorgi (2010), recommends that a researcher adopts a humanistic approach, a

"*… special sensitivity toward the phenomenon being investigated*" (Georgi, 2010, p. 5).

In this study, the phenomenological reduction is undertaken, and then during analysis, a psychological perspective is assumed. This is further explained in the data analysis section.

Giorgi's method is so far the best known descriptive phenomenological approach in psychology that adapts the approach from philosophical to psychological thinking. However, as mentioned earlier, there are other approaches to descriptive phenomenology, for example, Colaizzi's (1978) approach is widely known in health sciences research rather than in psychology (Morrow, Rodriguez, & King, 2015). However, both approaches are similar in many ways. They unequivocally agree that 'phenomenological reduction' is the underlying principle that involves bracketing of any preconceptions or prejudices about the phenomenon for the purpose of understanding and developing insight into the essence or essential meaning of the experiences under investigation. The process is a necessary preparation for deriving new knowledge (Schmitt,

1959). Husserl argues that bracketing is possible through intensive work and commitment (Husserl, 1965). However, Colaizzi (1978) recognise the impossibility of total bracketing (as cited in Morrow et al., 2015). Colaizzi developed a distinctive seven steps of descriptive phenomenological analysis (Colaizzi, 1978), while Giorgi limited the analysis to five steps, that are discussed in detail in the analysis section below. One of the two steps is an extension of the third step in Giorgi's approach but placed as a separate step in Colaizzi's approach. It involves placing identified meanings under common themes. In this step, the meanings are organised into themes of similar experiences that can be grouped into emerging themes (Colaizzi, 1973). The last step demands returning to the participants or sub-group for verification – participants have to verify whether the exhaustive description captures their experiences or not. The exhaustive description has to integrate all related information from the experience of the participant in the phenomenon. Hence, Colaizzi sees returning to participants for verification as a necessary step. However, this step of Colaizzi is controversial and is criticised even by Giorgi (2006). In his criticism, Giorgi underlined the difference between the researcher and participants' perspectives of a phenomenon, the former from the phenomenological perspective and the later from a 'natural attitude'. Therefore, there is an inevitable difference of perspective between them.

5.3.2 Sampling and Selection of Participants

Sampling, according to Nieuwenhuis (2007), refers to the process used to select a portion of the population for study. Several researchers agree that qualitative research is generally based on non-probability and purposive sampling rather than probability or random sampling approaches (Coyne, 1997; Nieuwenhuis, 2007). In qualitative research, the small sample size is generally purposively selected on the basis that they are information-rich cases. Further, purposive sampling is used when particular people, events or setting are chosen because they are known to provide important information that could not be gained from other sampling methods (Maxwell, 1996). The researcher thus exercises a degree of judgment about who would provide the best perspectives on the phenomenon of interest and invites these participants into the study. Bernard (2002) stated that the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of their knowledge and experience. One or a few individuals might be requested to act as guides to a group. The sample size may or may not be fixed prior to data collection, but it most often determined by the data saturation principle. It also depends on the resources and time available to the researcher (Nieuwenhuis, 2007).

The study participants were 14 African refugees. The study participants were both men and women, 18 years of age and older, who were refugees or asylum-seekers who resided in Durban, South Africa. Most of the participants, eight, were recruited from the Refugee Social Services (RSS) in Durban. RSS is an NPO that offers different social services such as basic assistance (food, accommodation and medical care for the venerable), language training, counselling, child protection services and self-reliance activities that promote integration and independence among refugees. The other six participants were the researcher's personal acquaintances. The researcher had good background knowledge of each participant prior to the interview as he was an activist for refugees' rights and a volunteer at RSS. Detailed information is shared regarding the position of the researcher in the study below.

5.3.3 Interview schedule

It should be noted that phenomenology is a qualitative research design that aims to collect the actual descriptions of experiences that participants themselves have lived through or experienced (Giorgi, 2010). The role of the researcher during the interview is thus to listen attentively to the experiential description provided by the participants and to promote more descriptions where necessary (Giorgi, 2010). This relationship between the researcher and participant, where the researcher does not have to '*know what to look for'* while it is assumed that the participant does not necessarily know or understand why or how something functions (Giorgi, 2010).

A semi-structured interview guide for this study was developed based on a literature review and on a phenomenological approach. The guide was piloted, and some follow-up questions were considered after the pilot interview. Therefore, the initial question to the participants was a very simple opening question to describe their experiences as it happened to them. In this study, participants were asked to describe their experience of migration and mental health in different stages, for example; "Can you please, as much as you can, describe what your situation was like in your home country before you decided to leave?" or "What are the factors that made you decide to leave your home country?", "Can you please describe your migration journey?" "What were the most stressful experiences you have witnessed or experienced in your home country and during migration?" "How do you describe your psychological and emotional experiences during your migration, i.e. while at home, in transit and in South Africa?" and "How were/are you dealing with your experiences?". These kinds of questions allowed the participants to explain their experiences

and in a particular context and how these impacted on them either positively or negatively. Through this process, relevant background information was provided to the researcher. This also implied that the participants have the power to make decisions and the verbal capacity to inform the researcher about the various aspects that are important to them and how they relate to the issues in meaningful ways (Giorgi, 2010). Giorgi et al. (2017), stated that the lived experience of the participant is the main interest of phenomenology and so

> "… *precisely how the experiences are lived need to be described by the experience*r" (p. 178).

Giorgi (2010) summarised the role of the two in a phenomenological study when he stated

> *"… the researcher does not have to ask about everything in the participant's life that might be of importance, but rather the participants make the decisions about where to start and what to include based on his or her own experience of what is important to him or her and excludes what is no*t" (p. 125),

And this provides rich data for the research as participants' descriptions differ in many ways, and what is important to one might not be to another.

Thus, the follow-up questions were not purposefully '*leading*' in the sense of trying to '*pull out'* particular information from the participant but rather to 're-open the door' to an aspect of the account that was presented but not fully and expressly described by the participant. For example, this interviewing technique is used as follows: 'When you spoke about this experience, you said …. such and …. such, can you share or elaborate more on this?'

5.3.4 Data Collection and Procedures

A gatekeeper letter was obtained from the RSS management to recruit and interview some of their clients. Ethical approval for the study was sought and granted from the Human and Social Sciences Ethics Committee (HSSEC) of the University of KwaZulu-Natal. Before the interview participants were informed about the aim and objectives of the study, in detail, in the language they understand. An explanation was given about the reasons why they were selected as participants of the study. They were assured that their names and information they share would not be divulged in any way as to identify them and that it would remain confidential with the researcher. The participants were assured of their anonymity when it came to reporting on the data. In this regard, numbers were used instead of names in the result section. The participants were also informed that participation

was voluntary and that they were free to withdraw from the interview process at any given time without any negative consequences. They were also informed that no rewards would be given for participation. However, basic refreshments were given during participation. Permission to audio record the interview was also requested from and granted by each participant. The participants were also informed that, should they experience any distress or emotional disturbance during the interview process, they may stop the interview and seek psychological support. A prior arrangement had been made with the counsellor at RSS to provide support to the participants should they require such support. Those who agreed to take part in the study signed an informed consent form in which the above matters were also clearly communicated in the languages they understand, i.e. the aims and objectives of the study, the confidentiality and anonymity of the information provided, the voluntary nature of participation and rights to withdraw from the study at any point in time, as well as their consent to tape-record the interview. The interview process only started once the participants were clear about all aspects of the study and satisfied with the answers. The informed consent form is attached as Appendix 3.1.

Furthermore, the participants were given a document with the contact details of the researcher, supervisor and an administrator at the HSSRC office for any further enquiries regarding the study or if they wanted debriefing after the interview. The participants were also encouraged to approach the counsellor at RSS should they so desire after sharing personal experiences. However, most participants preferred to be debriefed by the researcher, and some explained that the interview process had brought some emotional relief.

Most of the interviews were conducted at the RSS board room at a convenient time for the participants. A few interviews were conducted in churches, and one was at the workplace of the participant during quiet time as they could not close their business. Another interview took place in a park. Two of the participants were willing to come to the office of the researcher at Howard College Campus of UKZN for their interviews as they were familiar with the place. Most of the interviews were conducted in English – nine interviews. However, with participants who are not fluent in English, interviews were done in their preferred languages, three in Swahili and two in Tigrigna. Social work field workers at RSS were hired, one male and one female, as interpreters for the Swahili interviews, permission was also sought and granted from participants to use an

interpreter. The interpreters' mother tongue is Swahili, and they are fluent in English and had several years of experience in the fieldwork that includes interpretation as part of his job. However, he was briefed on the interview process and familiarised with the research questions' guide of the study. Two interviews were completed in Tigrigna, the mother tongue of the researcher so that there was no need for interpreters. The total number of participants and interviews conducted were 14, and most of the interviews were approximately one hour long.

During the interviews, two participants went through emotional trauma as a result of describing the traumatic events they had experienced and witnessed. The participants were told that it was not necessary to talk about those experiences. The interview had to be stopped to allow them time to compose themselves. The participants were reminded about their rights as participants to withdraw or not to talk about those particular troubling experiences. They were also reminded that they could see a counsellor that had been arranged beforehand. One of them, who works as an interpreter and lay counsellor in the community for RSS, decided to talk about her experiences. During the debriefing, she revealed that talking about her experiences was a relief and had worked as a coping mechanism. However, the second participant preferred not to talk about the experience further but decided to continue with the rest of the interview. Both preferred to be debriefed by the researcher instead of going to a counsellor. The researcher as a refugee activist and volunteer working with refugees have good access to and rapport with the refugee communities, and closely monitored the participants in particular and showed readiness to listen to them if they wanted to talk. The position in this research and the role of the researcher in the community is further discussed below.

My position as a Researcher and Refugees' Human Rights Activist

A researcher must always be aware of his or her position as a researcher during an interview and throughout the entire study. This is particularly true when applying a descriptive-phenomenological design. In my case, this demanded 'bracketing" of personal experiences, perceptions, and assumptions. As a researcher, a refugee and as a refugee activist/volunteer I constantly had to remind myself that I had to remain the researcher, i.e. mostly a listener during interviews and to suspend my experiences and assumptions as a refugee during data analysis and throughout the study. Furthermore, bracketing is a way to ensure the validity of data collection and analysis and to maintain the objectivity to the phenomenon (Ahern, 1999; Speziale, Streubert, &

Carpenter, 2011). I tried to achieve that position to my best ability, but the experience of suspending personal knowledge and experiences was not an easy task, particularly for a novice researcher in a phenomenological research study. However, as a refugee and an activist, I have good access to the refugee community in Durban South Africa and has built a good rapport with many of them.

In 2015, there was an eruption of xenophobia in KwaZulu-Natal. I was a master's student at that time. I have been actively participating in programmes and interventions aimed at resolving xenophobic issues. Since then, I have worked with organisations and even at a personal level, to build social cohesion among the local South Africans and African migrants. I have been advocating for the human rights of refugees. I have also used my educational skills to develop a psychosocial support programme to address the needs of recently arrived young refugees. I am therefore privileged to be familiar with the refugee community, have easy access to them and to be in a position to have developed a good rapport with them. Some of the participants in this study are my comrades in activism for social cohesion and human rights of refugees. Others know me as a volunteer in RSS - facilitating a psychosocial support group for youth who have recently fled their countries to South Africa. A few from this group also participated in the study. After the interviews, I did personal follow-up interviews with these participants to ensure that they get the psychosocial support they need and have access to counselling services should they so desire. The contents of these interviews were not included in the study.

5.3.5 Data Analysis

Giorgi (2009) stated that, as a method, descriptive-phenomenology involves only the participants' candid perspectives, in order to offer insight into the lived-context of the participant. Therefore, the method does not allow the abstraction of the participants' perspective during analysis. However, it enables the researcher to retain the 'voices' of the participants in the research. The interest of the researcher is thus, mainly in the subjective-psychological perspectives of the participants (Giorgi & Giorgi, 2003; Giorgi, 2007). The data is a description of participants' experiences from the perspective of everyday life and their natural attitudes and beliefs. The researcher assumes a phenomenological-psychological attitude involving sensitive awareness of the psychological aspects during data analysis. As such, it is not only the 'reactions' and 'behaviours' that are included in the data, but also the thoughts, impressions, feelings,

interpretations, and understandings of the participants' experiences that are analysed. Data analysis started when the interview was transcribed, and the transcribed data was considered as 'empirical evidence' for psychological meaning (Giorgi et al. 2017).

Below are the data analysis method in five steps, as outlined by Giorgi (2010, 2017). The steps are accompanied by the philosophical explanation based on Husserl's phenomenological philosophy.

1. The first step requires, *reading the entire transcribed description for a sense of the whole*. In this first step, the researcher has to read the description in order to get a sense of the whole description. Therefore, no further step has to be taken before getting the sense of the whole data. Appropriate analysis can happen as Giorgi et al. (2017) indicated when the researcher knows the end of the lived experience of the participant.

2. In the second step there is the *adoption of an open or unspecified attitude in the phenomenological psychological (scientific) reduction* process. Here, the researcher takes the objects within the description as phenomena

> "*... or simply objects that present themselves to the consciousness of the experiencer*" (Giorgi et al., 2017, p. 186).

To assume a phenomenological attitude implies thus performing

> "*reduction and ephoce (bracketing)*" (Giorgi, 2007, p. 64).

By reduction, the researcher does not posit the object or state of affairs present to the consciousness but rather takes it as it presents itself to the participant (Giorgi et al., 2017). Giorgi elaborated on the researcher's role pertaining to the principle of reduction as

> "*… to refrain from positing the existence of the given, ... assumed simply as something present to one's consciousness without affirming that it exists in the way it presents itself*" (Giorgi, 2007, p. 64).

The phenomenological-psychological perspective also involves 'bracketing' of everyday knowledge to allow for a fresh look at the data, i.e. the researcher suspends, to the best of his or her ability, previous presuppositions, theoretical, cultural, experiential knowledge, even past experiences of the same phenomenon (Giorgi, 2010). As Giorgi (2008) stated, one must explore a

current experience/phenomenon first before associating it with previous similar or relevant knowledge that is gained in different ways.

3. The third step is to *delineate meaning units.* In this step, the researcher rereads the data from the beginning, assuming a phenomenological-psychological attitude with the intention of differentiating unities from a phenomenological-psychological perspective. While reading, if a transition in the 'meaning of attitude' is sensed in the description, it is marked to establish meaning units. Giorgi et al. (2017) stated that determination of meanings is the concern of phenomenological analysis; therefore, the partition of the lengthy descriptions is based on meanings. Thus, individual descriptions were demarcated into meaning units that indicate a shift in meaning in the description. Doing this also makes the data manageable. Meaning units are written in the third person to eliminate confusion as they are basically participants' descriptions and not the researcher's (Giorgi, 2007). This is acquired only after getting the sense of the substance of the whole data. However, delineating meaning units (Giorgi, 2009), is not absolute, as different researchers could delineate different meaning units for the same description. Here, the different meaning units are just marked without judgment or interrogation, and only the difference is acknowledged. However, each meaning unit is interdependent and cannot exist on its own, and Husserl refers to them as "*moments of structure*" (Giorgi et al., 2017, p. 186). As more familiarity develops with the data, initial meaning units can be combined with or further separated from such units. There is no rule that stipulates that one has to retain them.

4. At this stage the meaning units are transformed into more psychologically sensitive statements using an '*Imaginative variation'* which is a technique postulated by Husserl (Giorgi, 2009), and used to differentiate the essential part of the description from the non-essential that is contingent (Giorgi, 2010, 2007). Giorgi (2007, p. 64) summed up the meaning of imaginative variation as

> "…. *one imaginatively varies different aspects of the phenomenon to which one is present in order to determine which aspects are essential to the appearance of the phenomenon and which are contingent*".

The use of imaginative variation requires the researcher to '*intuit and transform'* the lived experiences shared by participants into language that highlight the psychological meanings experienced by the participant. This means translating the implicit to an explicit description. Therefore, the original descriptions of the participants are changed into expressions to understand more directly the psychological meanings of their descriptions. At this stage, the description

employed a more psychologically sensitive expression. When doing this, the researcher assumes the '*psychological sensitivity*' towards the data to '*locate and elucidate*' the psychological meanings from the data (Giorgi, 2009; Giorgi et al., 2017).

The second purpose of this process is to

> "*generalize the meanings so that integration with other descriptions that may be very different becomes more feasible'* (Giorgi, 2017, p. 187).

In this way, the expressions become more generalised in their meanings that facilitate integration with other descriptions which were different initially.

Here the employment of imaginative variation is very important to differentiate the qualities of the description as psychologically essential or accidental. Then, after reviewing the psychologically sensitive expressions, essential structures of the experience are written with the help of imaginative variation. That makes the results more stable to communicate (Giorgi, 2017).

5. In this last step, *the transformed meaning unit expressions are used as the basis for describing the psychological structure of the experience*. The transformed psychological structures are not free from the context and are parts of the whole structure. The general, whole psychological structure is formed by the interdependence of each of the transformed structures with others, i.e. the researcher can see the shared meanings of the participants pertaining to their general psychological expressions. Then the outcome of the analysis is the assembled psychological structures in a descriptive paragraph which is the general descriptive psychological structure.

Thus, the data collected through interview with participants were analysed based on the above steps. The quantitative method applied is outlined in detail below.

5.5 Quantitative Study: Cross-sectional Survey

The main purpose of using a quantitative approach is to generalise from a sample to a population so that inferences can be made about some characteristic, attitude, or behaviour of the population (Babbie & Mouton, 2001). A cross-sectional quantitative survey design enables a researcher to collect information that describes, compares or explains knowledge, attitudes and behaviour of the participants at a particular point in time (Gray, 2014; Myers & Hansen, 2006). Further, the use of a cross-sectional survey in this research was appropriate as respondents' self-reported experiences,

beliefs and behaviours were the interest to gain a better understanding of the relationships between the specific variables as suggested by various authors (Myers & Hansen, 2006; Neuman, 2006). Thus, the design was used to examine the extent and prevalence of migration stressors, and psychological distresses as well as the resilience of refugees. Further, the study sought to examine the association between migration stressors and mental health of refugees throughout the migration journey (pre-, transit-, and post-migration phases). Furthermore, as a correlational study (de Vaus, 2001), the analyses focused on comparing refugees' responses and on accounting for variation between responses to specific variables in terms of variation between others.

5.5.1 Sampling

The study used a non-probability convenience sampling method. Convenience sampling is appropriate for the study as it allows the researcher to collect data from members of the refugee population who are available and accessible, as suggested by Sekaran (2003). Hence, participants from the target population were chosen because of their convenience and availability (Babbie, 1990). In addition, this approach is more convenient, less costly and not likely to result in the disruption of the population (Babbie, 1990). However, convenient sampling is not without disadvantage, as a non-probability sampling method, the selected samples are not representatives of the population and findings are restricted, i.e. cannot be generalized to the population as a whole. This shortcoming of the sampling method was addressed by attempting to increase representation, by reaching out to communities from several African countries. In this study, African refugees and asylum-seekers who were 18 years of age and above at the time of the study, who lived in Durban were eligible to participate in the study. A total of 220 respondents were recruited; however, 195 completed questionnaires (more than 88 %) were used for analysis. Even though the intention was to recruit up to 300, the length of the questionnaire, the time factor and lack of resources were a constraint in attempting to reach this goal. The motive for 300 samples was based on the assumption that 300 and more samples would make the data relevant for more statistical analyses, further, in a quantitative study the larger the number of the sample is the more the study can be representational and generalised (Pallant, 2011). The detailed description of the recruitment and selection of respondents is outlined below after the measurements are discussed.

5.5.2 Measurements

This section outlines first the process of translation and adaptation of the instruments used in this study. The measures were translated into Swahili and French as many of the refugees are from East and Central Africa, where Swahili and French are dominant languages. Thus, the respondents were requested to complete either an English, Swahili or French version of the questionnaire.

Adapting Instruments

Most of the instruments used in this study were developed in Western cultures; therefore, adapting the instruments to an African context and using languages appropriate for the participants was of paramount importance. Several researchers argue that adapting an instrument to a target language and culture is a complex process that demands careful planning to attain psychometric suitability and general validity of the instrument (Borsa, Damásio & Bandeira, 2012; Pena, 2007). Thus, a widely recommended guideline was followed to translate the instruments used in this study from English to Swahili as well as French (Beaton, Bombardier, Guillemin, & Ferraz, 2000; Borsa et al., 2012; Hambleton, 2005). Further, there is an advantage in adapting instruments, rather than developing new instruments for a particular context. First, findings from adapted instruments can be compared across different cultures and contexts, and secondly, generalisations can be made, and differences can also be examined (Borsa et al., 2012; Hambleton, 2005). Swahili and French are widely spoken in central and Eastern Africa where most of the refugees in South Africa come from. However, first, the English versions were paraphrased to adapt them to simple local expressions. For data collection Swahili, English and French questionnaires were used. Below is a brief explanation of the adaptation process followed to translate the questionnaires.

When there is a need to use an instrument for a new culture and language, that is different from the original one, an adaptation of the instruments is necessary as Beaton et al. (2000, p. 3186), stated to

> "… *reach equivalence between the original sources and target versions of the questionnaire*".

To achieve an equivalence between the original source and target language, in addition to the language translation cultural adaption of the items is necessary to maximise the validation of the instrument (Beaton et al., 2000). Therefore, Beaton and colleagues (2000) and Borsa and colleague

(2012), suggested a guideline for 'cross-cultural' adaptation - a process that tries to attain equivalence between the original instrument and targeted language and culture. They developed the guidelines after an extensive review of studies on cross-cultural adaptation, mainly psychological, medical and sociological studies (Beaton et al., 2000; Borsa et al., 2012).

This study applied the guidelines developed by Beaton et al. (2000) to adapt the instruments used in this study. The adaptation process involves each item, instructions for the instrument and alternative response adaptations. Further, they also argue that these processes do not guarantee psychometric properties of validity and reliability of the instruments as variation in cultural elements do not facilitate this (Beaton et al., 2000). The following steps outlined below were followed in translating the English versions of the instruments to both Swahili and French.

Stage one – Forward Translation involves two separate forward translations from the original language to target language by bilingual translators. Here, a literal translation of items is not recommended; however, adaptation must consider balancing linguistic, cultural, and discipline information (Tanzer, 2005; Borsa et al., 2012). Having two translators, with sufficient subject matter, allowed the researcher to note unclear wording in the original and comparison of the two works. For this purpose, two PhD candidates in the school of Applied Human Sciences who were originally from the Democratic Republic of Congo (DRC) were tasked with this role as they are both fluent in English (both wrote their master's thesis in English). Swahili is their mother tongue, and French is an official language in the DRC, and they are fluent in it. They both translated the instruments independently from English to Swahili and French.

Stage two – Synthesis of the Translation - at this stage, two versions of the translated instrument existed that required synthesis by involving both translators in the process of comparing and discussing the differences in wording and expressions in order to reach consensus. At this stage, the primary aim was to compare the versions with the original instrument in terms of "*their semantic, idiomatic, conceptual, linguistic and contextual differences"* (Borsa et al. 2012, p. 425) to develop the final instrument. The translators compared and discuss the differences in wording and expressions and reached consensus on a final version. Measures taken to resolve issues were recorded, and a synthesised version was developed

Stage three – Back translation. A translator who did not know the purpose of the instrument was assigned to translate the synthesised Swahili and French translations back into English. This process allowed the researcher to check whether the translated versions reflected the same item content as the original instrument and contributed to validity checking, particularly, the linguistic equivalence (Bornman, Sevcik, Romski & Pae, 2010). A lecturer and researcher in a research institution in the School of Social Science, originally from DRC and fluent in the three languages, was assigned with the task of back-translation. The process helped to identify inconsistencies in wordings and expressions between the original and translated versions, through this process validity of the translated version could be maximised. The researcher was also often in consultation with the translators to follow-up on the adherence to the outlined guidelines of the translation process.

Stage Four – Expert committee – the main purpose of this group is to combine a pre-final draft from the translated versions for a professional assessment. This group could include experts in the field of study, language professionals, researchers and if feasible, the instrument developers (Acquadro et al., 2008). However, in this study, the researcher, the supervisor and the translators reviewed the translated versions and reached agreement, in cases where opinions differed it was resolved through discussion. This group was required to make important decisions at a semantic, idiomatic, experiential and conceptual level to reach congruence. Idiomatic equivalence assures the functionality of the instrument for the target culture (Bornman et al., 2010; Pena, 2007) and this was assured by providing commonly known cultural expressions in parenthesis for some items.

Stage Five – Test of the Pre-final version involves piloting the pre-final questionnaire among a small number of people from the sample population. The questionnaire, for this study, was piloted among 15 refugees - five questionnaires from each version. The respondents self-reported the questionnaire, and then they were interviewed and encouraged to share their understanding on the different items and the corresponding instruments or to identify items which were ambiguous or conceptually unclear when they completed the questionnaire. This process further helped to maximise the translated equivalence to the original instruments.

Finally, the researcher noted the feedback from the respondents in the pilot study and discussed these with the supervisor, and where required, the necessary corrections were made to finalize the research instruments. After consensus was reached between the researcher and the supervisor on the readiness of the final research instrument, data collection was started.

Instruments

The questionnaire included a section to elicit demographic information and six instruments namely the Refugees Stress Scale (RSS), Post- Migration Living Difficulties Questionnaire (PMLD), Refugees' Defencelessness Scale (RDS), Connor-Davidson Resilience Scale (CD-RS), General Health Questionnaire (GHQ - 28) and Post-Traumatic Stress Disorder Checklist - civilian version (PCL -5). These instruments are widely used and were reported on to obtain good reliability coefficients among African refugee populations in Africa and elsewhere as well as with transcultural research. The instruments are further discussed below. The questionnaire is attached as Appendix 5.

1. **Demographic information** was elicited to identify the participants' age**,** gender, level of education, marital status, country of origin, year of arrival in South Africa, migrant status, i.e. whether they are refugees or asylum-seekers, as well as whether they are separated from family members, pre- and post-migration jobs … etc.
2. **Refugee Stress Scale (pre-migration Stressors)** was recently developed by Idemudia on a study with his colleagues among Zimbabwean migrants in South Africa (Idemudia, Williams, Madu, and Wyatt, 2013)**.** The RSS is a 22-item checklist that is used to measures refugees' pre-migration stressors in this study. The scale contains short and easy to understand statements, and it measures violation of human rights, victimisation of police or the military, lack of basic necessities and abuse (sexual or physical). In the original version, the author adapted some of the items from the Wyatt Sexual History Questionnaire, which assesses the child and adult sexual abuse (Idemudia et al., 2013). For the purpose of this study, five questions were added to the original scale. This was informed by the results of the qualitative data of this study. The original instrument also lacked items that measure refugees' experiences under totalitarian/oppressive regimes. The items included are as follow: I was forced to join the military (item 23), I was serving/working without payment (item 24), I was forced to act wrongly against other people (item 25), I

had limited freedom (item 26), and I had no clear vision about my future (item 27). The instrument is based on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). The original scale showed an excellent internal consistency with a Cronbach's alpha coefficient of 0.90 among Zimbabwean migrants in South Africa (Idemudia et al., 2013) and African migrants in Germany (Idemudia, 2014). The adapted scale also obtained an excellent internal consistency Cronbach's alpha coefficient of $\alpha = 0.93$ in this study

3. **Post-Migration Living Difficulties Questionnaire (PMLDQ)** is a self-evaluated questionnaire used to assess recent adverse life experiences typical of post-migration stressors (Silove, Steel, McGorry & Mohan, 1998). The instrument lists 24 possible post-migration living difficulties including unemployment, isolation from family members, difficulties in applying for refugee status, accessing health and mental health services, welfare support, poverty and cultural alienation, boredom and isolation. The developers reported a five-factor solution in a study with Tamil refugees in Australia. The factors are refugees' documentation process, health, welfare and asylum problems, family concern, general adaptation and social and cultural isolation (Silove et al., 1998). Even though the instrument is widely used, other studies did not report on the factor structure of the instrument (Aragona et al., 2011; Aragona, Pucci, Mazzetti, & Geraci, 2012). The respondents were requested to indicate the extent to which they were troubled by any of these living problems, ranging on a five-point scale from "no problem at all" to "a very serious problem". The items scored as "serious" and "very serious" problems are considered for statistical analyses (Aragona et al., 2011; Aragona et al., 2012; Schweitzer, Melville, Steel, Lacherez, 2006; Silove et al., 1998). The instrument was used among Sudanese refugees in Australia (Schweitzer et al., 2006) and other multi-cultural refugees including Africans in Italy (Aragona et al., 2012; Aragona et al., 2012). The scale also obtained excellent internal consistency, i.e. a Cronbach's alpha coefficient of $\alpha = 0.92$ in this study.

4. **Refugee Defenceless Scale (RDS)** is an instrument developed from the information obtained from the qualitative phase of this study with the intent to measure refugees' experiences of personal and family', particularly children's insecurity, uncertainty and

vulnerability in South Africa. The instrument measures refugees' experiences and feelings of being defenceless to stressors such as an insecure environment, lack of opportunities to secure a livelihood, general feelings of personal uncertainty and vulnerability but also fear of their children's involvement in risk behaviours and misconduct as well as fear of losing one's culture. Some of the items are: "fear for my life or family member's life", "lack of a better future for children", "lack of improvement in my living conditions", and "children getting involved in risk behaviours". The instrument is based on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). The scale obtained an excellent internal consistency, with an inter-item reliability coefficient of $\alpha = 0.90$ in this study.

5. **Connor-Davidson Resilience Scale** (CD-RISC; Connor & Davidson, 2003) was used to assess the extent of Resilience among refugees. The original CD-RISC is a self-report measure comprising 25 items developed to measure resilience among the general population and clinical samples (Connor & Davidson, 2003). The psychometric propriety of the original instrument showed an excellent reliability coefficient of $\alpha = 0.93$ (Connor & Davidson, 2003). The factor analysis of the scale yielded five constructs from data collected from the general population (Conner & Davidson, 2003). The general description of the factors is personal competence, tenacity and high standards for factor one (comprises eight items), factor 2 relates to trust in one's instincts, tolerance of negative affect, and strength effect of stress (7 items), factor 3 relates to acceptance of change and feelings of security in relationships (5 items), factor 4 related perceived control (3 items) and factor 5 related to spiritual beliefs (2 items) (Conner & Davidson, 2003, p. 80).

   The original CD-RISC (25 items) was used among South African adolescents and showed an excellent internal consistency of Cronbach alpha of .93 (Jorgensen & Seedat, 2008), and among multi-cultural refugees in Australia (Ziaian et al., 2012). It also obtained an excellent Cronbach's alpha of 0.88 among Congolese refugee in Uganda (Ssenyonga, Owens & Olema, 2013). In this study, the scale obtained an excellent inter-item reliability coefficient with Cronbach's alpha of $\alpha = 0.93$.

However, over time studies have been reporting different factor structures from the original one (Jorgensen & Seedat, 2008; Singh & Yu, 2010). Jorgensen and Seedat (2008) reported possibly two or three factors (tenacity, adaptation and spirituality) with samples of South African adolescents that can be different from different ethnic groups within the sample. Similarly, Asante and Meyer-Weitz (2014) found a three-factor solution from the data collected among homeless youth in Ghana, while, Burns and Anstey (2010) reported a one-factor solution with a large community survey in Australia. Furthermore, the factors were also found to be unstable over two identical populations (Campbell-Sills & Stien, 2007). Therefore, Dong, Ablah, Nelson, Shah, & Khan (2013) decided to modify the scale. They removed two items and replaced them with 'I feel obligated to assist others in need', and 'I have few regrets in life'. They also added three new items that are associated with resilience but neglected from inclusion in the original one. The three items are 'My family is willing to help me make decisions and listen to me' and 'My friends are willing to help me make decisions and listen to me' was added to address the social support component of resilience, and 'I find my job rewarding' to address job satisfaction. (Dong et al., 2013, p. 13). They also re-phrased all items into third-person statements which speak directly to respondents, and it makes them easier to understand. The modified 27 items CD-RISC showed excellent internal consistency with an overall Cronbach's alpha of 0.94. However, this resulted in four-factor structures which were different from the original one. In this study, the modified version was used, as social support was deemed to be a strong component of resilience, especially in the collective African context. Respondents rated items on a scale from '0 = not true at all' to '4 = true nearly all the time', the highest scores show that the person is more resilient.

6. **General Health Questionnaire 28 (GHQ-28) —** (Goldberg, 1978; Goldberg & Hillier, 1979) is a psychological instrument used in measuring psychological distress. It is a self-administered screening instrument designed to detect psychiatric disorders in community settings as well as primary health-care settings. Respondents were asked to compare their recent psychological state with their usual state. It consists of 28 items comprising four subscales with seven items each measuring: somatic complaints (1 -7), anxiety and insomnia (8 – 14), social dysfunction (15 – 21), and depression (22 -28). Seven of the 28

items are positive statements (e.g., have you recently been managing to keep yourself busy and occupied). The scaling for the positive statements was; 'more than usual', 'as usual', 'less than usual', and finally 'much less than usual'. The rest of the 21 items are negative statements (e.g. have you recently been getting headaches?) and 19 of the items used: 'not at all', 'not more than usual', 'a little more than usual', and 'much more than usual' scales. There are several scoring methods for the GHQ; the most commonly used are the Likert scale (0-1-2-3) and the GHQ method (0-0-1-1, Goldberg et al., 1997). Both scoring methods are recommended for survey studies (Goldberg & Williams, 1988), this study used the Likert scale, the GHQ method where the four alternative choices are scored as 0-1-2-3, e.g. 0 = not at all, 1 = not more than usual, 2 = a little more than usual, 3 = much more than usual scales. The higher scores indicate high psychological distress. The authors suggested a cut-off 23/24 for the Likert scale and 5/6 for the GHQ methods to determine psychological distress. However, having different scoring methods proved to be problematic for comparing psychological distress prevalence between the studies, but also studies reported different prevalence rates for the same samples when using different scoring methods with different defining criteria for psychological distress (Swallow, Lindow, Masson & Hay, 2003; Willmott, Boardman, Henshaw & Jones, 2004).

Furthermore, the GHQ-28 is a widely used instrument and validated for African refugees. It was used in an earlier study among Rwandese and Burundians refugees in Tanzania (de Jeng et al., 2000). In a more recent study, a test-retest with-in two weeks demonstrated good inter-item reliability of $\alpha = 0.91$ in a sample of Zimbabwean refugees in South Africa (Idemudia et al., 2013). The instrument was also validated for Namibian clinic attendees and showed a very good Cronbach's alpha coefficient of 0.86 (Haidula, Shino, Plattner & Feinstein, 2003). A Cronbach's alpha of 0.78 was also reported by Simich, Hamilton and Baya (2006) among Sudanese refugees in Canada. In this study, the scale obtained an excellent internal consistency with a Cronbach's alpha coefficient of $\alpha = 0.93$.

7. **Post-Traumatic Stress Disorder Checklist (PCL – 5 for DSM - 5)** (Weathers et al., 2013). The PTSD Checklist (PCL - 5) is a 20-item self-reporting measurement that assesses the severity of PTSD experiences in the past month based on DSM-5 criteria for PTSD

symptoms. The PCL - 5 is the latest version of PCL – S (with 17 items and three subscales) revised with the advent of DSM-5. PCL - 5 has four subscales, namely, re-experiencing (items 1 – 5), avoidance (5 - 10), alteration of cognition and mood (11 - 15) and arousal symptoms (16 – 20). Each of the subscales corresponds to each of the symptom clusters in the DSM – 5 (Weathers et al., 2013). Cross-cultural studies within different contexts (general population and clinical samples) have been replicating the four-factor model. However, recent studies reported six and seven-factor models of the PLC-5 (Armour et al., 2015; Ashbaugh et al., 2016). Each item is rated on a 5-point Likert-type scale (ranging from 0 = Not at all to 5 = Extremely) that indicates how much the participant has been bothered by a stressful event in the past month. To determine the prevalence of PTSD, Weather et al. (2013) suggested the scoring guidelines of the DSM-5, suggesting a provisional diagnosis if respondents score two and above (moderate and above) on one item of re-experiencing, a score of two and more on one item of avoiding, and two and more scores on two items of both the alteration of cognition and mood and arousal subscales. However, Weather and his colleagues also suggested consideration of the context and condition of the participants for scoring.

The older version (PLC – 17 items, Weathers, Huska, & Keane. 1991) has been widely used in South Africa and has been validated for the South African context (Peltzer, 1998, 1999; Smit, Van den Berg, Bekker, Seedat, & Stein, 2006). The instrument is also validated among refugee populations. Its Cronbach's alpha coefficient was $\alpha = .80$ with Zimbabwean refugees in South Africa (Idemudia et al., 2013) and $\alpha = 0.97$ with Congolese refugees in Uganda (Rees et al., 2013). The PCL-5 is yet to be tested in an African context; however, it scored an excellent internal consistency of Cronbach's $\alpha = 0.91$ among multi-cultural refugees in Germany (Kaltenbach et al., 2017). In this study, the scale obtained an excellent reliability coefficient of $\alpha = 0.95$ with African refugee samples.

5.5.3 Recruitment of Participants and Data Collection Procedures

As stated earlier, ethical clearance was obtained prior to data collection. The respondents for this quantitative study were recruited from the RSS, Refugee Pastoral Care (a faith-based organisation that provides basic necessities for needy and for refugees), churches, mosques, refugee communities and individuals who are personal acquaintances.

Gatekeepers' letters of permission or personal permission were obtained from the organisation's managers, church leaders and social workers who work with refugees. The same ethical procedures were followed as detailed in the qualitative data collection section. First, participants were informed about the aim and objectives of the study; they were assured of the anonymity and confidentiality of the data. The participants were also informed that participation is voluntary and that there is no reward for participation. Respondents were also assured that withdrawing from the study at any time is possible and that there would be no harm to them in doing so. Those who agreed to take part in the study signed an informed consent form (See Appendix 3.2). The form stated the objectives of the study, the key ethical principles as outlined above and gave the contact details of the researcher, supervisor and research ethics office administration for further information regarding the study. Once all the respondents' questions were answered, and they were satisfied with the responses, they were able to select questionnaires from any of the three languages, i.e. English, Swahili and French.

The total number of questionnaires distributed among refugees was 220; this included all those that indicated an interest to participate in the study. The questionnaires were personally handed to the respondents in the organisations, churches and at a Madrasa - an Islamic school. The researcher and a research assistant who were able to speak English, French and Swahili were available to answer questions raised by respondents with regard to the questionnaires. From RSS, located at Diakonia Centre, data were collected for six weeks every Monday after the orientation session. The RSS provides orientation guidance to refugees and asylum-seekers every Monday regarding the services it offers; however, data were also collected from those who came on the same day for follow-ups on their cases. From the Pastoral Care Durban (at the Denis Hurley Centre) data was collected from the English language students before class commenced in one day. I collected data on two consecutive Saturdays among refugee women who attended the Zoe-life awareness campaign for refugee women in the Islamic school. This was made possible through an acquaintance of mine. Furthermore, I approached church pastors in the Durban South Beach area, both were PhD students at UKZN, and with their help data were collected during the week after church activities. I also collected data from my other acquaintances. Most of the questionnaires were collected from the respondents on the same day; however, a few took the questionnaire home to complete and were able to bring them to the next meeting. They were asked to answer truthfully

and not to discuss the questions with family or friends. The questionnaire took between 30-40 minutes to complete. The data collection process was completed in about three months.

5.5.4 Data Analysis

For the final analysis, 195 questionnaires were used, 26 questionnaires were excluded because a few were lost as the respondents did not bring them back, while others did not answer many of the questions. The data were analysed using the Statistical Package for the Social Sciences (SPSS) version 25. First, the necessary measures were taken to ensure data quality. Frequencies were calculated for all the items to check if there were any errors in the data capturing process and also to gain an overview of the responses on the items. Frequencies were used to describe the socio-demographic characteristic of the participants and the prevalence and patterns of mental health problems.

Exploratory factor analyses of the instruments were conducted in order to define the factor structure of all the instruments used and to calculate the number of factors that best fitted the collected data as outlined by Pallant (2011). All measurements were subjected to Principal Components Analysis (PCA). However, first suitability of the measures for factor analysis was checked using the Kaiser-Meyer-Olkin (KMO, Kaiser, 1960), Bartlett's Test of Sphericity (Bartlett, 1954) as well as the correlation matrix was checked for majority 0.30 correlations between items. Then eigenvalue above one, scree plot above-elbow (Catell, 1978), and parallel analysis were considered to determine how many factors to retain, before subjecting the items for oblimin rotation. The psychometric properties of all the measures and sub-scales were determined using inter-item reliability coefficients, i.e. Cronbach's alpha.

The scales were computed, after satisfactory Cronbach's alphas were obtained, by summing the relevant items, after the necessary recoding was done to ensure that all the item responses were in the same direction. Descriptive analysis was carried out to summarise data and to assess the central tendency of the responses. Then measures were then subjected to descriptive explorative analysis to check the normality distribution of the measurements using the Explore option in the statistical package. In cases where outliers were detected, they were replaced with less outlined numbers (Pallant, 2011). This decision was taken instead of deleting the outliers because of the relatively smaller sample size. Depending on the distribution of the responses both non-parametric (e.g. Chi-

square tests) and parametric analyses (e.g. t-tests and One-Way ANOVA tests) techniques were used to determine the mean score difference on the scales across the different demographic groups as outlined by Pallant (2011). The Pearson moment correlation coefficients were conducted to examine the strength and direction of the relationships between different variables, e.g. between pre-migration difficulties and depression. Cohen's (1988) criteria were used for indicating the strength of the correlation i.e. r = 0.10 to 0.29 as small correlation, r = 0.30 to 0.49 as medium correlation and r = 0.50 to 1.0 as a strong correlation.

To determine the predictors of major mental health problems, different regression analyses were carried out, e.g. standard regression analysis was conducted to understand the predictors of PTSD. All analyses were two-tailed, and a *p*-value of less than 0.05 was considered to be statistically significant.

5.6 Chapter Summary

This chapter firstly presented the mixed-method - sequential exploratory study design and its relevance followed by a detailed account of the two phases of the study, i.e. the qualitative study and then the quantitative phase. In the first section, a general overview of the descriptive phenomenological method was outlined, followed by a descriptive phenomenological psychological design adopted for psychological research. This was followed by the sampling procedures and participant selection process, and then the data collection and procedures followed. In the last section of the qualitative phase, the five steps data analysis method and the philosophical explanations were outlined. In the second section, the cross-sectional quantitative design and its relevance to the study were discussed in detail. The sampling procedure was presented, followed by a discussion of measurement translation and adaptation processes, the measurements inclusive of the factor structure, where relevant and the psychometric properties. The data collection and procedures were discussed, including the participant recruitment and data collection process. Lastly, the data analysis techniques employed in the study were outlined.

Chapter Six

Results of the Qualitative Study

6.1 Introduction

Refugees and asylum-seekers are increasingly growing in numbers as a group in the general population worldwide. The persistent conflicts and violence within and between countries create forced displacement. It takes the lives of their loved ones and threatens their survival, destroys their livelihoods, and for many, their human rights are jeopardised and oppressed by dictatorial regimes. Not by choice, they are forced to leave their home countries and embark on a journey to save their lives. However, it is paradoxical, in many instances, the stressors that threaten their lives and wellbeing follow them to the place where they resettled.

The mental health of forced migrants has not received the necessary attention it deserves. Among other factors, the reason could be a lack of studies that explore their migration experiences and psychological problems to inform the public and policymakers of the plight of refugees. This is, especially true for the South African context. To address this gap, partly, this qualitative-phenomenological sub-study was used to explore refugees' migration experiences and psychological problems. The experiences shared include participants' difficult experiences, psychological distresses, coping mechanisms and resilience at different stages of the migration process, i.e. pre-migration, transit-migration and post-migration. The results presented in this chapter are from the qualitative data, collected through face-to-face interviews with purposively selected refugees. The uniqueness of this study lies in the fact that it depicts the full migration process and related experiences of refugees to better understand their psychological health needs and essential aspects to consider in the development of relevant mental health interventions.

The analysis followed a phenomenological-psychological descriptive method, a step-by-step process developed by Giorgi (2005) based on Husserl's phenomenological philosophy. Summaries of the participants' descriptions of lived experiences are presented with illustrative captions from the interviews. When the participants shared their migration experiences, it was a long description that included stressors, challenges, and psychological distresses they experienced and the coping mechanisms they used and the resilience they displayed. Description of the experiences are intertwined, and so, to answer the research questions in a more coherent way, the results are presented in a more structured way by using the key research questions. Therefore, refugees'

stressors, psychological problems, coping mechanisms and resilience experiences of migration are presented successively. However, this form of presentation does not mean that each participant shared his/her experience uniformly. As discussed in the methodology chapter, the participants guided the interview and thus, the description of their experiences; in other words, they determined what they wanted to share or not. Therefore, the sequence of the description of their experiences differs from one to another. Besides that, the description of experiences also varies, some of them shared detailed descriptions of one stage but might not have enough experience or willingness (not yet ready, particularly if it was more recent) to share about another stage. However, it is noteworthy that most participants provided a poor description of their psychological experiences compared to how they described migration stressors. This might be because of difficulties to articulate psychological and emotional experiences due to lack of vocabulary with which to describe psychological states of mind. It should be noted that the participants are referred to as P. 1, P. 2, P. 3 … P. 14, mainly to honour the assurance given of participant anonymity, but still to denote the responses of each participant.

Thus, this chapter first presents the socio-demographic information of participants, followed by descriptions of their pre-migration experiences that are presented as stressors, mental health experiences and coping mechanisms. The description follows the migration route; experiences at the country of origin, participants' transit- and post-migration experiences outlining the stressors, mental health experiences and coping mechanisms employed in each stage. The chapter is concluded with the participants' perceptions of a future in South Africa and important recommendations pertaining to the kind of support they believe would have been necessary to assist them in settling in South Africa

In summary, the refugees' thick descriptions of migration experiences are presented in three stages, pre-, transit- and post-migration. In each of the stage's migration stressors, psychological distresses and coping mechanism are presented in separate sub-sections. This structured approach is favoured instead of integrating the whole migration experience into one section. The purpose is to depict a general picture of each stage's migration stressors among refugees, similarly by presenting the psychological problems as well as coping mechanism separately the reader is also expected to have a general understanding of refugees psychological and coping experiences. The shortcoming of this structure might be some repetition or overlap of some descriptions.

6.2 Socio-demographic characteristics of the participants

The total number who participated in the study was 14; most of them were males (10), and their ages ranged between 24 and 42 years of age. Five of the participants are from the Democratic Republic of Congo (DRC), four from Burundi, two from Eritrea, two from Zimbabwe and one from Somalia. Seven of the participants are married, one is divorced, and six of them reported that they are still single. The participants came to South Africa as early as 1999 and as recently as 2017.

Table 4

Socio-demographic background information of qualitative interview participants

Characteristics	N	%
Gender		
Male	10	71.43
Female	4	28.57
Age (M = 30.27, SD = 9.27, Range: 24 - 42)		
Age group		
24 – 30 years	6	42.85
31 – 36 years	4	28.57
37 – 42 years	4	28.57
Country of Origin		
DRC	5	35.71
Burundi	4	28.57
Eritrea	2	14.29
Zimbabwe	2	14.29
Somali	1	7.15
Marital Status		
Single	6	42.85
Married	7	50
Divorced	1	7.15
Year of Arrival to SA		
1999 – 2007	5	35.71
2008 – 2017	9	64.29
Status in SA		
Refugee (Section 24) *	6	42.85
Asylum-Seeker (Section 22) **	8	57.15
Level of education		
High school complete and less	5	35.71
Tertiary education	9	64.29

***** Refugee status

** Temporary permit

With regard to their status, six of the participants have Section 24 refugee status implying that they were accepted as refugees, while eight of them are still using the Section 22 permit, i.e. a temporary permit that is supposed to be adjudicated after six months. It is, however ironic as some of them has not yet had their cases adjudicated, irrespective of the fact that some of them have been waiting for more than 13 years. Most of them (9) have either a certificate, diploma or degree from a higher institution of learning while five of them completed or studied at high school. See table four above for more detailed information

6.3 Pre-migration Experiences

Results in this section were from the refugees' detailed description of their experience when they were still in their country of origin. The main research question guiding this section pertains to their pre-migration experiences, specifically stressors and challenges that forced them to leave their home countries as well as descriptions of the psychological distress they experienced during that time. In this pre-migration stage, participants' coping mechanisms and resilience were also explored.

6.3.1 Pre-migration Stressors

The participants shared detailed descriptions of their experiences before they fled from their home without a second thought, as it happened to some. Most of them started sharing good experiences they had from supportive family members and from the environment and culture they know and appreciate, which is very meaningful to them.

> *I had a good life at my home country, I had parents and siblings, I had all the necessary things I wanted, and my parents were taking care of everything for me* **(P. 10).**
>
> *At home, I was working as a public health educator in an HIV/AIDS project, I was getting paid well, and I was supporting my family* **(P. 4).**
>
> *My life was good, living with family and studying. Before the war, I had a normal life* **(P. 5)**.

However, those descriptions were short and introductory, and then they described reasons that forced them to leave. Participants shared disturbing and inhuman experiences they encountered. Some of the participants endured the difficulties until they came to a decision to leave and to seek an opportunity to flee. Some of them had time to plan their escape, made it as safe as they could, and were able to carry some belongings with them, but others had no time, not even to say goodbye

to their loved ones because they might have lost all or some of their loved ones, they had to embark instantly on a journey not knowing where they were going.

The main pre-migration stressors shared are experiences of threats and insecurity to their lives and loved ones; some lost their family members mostly due to the state's atrocities through its militia or other agents. Those life threats and insecurity were also caused by consistent civil wars between rebels and the state; conflicts between opposition parties and the ruling party that escalated to bloodshed; persecutions because of their tribe and allegations of supporting the other side in the conflict. Other pushing factors include state oppression and violence characterised by arrest and disappearance of comrades or family members; physical violence like beatings, rape and torture; harassment and total restriction of ones' human rights and total control from the state through endless conscription into military services. For a few, tribal conflict based on class or caste systems and unbearable economic difficulties were the pushing factors. The common pushing factors are grouped under the common themes of war and tribal conflict, state organised violence and oppression and economic difficulties as presented below.

6.3.1.1 War and tribal conflict

Participants shared how, during civil wars, they became targets from both sides in the war that could involve more than one rebel faction and the state. They witnessed the killing and rape of their family members, and looting of their properties (P. 1, P. 13, & P. 14), and the disappearance of people around them. They also had to escape forced recruitment by rebels' groups and persecution from their communities (P. 4 & P. 5).

> *It was wartime … everybody was running. They were fighting all the time, they were raping, looting houses and there was insecurity, it was a very difficult time. So, we decided to run away before being raped or getting killed* **(P. 14).**
>
> *When the war started at Bukavu, East Congo, I was in grade 10, the rebels came to my school, and they were forcibly taking youth to join the army. We were scared, and then we* [with three friends] *jumped out of the window and ran into the bush unprepared. The rebels were taking people, but those people never returned, even my friends* **(P. 5).**

The subsequent conflicts in the DRC and Burundi made the lives of most unsafe. In addition, for Participants 1 and 7 state persecution was a pushing factor, because they belonged to the same tribe as the rebels. The state accused and persecuted them for supporting and becoming part of the rebels.

> *In 2002, we were armed by the state to patrol our surroundings* (neighbourhood) *from the infiltration of rebel groups… however, the accusation was based on suspicion because my tribe belongs to the rebels. I witnessed the killing of close relatives, where six family members were murdered in one event. Then, we* (all his family members) *left the country* **(P. 1)**.

> *My family was persecuted because of our tribe … we are scattered all over. I was traumatised when one night around 11 pm soldiers came and broke-in to our home and took my father without explanation. They sent him back after three days. The second time they took me on the same accusation of being part of the rebels, the third time the soldiers took my father, he never returned, and we do not know what happened to him. The same night my family decided that we have to leave. I left with my sister* **(P. 7).**

During the 1998 civil war in Burundi, Participant 13 said her husband was accused by both the government and rebels for helping the other, *and* he then decided to run away. She was pregnant and left with her sister at home. The rebels were frequently coming to check his whereabouts, she said:

> *One day the rebels came and raped my sister, five of them, in front of my eyes, and my sister passed away at the same time. I was shocked and went into labour for delivery. I did not bury her. I do not even know where they buried her or took the body. I could not return back to the same house, I went to another place, but I heard the rebels were looking for me, then I left my newborn baby with a lady who was sheltering me and went to Uvira, Congo* **(P. 13)**.

The rebels favoured participant 4 as he was supplying them medicine in return to get access to his patients as a public health worker in the DRC. However, his community became suspicious of his friendship with the rebels who were attacking and looting the community.

> *Then the community accused and persecuted me for assisting the rebels. The community supported by the government, vandalised and burned down my property and project, and threatened to kill me, and I had to run away to save my life* **(P. 4).**

For participant 9, a 37-years-old woman from Somalia, tribal conflict was a pushing factor for her to leave the country. Her family is considered to be from a lower caste, and they were oppressed and persecuted by the higher caste tribe.

> *People from my tribe were not even permitted to fetch water before them. There was constant fighting between the tribes. One day my sister was abducted when she was going to the market. We found her dead body after three days; she was raped and killed by the other tribe. Then my family decided to move to another town, but I was afraid for my life as the hatred was getting worse, then we decided to leave the country and went to Kenya* **(P. 9)**.

6.3.1.2 State organised violence and oppression

Most of the participants were victims of state violence, oppression and persecution. Some participants described how their family members were killed, and they were persecuted by the state because of their different views and support for opposition parties. Participants 8 and 10 are both from Burundi who came to South Africa in 2016, almost at the same time, their entire families were murdered because they were members of the opposition party. They fled to save their lives.

> *I left my country because people who killed my parents and siblings were also looking for me. Those people thought I would seek revenge. The people who murdered my family were sent by the government. They are not soldiers. I was at school when my family was murdered. Then I realised I would be the next and can be killed at any time. I feared for my life, so I left to look for safety* **(P. 10).**
>
> *In 2016, the government militia killed all my family members, my parents and two siblings because my father was a member of the opposition party. I survived because I was at work, then I was advised by friends to save my life before they came and killed me too. Then, I left the country, and I did not even attend the funeral of my family* **(P. 8)**.

Participant 8 also mentioned that earlier in 1995, and the government burnt their house and his whole family fled to Tanzania and lived in a refugee camp. They returned, however to Burundi as life in the refugee camp was very difficult. The killing of his family he mentioned above was the second attempt on their lives.

Participant 11 is a 27-years-old mother of five children from the DRC. She was a member of the opposition party who demanded the president to step down at the end of his term. She fled with her three children to South Africa after government soldiers raped her. Since this day she does not know where her husband and her two children are.

> *When the president refused to leave power, conflict erupted with the opposition parties. The government soldiers were killing, raping and vandalising people's property. The soldiers raided my place and raped many of us. They tied my face, I could only feel the movement, there was nothing I could do, and I could not even see the person who was raping me. When the soldiers left, members of the opposition party came and helped us to run away* **(P. 11)**.

Participant 6 is a 42-years-old man from Zimbabwe. He was a member of the opposition party and crossed the border to South Africa in 2006 to save his life when he received a short notice to leave.

> *I was living a normal life until the advent of the Movement for Democratic Change (MDC) as the main opposition party in Zimbabwe. I was arrested many times since 2002, and many people died from my party. During the presidential election 2005 … a lot of my comrades were sentenced to long terms in jail, some of them disappeared, and some of*

> *them died, I feared for my life and crossed the border to South Africa unprepared and with short notice* **(P. 6).**

Other participants shared how they were oppressed to the extent that they felt as if they were in prison, under the total control of the military, and experienced routine abuse of their human rights. The state-controlled their movements and forced them to work for unlimited time without payment. Participants 2 and 3, from Eritrea, explained their lives were difficult with no rights to do and practice what they wanted and be conscripted to endless military service as well as often experienced harassment at the hands of the military.

> *I had no vision when I was in my country, and I was just consuming my age* (drifting) *without a goal to achieve. My life was under total control by the military rule in the country; restricted movement, all movements were by order and permission. There was no way that I could do what I wanted. Living in Eritrea is like living in prison. I did not own my life. I was like a prisoner and a visionless person* **(P. 2).**

> *When I finished high school, I would be forced to join the army, as every Eritrean for national service, however, people were not coming back to their homes because it is unlimited military conscription – working for the state without payment for an unlimited time. I did not accept that, and then I tried to escape from the country - twice to Ethiopia. However, I was caught both times. I was subjected to cruel prison conditions and forced military training* **(P. 3).**

The participants described how very difficult it was to escape from the country once they had decided to leave. It was a life-threatening risk; they could have been killed by the border guards as there is a 'shoot to kill' order or subjected to cruel prison conditions if caught, as happened to Participant 3. He was jailed without a court hearing and sentenced. He was also forced to undergo military training after jail.

> *I was subjected to bad treatment in prison. The prison was in a hot area called wi'ao, with massive security, parents do not visit, we had a shortage of water for drinking and allowed to wash our bodies once in a week, we suffered from insufficient and poor-quality food, and we were forced to walk barefoot. I witnessed tortures and beatings of mates…*

> *The condition in the military camp was worse, and it was in a desert area. I was sick for the whole period and had a lot of pain from my lower leg. I did not get medical treatment. The leaders did not care. I felt I was living with animals – beasts* **(P. 3).**

For Participant 3, the difficulty has not stopped there. He was dispatched to the army unit. He said that there is a lot of hardship in the army and he deserted several times, and then he tried to escape from the country. He was caught twice but escaped successfully during his third attempt to escape.

6.3.1.3 Economic difficulties

Economic difficulty and a lack of money for necessities was the pushing factor for Participant 12 to leave his country Zimbabwe and look for other ways of surviving.

> *By the time I was doing secondary school, life had become challenging, and the economy of the country become difficult to the point I couldn't get enough money for school and other necessities to further my education, even to buy what is needed. When I finished, things became harder. I then left to look for another way of surviving* **(P. 12).**

6.3.2 Experiences of Psychological Distress

In this section participants' descriptions of their psychological and emotional experiences in reaction to the stressors and challenges they endured during the pre-migration stage is presented. For those who experienced civil war and violence, their psychological distress was mostly traumatic with PTSD symptoms that they still experience, they also shared symptoms of depression and anxiety, overwhelming fear, talked about their sleeplessness, sadness, helplessness, feeling of worthlessness, short-temperedness, them re-experiencing trauma and confusion.

> *I was traumatised by the accusation, even though I was protecting my area. I felt a total fear for my life. I also witnessed the killing of relatives, and then I realised that I was not safe. I was experiencing that traumatic incident in my dreams… it was coming like a bad dream sometimes* **(P. 1)**.

> *We were living in fear; if we slept, we did not know if we were going to wake up alive. If we went out - we might not come back by the evening. We were really traumatised. I witnessed people being killed, raped, kidnapped, and houses looted and burned* **(P. 14).**

> *The difficult thing was that I did not go back to my home, to my family, the war was everywhere, I also did not know where I was going, we still had also to hide, everything was confusing* **(P. 5)**.

Participant 4 explained that he left his parents in danger, and he also saw when his property was vandalised and burnt down by local people. Leaving his home country and the thought of his family being in danger was overwhelming.

> *…it was so painful and very difficult for me to move out of my country. I was very shocked; I had no intention of leaving my country. I was also worried that I left my family in danger, if the government came and could not find me, they could take my family members - that was another thing stressing me. I was in shock, and much stressed, and I spent a week without sleeping and eating.*

For those who were enduring state oppression, their planning of escaping was psychologically more distressing than actually living under oppression.

I was forced to take a life-risking decision because the situation was stressful and not comfortable, I was in prison, controlled and felt owned by a company or individuals, and I was just accepting orders. So, I was feeling short-tempered and intolerant, not feeling good mentally, unable to think about a future and confused **(P. 2)**.

...the most difficult thing was planning and executing my escape. There is very tight security in the border towns. The decision was very risky for my family and me. There are spies who can inform the authorities. It feels like everyone is spying someone… No one knows, except my mother and small brother. And the border guards have a shoot to kill order if they detect someone crossing the border, or if I was caught alive, I would be tortured and imprisoned. So, I was not feeling right, so disturbed and stressed **(P. 2).**

To escape unlimited military conscription, I tried to escape unsuccessfully two times, after the first failed attempt, I was imprisoned and joined the army. I was feeling sad and had a lot of stress. Then I was deserting (leaving) the army several times. I was feeling not a human, not even an animal, just a thing. I do not think there is barbarism anywhere else in the world besides in Eritrea **(P. 3).**

Participant 3 was from Eritrea when he deserted the army he had to continuously run and hide because the army was coming to his home to take him back, he said he never slept well and always had his clothes on him, and his shoes close in case they came, he was always ready to run.

I was even dreaming of running from those who came to catch me. I was too stressed; that was why I tried three times to escape from the country, and I succeeded in the third attempt **(P. 3**).

Participants 8 and 9 felt that life became meaningless when their families were murdered by the government militia in Burundi and wished for death.

When my parents were killed, I felt like my life was also finished and could not live if someone had asked me to finish my life (to kill him), *I would have agreed* **(P. 8)**.

I saw my entire family murdered, and I felt as I was also dead. I also had a fear for my life, that they might come and kill me, so I left to look for safety **(P. 10)**.

Government soldiers in the DRC raped Participant 11 in 2017, she is still living through the traumatic experience, and it is still difficult for her to talk about it. Participant 13 witnessed her only sister being raped by a group of rebels and died at their hands, in Burundi in 1999. She said that she still has vivid memories of the incident, and she feels as if she herself experienced the traumatic incident.

… *when the government soldiers raped me. I was very sad and feared. I did not even tell my parents what happened to me, and I just wanted to run away. I felt very bad…* **(P. 11).**

> *…my body was more than shaking, I was vibrating more than shaking because I was watching when the rebels were raping my sister. I saw everything. What they did to my sister was as if they had done it to me. I was feeling what my sister was feeling. I was the one feeling what my sister felt …* (she cried) **(P. 13).**

In the above two cases, participants were advised not to provide detailed information that could lead them to re-experience the trauma. They were requested to be referred to a counsellor. However, one preferred not to talk about it and the second one insisted that talking would be relieving. It should be noted that while a few cried during the interview when sharing their traumatic experiences, they preferred not to terminate the interview, but, in most cases, insisted on sharing their experiences. All participants were time and again reminded of the counselling support available at RSS.

6.3.3 Coping Mechanism and Resilience

To most, the decision to escape was one of the major coping strategies used for the life-threatening stressors they experienced. There were not many resources that they could rely on as the lives of their families and their own were in danger. It seems that for most, it was an immediate decision to leave their homes in order to save their lives, even though they never had an intention of leaving their home countries or had not formed an initial plan. A few shared ways of coping and particular actions that reflected courage and resilience, i.e. thinking and actions on how they could overcome the threats. Participants 1 and 7 explained their decision making to escape from state persecution:

> **…** *even though it was a bad period for me, I had to think about how to overcome the situation and save my life. I was in total fear; however, I said to myself that this could not be the end of my life. I organised myself and decided not to dwell in fear, but to leave the country* **(P. 1).**

> *Even though I had a fear, I also thought of how I could overcome the situation and be safe. I knew I could not be safe in my situation at the time because they were not merciful; they could kill anyone, anytime. I decided to run away (escape)* **(P. 7).**

For Participant 14, her faith in God was a way of dealing with her fears during the civil war in the DRC, where she witnessed many killings, rape, torture and lootings by rebels.

> *It was a very traumatic experience. I thanked God because I believe in Jesus Christ. I was doing better. We used to pray that was helping me out a lot* **(P. 14)**.

Participant 3, from Eritrea, as mentioned earlier, was caught twice when he tried to escape from his country and jailed both times, he described how his hopes and support from prison mates helped

him to deal with the inhuman conditions he was subjected to in prison and in the military. He said he was also deceived by empty promises from the government that things would be changing for the good.

> *In prison, we* (mates) *were like a family, supporting each other, we were comforting each other when someone was tortured, and we shared what we had and respected each other. The difficulty of the situation made us be united and help each other* **(P. 3)**.

6.4 Transit-migration Experiences

Transit-migration experiences include refugees' migration experiences from the time they crossed the border of their home countries until they reached South Africa. Some of them travelled for a day or a few days without difficulties. However, some of them travelled months and even asked for asylum in some of the countries along the way. The participants' description of their transit-migration experiences, i.e. their stressors, psychological distress and coping mechanisms are presented below.

6.4.1 Transit-migration Stressors

Many of the participants had not planned their escape, and they were fleeing from war and persecution to save their lives. Therefore, they did not know where they were going, so most of them just '*followed the road*'. They used different means of travelling. In most cases, they had to walk for long distances through bushes and roads before they found tracks or buses, used boats to cross rivers and few could take a direct flight from a third country to South Africa. For most, it was a desperate journey. They travelled as far as they could until they reached a place where they could feel safe and a place with some level of security where they could live. The most difficult thing for most of them was not knowing where they were going and trusting strangers they met along the way. They were frustrated by their lack of money, food and language problems experienced in their journey. Some had traumatic experiences in places where they assumed to be safe but ended up doubting whether they would survive or lose their lives.

Participant **1** fled from Burundi with his family. However, he felt insecure in Tanzania - fearing that the government might send someone to follow him. He left his family in Tanzania and continued his journey to South Africa.

> *The most challenging things were that I was travelling alone, there were language problems, especially in Mozambique, I had also financial problems, - I had not enough*

> *money to keep going. I was not feeling safe, travelling with strange people and trusting them* **(P. 1)**.

For Participants 5 and 9, the difficult experiences were particularly travelling long distances without having enough food and water.

> *I travelled for two weeks in trucks, and it was a difficult and the toughest journey ever. We were tired, hungry and weak, and our appearances were changed* **(P. 5).**
>
> *It was a difficult decision, we were about 40 Somali, and there was someone who was leading us. The journey was difficult, and we had to walk during the night until I had blisters on my feet* **(P. 9)**.

A participant decided to join his father in South Africa. He agreed to pay $1000 US dollars to a smuggler who arranged his illegal travel from Ethiopia to Kenya. They used a forged document of the UNHCR. However, they were caught and jailed by Kenyan officials. He said for the first time they put a chain on his hands. He was sentenced for three months for the transgression and was in a jail where inmates were serving for life or more than 35 years for killings.

> *I was stressed by the inmates' history, besides that, we had food problems and the place was cold and dirty with too many lice. I lost a lot of weight, my appearance was changed, and my cheeks were diminished, I was in a bad situation, I had diarrhoea, there was no water, and we couldn't wash our bodies* **(P. 2)**.

When Participant 13 fled from Burundi to the Congo, the war started among Congo rebels (Mai Mai) and Rwandese (Bagna Murengi), her husband's life was in danger because he looks like a Rwandese. The Congolese assumed he was Rwandese and the Rwandese wanted him to work for them, so they decided to leave and went to Zambia and then to Mozambique

> *In Mozambique, I stayed in the refugee camp for three months. I had a lot of stress, and I was sick and lost my pregnancy due to a miscarriage. The life in the refugee camp was not good, and we had a lack of (nice) food* **(P. 13)**.

Participant 14 fled from the DRC with her husband, then when they were in Tanzania, Dar es Salaam, more than 25 gangsters broke into their house one night and attacked them.

> *They beat and tortured us a lot. They cut my hand with a knife* (she showed me the scar). *Still, I do not have a feeling in my finger. They stabbed my husband in his arm. They asked us to give them dollars which we did not have. But they took everything we had, even documents* **(P. 14)**.

Participant 14 indicated that from Tanzania, they went to a Malawian refugee camp in Saliga, but they were told that the camp was no longer receiving new asylum-seekers. She stayed in the camp when her husband left to South Africa for greener pasture.

> *It was hard for us to live there, but I stayed in Malawi for three months because I gave birth. It was hard for me to continue the journey with a small baby. However, my husband came to South Africa, promised to send me money once he got the money* **(P. 14).**

Participant 8 left Burundi and decided to continue his journey further from Tanzania to Mozambique as he had bad experiences in a Tanzanian refugee camp during the 1990s when he was there. However, he was almost killed by rebels in Mozambique.

> *I went to Tanzania from Burundi, but I did not want to stay there, I remembered the difficult life I had in Kigoma refugee camp, I thought about the people who died due to a lack of food and diseases in the camp. I decided to go to another place. In Mozambique... the rebels killed many people and even burned the car, and I thought my life would end then. However, they let me go, and it is from God* **(P. 8).**

Participant 12, who is from Zimbabwe, explained that he first went to Botswana to find another way to survive. He explained that the difficult thing in Botswana was being a stranger and not supported by local people as he was selling his artwork.

> *It is difficult when people don't know a person. It is very hard for them to come and help me. Just to support me* (buy his artwork), *it takes time until they learn more about you and they can understand you* **(P. 12)**.

6.4.2. Experiences of Psychological Distress

While some of the psychological distress was mentioned above, it is clear that the psychological experiences from pre-migration and during transit migration were a continuation of similar psychological distresses. During the transit migration process, most of them were overwhelmed by thinking either about their traumatic experiences, or the families they lost or left behind in danger. In addition, the difficulties they were experiencing at this stage of their journey also contributed to even further psychological distress.

First, most of them were travelling with the fear and insecurities from their traumatic experiences that made them feel apprehensive and unsafe. Some participants, even though they escaped the immediate threat at their homes and had crossed borders to neighbouring countries, they still felt fearful and insecure due to the proximity of the threat. They were driven to travel as far from their

home countries as possible as it was deemed to be more secure. As participant # 8 said, "*I would travel down further to the south if there was no sea*".

> *Once I reached Kigoma* (Tanzania), *I was feeling insecure and unsafe. I had a big fear* (from follow-up by the regime). *Tanzania is close to Burundi, and there were a lot of Burundians. I did not feel safe and thought anything could happen related to the problem I experienced before ...* **(P. 1)**.
>
> *When we crossed the border into Rwanda, I knew that Rwanda was attacking the Congo, so I did not want to stay there. I was scared and had a strange feeling of fear and insecurity … of discomfort staying with the people who were attacking us* **(P. 5).**

Participant 10 lost his entire family in Burundi when he was in Tanzania, and he said he was not good spiritually and mentally, he kept re-experiencing the traumatic event.

> *I was thinking and often dreaming, seeing my family dying, all the time I was hearing noises. I was also thinking about all the things that happened around us, and I was not sleeping well. When I was awake, I was thinking about how I could run and go faster and very far away because Tanzania and Burundi are near, and anything can happen. Those people can follow people and kill me…*
>
> *It was not me; it was the thought that was coming to me… told me to go very far because when I was sleeping I had those dreams and when I woke up, I just wanted to be far from where I was because they can follow me and they can catch me* **(P. 10)**.

It was difficult and stressful for others to travel, not knowing where they were going. Participant 4 felt a sense of worthlessness and a detachment from life.

> *The difficult and stressful thing is that I did not know where I was going and how my life would be. I was stressed and felt like as if I was nothing and just worthless. I told a truck driver that my life is in danger and that I needed to move away from the DRC. The driver hid me in the truck and took me to Zimbabwe. I did not know where he was going***…**
>
> *During the time I was running away I was like a dead man for six months; I had sleeping problems and not eating much, I started coming back* (to normality) *slowly when I came to Durban and it took me almost a year to recover* **(P. 4)**.

Apart from the traumatic experiences in their home countries, leaving loved ones behind in life, threatening situations was another aspect that occupied their minds and caused distress. They talked about 'overthinking' the fate of their families and wondered whether they were alive and safe.

> *In the journey my biggest worries and what kept repeatedly coming to my mind were the people I left behind - how they were doing and whether they were safe* **(P. 1)**.

> *The difficult thing… I left my wife pregnant and I was thinking too much about her* **(P. 3).**
>
> *I was overthinking all the way about my family and people I left behind without saying goodbye, whether they were alive because the whole country was at war, I was not talking even to my friends who were with me...* **(P. 5)**.
>
> *On the way to South Africa, I had two things on my mind, one to get out safely and I was worried about my family and father. I was not sure whether my decision to run away was right… - I knew that my life was in danger, but I was worried about my family more than himself. The soldiers were targeting selected people and my family was one* **(P. 7)**.

The stress they were experiencing seemed to have exacerbated the psychological problems they had. A lack of money to continue the journey, the lack of food, language problems and the uncertainty of whether they can trust the people they met on the way made their journey stressful and desperate.

> *The challenges along the way affected my mind and stressed me. I had the courage to continue, but it was a desperate journey as I was facing more and more challenges because I did not know where I was going. I just wanted to go far from home to a place where I could feel more secure. There was a time that I lost hope and felt hopeless and powerless when I thought that it might be the end of my journey, but in spite of the difficulties I had to continue* **(P. 1)**.
>
> *We were desperate and had a lot of pressure and we believed what the driver told us, we just prayed to reach safety. We did not have a choice too, either we go or die. I had some second thoughts and of death but reconciled by saying whatever happens let it happen. I did not want to think too much about the things I could not solve* **(P. 5)**.
>
> *I was regretting my decision to flee. When I was tired, I said if I knew about the way… I would have stayed with my mom. Then my mom would have known what happened to me, but here* (in the middle the journey), *I could not even describe to her how I was feeling and what I was going through. I was going to South Africa but who was there waiting to help me?* **(P. 9)**.

Participant 14, as mentioned above, was traumatised when a gang broke in and tortured her and her husband demanding their money. She was re-experiencing the traumatic incident in her dreams and had sleeping problems. She was fearful of clues that reminded her of the incident.

> *I was very traumatised, even I changed the room. The experience was coming in my dreams, and sometimes if I was sitting in the house, I was jumping if I heard the sound of cockroaches thinking someone is breaking-in the house. It was very traumatising. Even the sound of a cockroach terrified me... I was shocked and I was feeling my heartbeat going up, I was sweating, and my fingers were freezing, and I was feeling as though my hair was coming out* **(P. 14)**.

Participant 14 explained that it took her a long time to forget the traumatic experiences. Sometimes she could not sleep properly because she was feeling a lot of stress.

However, the participants from Eritrea felt relieved for escaping safely from their country. Being away from the oppression and to have safely crossed the border where the shoot-to-kill order was in place, meant freedom and psychological relief.

> *Even though I was forced to leave my people and the culture I love, I was happy and felt relieved when I reached Ethiopia safely, I enjoyed the freedom I had never experienced in the refugee camp and I felt mentally free* **(P. 2)**.

> *When I reached Ethiopia safely, the people welcomed us and there I enjoyed the peace and life in the refugee camp were good. The Ethiopian people showed me respect and I tasted the freedom a person should have* **(P. 3)**.

6.4.3. Coping Mechanisms and Resilience

Even though it was a desperate journey for most of them, participants shared different coping strategies and experiences of resilience to overcome the difficulties and psychological distress they were experiencing. The coping strategies included seeking help from people to continue their journey; to trust information from travellers; faith and trust in God, a determination and unwillingness to give up; seeking alternative solutions; giving meaning to the actions taken for self-preservation; hope for a better life and willingness to risk and seek the unknown.

> *Although I was discouraged, I was also thinking, coming back and make myself ready to try another way to cover my shorts* (lack of resources) *through different means, that back-up feeling was boosting my mind in the situation that weakened my courage and resilience* **(P. 1).**

For Participant **1** to resolve the overthinking and disturbing thoughts he had about his family who he had left behind, he attributed meaning to his decision by having faith in God for his family's safety.

> *I convinced myself that what I was doing was my decision for my own safety. So, I was praying to arrive safely, and I was hopeful that by God's wishes, my family were also doing well, as I was safe and not harmed, I thought that they are also safe. This was giving me a big morale boost and strength* **(P. 1)**.

It was evident from Participant 1 that self-preservation and faith in God were used as coping mechanisms. It was similar for Participant 14 whose faith in God and continued prayers were the

main way of dealing with traumatic experiences. In addition, giving birth to her firstborn helped her in reducing the anxiety she was feeling.

> *We used to pray a lot. It was the prayer which helped me to forget the traumatic experience, only the prayer because if someone believes in Jesus Christ, he/she knows how to maintain belief. Once that person prays, God gives him strength* **(P. 14)**.

> *When I gave birth to my first child, I was very happy to see my child alive. It relieved my stress from the traumatic experience. I was very happy, even my husband because if they had killed me, I was not going to see that child. Then we named the child Joy. We were very excited that birth helped us to forget a little bit, the child brought joy to our life again* **(P. 14)**.

Most of them also received support from people who empathised with them. The support received from strangers or acquaintances included financial assistance, offering transport or food to resume their journey. They had to lower their statue in order to get the support, they became beggars.

> *To solve my financial problem, I was approaching Muslim communities in every place I was passing, I was getting support to continue. Mosques were a centre of gravity for me as they were shaping my journey. I was also asking favours from drivers, because I could not pay the same price as the normal travellers, I had to beg and negotiate. I was also begging for money and food from people* **(P. 1)**.

> *My friend in Tanzania was the one helping me, I stayed with him for a week and used his money for transport to South Africa* **(P. 10)**.

> *Life was hard in the refugee camp, we were not received as refugees, so we were not given any support, but we were staying and supported by other refugees who were there before the camp was closed* **(P. 14)**.

Knowledge about the difficulties that might have to be faced, the ability to communicate with people and knowing that there is a way of resolving the difficulty, apparently helped Participant 2 not to stress too much and to remain psychologically positive despite the fact that he was jailed for three months in Kenya, as mentioned earlier.

> *When I was jailed in Kenya, my ability to communicate in English helped me to make a deal with people to take me out and I was hopeful. I had information that everything can be solved in Kenya using money* (bribing), *so I was hopeful and did not stress much. Our parents were also trying to solve the issue and they were giving us hope. I paid about 2000 dollars to a dealer to be released from prison* **(P. 2)**.

Information about South Africa as a destination that held out the promise of a better life and job opportunities influenced some in their decision to migrate to South Africa and it also helped them to travel with hope.

Before I knew South Africa only in a geography subject, I never thought of South Africa. When I was in Burundi, we found a truck driver who told us that he lived in South Africa and he was going there, he agreed to take us for free. He said we would be safe there and SA is the best country in Africa. We became more interested **(P. 5)**.

In Mozambique I met a group of people coming to South Africa, they told me that there is a good life in South Africa, people eat and can have a good life, but South Africans are killing people. I joined the group **(P. 8)**.

When I was in Kenya, I was listening to people saying there is a job opportunity in South Africa, I said staying in Kenya was not helping me, so I decided to come and look for a job. Then I found a group of people who were going to South Africa, I joined them… the men were so protective and doing everything to help the women **(P. 9).**

When we were in the Mozambique refugee camp, people were talking about how life is better in South Africa. They said refugees could work and pay rent. Then my husband left me there and he came to SA. Then after a month, he sent someone to bring me to Durban **(P. 13)**.

6.5 Post-migration Experiences

Participants shared detailed information about their experiences from the day they crossed the border into South Africa. Those that crossed the border illegally through bushes and border fences paid smugglers and bribed guards. Others entered through the border checkpoints and were provided with a14 day permit for asylum-seeking at the Home Affairs Refugee Reception Centre (RRC). Participants' shared different stories of the asylum-seeking process, for some, it was easy to access and for others it was a daunting process. Besides approaching Home Affairs for documentation, asylum-seekers were left to fend for themselves since the first day they arrived. Most of them were received and accommodated by family or friends who came to South Africa earlier, those few who were not fortunate to have had someone in South Africa had major difficulties until someone came to their rescue.

Participants shared post-migration experiences by stating how they found South Africa in comparison to their expectations of South Africa. In the section below, this issue is first presented followed by participants' experiences of post-migration stressors, psychological experiences, coping strategies and resilience.

6.5.1 Refugees' Expectations and the Reality

Information regarding South Africa's peace and democracy, accepting asylum-seekers and job opportunities were attracting factors for most participants in deciding to come to South Africa.

When they arrived in South Africa, some of them felt secure and safe and appreciated the democracy especially those who escaped from oppressive regimes and persecution, even though they are experiencing different forms of stress. To others, South Africa is described as an insecure and xenophobic environment beyond their expectations. Participant 1 from Burundi fled persecution.

> *My expectations to be safe and secure in South Africa were met, but I faced other challenges like adapting to a new culture, language, rules of the country and a lack of opportunity to continue my studies. It was not a smooth process; there were pressures* **(P. 1)**.
>
> *I experienced both sides of SA, and it is a democratic and free country with an opportunity to study or work, people can move freely. I also witnessed the xenophobic violence and experienced criminal activities. I was stressed in the beginning, the crime is too much in SA, and I was victimised several times, criminals beat and harassed me to take my phone, now I am used to the criminal environment - unconsciously* **(P. 2).**
>
> *I thought when I came here, I could find a good life and forget everything that happened to my life - but I did not get what I was thinking. I found out that life in South Africa is very difficult compared to the life I was living at home. Life is becoming more difficult* **(P. 10)**.
>
> *I was surprised when they offered us jobs as security guards for ZAR2000 in the night we came to South Africa, I thought the country must be good. I thought it was big money when I changed it to Congo's currency, I was tempted to take it, but I did not* **(P. 7)**.

However, later Participant 7 realised that there are many difficult things to deal with. He came when he was 21 years old and has been here for nine years.

> *I spend most of Christmas alone. Emotionally it is very difficult, I have to face challenges alone and there are financial challenges, I have to be on my own, I was also overthinking about my future and what kind of future I want for myself* **(P. 7)**.

6.5.2 Post-migration Stressors

Refugees' post-migration difficult experiences include, but are not only, a lack of basic needs since they arrived in South Africa, accessing different services like home affairs for documentation and different public services, language problems and experiences of violence related to xenophobia and crime. They also feel insecure because of the current xenophobia and unconducive environments for bringing-up children. Participants shared in detail their experiences, and these descriptions are grouped into themes, mentioned above, based on the commonality of the experiences.

6.5.2.1 Accessing the Department of Home Affairs (DHA)

The first challenge for refugees after crossing the border was accessing the DHA. Most of them crossed the border illegally through bushes and fences bribing border guards and was informed about the asylum-seeking processes and were accompanied by the people who received them. Participants shared different experiences of accessing DHA and asylum-seeking processes. Even though they had a chance to present their cases, some felt that their status was not a true reflection of their cases. Seven of the participants have refugee status (Section 24 permit) and the other seven are using asylum-seeking permits (Section 22 permits), i.e. they are still waiting for adjudication, some since 2006.

Participant 1, even though he approached the RRO several times, he was imprisoned for a month due to a lack of documentation before he accessed the RRC for documentation.

> *In 2002, even though I approached the RRO at Braamfontein in Gauteng, I could not make it as they were accepting only a few people in a day, I was caught by police and imprisoned at Lindela* (a prison for undocumented migrants) *for a month, from there I was given a six-day permit to go and present himself to RRO* **(P. 1)**.

Some of them experienced difficulties in accessing the RRO and felt harassed and mistreated by the office, for example, Participant 7 came to SA in 2009, he went straight to a border point and he was given a paper to go to home affairs RRO within 14 days. Those who were rejected asylum had to appeal and secure an asylum-seeker permit.

> *It was hectic to get access to home affairs. We had to sleepover. The first time, it was very cold, and I came at 2 am to be opened at 7 am, however, already there were a lot of people before me in the queue. I went another day, after registration, I was interviewed by an officer. I was rejected, however, I wrote an appeal, and was given a six-month permit (***P. 7).**
>
> *I went to RRO and sought for paper, it took me some time to get access. There were long queues. There was a delay in getting papers, and people were harassed* **(P. 12)**.
>
> *I went to home affairs, during the interview I was not given enough time to explain my problem and I was rejected. Then I went to Lawyers for Human Rights and explained the issue. LHR helped me to get a six-month permit* **(P. 8)**.

On the other hand, others accessed the RRO easily, when they crossed through the border entry points, they were given the necessary supporting documentation to access the RRO. Those who came earlier, i.e. before 2006 their cases seemed to have been adjudicated swiftly.

> *I crossed the border without any problem, I was inside the truck and the driver brought us directly to Durban. It was simple to get a permit during that time* (at 2002). *I was given six months permit in the beginning, then after two years, I was given refugee status. It was not complicated like today where people have to sleep over* (in the row queue) *to get access* **(P. 5)**
>
> *I came to South Africa through Zimbabwe, I was asked for documentation at the border and I told them I did not have any documents. Then they gave me a 14 days paper. I approached the home affairs at Port Elizabeth, it was easy to get access, when I gave them the fourteen-day paper from the border officials, I was given a two years permit* **(P. 9).**
>
> *We crossed the border through the bushes and fences, the guy bribed the guard. My husband took me to Home Affairs. At that time, it was not hectic like these days, I did not wait long, I just stayed outside, they gave us the papers and we wrote our names, date of birth and then we were called and given the asylum seeker permit without even an interview. However, after a year, I had an interview and I was given refugee status* **(P. 14)**.

Those who are currently using asylum-seekers permits (Section 24), renew this every six months and are still waiting for their cases to be adjudicated. Using that temporary permit restricted them from employment opportunities, travelling and access to public services such as access to housing and banking services.

> *I was given an asylum permit for six months and had been renewing this for the last 11 years. My asylum-seeking case has not yet been verified since then, my status is not determined. If my document was proper, my life would have been changed a long time ago. I do not have a permit that is recognised and known by employers, even if some employers do not know there is such a paper. Home affairs is very difficult; it needs to be more friendly* **(P. 6)**.
>
> *SA is better than where I was, but I am also restricted by documentation from using other opportunities… like in education, to use my all potential and other services. I feel I am limited in some situations because I am a foreigner. If I was able to travel, my life would not be like this* **(P. 2)**.
>
> *I am using a six months permit. I could not travel even within Africa, but European countries are giving Africans citizenship, but an Africa country is denying us proper documents, and it stresses me too much because I cannot be employed using that paper and nor can I have a bank account* **(P. 3).**

Others were forced to write other cases and pay bribes to the officials via interpreters. Participant 2 had to pay a lot of money to dealers to facilitate his entry, and similarly, he bribed RRO officials to earn his refugee status.

> *A Burundian interpreter advised us that they would not accept our case. We were wrong to listen to him. The interpreter used another name for me and a false case, I am still using*

that name which is not my real name. I keep complaining about the name, they always tell me it would be fixed when I renew it, but it is not fixed yet **(P. 13)**.

I paid ZAR40, 000 to dealers to fly from Kenya to Johannesburg, South Africa. I also paid ZAR5000 at home affairs in order to get the refugee status. The interpreter arranged it and he wrote a false religious case for me, because the DHA is believed to accept only religious persecution cases of Eritreans. What mattered most was getting the refugee status. Then I was given a two years permit, now I have to renew my status every four years **(P. 2)**.

6.5.2.2 Lack of basic needs

South Africa does not provide any welfare services to asylum-seekers on their arrival resulting in feelings of destitution for some participants who had no access to food or shelter since the first day they arrived in South Africa, especially if there is no family or friend to take care of them. The need for basics necessary to sustain a livelihood continues to be a stressor that challenges most participants to this day. Their descriptions included the stressors and struggles they were going through and still do to make a living for them and their families. Most feel that they were not given an opportunity to use their potential and to overcome their livelihood stressors.

Participants 9 and 10 shared the difficulties they experienced and their struggle to meet basic needs:

When I came to Durban, I did not know anyone, so I was sleeping outside in the road until someone who saw me living in the road offered me a place with him **(P. 10)**.

He only later went to RSS, and was supported with two months rental payment, he said after few days he would be in trouble, as he does not have money for the rent as the man supported him moved to another town.

Since the first day in SA, I didn't even have clothes. The only clothing I had were the ones I came with. Since the first day I was looking for a job. It is even difficult for a woman, they might have periods, they did not get clothes to change, and it is very difficult for them. Then I got a small job then I bought clothes to change **(P. 9).**

When I crossed the border from Zimbabwe, I walked a long distance because I had no money for transport. I was sleeping outside and begging for help from people. I even walked from Pretoria to Johannesburg to ask a friend for help who was staying there **(P. 6)**.

Some of them are still unable to meet the basic needs for themselves and their families, for Participant 8 getting enough money to ensure daily food is the main stressor.

My life is very difficult, and there is no one who is helping me, those people who sheltered me do not have much, it is very challenging. My main problem is finding enough food, in

> *the place where I am staying there is no food, if they get food, they give me once a day. There is a time that I stay days without food because I could not tell people that I did not eat food* **(P. 8).**
>
> *I am doing everything on my own, pay rent and buy food. I was not used to this life, I was not ready to do all this. The difficulty in SA makes me remember the life I had with my parents, they were providing everything for me* **(P. 10)**.

Some of them stated that living in South Africa is becoming worse from what it is used to be as their incomes are stagnant while living costs are escalating.

> *Life was ok, goods were very cheap in the beginning, now goods are becoming expensive, but the income had not much changed. There is a housing problem, rent is expensive. The monthly payment could finish paying rent and food* (rent and food exhaust all disposable income). *Even it is difficult to pay school fees* **(P. 14).**
>
> *Now I am staying in a shelter taking responsibility for myself. I am not working, it is difficult to pay the rent. I looked for a job in Somali's shops, I did not get any. I need daily bread, a safe place, I am not working. Where am I going to get the money?* **(P. 9)**.

Participant 5 worked and studied for five years. He felt so tired, he could not do both work and study anymore and he was not able to pay his fees. He still owes money for fees. He also did not find a job as he did not finish school. He was tempted to do something he does not want to do, like becoming involved in crime.

> *I am working on a freelance basis as a sound engineer, which has no guarantees, if I had a diploma, I would have a permanent job. I am facing a tough situation where I do not know what to do. I was tempted to become involved in criminal activity. I know people who are doing those things, they are doing well, but there is something that keeps holding me back* **(P. 5).**

6.5.2.3 Xenophobic Environment: Feelings of Insecurity and Vulnerability

"*Dying with bullets rather than stoned…"*
"… Even if they hate us, we cannot go anywhere, we have to forgive them"

Participants' experiences of xenophobia range from daily encounters of verbal harassment to physical violence that makes their stay perpetually insecure and vulnerable. They explained that xenophobia is not a one-time incident, it is a recurring daily event. However, there are days in which it escalates to a higher level of violence. Participants also pointed out that hate and discrimination are not only from local people but also from government institutions. Xenophobia

is displayed in various ways, such as being called names, harassment, beating and violence, including mob attacks and looting of property.

> *I was working as a hairdresser but during the xenophobic violence* [2008] *the mob broke into the salon and stole everything. Since then, I have had financial problems and not able to reopen the salon* **(P. 13).**
>
> *In the place I work, there is a person who does not like me because I am a foreigner. He sends young men at night to beat me. I was almost dead when they beat me and left me to die* (happened four months before the interview*). I did not get help from anyone, I am also afraid to report the case to the police because I hear the same people will come and kill me if I report them* **(P. 10).**
>
> *I am living in shacks/informal settlements, surrounded by local people and it is not safe. If there's any trouble, we are the ones who are targeted* **(P. 8)**.

There was a time when some of the participants feared for their lives because of xenophobic violence, and they felt like going back home. However, as their home countries are in worse condition because of war and conflict, they are still in South Africa. While some feel isolated, unwanted and powerless to express their anger and to respond accordingly, most of them see themselves as being vulnerable and insecure.

> *During the xenophobic attacks, we feel like going home even if there is still a war there. We say we can go back dying with bullets rather than dying stoned. Looking at how they stone people to death. It is very hard, and there is nothing we can do. However, when we phone home, they told us they were attacked and relatives or neighbours killed* **(P. 14).**
>
> *During the 2008 xenophobic attacks, I was scared to go outside. Because I heard the story of xenophobic attacks and killings, I thought if I went out, I might be the one to be killed* **(P. 9).**
>
> *Refugees are being discriminated against on a daily basis in busses where we are called names, that's something refugee is used to... I feel bad emotionally, I feel really rejected and powerless as well, and they make me feel I am not in my place, I need to get my right place* **(P. 7).**
>
> *When I am called 'a foreigner' or people shout at me 'you are a foreigner, how can you talk to me like that'. It is really hurting, and it tells me that I am not needed here, I am forcing myself to be here* **(P. 9)**.
>
> *The harassment from local people showed that in a foreigner land, a foreigner could not expect to live a hundred per cent in a good way like once in one's own country. The challenge refugees face here is hatred of people. Sometimes I think a lot, and we pray to God to get peace in our home country. So that we could go back. The hatred of these people is too much* **(P. 14)**.

> *The main problem is the way South Africans treat foreigners. They always remind us we are foreigners. Now, I am used to it. There are some people who are very xenophobic, even in my organisation, they feel like they are superior beings. South Africans have their own way of doing things, even if I am a friend to them, when push comes to shove, they leave you alone* **(P. 6).**

Participants also shared how South Africans' attitudes and actions towards non-South Africans become aggressive from time to time. They described the frequency of xenophobic attacks as an indication of a worsening situation:

> *In the beginning, there was no xenophobic violence, they were hiring refugees in companies, since the xenophobia started; they are not hiring refugees* **(P. 14).**

> *Since I came here, I have seen a lot of things, anything can happen to anyone in South Africa. Before the xenophobic violence of 2008, our life was normal, we were living and working among the locals no matter how they treated us, even they called us names, "Kwerekwere", because we are here to make a living. But things changed… co-workers started treating me differently* **(P. 13).**

> *The 2015 xenophobic attack showed us the rise of hatred against Africa foreigners, there is a clear feeling that we are unwelcomed, we feel isolated, not only from the people but also from the government. On the ground, local people are showing refugees that we are not welcomed. There are verbal abuse and physical violence, people are being killed because they are foreigners. This time it is worse than at the beginning* **(P. 7)**.

Some of the participants described that the government and other institutions are also displaying xenophobic attitudes.

> *The xenophobia did not start with street boys, but the government is xenophobic itself. Because since 2006 the government stopped security training for refugees, so they cannot obtain the certificate to be hired as security guards. Now this is only for citizens* **(P. 14).**

> *There are even government policies which are put in place to isolate refugees from studying and employment, especially if you have an asylum-seeker permit- it is difficult to find a job. And now they are saying they will put people in refugee camps* **(P. 7)**.

Participant 2 explained how refugees are affected, in terms of insecurity, by the xenophobic violence, on top of the high crime rates that jeopardised the life of everyone in South Africa.

> *The 2015 xenophobic attack made me to overtly think about Human Dignity, and I questioned myself a lot about the place I am living in? I was wondering as a refugee whether anything worse could happen to me. I do not feel secure in South Africa. South Africa is not secure for South Africans too. Criminals target everyone, however, refugees are more affected by a lack of documentation and xenophobic* attacks **(P. 2).**

Refugees experience xenophobic attitudes and discrimination at institutions of public service. Documentation is needed when wanting to access hospital and banking services. Participants also

shared experiences of discrimination when seeking health care services particularly refugee women when talking about hospital deliveries. It also seems that asylum-seekers with six months' permits suffer the most.

> *I experienced discrimination in hospital. When I went to King Edward Hospital the nurse told me to go back to my country. They said "kwerekwere go back home". I approached the management, but she did not do anything* **(P. 4).**
>
> *The most difficult problem refugee women face is in hospital when they deliver. Nurses do not give much attention to refugee women, even if you feel the baby is coming out… Sometimes the nurses beat the women, I know a woman who was beaten by a nurse during delivery* **(P. 9).**

Participant 13 shared her own experience in a public hospital when she went for delivery. She felt discriminated against because she is not a South African. She said she prefers to take her boys to a private hospital if she has money. She said that in a private hospital they treat them well and give them medicine

> *When I went to the hospital to deliver my second boy, the nurse neglected me even though I was in labour, screaming and crying from pain. I was told to sit and wait. But they were assisting South African women who came after me. Then another woman came, and she was also told to wait, I asked her where she is from, she was a foreigner. Then I realised that it is because we are not South Africans. We did not get the attention and care.* **(P. 13)**.

Some of the participants feel they have not received the medical attention they deserve and are mistreated by health care practitioners in public hospitals because they are refugees.

> *When I found a lump in my breast, I was scared it might be cancer. I went to the hospital for checking, it is not cancer, but a breast disease. I asked them if they can operate because I still have pain. They told me they could not operate. They told me to buy medicine if I feel pain* **(P. 9).**
>
> *I went to the clinic several times and told them that I had psychological problems, but they keep giving me Panado and the like. They do not even let me explain. I felt more stressful and abandoned* **(P. 4)**.

However, to Participant 6, who is an asylum-seeker accessing a banking service is the main stressors he is facing because of the nature of his permit.

> *There is a lot of difficulties in accessing services; however, Opening and sustaining a bank account is very difficult* **(P. 6)**.

The hostile environment, including xenophobic violence, is the main reason for *insecurity and uncertainty* that participants are feeling. Further, they feel insecure and uncertain about their children due to a perceived child-unfriendly environment and high crime rate. Participants shared their fear about their children's future in South Africa. They do not believe that South Africa is the right place to raise children. Further, they do not want their children to have the same experiences they are currently experiencing and are concerned about the lack of opportunities.

> *Many refugee children end up in the streets when they finish their matric and get involved in alcohol and drug use because their parents don't have money to send them to varsities. Looking at the refugee children in the streets, I worry a lot, and it frightens me. I wonder whether the same thing is going to happen to my kids* **(P. 5).**

South African legislation pertaining to child rights and in particular, the prohibition of corporal punishment is viewed in a problematic light. It is perceived that restricting parents from disciplining their own children was culturally inappropriate and problematic for parents. Participant 14 said what children learn in South Africa is different from her culture. Here the policy prevents even teachers and parents from disciplining the children.

> *Another problem is more freedom for children. Parents could not discipline their children if they did wrong. When they do, the children sue them, and this creates a lot of confusion in the refugee community. As a result, there is delinquency, teenage pregnancy, drinking ganja and taking drugs because children are missing the basic education from parents at home* **(P. 14)**.

School children are taught to report abuse at home. The refugee mother shares her experiences when her children came with a police phone number from school and told her that they were told to call the police if they are abused at home.

> *Then I explained to my children why parents beat them. Then the children told me that they don't want the number and will never call the police for their parents. I told them in my culture children have to respect elders, and we are Christian and must know what the Bible tells them, must respect parents and love each other* **(P. 14)**.

The high crime rate in South Africa is another reason for refugees feeling vulnerable and insecure. They are feeling consistent fear and not knowing what is going to happen next. Crime also seems to affect their general interactions and attitudes towards the local South Africans.

> *It is difficult, and I am living under pressure. There are a lot of things that scare me; people might attack and rob me at any time. I do not know. There is a lot of robbery in the streets;*

*even they can come to where we live and take everything that someone has been working for ages***.** *When I was at my cousin's shop, robbers with guns came and took many kinds of stuff from the shop during daylight, and I was shocked by the incident. Never expected such thing in daylight* **(P. 3).**

The crime and my experiences affected my interactions with the local people. If someone has done something bad to me, when others come for help, you interact with everyone negatively. It really affected my attitude **(P. 3).**

I have an asylum-seeker permit. Thus I could not find a good position, and even if I work I do not feel like staying in SA because many people are bad here, there are attacks, and I can lose my life in SA anytime. Street thieves caught me one day and took my phone **(P. 4).**

6.5.2.4 Unemployment

Unemployment is one of the prominent post-migration difficulties experienced by most participants. Even though participants' acknowledged unemployment is not only a refugee problem, they feel, however, that refugees are denied opportunities while they have the required qualifications and skills for many vacancies.

For refugees in South Africa, life is becoming harder than at the beginning. My husband has a proper document, and he is a qualified driver, but he has not found a job because he is a foreigner, and they give priority to citizens **(P. 13).**

I graduated and have a teaching certificate, yet I am unemployed even though I applied many times. I have not been able to improve my life. Unemployment is not only among the migrant community; there is a high unemployment rate among the local South Africans **(P. 1)**.

My husband studied in South Africa, and he is a qualified teacher, but since 2013 or 2014, the government told the Department of Education not to employ refugees. Still, schools have vacancies, but refugees are blocked in the system. There is a high unemployment rate in the refugee community, even though it is also a realty among South Africans, but refugees have skills, but the politics put refugees aside **(P. 14)**.

Those few who were lucky to find some opportunity complained that their payment was not at the appropriate rate aligned to the specific job.

Even though I was able to lead my life and save a little money, I was working for a small payment without any overtime payment for five years **(P. 1)**.

Living in South Africa is very scary… even if someone has a job, the payment is according to who he/she is. Therefore, I am working just to feed myself and to pay my bills **(P. 4)**.

6.5.2.5 Language Issues

Participants' shared how they struggled in the beginning because they could not speak English or isiZulu - the local language. Either they miss getting work and other opportunities, or they were intimidated for speaking their own language.

> *The language was the main challenge in the beginning,* [2002]. *The locals were not willing to communicate in English, and even we had a problem speaking our home language in a public place like a taxi. We were intimidated if we did speak* **(P. 1)**.
>
> *I was not speaking English and isiZulu; I was working as a car guard at Smith Street. It was a tough job. It was a huge challenge to communicate with customers when they knew I could not speak* (English or isiZulu)*, they did not talk to me for a second time and some people also did not pay* **(P. 5)**.
>
> *Life was not easy at the beginning because I was not speaking English. I did nothing for the first year. I was asking for money for food from my parents back home and friends, I was also working as a car guard to get money for rent and food* **(P. 4)**.
>
> *I cannot work now because I still have a language problem when I know the language, I think I will look for a job. Now I am not doing anything* **(P. 11)**.

However, for a Zimbabwean refugee the cultural and language similarity helped him to settle.

> *… culture and language similarity with South Africa were an advantage I had as comparing to refugees who came from other regions. In terms of communication I do not have a problem as I can speak the local language* **(P. 6).**

6.5.3 Experiences of Psychological Distress

In the post-migration stage, the refugees' mental health problems mostly stemmed from separation from their family and culture, the earlier traumatic experiences and various post-migration difficulties. The most common symptoms of psychological distress participants' experience are; fear, overthinking, stress, sadness, loneliness, hopelessness, irritation, short-temperedness, feelings of worthlessness and guilt, the re-experiencing traumatic events in the form of dreams and rethinking.

Participants are highly concerned and worry about *their families* they left behind in an unsafe situation. Their psychological distress was unbearable until they were able to establish their whereabouts and was assured of their safety. Even though communicating home helped to reduce the distress, they remain in a constant state of worry and fear for their families' safety.

My biggest worry was about my family, there was not a day that passed without me thinking about them until I communicated with them at a later stage **(P. 1)**.

I used to dream about my family often, if I dreamt about them, I would phone them even in the middle of the night. I call them often. My father is no more working because of me, I feel guilty and it is painful **(P. 4)**.

I am here in Durban, it is safer for me. My family is still back home and what worries me more is the lack of peace in my country. It means people are not safe **(P. 11)**.

I sometimes get irritated when I think about being separated from my mother, not completing my school as I planned and being far from my culture and community and not contributing to my community **(P. 2)**.

Other participants were re-experiencing the traumatic events from their past, in the form of dreams and visual (flashbacks) during the day, they also experience sleeplessness, loneliness, withdrawal, fear, and a feeling of worthlessness (emptiness).

During the first two years, I was drinking a lot, just to heal myself. It was a way of running away from those thoughts and flashbacks, which kept coming, to forget about everything and to get a good sleep… I still have a problem to sleep early. I cannot sleep before 1 am. The problem is my past experiences, I always have a fear, and still have an image of someone breaking into my house and taking every valuable thing from me. This thing keeps coming in my thoughts. I also constantly think about my father **(P. 7)**.

Experiences of symptoms related to Post-Traumatic Stress Disorder (PTSD) seems intense among participants who lost family members and recently experienced or witnessed traumatic events. It is also exacerbated by post-migration difficulties such as the lack of resources to fulfil basic needs and the hostile environment in which they live. Participants 8, 10 and 11 came recently, two of them lost their parents (P. 8 & P. 10) and P. 11 was raped and did not know where her children are.

Sometimes I dream. Even now, when I sit here, I can see whatever happened. Mostly when I am hungry, when I do not have anything, everything comes to my memory and I think about what happened. Most of the time I don't sleep, sometimes I wake up at 12 o'clock, one o'clock, two o'clock …I do not sleep because I see my family, and I feel my life ends here, I feel I can't go further, I do not even know anywhere else **(P. 8)**.

When I go to sleep, still I dream the bad things. When I sleep, I still see how my parents died. I still visualize the way they died. I still see them in my dreams. Now I added another sickness, TV, which makes my life very difficult. Every time I feel like I am alone… I am useless, everybody looks at me like I am useless. I did not go to anybody for help **(P. 10).**

Always I am thinking about the children and the problem that happened in Kinshasa. Sometimes, I sit and think about what happened. I am not living freely. When I sleep it comes

to my dreams, even when I sit somewhere, I just think, and I cannot see what is going on around me. I just keep thinking, think about my children and everything that happened **(P. 11)**.

I was excited in the beginning, I had no stress. When things started getting harder, I started having dreams and flashbacks of the past experiences at home. After knowing about the violence in South Africa I worried too much, and I was overthinking my decision to come to South Africa, I doubted, whether it was right **(P. 7).**

The post-migration difficult experiences are linked to the high crime level, the hostile environment and the failure to support their families, and these negatively affect participants' psychological health. The common symptoms of psychological distress include fear, overthinking, sadness (crying). Participants are also sad about the loss of their social roles when they came to South Africa, they continue to compare their current roles and living standard to what they had in their home countries.

There is no security in SA, you don't know when robbers will come and attack you, I just keep thinking if they will come today or tomorrow and kill me. Even if they give you a paper for 10 years but if there is no safety, you are always under fear, it stresses me a lot and makes me mentally sick **(P. 3)**.

My expectation about SA was high in terms of safety, I came from a brutal environment and found the same brutal environment here. Before it was really a critical situation for me, it was a very unhappy period of my life, because I was working very hard and I was really worried about being here. I was a bit disappointed by the environment and I had a very bad time for the two years **(P. 7).**

Most stressful things were calling back home and asking for money, my parents have done everything for me, paid my school fees, but when I was old enough, I was asking money, it was so stressful **(P. 4)**.

I have nothing in my hand (money), *I would have brought my daughter to South Africa and took her to school* (She is in Somali). *She is 14 and not going to school. She only goes to a madrassa* (Islam school). *This is my main pain* **(P. 9).**

When they were in their home countries, Participants 6 and 4 were employed as a secretary and a public health worker, respectively. However, when they came to South Africa, they worked at lower levels and at lower-paying jobs. Consequently, this affected their mental health negatively.

When I came to Durban, I worked in the harbour, on a construction site, in a shop with many others. Adjusting is very difficult, very tough, it reduced me mentally. It reduced me to nothing. I was used to a safe lifestyle and then sadly I found myself in a room of five people. The high crime rate was stressing, and I was emotionally affected **(P. 6).**

Life was not easy; I was crying in the parking over what I was doing (car guard) *compared to what I was doing in my home country. I felt I was a beggar for small money* (little money*),*

> *while at home I was working as a public health campaigner and paid good money. It was so stressful, I was not interacting and talking with people; sometimes I was getting angry, short-tempered and easily irritated, crying often. I was not sharing my problem with anyone* **(P. 4).**

Similarly, Participant 5 was a student in the DRC and when he came to South Africa, he started working as a car guard.

> *I was 18 when they found me a job as a car guard, it was my first time out of my country and I was working as a car guard, I was crying every day on the site. There was a time I would sit and just think, overthink about my situation, but I never got an answer* **(P. 5)**.

Participant 5 is sad and feels guilty for not doing enough for his children's future. He said he always cries for the future of his kids, he feels he is not giving them a better future.

> *I have not done something; there is nothing that I am proud of. Most of the time, I cry inside when I look at my sons. What can I do, it is not me. I do not know what to do, I have a lot of plans to do, but how am I going to do it. So, it gives me a lot of stress even sometimes I overthink while I am walking in the streets. It is not about me anymore but about my wife and sons. Sometimes, I feel stupid that I cannot do anything, it is the system, not me* **(P. 5)**.

6.5.4 Coping strategies among Refugees

In the post-migration stage, refugee shared a range of coping mechanisms. Faith in God and religiosity are the most common ways of coping and religious institutions are an important source of support. Participants also shared their experiences of support from their families and communities. The responsibility of having children and being married also helps them to be goal directed and to go the extra mile. Most of them also showed hopeful attitude for future, self-efficacy and resilience that can be called psychological capital that was demonstrated in finding different ways of managing their difficulties. While some of the coping mechanisms, e.g. faith in God was evident throughout the three stages of migration, they also employed more and different coping mechanisms in this stage than in the earlier stages of migration.

6.5.4.1 Faith and Religiosity

To most of the participants, their faith in God and support from church members, especially pastors, are the main sources of support to deal with their stressors. They perceive their belief in God as a solution to their problems, as God determines their destinies and is able to help them calm their psychological distress. Their belief and prayer are ways to deal with their difficulties.

It is my belief in Jesus that helped me to pass through all the difficulties because once a person believes in Jesus, it is all His treatment…. because the way a believer can handle things is different from a pagan or those who do not believe in Jesus **(P. 14)**.

*My faith in God gives me strength and encouragement, all is from God (***P. 3).**

I am still alive because of God, I do not think anything else is the reason that I am still alive, but only God. Even when I am sleeping and waking up - that is God and I pray a lot. Everything is just God. Who I am now is from God. I always pray for my family **(P. 8)**.

*I believe that peoples' situation is determined by God, not by people, no one can take some body's destiny away, unless the person himself takes his destiny away***.** *I have hope it will pass; definitely, I have faith in God, I might have better opportunities. I have not given up; I am still fighting and believe that I will go through* **(P. 5).**

I am praying a lot, now it is not like before, I am not dreaming about it **(P. 13)**.

I keep God in my heart, it is helping, things will be right. I always think where I am going to get money for the rent and to send money to my daughter? However, I find some way to get by the end, God has His ways **(P. 9)**.

The Spirit is leading us, even where we are today, we are still strong, that is how we are living **(P. 12)**

The support and encouragement from the church community plays an important protective role in positive coping rather than dealing with stressors in alternative negative ways. The church community also assisted newcomers in finding jobs and begun their live by share accommodation with people of the same background.

The Congolese church welcomed us (with his three friends) *and provided us with food and clothes. I was relieved when I met people who talk the same language as mine in the church. I was in the church until they found me a job as a car guard and rented accommodation with fellow countrymen* **(P. 5)**.

Going to church helped me to recover slowly, also the material support from the Pastor. At the church I was participating in focus groups and dialogue, we were talking about our issues among each other and it helped me a lot, listening to people's bigger problems also helped me to realise my problems are smaller **(P. 4).**

I came to Durban and I went to the church, the church gave me a place to stay. The person who is helping me is someone who came from my home country, we met here **(P. 11).**

The thing that keeps me together is my Christian faith and the support I get from the church and the pastor. My background as a Christian family taught me right manners. My faith also helped me not to do bad things. I am encouraged by the Gospel and the Bible; I do not want to commit a sin. My connection with God through prayer helps me **(P. 5)**.

Participant number 14 shared how the preaching of forgiveness provided an alternative way of dealing with the discrimination and hatred experienced from South Africans.

> *…We cannot fight back. We just forgive them and live. Even if they hate us, we are living together, there is nowhere we can go* **(P. 14).**

6.5.4.2 Social support and responsibility

Social support, as alluded to above as well, as a coping strategy and protection is also a common coping mechanism, similar to faith and religiosity among the participants. They shared that getting material and psychosocial support from families, friends and strangers as critical in dealing with their stressors. Their interactions with a group of people who had similar experiences help them to develop a sense of belonging. Participants also shared that giving birth to a child brought them joy and helped them to be more determined to deal with their stressors while for others, the birth of a child brought relief from their psychological problems.

> *When I first came, I went straight to my family and brothers, so there was no challenge and stress, I had freedom of movement* **(P. 2).**

> *I am married and my wife supports me a lot, she is a Christian, both of us have the same belief and faith. We have aimed at something and we are working together* **(P. 4)**.

Participant 1 said that when he came to Johannesburg, he wandered in the streets for help, then a Rwandese who was passing by offered him help and took him to his place. He offered him a place to stay and after few days he found him a job. He also mentioned that staying closer to his cousin and interact with people helped him to get relief.

> *Coming closer to my cousin who was in Durban helped me, I knew that once I meet him my mind would be free, and frustration would go. My continuous interactions with people also helped me to overcome challenges and keep me strong. Some people encouraged me by sharing their stories and by offering encouraging words* **(P. 1)**.

> *My main support was the good people I met in my life, I met a professor, who was not only a supervisor but also a mother, she supported me in many ways knowing my background, I would not have obtained my masters if I had not met her* **(P. 4)**.

It is clear that socialising and interactions with groups of people are used as ways of coping. Social interaction provides an opportunity to open up to people from similar walks of life and it seemed that they were strengthened through these connections and interactions.

> *Talking about the experiences of people helped me and gave me strength, I attended many meetings where people talk, and I listen* **(P. 13)**.

> *The family of Rasta support one another, we give ideas to one another, and there is very big support more than money and silver. Rastafarian is a full order of everything* **(P. 12).**

> *I started to actively interact with people when I started becoming involved in Activism and with activists. That's how I started opening up to, connecting with and meeting other people because we are all part of the same journey* **(P. 7).**

Participant 14 lived in a community where Indian and Coloured South Africans are in the majority, and she said it is safer to live among those communities.

> *I feel safer than living in a black community. I chose to live there because there is no crime, vandalism and jealousy, people mind their own business. During the xenophobia the community vowed to protect us from people who would come to attack us* **(P. 14)**.

Having a family and children to look after also helped to get relieved from their past-traumatic experiences and to be more socially responsible and future-oriented.

> *By the time I got my first born, some of the stresses went away* **(P. 13)**.

> *Now I am married and have kids. Even though I am desperate sometimes, I cannot involve myself in crime and end up in jail and die, I fear doing crime. Having a family is a support in terms of responsibility, I cannot live my life anyhow. When I look at my wife and two sons, I feel so happy, and encouraged to do even more, but it is a lot of stress* **(P. 5)**.

> *I have kids that I am raising, and I need to stay to raise them until they grow up. That is what keeps me going* **(P. 6)**.

> *I have to stand and overcome challenges to accomplish the expected responsibility for my children even though I have not done anything yet, I plan to support and provide for them* **(P. 3).**

However, others also shared how their communities are incapable of supporting them because either they do not have the capacity to do so, or not organised for that purpose.

> *I went for help to the Burundian community and some of them helped me in the beginning, but when I went back, I found that everyone is having too many problems and I told myself that it's better for me to be on my own because everyone is having his own problems* **(P. 10).**

> *I was expecting that the Somali and Muslim community would help us, but I did not get help from anyone, I had to struggle for myself, there is a Somali community, but I did not get help* **(P. 9).**

Professional support from a psychologist as a coping strategy was mentioned by one participant. He explained that when he lost his two close friends and supporters, he sought help from a counsellor at school (university) to manage the stress and loss he was feeling:

It helped me to adjust to academic life. Without the counselling, I would not have completed my first year **(P. 1).**

6.5.4.3 Utilising psychological capital

The participants were also able to draw from their psychological capital - positive inner resources to cope. They shared their hopes for a better future, showed confidence when achieved reliance and became optimistic that they could change the conditions that required them to be resilient.

Hope for the Future

For others, a positive attitude towards a better future and an attitude that 'things pass' helped them to *be strong* (remained focussed) and to work hard. This mentality *took them out from the dark* (e.g. enabled them to leave their own countries) and it encouraged them to be hopeful for a better future.

There was time I felt my life was ending up, but I also realised that I did not know what the future will bring. I was working as a car guard; instead of crying, I decided to add another degree to what I already have from home. That is why I went back to school. I thought my education would be for nothing if I work as a car guard. I was motivated to go back to school. Now, I am not doing so bad. If I had kept stressing myself, I would not have reached this far **(P. 4).**

I am thinking about a better tomorrow and is not discouraged by what happened, and I am trying to take things easy. My past hardship experiences also help me to see things in an easy way (better perspective) **(P. 3).**

The factors that helped me to pass through my difficulties are first my belief that I always carry with me… no matter the situation I am in, whether good or bad, those things pass, they are not there forever, but for a short time, I live, hoping for better **(P. 5)**.

Participant 7 is an activist for refugee rights and works for social justice in his home country in the DRC. He said one thing that keeps him going is the ideas that he puts in his mind that a better future is possible. He said he has an idea of stopping the suffering of the people in his country who are marginalised based on their tribal affiliation. He aimed to achieve equal rights and opportunity for everyone in the country regardless of their tribe. He said:

If I am fortunate enough to run away (getaway) *from the country, my experience in South Africa showed me how things can be changed at home. These ideas made me keep pushing and helped me to discipline myself, even to stop drinking. Even though there are*

challenges, but a better future for everyone is possible, that is the main motto that keeps me going **(P. 7)**.

Self-efficacy and resilience

The participants also draw on internal resources to deal with the difficulties they are experiencing. They described their resilience as *developing a sense of self-agency* that helped them to look for opportunities. When they performed better and gained financial independence, they became more self-confident, developed self-efficacy, and this assisted them in reducing psychological distresses.

Participant 1 shared that when he was fired from his work, he took it as an opportunity to pursue his studies, and now he has completed his degree, though he was not able to find a job with his qualification yet. However, he prefers to work as a barber and make "*small (some) cash*" to cover his expenses, instead of sitting at home and looking for a better job. He used the opportunity to study and work, to become financially independent and to gain self-confidence.

It was not an easy decision to go to school. I struggled mentally, had many questions whether I am going to cope academically and financially. However, I also saw people like me managing, and I had the courage to study. Things become easier when I was inside (enrolled). *I knew if I work hard, I will get what I wanted* **(P. 1).**

And now instead of waiting for a job he is cutting hair…

It stabilises my mental problem. I cannot say I do not have stress; however, the work alleviates some of the mental issues because I am able to cover my living costs. I am not bothered by being unemployed, but I am still looking for a job **(P. 1).**

Another participant is also a barber, and the income brings him and other participants relief from stress.

I have been learning how to cut hair and now I am managing to cut people's hair, and I am living from the money I am getting **(P. 10)**.

It is almost two years now; my tempers are down, and I can balance things. I was able to manage my life without asking my parents. I started getting hope when I was able to make some money on my own, I optimist things will change, and a new day will come and new things as well **(P. 4).**

Similarly, Participant 5 was determined to change his situation and felt more confident in himself when he did achieve something.

It was a tough situation, but I was so determined to change my life, I did not want to remain a car guard, I had to do something. Something, inside me, told me that a car guard was not who I am and what I wanted to be. When I decided to learn, I was told, above the age (old to be enrolled in high school)*, however, I met a pastor who took me to an adult school*

> *and paid my school fees. I was bothered about how I would pay rent and buy food if I am going to study, and that I will not have time for work. But I also did not want to be a car guard forever. Then I found work as a security guard, and I was working night shifts while studying during the day, I was sleeping only a few hours. When I passed the matric, I realised that my life is coming together, and I convinced myself I could do something. My energy was coming, and I want to further my studies* **(P. 5)**.

Other participants shared their **optimism**; how their activist roles for change in their communities and to resolve their challenges through active civic engagement, brings purpose and meaning to their lives. This shows signs of Post Traumatic Growth.

> *I am always an optimist. In fact, I did another course to upgrade myself. Now I am an activist, a member of an organisation that advocates for the rights of refugees and social cohesion among local and refugee communities. We may not have done big things yet, but we believe there are changes in the minds of some people* **(P. 6)**.

> *I am building a future because I am not returning back. When I am doing what I am doing, I must be patient and never lose hope, I look upwards for ideas for advice and support* **(P. 12)**.

Participant number 12 is a Rastafarian. He said his positive way of life helped him to live amicably with everyone.

> *I am living without pressure* (tension) *with local people. It depends on how you live with people, I cooperate with everyone in the community I live in and people like people who can cooperate with them. I do not have problems to interact with the people, they love me, and I respect them and that is how I survive* **(P. 12).**

6.6 The future of African refugees in South Africa

Participants were also asked whether they see South Africa as a permanent residence or their home. Most of them have never thought of South Africa as their home and do not have a plan to stay permanently. However, the unresolved socio-political problems in their home countries and having nothing to take home, are the main reasons that keep them in South Africa. On the other hand, the uncertainty about a future for their children and the unconducive socio-economic environment to raise children, the lack of opportunities to make a living, and the crime and xenophobic violence are important considerations informing their desires about *going back home*.

> *South Africa is not my future home. I was thinking of going back to my home country. I planned to go this year* (2017) *but another conflict erupted. Another problem is the refugee children who are growing up here, don't have a good education for life in the society… I am getting kids who are growing up here, so tomorrow I do not know what will happen and that makes me scared* **(P. 4)**.

If the political situation changes in my home country, I have no reason to stay in South Africa. The space for foreigners is closing gradually but surely in South Africa, that is why I always long to go back home. I am just waiting for things to change **(P. 6).**

I think all refugees can go back because the hatred of these people is too much. I do not feel at home in South Africa, I am just pretending **(P. 14).**

There are also a lot of things that I do not like, I will have a family and want my family to be attached to my community, to learn their culture and responsibilities. South Africa is not good for raising children when comparing it to my home country, here is a high crime and it is open to sexual practices which are not good for children **(P. 2).**

Participants also shared their longing for their families and culture; however, their thoughts about returning is far from materialising as they do not have any material resources to take back home after being away for so many years. For many, it is also a daunting thought that they might have to start life all over again at home. A few are looking for opportunities to migrate to other developed countries as they have become discouraged by the situation in South Africa

I am thinking to go back home and stay with my family because I already missed them. It has been ten years. I am thinking of going back home, but I am away for ten years, and what was I doing? What will I take back home? I do not have anything to go with, still difficult. What am I going to start with? I do not have anything to go with and start with. I also wonder if I can start from zero again **(P. 9)**.

I think of going back of home, but I do not have anything after 15 years being in SA, my parents are getting old, and they do not have anything. However, I also realised that I could not make a life in SA, I have been pushing (trying) *so hard but there is something pulling me back. It seems every door is closed for refugees in South Africa, I am really thinking of going away, maybe to America or Canada or Australia, for a proper future for my children. When I look at my kids, I won't feel ashamed of being a father. I do not want my children to experience the things I went through. My only prayers and fight at the moment are that I do not want to be here anymore* **(P. 5)**.

I am thinking about going to another country because I cannot go back to my home country, I could be killed. I want to go to Canada **(P. 10).**

While a few consider South Africa as their second home country, they still think about going back to their home countries. However, the pushing factors that contributed to their decisions to flee their home countries are still a reality i.e. war, political violence and conflict and are thus valid reasons why it is not feasible to go back to their countries of origin.

South Africa is my home country because I am still in Africa, Africa is for Africans - those who are at home and aboard. So South Africa is still my home. I think about going back home every time, but the situation is that I still need to obtain many things, I can only go home with enough equipment to tackle my issues at home **(P. 12)**.

> *I call South Africa my second home, even though there is a lot of challenges. I have been here for 15 years, but whilst going back to my country is necessary, the political instability continuously raises my fear that I might experience the same things that made me flee* **(P. 1)**.

6.7 Refugee Recommendations

At the end of the interview the participants were given an opportunity to talk about their concerns in general and if they wanted, to offer recommendations pertaining to the issues that would have made a major difference in helping them to settle in South Africa. It was very clear that they believe South Africa should have greater concern for the general refugee community. The main challenges are a lack of an orientation programme to inform refugees of the culture and laws of the country, the lack of basic needs, and psychosocial support for new asylum-seekers as well as access to mental health services.

> *Social healing* (counselling) *where newcomers can express their feelings is needed, because when they come, they have low morale and lack courage, they cannot think critically and plan for their future. They also need a workshop or educational programme run by Home Affairs that introduces them to the environment they are getting into and what is expected from them. This will help them to adapt to the environment. I missed that bridging, and I did not adapt well* **(P. 1)**.

> *Refugees must be given an orientation about South African people, the culture and the things expected from them before they are given any papers. Better and more cohesive communities can then be built. Concerned government bodies and NGOs have to provide the information* **(P. 2).**

> *Welcoming refugees and giving them permits is not sufficient, we come empty-handed, and we are thrown into South Africa, how are we going to survive? We need more material support and orientation classes to learn about the laws of the country. There is a problem for the country because when people are hungry, they will do whatever is necessary to survive. That is why some people are into prostitution or selling drugs and doing other criminal activities; it is their only option to support themselves. The problem is the government, it is not doing its role, it must have a centre to support and teach refugees* **(P. 5).**

An urgent need for psychosocial support was shared by the participants irrespective of the words they used to articulate this need.

> *When someone leaves his country and comes to a different country, that person needs counselling so that he can adjust properly rather than him understanding things as he goes - alone. Because, in that process, the person would make a lot of mistakes* **(P. 6).**

> *It is very important to get professional help, especially for newcomers because they are left to themselves. Asylum-seekers need a proper process of healing or counselling, from my own experience; I had no one I could talk to or tell from where I came* **(P. 7).**
>
> *The authorities have to create a place where the asylum-seekers can get training and support to help them find jobs. Others have health problems when they come here and there is no one who supports them to go to a hospital. I am a lay female counsellor; counselling is necessary for the community because there are people who are psychologically affected but who could not talk to anyone and they do not know where they can go for help* **(P. 9).**

Others felt that refugees are not properly integrated into the South Africa communities through the appropriate channels and this is becoming a problem between the communities. Refugees, themselves, reside among local communities without the knowledge of the local administration or traditional leaders.

> *The integration has to begin at the community level. Refugees must be introduced to the communities through local structures. Local communities also lack information about refugees and why refugees are in their communities now* **(P. 6)**.
>
> *There must be a structured way of integration for asylum-seekers, at least 3 – 6 months of orientation about the challenges in SA and what they could do about them* **(P. 7)**.

Participant **1** is concerned about the lack of parental monitoring and guidance for their children. This seems to be a common fear of most participants, even those who do not have children yet.

> *Most parents do not follow-up with the academic progress of their children. Parents also do not create space and spend time with their children. In most cases parents are busy working to provide for the family. Therefore, many of the children are involved in health risk behaviours like smoking and drug use ganja* (Marijuana) *and Whoonga* (heroin mixed with other substances) *at a very young age. The younger generations in refugee communities are completing their Matric without good marks and without knowing what their career ambitions are. I am scared that at some point refugee children might stop going to higher education* **(P. 1)**.

6.8. Chapter Summary

This chapter presented, first, the socio-demographic information of the participants. The results of pre-migration experiences in terms of the four themes of pre-migration stressors; civil war, state organised violence and conflict inclusive of tribal conflict, state oppression, and economic hardships were addressed, followed by refugees' mental health experiences and coping mechanisms employed during the pre-migration stage. This was followed by results of refugees' descriptions of their transit-migration experiences; stressors and psychological distresses and coping mechanisms. At post-migration, first refugees' expectations before entering South Africa

and the realities they experienced after arrival were outlined. Post-migration stressors, mental health experiences and coping strategies were presented and lastly, refugees' opinions as to whether they see South African as their home country or not and various recommendations pertaining to assistance required to newly arrived refugees inclusive of addressing their psychosocial and mental health needs are outlined.

Chapter Seven

Discussion of Qualitative Analysis Results

7.1 Introduction

This study aims to contribute to the knowledge of forced migration and mental health. The migration experiences of refugees regarding their stressors, mental health problems, as well as coping mechanisms, are discussed with reference to the relevant literature and theoretical perspectives. Because of some overlap of the stressors, mental health impact and coping mechanisms used in the different migration phases, the discussion of the thick descriptions of the participants will be structured around these aspects.

7.2. Migration Stressors

The results show that civil war, organised state violence, tribal conflict and economic hardships are the main ***pre-migration stressors*** forcing African refugees to flee from their home countries. This is consistent with several studies among African refugees that resettled in different parts of the world. For example, Nakash et al. (2014) among South Sudanese and Eritreans in Israel; Abraham, Lien and Hanssen (2018) among Eritreans in Norway; Khawaja et al. (2008) among South Sudanese in Australia; Smit and Rugunanan, (2014) among women refugees from the DRC, Burundi and Zimbabwe in South Africa.

In pre-migration, refugees experienced and witnessed traumatic events that took the lives of their loved ones and endangered theirs too. Because of persistent civil wars, most of the participants experienced or witnessed traumatic events including killings of family members, torture, rape, arrest, the disappearance of people, with burning and looting of their property. These traumatic experiences are widely documented among African refugees (Akinyemi et al., 2012; Fox & Tang, 2000; Idemudia et al., 2013; Onyut et al., 2009; Rassmussen et al., 2010).

State-organised violence and oppression is also a major reason for the flight from countries of origin among African refugees. Refugees experienced atrocities instigated by the state, including persecution, rape, witnessed killings and disappearances of family members (Abraham, Lien & Hanssen, 2018, Chitando & Togarasei, 2010). Refugees from Eritrea felt like prisoners in their country because the state totally restricted them from enjoying basic human rights such as freedom of movement, speech and faith, and conscripted them into endless military service entailing forced

labour without payment, harsh corporal punishment and inhumane imprisonment for non-compliance (Abraham et al., 2018; UN, 2016). For example, a gross violation of human rights was reported by the Commission of Inquiry on human rights violations in Eritrea, the commission:

> "*... has reasonable grounds to believe that crimes against humanity, namely, enslavement, imprisonment, enforced disappearance, torture, other inhumane acts, persecution, rape and murder, have been committed in Eritrea since 1991*" (UN-HRC, 2016, p. 1).

Similarly, a study by Abraham et al. (2018) among Eritrean female refugees in Norway found experiences of endless military conscription and military training under veteran soldiers who they described as men "*who have lost some of their humanity*', and also endured physical violence like being tied up and locked in ship containers, and rape by officers. Similarly, other studies also reported state organised violence among Zimbabwean refugees in addition to economic deprivation (Chitando & Togarasei, 2010; Idemudia, Williams &Wyatt, 2013). A study by Chu et al. (2016) found gross human right violation that includes lifelong exposure to torture and inhumane treatment, discrimination, absence of freedom of movement and residence, denial of freedom of thought and religion among North Korean refugees in South Korea. Further, more than two-thirds of the participants also reported violation of their rights to food, health and a basic livelihood (Chu et al., 2016).

However, tribal conflict as a cause for the flight was mentioned by one participant. Some civil wars in Africa are based on tribal or clan conflicts, for example, for the past decades, Somalia has been devastated by a civil war that involved clan conflict (Sadouni, 2009; Ssereo, 2003).

It is evident that there is a lack of literature regarding refugees' experiences during the ***transit-migration stage***, particularly among African refugees. The findings of this study indicate that refugees also experienced life-threatening and traumatic events that are psychologically distressing during this stage of the migration process. Therefore, understanding the experiences of refugees at this stage is critical for reducing the impact and related challenges of transition and is useful for better policy formulation to ensure the safety of refugees in transit.

Refugees who escaped from the immediate danger to save their lives were followed by subsequent challenges of the migration process. It seems that the most common stressors in the transit-migration were to find a suitable place of safety with the uncertainty about the ultimate destination; the problems encountered when travelling alone and outside your own country for the first time; to put

your trust in strangers they met on the journey, including not knowing where they were going and travelling alone. This shows the consequences of the difficulties they experienced at home that forced them to flee unprepared and without a plan of where to go. Refugees' experiences of civil war and conflict destroyed their level of trust, which induced fear and thus distrust of strangers, which ultimately also affects their sense of belonging and integration with a host community at a later stage (Griffiths, 2012; Hynes, 2009).

Furthermore, for most, it was the first time to travel alone, far from their home, which was considered a challenge on its own. Not trusting people who they met on the journey showed their fear and the desire to avoid re-experiencing a threat. Refugees from Burundi, particularly, feared follow-up persecutions from the state, even when they were out of the country. The Burundian government was accused of cross border persecution of political dissidents (FIDH, 2016; The Guardian, 2016).

Other stressors of transit-migration were a lack of money, travelling for a long time without food and language comprehension problems. Refugees also experienced poor conditions in refugee camps with a lack of food and poor hygiene as transit stressors. This was also documented among African refugees in refugee camps in Nigeria and Chad (Ankinyem et al., 2012; Rasmussen et al., 2010), and South Sudanese refugees in Ethiopian and Ugandan refugee camps before they resettled in the USA (Goodman, 2004). Studies reported violence, poverty and disease, death and attacks or hostility from local communities experienced by African refugees in Ethiopia, Nigeria and Uganda refugee camps (Akinyemi et al., 2014; Goodman, 2004). Sadouni (2009), in his work, explained the life of Somali refugees who transited through refugee' camps in Eastern and Southern Africa countries as 'dependency and deprivation' experiences (p. 237).

This study also attested to the deprivation experiences of refugees in transit as the findings indicated that refugee women gave birth without proper medical attention, experienced pregnancy miscarriage due to neglect, sickness as a result of hunger and unhygienic food and water, refugee camp insecurity, being trapped in rebel ambushes, falling prey to smugglers who deceived them with false information to rob them of their money—in addition, being targeted by gangs and vandals in muggings as they were assumed to have money and other valuables.

A few studies have reported similar stressors of transit-migration, for example, Nakash et al., (2014) found Eritrean and Sudanese asylum-seekers in Israel experiencing and witnessing violence

(physical and sexual). Similar experiences were reported by Idemudia et al. (2013) among Zimbabweans in South Africa where women particularly were forced to engage in 'survival sex' for food and water and to get assistance to cross the border. Studies have been reporting institutional abuse including lack of proper protection, uncertain futures, humiliation while attempting to access basic services, a constant fear of deportation and organised state violence as main difficulties among transit-migrants, mostly from Syria, across the Balkans to Europe (Arsenijevic et al., 2017; Eleftherakos et al., 2018; Farhat et al., 2018). The refugees who were crossing the Balkan countries to Europe reported experiences of trauma due to acts of violence, where the majority was perpetrated by state authorities (police, border control guards) within or outside Europe. The most common violence was physical violence by authorities, smugglers and community members, and kidnapping and discrimination and exclusions (Arsenijević et al., 2017). The violence by state authorities was explained by the authors as "systematic and organized nature" (p. 6). Similarly, refugees in transit reported finding themselves in a situation where they had no control, difficulty to communicate and being mistreated by smugglers (Farhat et al., 2018). It is therefore certain that refugee in transit, wherever they are, can give an account of dehumanising experiences. There is a need for international policy intervention that assures the safety of migrants and refugees.

For the ***post-migration phase***, refugees shared a greater number of more detailed descriptions of their experiences than for the pre- and transit-migrations phases. This could be due to the salience of the current difficulties they are encountering some on a daily basis, but also, might want to use the opportunity to share their views as a way to seek assistance and bring attention to their plight. It should also be noted that it is easier to bring to mind the stressors that are ongoing, while it is to describe events of what happened years ago.

Even though they had very little opportunity to decide where to go, the information that South Africa was receiving asylum-seekers in combination with information about South Africa's peace and democracy and job opportunities that were said to be available, played a role in their decision to come to South Africa. Refugees' expectations and excitement at the prospects of experiencing South Africa's democracy and peace were, however, swiftly dispelled and replaced with feelings of insecurity when they encountered an unwelcoming xenophobic environment, a general lack of opportunities to make a living and criminal activities.

In post-migration, refugees are experiencing several stressors in South Africa including problems of securing and maintaining documents, lack of basic facilities, xenophobic violence, access to public services, insecurity and uncertainty, language problems and unemployment as highlighted by the mentioned literature above. It is noteworthy to recognise that these problems are interconnected and thus influence one another.

Refugees who crossed the border illegally had to bribe smugglers or border guards. However, experiences of sexual and physical abuse were not found in this study as reported by Idemudia et al. (2013), in their study among Zimbabweans refugees in South Africa while crossing the border. Accessing documents and going through the asylum-seeking processes, at RRO, was easier for those who came in earlier years. However, refugees experienced several difficulties in accessing the services, e.g. standing in queues for a long time or even having to sleep over to maintain your position in the queue, coming back again and again and being forced to bribe officials (CW, 2016).

Asylum-seekers whose asylum cases were rejected felt their cases had not been fairly processed. However, when they appeared, they were granted a six months permit (Section 22). That means, their asylum claim is pending, leaving them in limbo, and as noted in this study even for as long as ten years and more. The number of asylum-seekers (with Section 22) awaiting decisions on their asylum claims in South Africa is 1 096 100 (DHA, 2017), far more than the number of refugees to whom asylum has been granted. Section 22 permit restricts refugees from accessing employment opportunities, travelling and access to public and private services like housing, education, health and banking. These problems pertaining to documentation has been highlighted in various studies over the years (Belvedere, 2007; Landua, 2006; Sutton, Vigneswaran & Wels, 2011; Vigneswaran, 2008). Moreover, recently, Smit and Rugunanan (2015) reported in their study among Congolese and Burundians the problems of inaccessibility and exploitation with regards to documentation. Furthermore, the Corruption Watch Project Lokisa (CW, 2016) publicised its findings drawn from 314 reports of migrants that 'extortion, threats and solicitation' by government officials, of which 80 per cent involved RROs that included Home Affairs officials, security guards, administrators and interpreters. The report also indicated that 74 per cent of the report involved bribes demanded for asylum and refuge permits, worst of all demands are made for the refugees to pay ZAR100 to ZAR200 just to get access to the RROs in Pretoria (CW, 2016). However, there seems to be a lack of political will by the Department to resolve the issue. This was indicated by the CW's letter to the

Home Affairs' parliament portfolio. The DHA failed to respond to the consistent effort of the CW to engage and resolve the issues (CW, 2016).

Furthermore, since the amendment of the International Migration Policy (DHA, 2017) and the Refugee Amendment Bill (2017), the DHA has shown a further regression in the processing of asylums applications and in renewing permits. For example, migrants' community leaders in Durban reported 100 per cent rejection rate for new asylum-seekers who approached the Durban RRO in 2018. This rate is consistent with the report by UNHCR of 90 – 100 per cent in 2015 (iAfrica, 2015) and a report from the Lawyers for Human Rights who gave a figure of 96 per cent rejection rate (Postman, 2018). Asylum-seekers from some nationalities were also totally prevented from accessing the reception office in Durban, e.g. Ethiopians were denied assistance since the beginning of 2017 and asylum-seekers from the DRC were denied access since the beginning of 2018 (Community Leaders, 2018). Furthermore, from the seven RROs, four are closed or suspended, and asylum-seekers are forced to travel to Durban, Marabastad (Pretoria) and Musina. The community leaders also reported that the DHA is withdrawing refugee status and issuing asylum permits that resulted in some refugees to lose their jobs while learners were also denied registration at some schools (Community Leaders, 2018).

According to Giddens' (1984) structuration theory, migration policies, and asylum-seeking processes are structures limiting refugees from securing and maintaining proper documents. Consequently, refugees experience problems in seeking employment and accessing other services.

In South Africa, refugees experience *daily stressors* including the lack of basics (food, clothes, money, shelter), and information from the first day they arrived, particularly if they do not have a family member or friend who received them. South Africa adheres to a self-settlement and local integration policy that avoids encampment of refugees. As a result, there is no governmental and UNHRC support for refugees (Amit, 2011; Kavuro, 2015). Incapacitated NPOs assist very few refugees - who are informed about their operation, and they can cater only for a few of the most vulnerable (women and children). The NPOs (e.g. RSS) provide for very basic needs, including two months' rent, food, shelter, language training and legal advice (Maharaj et al., 2016). What has been overlooked by authorities and researchers is the need for basic psychosocial support (Miller & Rasmussen, 2010), particularly for those newcomers who do not have anyone to assist them. The mental health outcome of all the stressors that are experienced can be severe, as noted in this study.

However, even after extended years in South Africa refugees are still experiencing a lack of basic needs which is a consequence of little job opportunities, absence of recognised documents pertaining to their status and increasing living expenses (Idemudia et al., 2013; Morof et al., 2014). This places them in 'precarious economic' conditions (Jinnah, 2013; Smit & Rugunanan, 2014).

The daily stressors can be extended to include refugees' general experiences of insecurity and problems in accessing public services. This arises from the hostile climate described as xenophobic, with high crime rates and child-unfriendly environments. Most refugees are forced to live in crowded inner cities areas known for high crime and risk behaviours as they could not obtain more secure accommodation because of their precarious economic situations (Jinnah, 2013; Smit & Rugunanan, 2014, 2015). However, these living conditions are viewed to create insecurity and endanger the upbringing of their children. For example, Jinnah (2013), reported that many Somalis families in Johannesburg live in 'multi-family households' characterised by severely overcrowded places. Furthermore, Smit and Rugunanan (2014), in their study with refugee women from Burundi, the DRC and Zimbabwe reported feelings of insecurity and unsafety for themselves and their children. The women also worried about the living conditions of their families and financial challenges in South Africa (Smit & Rugunanan, 2014), similar to the findings in this study as outlined below. As a result, the feelings of defencelessness is common among the participants.

One of the key findings of this study is refugees' concerns about the effect of poor socioeconomic conditions and living in a hostile environment, in particular a hostile refugee environment on their children and parents-children relationships. These aspects have not yet been adequately researched. The African refugees in this study are extremely worried about the uncertainty of their children's future as they cannot provide sufficiently for them nor assure a better future to their children. The refugees feel restricted in many ways from providing and granting a future for their children. Furthermore, all refugees, including those that are not parents, view South Africa an unfavourable place in which to raise children, particularly when comparing their own ways of growing up with the current conditions in South Africa. In addition to the hostile environment and precarious economic conditions, African refugees are also critical of the Rights of the Child and the 'Child Protection Rights' that prevent them from disciplining their children, and they feel prohibited from performing their parental duties.

It was described that in African culture, parents use corporal punishment as a way of disciplining their children. There is a literature that found many among refugee parents consider corporal punishment as an acceptable child disciplining practice based on their cultural values and religion (Larriee, Tourigny, & Bouchard, 2007; Lashley, Hassan, & Maitra, 2014). It has been reported that practices based on the host community cultural values, lacks consideration of the socioeconomic experiences and cultural complexity of the migrant communities and contributes to increased conflicts between children and their parents and even bring disinvestment of parents in their children's upbringing (Hassen et al., 2011). It seems that this is particularly so if such practice de-values the authority and culture of parents (Lashley, Hassan, & Maitra, 2014).

However, Refugees further believe that the Child Protection practices as taught in the school and the encouragement they receive to report parents who use corporal punishment to the police directly conflicts with African views of the Parent-Child relationship (Hassen et al., 2011). While South Africa is advanced in many 'Human Rights' practices by comparison to other African countries, encouraging children to report to your parents to the police is an unbearable thought. Even though child abuse is a serious issue in South Africa (Artz et al., 2016; Meinck et al., 2017) and Child Protection Rights is meant to protect children, for African refugees not disciplining one's child through the means that they believe in will result in children missing the basic education they are supposed to receive from parents at home.

When practitioners and authorities view physical disciplining by parents as a 'family pathology' it may result in mental health problems (Hassan & Rousseau, 2009), particularly when authorities and psychosocial providers place children under foster care or charging the parents. This is likely to have very negative unintended consequences on family mental health, including the child. In this case, Lashely et al. (2014) suggested an intervention of culture consultants to bridge the gap between host countries' policies and related practices and the refugee communities. This area seems not adequately explored, and research is needed to better understand African refugees parents' cultural views on child disciplining to develop interventions, to create dialogue around cultural and alternative practices pertaining to child-rearing and disciplining and inform further intervention that promotes the wellbeing of the refugee families in South Africa.

Accessing public services, such as hospitals, banks and housing, is largely determined by the documents. Asylum-seekers with six months permit are the most affected as their documents are

not recognised in most public and private institutions. There is also discrimination in health care services particularly amongst women refugees while others experience verbal and physical harassment and a lack of attention to their health needs also supported by the studies of Crush and Tawodzera (2014). These are against the legislative rights of refugees granted by the *South African Constitution and Refugees Act* (The Republic of South Africa, 1996 and 1998 respectively). At a health policy level, Zihindula, Akintola, & Meyer-Weitz (2017) found only five from 12 reviewed health policy documents in South Africa, that made provision for refugees' rights to access health services; however, only two international policy documents made provisions for mental health. Moreover, they have also documented that there is a wide disparity between policy provisions and practices (Zihindula et al., 2017). Further, Crush and Tawodzera (2014) argued that medical xenophobia is deeply entrenched in the South African public health system. Earlier the evidence-based report of the Consortium for Refugees and Migrants in South Africa (CoRMSA, 2011) asserted that refugees and migrants are denied services based on documents, and 'being foreign' and thus experienced problematic interactions with health providers (Landau, 2006).

Economic marginalisation causes major problems for the participants who are denied employment opportunities, even if they are qualified and skilled. Refugees are permitted to work and study in South Africa (Refugee Act, 1998), however, as Kavuro (2015) argues, refugees are marginalised from employment mainly because of measures placed to privilege local citizens and to prevent non-citizens from accessing the labour market. Secondly, employers and professional bodies fail to recognise the legal rights of refugees. This conflicts with Chapter 2, Section 23 (1), of the South African Constitution that states "*Everyone has the right to fair labour practices*" and the Refugee Act (130 No. 130) that enshrines refugees rights to seek employment. The study findings also support similar earlier findings (Polzer & Landau, 2008; Smit & Rugunanan, 2014). For example, consistent with this study's findings, Smit and Rugunanan (2014) found xenophobic and discriminatory attitudes, lack recognition of qualification and language barriers as factors preventing refugee from accessing employment. Therefore, refugees are forced to engage in what researchers call 'Precarious jobs' characterised by inconsistent and not secured low-income jobs without benefits. Some of them are underemployed, which means "a worker is employed in a job that is inferior by some standard" (Harvey 2011, p. 962). A good example of the underemployment of refugees is a qualified public health practitioner working as a car guard, as described in this study. Most of the refugees in this study (9 out of 14) are educated at a tertiary level while one of them are

currently busy with tertiary studies. Furthermore, even those refugees educated and qualified in South Africa are experiencing challenges to access employment; therefore, they are underemployed and not utilised to their full potential (Polzer & Landau, 2008; Smit & Rugunanan, 2014). Due to the lack of market absorption, many refugees are also involved in self-employment. However, those who get the rare opportunity to be employed experience exploitation, e.g. low payment (Tshishonga, 2015). The challenge of unemployment produced a desperate need of income to provide adequately for themselves and for their families, and this financial constraint also prevents refugees and their children from furthering their education.

Xenophobic violence is a recurrent daily event for most refugees who reported being called names ('*maKwerekwere*' meaning foreigner or outsider) and being the victims of harassment, beatings, mob attacks and looting of properties. The experiences of xenophobic violence and its impact on refugees has been extensively studied (Crush, 2008; Harris, 2002; McConnell, 2008; Mothibi, Roelofse & Tshivhase, 2015; Neocosmos, 2010). The result of this study indicates experiences of hate and discrimination on daily biases from local communities, and public and private institutions through policies that restrict them from enjoying their fundamental human rights (Hanekom & Webster, 2009; Neocosmos, 2008; Tella, 2016). Some of the findings of this study are supportive of findings in earlier studies as follows: Schippers (2015) and Tshishonga (2015) reported increasing intolerance and negative attitudes among local South Africans towards migrants; at an institutional level, Hanekom and Webster (2009) argued that government maintains and exacerbates the xenophobic problem that supports the results of this study, e.g. the Zulu King, Goodwill Zwelithini's speech is believed to have prompted the 2015 xenophobic violence (Tella, 2016). Experiencing and witnessing xenophobic violence threatened refugees' life, and a common feeling of insecurity, rejection and powerlessness exists, even to express their anger or to respond.

Despite these challenges, the refugees remain in South Africa because of persistent war, political and economic instability in their home countries, and the shame of going back empty-handed, even though they long and desire to go back home. Very recently, the Insider (news outlet) has reported that refugees in South Africa will be deported should they involve in any political platforms regarding their country of origin or if they 're-avail' themselves to the embassy of their country of origin in South Africa, even requesting educational or marital documents (de Wet, 2020). This amendment also prohibits refugees from involving themselves in South African politics. The Home

Affairs Minister, Mr Aaron Motsoaledi, gazetted this new regulation on 27 December and was effected from first January 2020. This was called a 'paper wall' by analysts that protect refugees from involving into political platforms to bring permanent solution in their countries of origin (de Wet, 2020). Such a declaration also increases the powerlessness of refugees to engage meaningfully in the root causes of their flight and to bring permanent change.

Lastly, some share difficulties related to *language*, especially as some refugees were disadvantaged in finding a job because they could not speak English or isiZulu. In some instances, they were intimidated because they spoke their home language. Smit and Rugunanan (2014; 2015), found that Zimbabwean women who speak English fluently had better job opportunities than their counterparts from Burundi and the DRC who do not.

7.3 Mental Health Experiences

Generally, the results show that psychological distresses are main symptoms of PTSD, anxiety and depression; these symptoms include excessive fear, sleeplessness, sadness, hopelessness, and feelings of worthlessness, short-temperedness and confusion. Even though participants shared migration stressors that are particular to the stages of migration, some descriptions of mental health distress seem common across the stages.

The symptoms of PTSD are more common among those who experienced and witnessed traumatic events such as rape and the death of loved ones. The thoughts of leaving their families behind were emotionally painful for the refugees. Those who lost their family felt meaninglessness; they engaged in suicidal ideation, i.e. having a death-wish while simultaneously also feared for their lives. The refugees were really traumatised by the violence and were re-living the traumatic events in their dreams. Similar symptoms of psychological distress have been reported among most African refugees (Akinyemi et al., 2014; Fox & Tang, 2000; Idemudia et al., 2013; Karunakara et al., 2004; Onyut et al., 2009).

The psychological problems of refugees who fled war and violence are mostly reflected at a later stage. However, refugees who were living under consistent threat and pressure have been psychologically challenged long before they fled. For example, this study shed some light on research into mental health experiences of refugees who fled oppressive regimes and state organised violence – which is under-researched. Refugees from totalitarian states were under total state-

military control; they suffered fear from constant repressive measures. They endured such conditions for long periods of time, and their experiences are different from other refugees who fled due to sudden traumatic experiences and violence (Abed, 2005). They experience emotional disturbance and confusion, with a sense of hopelessness for their futures. This was seen among Eritreans and Zimbabweans. For example, in Eritrea the youth, 18 and above are subjected to mandatory and unlimited, forceful military conscription under the pretext of 'national service' (Kibreab, 2014, UN-HRC, 2016). Abed (2005) stated that oppressive states are known for: institutionalising torture, inventing constant internal and external enemies, strengthening their armed forces and forces of internal repression, that leads to inevitable human rights violations. Victims frequently report symptoms of chronic low mood, lack of interest and sleep disturbance, especially insomnia, PTSD symptoms such as flashbacks, recurrent nightmares, anxiety, reduced interest, and poor concentration (Abed, 2005; Chu et al., 2016; Lee et al., 2016).

For Eritreans, deserting from the conscription means continuous surveillance by the army and harsh punishment. This seemed to have affected their mental health and wellbeing. The thoughts of getting caught and to be subjected to harsh punishment in military prisons were stressful and overwhelming, manifesting itself in symptoms of sleeplessness and frequent dreams as mentioned. Furthermore, for the Eritrean refugees planning to escape and escaping the country were psychologically distressing, particularly because of the shoot-to-kill order that prevails at the borders or harsh punishment if caught alive (Abraham et al., 2018; Nakash et al., 2014; UNHRC, 2017).

The psychological distress of refugees at the ***transit-migration stage*** is the outcome of the traumatic events they experienced or witnessed in their home countries and on their journey. The most common symptoms include overthinking and recalling of the traumatic experiences and remembering the families they lost or left behind in danger. Witnessing killing of family members and experiences of rape and torture resulted in PTSD symptoms including re-experiencing the trauma in dreams, sleeplessness, hearing noises and visualising the event. There is no study that particularly documented the mental health experiences of refugees in transit-migration, however, the results in this study show experiences of psychological distress that exacerbate their vulnerability as a group in their journey – a desperate journey with feelings of uncertainty and powerlessness.

During the flight, they had little sleep, lost their appetite and felt directionless as they were fleeing, not knowing where they were going and also had feelings of worthlessness, suggestive of depression symptoms. Most of them were travelling with fear, feeling insecure and unsafe, even when they were far from the immediate threat, but continue to have fear due to the proximity of the threat, particularly Burundians. In addition, the stressors in transit-migration exacerbated refugees' psychological distress. Most of them were in a desperate mood characterised by grief, sadness and powerlessness to change the situation. Recently studies have reported symptoms of psychological distress including anxiety, adjustment/acute reactions, depression, psychotic disorders, PTSD and behavioural problems among refugees in transit and in camps, particularly among refugees who were crossing to Europe through the Balkan countries and the Sahara desert (Arsenijevic et al., 2017; Crepet et al., 2017; Eleftherakos et al., 2018; Farhat et al., 2018).

However, Eritreans, in particular, felt relieved and experienced a sense of freedom when they safely crossed the border out of their country and felt the peace of mind in the easy environment and amicable reception at the Ethiopia refugee camp where they met friends or close relatives who had crossed the border earlier. The ease in which they found supporting networks and comfort from kinship who migrated earlier might have played a role for the Eritreans to feel relieved and elated by the freedom from a lifetime of repression and the risks inherent in the escaping process. The cultural similarity and of the same ethnic group within the neighbouring hosting country might also have contributed to their positive experiences.

In post-migration, the refugees' description of psychological distresses generally included symptoms of sadness, loneliness, insecurity, uncertainty, withdrawal, irritation, short-temperedness, fear and feeling worthless and guilty, re-experiencing traumatic events in the form of dreams, visualising and rethinking as outlined by Lacroix and Sabbah (2011). The results concur with the studies that found persistent PTSD symptoms among refugees who directly experienced traumas (Goodkind et al., 2014; Miller & Rasmussen, 2010). Experiencing or witnessing a rape, recently or a long time ago, seems to remain a vivid memory for the survivors, and re-experiencing these traumas are common, emotionally and physically, including crying, the shaking of their bodies and feeling ashamed and sad.

The results indicate that separation from and insecurity of family members left behind and being away from one's culture are among the key factors impacting psychological distress. This supports

previous studies (Haslam, 2005; Nickerson, Bryant, Steel, Silove & Brooks, 2010). The psychological distress seemed to have been much higher before reconnecting (via phone or mail) with family and friends at home as refugees continue to worry about their families' unsafe contexts. A study among Iraqi refugees who left their families in a war zone (Nickerson et al., 2010) reported similar findings, and Porter and Haslam (2005) also reported worse mental health outcomes among refugees whose countries are in continuous war than others. The refugees re-experience traumas in the form of a dream and visual flashbacks during the day or night accompanied by withdrawal from social contact. Alcohol abuse was mentioned as a way to forget disturbing thoughts and to get sleep. Symptoms of PTSD are intense among participants who lost parents and personally experienced traumatic events. Also, there seems to be exacerbated by post-migration difficulties such as lack of basic needs and a hostile environment as also pointed out by Lacroix & Sabbah (2011); Rasmussen et al. (2010) and Tempany (2009).

The post-migration stressors: high crime levels, hostile environment and precarious economic conditions are described as the leading factors for psychological distress in this study and elsewhere (Rasmussen et al., 2010; Smit & Rugunanan, 2014; Tempany, 2009). Refugees' fear stemmed from them being vulnerable and insecure. They seem to be pre-occupied with their future, as well as with their children, which was found to be highly psychologically distressing and disturbing among parents. The refugees are also depressed about their poor conditions, including lowered socioeconomic status compared to what they had at home and them failing to fulfil their parental role.

7.4 Coping Mechanisms

Participants shared diverse coping mechanism that was highly informed by the stressors they were experiencing at each stage of migration; hence they used different mechanisms accordingly. However, some coping mechanism were used across the migration stages. At the *pre-migration stage*, escaping or fleeing, commonly referred to as running away, was the most commonly used strategy among African refugees who came to South Africa. For most of them, it was the immediate threatening situation that demanded swift action in order to spare their lives from immediate danger. However, there were some participants who had time to think about how safely they could escape. It can be said that long-term migration was not a plan at first for most. The same story was recorded among South Sudanese refugees in the USA, who had to flee from danger just to survive (Goodman,

2004). Other coping mechanisms included having faith in God and prayer, hopeful thoughts (like believing that the stress will pass as time goes on) and support from prison mates as a coping mechanism at the pre-migration stage. These are known mechanisms for dealing with stressors among refugees in the pre-migration stage (Goodman, 2004; Khawaja et al., 2008; Schweitzer, Greenslade & Kagee, 2007).

While in *transit migration***,** African refugees used several coping strategies including meaning giving, faith in God and prayers, being informed (gathered information) about possible difficulties they could experience on the journey and seeking social support. Similarly, El-Khani, Ulph, Peters and Calam (2017) reported seeking social support as one of the coping mechanisms employed by Syrian refugees. Refugees also showed perseverance as not to give up easily and resilience in flexibility and when seeking for different alternatives to overcome the stressors in their journey. They seemed to draw on their inner resources, a durable personal coping resource available for buffering when faced with adversity (Crawford et al., 2006). Thus, resilience as a positive psychological and contextual resource that enables individuals to draw from available resources such as competence, self-efficacy and positive assets that reside within the individual (Fergus & Zimmerman, 2005) and to also seek opportunities or resources in their contexts.

The meaning-making process that the participants engaged in regarding their decisions to leave their countries and to leave loved ones behind, helped them to come to terms with their decisions. The self-talk they engaged in to assure them that their loved ones were safe was another way of coping with them leaving their home countries. Migration stressors cause enough stress that involves refugees to make-meanings of their experiences, first to minimise disturbing thoughts (Park, 2010) and then regain positive perceptions (Ramos, Leal, & Tedeschi, 2016). This also leads to beliefs of the benefits by restructuring cognition that requires changing of perspectives about the experience(s) (Wright, Crawford, & Sebastian, 2007).

Goodman (2004) also found meaning-making as a coping mechanism but in a different way. The young Sudanese refugees attributed their suffering to 'God's will', rather than questioning why they suffered too much. This shows refugees give different meanings to their adverse circumstances to reduce their stress over something they cannot change or control. For the refugees in this study, having faith in God and use of prayer were the most common coping strategies employed and helped refugees to give meaning to their experiences and to persevere regardless of adversities.

Social support provided by individuals and communities, not necessarily from family and friends, but also strange people who were touched by their plight, for example, truck drivers and religious communities, was critical in helping refugees deal with challenges. Religiosity and seeking of social support are commonly researched coping mechanisms among refugees (El-Khani et al., 2017; Goodman, 2004; Halcón et al., 2004; Schweitzer et al., 2007; Sulaiman-Hill & Thompson, 2012).

Being informed (gathered information) about possible difficulties that might happen along the way and knowing for sure that there is a way of resolving problems, helped refugees to stay positive during adversity. Furthermore, refugee travellers also relied on hopeful information about a resettlement place to minimise the effects of the adversities they experienced at pre-migration and during their journey. They hoped for a better place to live in regardless of the adversities. One unexpected finding was the narration of the joy and containment by a female refugee after giving birth to her baby. She felt comforted and the impact of the previous traumatic events experienced and witnessed was less overwhelming. However, both parents shared the joy and felt relieved from their immediate problems and psychological distress. The birth of a child gives meaning to life and brings gratitude for the joy offered.

Faith in God and religiosity and social support are common coping mechanisms for the refugees across the migration stages. These coping strategies were found to be common among Africans (Adedoyin et al., 2016; Khawaja et al., 2008). Most of the refugees believe that their faith and prayed to God helped them to pass through their difficulties, strengthened them, reduced and treated their psychological distress. They also believe that they are alive because of God and only He can define their destiny. Further, as Adedoyin et al. (2016) stated, faith increased the tendency of refugees to overcome traumatic experiences, acculturation stressors and to have the added benefit of empowerment. Church community pastors particularly play a great role in providing support and a sense of belonging. The church accepted and provided (food, clothes and shelter) for some of them, for months, when they arrived in South Africa.

The role of religion and the church may also enable forgiveness. A refugee used forgiveness as a way of dealing with the hatred and hostility from local South Africans. Even though mentioned by only one participant, it is interesting to explore the contribution of forgiveness in mental health promotion among refugees who are still haunted by their traumatic experiences. It can be argued that the power of forgiveness could give victims of trauma peace of mind and paved the way for

healing (Worthington & Cowden, 2017). Forgiveness was found to improve the mental wellbeing of refugee women from the DRC who have forgiven the perpetrator of violence (Kandemiri & Nkomo, 2019). Further, the participants reported reduced anger, anxiety, depression, stress, and rumination when they considered forgiving.

Material and psychosocial support from families, friends and even strange people was used as a way of coping with distress and survival. Interaction with people going through similar experiences helped refugees to develop a sense of belonging and strength. Khawaja et al. (2008) also reported that social networks offered emotional support which refugees were supposed to get from families they left behind. In post-migration, refugees used available social networks (church communities) and other space (counselling and training offered by civil society) with the intention of addressing their psychosocial problems, which are different from pre- and transit- migration (El-Khani et al., 2017, Sulaiman-Hill & Thompson, 2012). In other words, they have demonstrated agency by seeking solutions regardless of the outcome. However, professional counselling was mostly inaccessible for most of them because of its high cost and a general lack of knowledge and information. Those who approached health care services for psychological problems were treated for physiological illness rather than being referred to a psychologist. However, Sulaiman-Hill and Thompson (2012) found only male Afghan and Kurdish refugees in New Zealand and Australia seeking help from professional doctors and counsellors, even though these were accessible to all. Seeking help for mental distress is often hindered by a lack of awareness and stigma surrounding mental health and illness (David & Nadal, 2013; Weine et al., 2000).

In this study, it was noticeable that having a family and related responsibilities helped refugees to be goal-directed and determined to deal with their difficulties. As mentioned above, having a family and children give meaning to life and brings responsibilities that need their full attention and focus. This helped the refugees to live in the now, become more resilient and socially responsible and therefore force them to become more distant to their traumatic past. There seems a lack of literature that reported having a family been used as a relief from psychological distress.

Another source of coping noted was a positive orientation and future vision. The attitude that difficulties experienced ‘will also pass’ moved them from perceiving themselves as victims and in a psychologically desperate situation to being hopeful for a better future (Goodman, 2004; Sulaiman-Hill & Thompson, 2012). Furthermore, some also mentioned that the difficulties they

pass thorough helped them to develop this attitude in achieving a better future – 'if I passed through more difficult situations, this would pass too'. Similarly, Goodman (2004), found making meaning and emerging from hopelessness to hope as a main coping mechanism among African refugees.

Refugees also showed resilience and bounced back from their difficulties and looked for opportunities using self-agency as a way out of their difficulties. When they realised, they could do better and achieved financial independence, their psychological distresses decreased, and they gained self-confidence. As Bandura (1998, p. 2) states "successes build a robust belief in one's personal efficacy" and those who feel accomplished a task and master an experience have a strong sense of efficacy for themselves (Bandura (1998). Getting a sense of achievement and independence resulted in working harder than usual. A few refugees also showed PTG by actively becoming involved in civic organisations in order to deal with problems affecting the general refugee community and participated in political forums to bring solutions for problems in their home countries which they believe is the main cause of their migration.

PTG is closely related to resilience; however, according to Kilic et al. (2015), resilience requires returning to the original level of functioning while PTG promotes an advanced level of functioning after traumatic experiences. Some of the refugees in this study bounced back to normality after psychologically devastating experiences and now are actively working at resolving national and local political issues. This is a positive psychological change people experienced when they had traumatic experiences (Tedeschi & Calhoun, 1995). The positive psychological attitudes and experiences demonstrate the extent of psychological capital that was developed. The self-confidence and developed agency (self-efficacy) and being hopeful and optimistic about their future and themselves as well as being resilient, e.g. reach out for help, able to function despite difficulties and to persevere. Psychological capital, as a core construct of inner resources, i.e. resilience, self-efficacy, hope and optimism, is known for a positive state of mind that influence mental health positively. However, it has not been researched as a core construct among refugees, and its impact on promoting mental health among refugees is not yet investigated.

Lastly, language and cultural similarity, particularly for the refugee from Zimbabwe, and knowing and understanding how the system operates helped refugees to cope in a better way. Hence the study argued strongly for the importance of a cultural orientation initiative within a psychosocial programme for asylum-seekers. While not evident from all refugees, one's worldview, style of

socialising and emotional intelligence help as a way of coping. In the case of the Rastafarian refugee who has a friendly attitude and appreciates being among culturally different people and embraces challenges rather than viewing these as stressors, helps him to feel more included and a sense of belonging.

7.5 Suggestions and Recommendations of Refugees

Lastly, refugees were asked to add their final thoughts on the general concerns of the refugee community in South Africa. The main challenges that concern most of them are The lack of orientation programmes that informs refugees of the culture and laws of the country, the lack of basic resources to fulfil their needs and the provision of mental health services or psychosocial support for new asylum-seekers. The urban settlement policy that South Africa adheres to is where refugees are left to resettle and integrate themselves without any psychosocial support and cultural orientation. The refugees suggested that providing psychosocial support would have improved their adaptation and integration processes. Similarly, Berry (2006), argues that teaching refugees' language and rules could be used as an entry to the hosting culture and to facilitate integration. This supports the urgent need for psychosocial support. Furthermore, it also clearly shows refugees' understanding of the importance of psychosocial support in reducing their psychological problems. This assertion is profound because most of the refugees experienced or witnessed traumatic events before they came into South Africa, which is exacerbated by post-migration difficulties.

Other concerns are a lack of proper integration processes and a hostile environment in which to raise children with growing delinquency among the young refugee generation. They are of the view that their poor socio-economic condition exposes them to insecurity as a family and as parents, they are sceptical about the 'Child Rights' policy that restricts parents from disciplining children and resulting in inadequate parental guidance, as discusses above.

Most of the participants have never thought of South Africa as their permanent home and do not have a plan to stay permanently. The yearning to go back to their family and home country is unequivocal. However, a few do see South Africa as their second home, but still long to go back to their home country, and this is only delayed because of the ongoing violence in their own countries.

7.6 Chapter Summary

This chapter discusses the results of the qualitative data. The study presented some insightful findings in the field of forced migration and mental health. The study traces the whole migration history of African refugees and the outcomes of mental health experiences and coping mechanisms used across the migration processes. The major stressors are life-threatening events related to war and violation of human rights throughout the migration process. The refugees' emotional and psychological distresses resulted from the immediate stressors and lingering difficulties. The experiences of psychological distress are disturbing for refugees who recently experienced traumatic events and are experiencing poor socioeconomic conditions. Throughout the migration process faith and religion are the most common coping mechanism among African refugees in South Africa. Further, thoughts that are more hopeful and support from social networks are also used as a way of coping with stressors.

Chapter Eight

Quantitative Survey Results

8.1. Introduction

In this chapter, the results of the quantitative study aligned with the research questions are presented. The demographic characteristics of the participants are outlined in the beginning, followed by the factor analysis. The psychometric properties of each of the measurements used in this research, namely; Refugee Stress Scale (RSS), Post-Migration Living Difficulties Questionnaire (PMLD), Refugees Defenceless Scale (RDS), Connor-Davidson Resilience Scale (CD-RISC), General Health Questionnaire (GHQ-28) and Post-Traumatic Stress Disorder Checklist (Civilian Version, PCL - 5), are presented. The descriptive statistics that describe the mean scores and standard deviation (SD) of participants on each of the measurements and normality distribution of the data are described. Refugees' pre- and post-migration stressors (measured by RSS, PMLD & RIVS), resilience and psychological distresses (measured using GHQ and PCL-5 respectively) are then presented. This is followed by the Pearson's correlation coefficients showing direction and strength of association among the measurements and their respective sub-scales. The results are declared of the independent sample t-tests and Analysis of Variance (ANOVA) showing mean score difference between demographic groups on the measures used. Finally, the results of the regression analysis are presented. The Statistical Package for the Social Science (SPSS) version 25 was used for all analysis.

8.2 Socio-demographic Characteristics of the Sample

Table-five below shows the socio-demographic characteristics of the sample. The total number of participants was 195, and two-thirds were male (N = 130, 66.7%), and there were 65 females (33.3%). The age of the sample ranged from 18 to 56, with a mean age of 32.93 (SD = 8.04). The majority of the sample were from DRC (N = 110, 56.4%), followed by Burundians (N = 30, 15.4%), Zimbabweans (N = 26, 13.3%) and Eritreans (N = 18, 9.22%). A few were from other parts of Africa namely Ethiopia (4), Somalia (2), Rwanda (1), Kenya (1), Tanzania (2), and Congo-Brazzaville (1).

More than 50 per cent of the participants came to South African between 2005 and 2012. Regarding their status, 47.1 per cent are refugees, and 52.9 per cent are asylum-seekers.

Table 5

Socio-Demographic Information of the respondents

Characteristics	Number	%	Characteristics	Number	%
Gender			**Level of education**		
Male	*130*	66.7	*No education*	1	0.5
Female	*65*	33.3	*Primary*	6	3.1
Age (range 18 – 56, M = 32.93, SD = 8.04)			*Secondary*	67	34.7
Younger (25 & below)	*40*	21.4	*Tertiary*	119	61.7
Middle age (26 – 35)	*73*	39	**Employment BM**		
36 and above	*74*	39.6	*Trained Professional*	50	32.1
Country of Origin			*Skilled workers*	17	10.9
Burundi	*30*	15.4	*Self-employed*	18	11.5
Eritrea	*18*	9.22	*Student*	45	28.8
DRC	*110*	56.4	*Irregular job*	13	8.3
Zimbabwe	*26*	13.3	*Unemployed*	13	8.3
***Others** (Ethiopia 4, Somalia - 2, Rwanda -1, Kenya 1, Tanzania -2, Congo-Brazzaville -1)*	*11*	5.6			
Religion			**Employment in SA**		
Christian	136	77.7	*Trained Professional*	26	15
Muslim	39	22.3	*Skilled worker*	31	17.9
Date of Arrival in SA			*Self-employed*	47	27.2
Early (before 2005)	*35*	19	*Students*	23	13.3
Middle (2005-2012)	*94*	51.1	*Irregular jobs*	21	12.1
Late (2013-2017)	*55*	29.9	*Unemployment*	25	14.5
Date of Application for Asylum			**Source of income now**		
Early	*30*	18.5	Regular job/income	41	29.5
Middle	*86*	53.1	Self-employment	41	29.5
Late	*46*	28.4	Irregular job/income	14	10.1
Status in SA			Allowance	17	12.2
Refugee	*88*	47.1	Nothing	26	18.7
Asylum-seekers	*99*	52.9	**English language understanding**		
Number of Times Permit Renewed			Not at all	8	4.1
≤ 5 times	*64*	46.4	A little	22	11.4
6 to 16 times	*41*	29.7	Moderate	72	37.3
More than 16 times	*33*	23.9	Very well	91	47.2
Marital status			**English language speaking**		
Never married	71	37	Not at all	8	4.3
Engaged	13	6.8	A little	29	15.4
Married	95	49.5	Moderate	72	38.3
Divorced	7	3.6	Very well	79	42
Widow	6	3.1			
Do you Live closer to your partner?					
Yes	94	57.3			
No	70	42.7			
Number of Children					
No child	56	33.3			
One or two	66	39.3			
Three and more	46	27.4			

Most of the respondents had a tertiary level of education (N = 119, 61.7%). When they were in their home countries, 32.1 per cent were working as trained professionals, that included nurses, teachers, engineers, accountants, radiologists … etc.. However, this group of trained professionals shrank to 15% in their post-migration. The main sources of income for the participants were: regular jobs/ income (29.5 %) and self-employment (29.5 %), however, 41 per cent of them had irregular sources, or allowances (mostly from partners) or did not have any income at all. Most of the participants understood and speak English, 37.3 per cent, and 47.2 per cent understood English moderately well and very well respectively. Similarly, 38.3 per cent and 42 per cent spoke English moderately well and very well respectively.

8.3 Primary Results of the Factorial Analysis

To determine the underlying factors of the measures, factor analyses were conducted using Principal Components Analysis (PCA). The suitability of the measures for factor analyses was checked using the Kaiser-Meyer-Olkin (KMO; Kaiser, 1970), Bartlett's Test of Sphericity (Bartlett, 1954) as well as the correlation matrix (the majority correlation coefficients were $r \geq 0.30$). Therefore, observation of the correlation matrix for the six measure (RSS, PMLD, RDS, CD-RESC, GHQ-28 and PLC -5) showed most correlations above 0.30. The KMO measure of Sampling Adequacy obtained for the measurements ranges from 0.86 (RDS) to 0.94 (PLC – 5) exceeding the recommended value of .6 (Kaiser, 1974). The Bartlett's Test of Sphericity of the measurements reached statistical significance at $p < .001$. Therefore, factor analyses of the measurements were supported. Further, when retaining factors eigenvalue above one, the scree plot above-elbow (Catell, 1966), and parallel analysis were considered - to determine how many factors to retain, before subjecting the items for oblimin rotation. In Parallel analysis (Monte Carlo PA), eigenvalues obtained with SPSS were compared with the values obtained by PA.

The tables that depict the results of the factorial analysis show the pattern and structure matrix. The pattern matrix shows the loading of each variable on the factors while the structure matrix informs about the association of the factor and the variables. Further, the tables also show the commonalities that describes information on how much of the variance in each item is explained. Variables with lower values (less than 0.3) display loss fit of an item with other items in the factor and Pallant (2011) suggests removing the items with less than 0.3 commonalities if there is an interest of refining a scale, while other researchers suggest items with low commonalities as in less than 0.20

to be eliminated (Child, 2006 cited by Young & Pearce, 2013). In this study, items with less than 0.3 were eliminated. The results of factor analyses were followed by descriptions of the factors and the overall measures that resulted from this study (see table 11).

8.3.1 Refugee Stress Scale (Refugee pre-migration Stress)

As mentioned earlier, the Refugees Stress Scale (RSS) was developed recently by the first author ((Idemudia, Williams, Madu, and Wyatt, 2013), and used in this study to measure pre-migration stressors. The measurement does not have subscales. The authors sub-scaled it only for the purpose of a particular study (Idemudia et al., 2013). In this study, the result of the initial PCA showed the presence of five factors with eigenvalue of one and more; however, four factors were retained, explaining a total variance of 61.07 per cent. To reach a four-factor solution conclusion, the scree-plot was checked showing a break after the fourth factor. More importantly, this was supported by the results of the Parallel Analysis - four factors with more than one eigenvalue from SPSS are greater than the values obtained by PA. Therefore, four factors were obtained that measure four areas of pre-migration difficulties, see table six below. When Oblimin rotation was performed, the following items loaded on the first factor: items 10 – 16 named *Absence of basics,* secondly *Organised Violence* (items 1-9 & 22), third *Sexual Abuse* (items 18-21) and the fourth-factor *Oppression/ lack of freedom* (items 23-27). However, item 17 showed lower commonalities with the other items (0.157); therefore, it was omitted. Each of the four factors explained variance of 35.4 per cent, 12.9 per cent, 8.97 per cent and 5.73 per cent respectively, and 63.05 per cent a total variance. The factors also obtained an excellent Cronbach's alpha coefficient of internal consistency; $\alpha = .91$, $\alpha = .91$, $\alpha = .85$ and $\alpha = .82$ respectively and the overall scale Cronbach's alpha was 0.93.

Table 6

Pattern and Structure Matrix with Oblimin Rotation of Four-Factor Solution of RSS Items

	Pattern Coefficients				Structure coefficients				Component
	Component				Components				
	1	2	3	4	1	2	3	4	
RSS_14	.860				.840				.708
RSS_13	.839				.856				.741
RSS_12	.837				.878				.800
RSS_15	.800				.784				.675
RSS_11	.697				.822				.734
RSS_10	.611				.769				.674
RSS_16	.558				.582				.344
RSS_3		-.853				-.836			.726
RSS_1		-.814				-.773			.624
RSS_4		-.78				-.764			.597
RSS_7		-.781				-.794			.642
RSS_6		-.736				-.786			.647
RSS_9		-.729				-.750			.573
RSS_8		-.723				-.751			.585
RSS_2		-.657				-.701			.510
RSS_22		-.516				-.627			.515
RSS_5		-.481				-.592			.466
RSS_19			.909				.883		.790
RSS_21			.810				.833		.703
RSS_20			.802				.834		.723
RSS_18			.754				.747		.570
RSS_23				.908				.849	.747
RSS_25				.669				.767	.641
RSS_24				.667				.748	.599
RSS_26				.564				.652	465
RSS_27				.538				.690	.594

8.3.2 PMLD (Post-Migration Living Difficulties)

The instrument originally had five factors; 'refugee determination process', 'health, welfare and asylum problems', 'family concerns', 'general adaptation stressors' and 'social and cultural isolation' (Silove et al., 1998, p. 179). In this study, when the 24 items of PMLD subjected for PCA initially results showed five factors with more than one eigenvalue, however, four factors are retained after considering the scree-plot and the PA (see table 7 below). Therefore, the data collected from African refugees in this study showed a four-factor solution and explained 59.26 per cent of the variance; of this, the first factor contributed 34.74 per cent of the variance. The rotated factors showed that the first factor loaded on Access to health and welfare (8 items), the second factor included items that measured refugees' documentation stressors (5 items) and explained 9.51 per cent, the third factor loaded on items that measured worries about the family at home country, named family stressors (3 items) that explained 8.71 per cent, and the fourth-factor measures

resettlement issues in South Africa, named as acculturation stressors (8 items) explained 6.29 per cent.

The factors obtained high Cronbach's alpha coefficients: α = 0.90 for the first-factor access to health and welfare, α = 0.76 for documentation stressors, α = 0.71 for family stressors and the fourth factor, acculturation stressors, obtained a good Cronbach's coefficient of α = 0.87. The overall scale, the PMLD, also obtained an excellent Cronbach's coefficient of α = 0.92.

Table 7

Pattern and Structure Matrix with Oblimin Rotation of Four-Factor Solution of PMLD Items

	Pattern Coefficients				Structure coefficients				Communalities
	Components				Components				
Items	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	
PMLD_16	.894				.858				.741
PMLD_14	.860				.881				.780
PMLD_15	.849				.810				.661
PMLD_13	.807				.826				.685
PMLD_12	.726				.822				.708
PMLD_9	.624				.684				.478
PMLD_11	.493				.624				.532
PMLD_10	.483				.698				.427
PMLD_6		.767				.780			.652
PMLD_5		.762				.760			.611
PMLD_8		.690				.694			.527
PMLD_7		.609				.667			.489
PMLD_3		.518				.560			.518
PMLD_1			.840				.863		.778
PMLD_2			.767				.799		.672
PMLD_4			.539				.597		.568
PMLD_22				-.781				-.768	.599
PMLD_24				-.728				-.736	.576
PMLD_18				-.706				-.708	.531
PMLD_23				-.667				-.753	.609
PMLD_17				-.662				-.670	.468
PMLD_21				-.634				-.715	.550
PMLD_19				-.629				-.663	.539
PMLD_20				-.615				-.691	.524

8.3.3 Refugees Defenceless Scale (RDS)

Informed by the results of the qualitative data analysis, the researcher designed this instrument with 16 items. It measures refugees' experiences of insecurity, uncertainty and personal and family (children in particular) vulnerability. When subjected to PCA, in the beginning, four factors showed

eigenvalue of one and more. However, when scree-plot and PA were examined, a two-factor solution decision was supported (see table 8 below). The total variance explained by the two-factor solution is 51.12 per cent of variance; the first item accounts for 39.8 per cent of the variance. The two-factor solution meaningfully separated the items into two dimensions, named; *Refugees' Uncertainty and Vulnerability* (items 7-16), and *Refugees' Insecurity* (items 1-6). The Cronbach's coefficient for the measure was $\alpha = 0.90$, and for the factors was $\alpha = .88$ and $\alpha = .78$ for the first and second factors respectively.

Table 8

Pattern and Structure Matrix with Oblimin Rotation of Two-Factor Solution of RDS Items

	Components				**Communalities**
	Pattern coefficients		**Structure coefficients**		
	1	**2**	1	2	
RDS_12	.913		.851		.740
RDS_13	.895		.806		.684
RDS_14	.872		.819		.683
RDS_11	.642		.755		.625
RDS_9	.602		.684		.496
RDS_7	.435		.595		.309
RDS_15	.430		.594		.472
RDS_16	.427		.573		.421
RDS_10	.427		.594		.473
RDS_8	.385		.545		.409
RDS_3		.945		.843	.755
RDS_4		.788		.742	.560
RDS_5		.600		.660	.452
RDS_1		.535		.587	.356
RDS_2		.520		.584	.300
RDS_6		.426		.541	.449

8.3.4 Conner-Davidson Resilience Scale (CD-RISC)

The factor analysis of the original CD-RISC had five constructs from data collected among the general population (Conner & Davidson, 2003). However, over time studies have been reporting different factor structures from the original one (Asante & Meyer-Weitz, 2014; Jorgensen & Seedat, 2008; Singh, 2010). In this study, the initial PCA resulted in six factors above one eigenvalue, explaining a total variance of 61.54 per cent. However, the examination of the scree plot and PA supported a one-factor solution that explains 37.648 per cent of the variance. Therefore, with the data collected from African refugees in this study, the measure resulted in one-dimensional. The Cronbach's coefficient for the measure was $\alpha = 0.93$.

8.3.5 General Health Questionnaire (GHQ- 28)

The 28 items measurement was subjected to PCA. To decide on factors to retain factors, the eigenvalue, the scree plot and the parallel analysis were checked. Four factors above the elbow in the scree-plot supported by the parallel analysis were retained and loaded similarly on the four factors as the original instrument (see table 9 below). The four components solution explained a total of 54.88 per cent of the variance; of this, the first factor contributed 34.41 per cent of the variance. When Oblimin rotation was performed, the first component was strongly loaded on the Anxiety and insomnia items, the second component on the depression items, the third on social dysfunction and the fourth component on somatic complaints items. This means that the data from the African refugees repeated the same factors as the original ones. The Cronbach's alpha reliability coefficient for the total scale was $\alpha = 0.94$ and for the four factors wads: anxiety and insomnia $\alpha = 0.92$, for depression $\alpha = 0.88$, for social dysfunction $\alpha = 0.81$ and for somatic complaints $\alpha = 0.88$.

8.3.6 Post-Traumatic Stress Disorder Checklist – 5 (PCL – 5)

The original instrument had four subscales (20 items), namely, re-experiencing, avoidance, alteration of cognition and mood, and arousal symptoms. However, in this study, the factor analysis result shows a complicated two-factor solution that was not retained. The first factor included ten items from the third and fourth subscales and four more items (2 items each from the first and second) of the original instrument. The second factor included six items (three of the first and three of the second original factors). However, two items (items 7 & 6), the other four items (4, 8, 5, & 1) in the second factor also loaded in the first factor, as showed in table ten below, and this complicated the factor solution. This overlapping of the items forced reconsidering the decision of accepting a two factors solution for the data, therefore, for comparative purposes PCA was forced for one, three and four factors solutions, however, a one-factor solution seems most explanatory of the data and thus a one-factor solution was retained explaining 52.5 per cent of the variance. The Cronbach's alpha reliability coefficient for the measure was $\alpha = 0.95$.

Table 9

Pattern and Structure Matrix with Oblimin Rotation of Four-Factor Solution of GHQ Items

	Components								Commonalities
	Pattern Coefficients				Structural coefficients				
	1	2	3	4	1	2	3	4	
GHQ_10	.834				.841				.712
GHQ_8	.780				.797				.649
GHQ_9	.727				.789				.634
GHQ_11	.684				.747				.569
GHQ_13	.584				.700				.561
GHQ_12	.552				.697				.525
GHQ_14	.520				.686				.560
GHQ_23		.791				.787			.630
GHQ_25		.777				.764			.612
GHQ_27		.764				.745			.591
GHQ_24		.743				.757			.610
GHQ_22		.566				.642			.489
GHQ_28		.554				.602			.449
GHQ_26		.459				.540			.371
GHQ_15			.736				.747		.631
GHQ_17			.718				.698		567
GHQ_18			.711				.763		.595
GHQ_19			.660				.743		.504
GHQ_16			.470				.557		435
GHQ_20			.455				.589		.349
GHQ_21			.410				.545		.400
GHQ_4				.758				.796	.652
GHQ_2				.718				.741	.621
GHQ_5				.648				.715	.573
GHQ_3				.636				.725	.573
GHQ_7				.546				.658	.502
GHQ_1				.540				.641	.450
GHQ_6				.521				.676	.554

Table 10

Pattern and Structure Matrix with Oblimin Rotation of One-Factor Solution of PCL -5

	Pattern Coefficient		Structure coefficient		Commonalities	Loading of one-factor solution
	Comp. 1	Comp. 2	Comp. 1	Comp. 2		
PCL_15	**.925**		**.845**		.730	.774
PCL_11	**.827**		**.842**	0.450	.716	.823
PCL_14	**.814**		**.819**	0.417	.671	.792
PCL_19	**.796**		**.738**		.555	.685
PCL_13	**.795**		**.761**	.328	.582	.717
PCL_16	**.790**		**.703**		.517	.638
PCL_20	**.754**		**.774**	.418	.601	.756
PCL_10	**.752**		**.798**	.468	.644	.791
PCL_9	**.717**		**.807**	.537	.675	.819
PCL_18	**.679**		**.733**	.447	.547	.732
PCL_12	**.675**		**.738**	.464	.557	.741
PCL_2	**.535**	0.416	**.743**	.683	.682	.812
PCL_3	**.509**	0.430	**.724**	.684	.662	.796
PCL_17	**.396**		**.450**	.306	.211	.459
PCL_7		**.851**		**.798**	.645	.503
PCL_6		**.828**		**.796**	.637	.527
PCL_4	0.379	**.588**		**.777**	.711	.784
PCL_8	0.363	**.547**		**.728**	.629	.739
PCL_1	0.401	**.475**		**.675**	.577	.725
PCL_5	0.437	**.443**		**.662**	.581	.737

Table 11 below shows the descriptive statistics of the measurements. The data was examined using explore descriptive to check outliers and normality of the data distribution. The outliers were replaced with less outlined numbers (Pallant, 2007) as discussed in the methodology analysis section, and the measures show an acceptable level of normality (Pallant, 2013; Tabachninck & Fidell, 2007).

Table 11

Descriptive Statistics analysis of measures

	N	Min.	Max.	Mean	SD	Skewness	Kurtosis	α	r*
RSS	127	26	122	69.14	22.065	.283	-.308	.93	
Absence basics	172	7	35	18.80	8.188	.372	-.783	.91	.593
Organised violence	158	10	50	31.16	10.848	-.106	-.727	.91	.536
Sexual abuse	179	4	19	6.66	3.427	1.275	1.104	.85	.570
Oppression	169	5	25	13.25	5.642	.199	-.846	.83	.490
PMLD	153	24	120	76.72	20.451	-.316	-.183	.92	
HWS	176	8	40	25.72	9.132	-.234	-.905	.91	.546
DS	179	5	25	14.06	5.211	.043	-.800	.76	.388
Family Stressors	190	3	15	10.29	3.352	-.478	-.529	.71	.453
Acculturation stressors	171	8	40	25.91	8.507	-.220	-.731	.87	.465
RDS	147	16	79	57.22	12.989	-.519	.032	.90	
RUV	155	10	50	36.37	9.368	-.596	-.206	.88	.445
Refugees Insecurity	172	6	30	20.64	5.160	-.420	-.023	.78	.373
CD-RISC	132	8	105	72.26	19.227	-.954	.632	.93	
GHQ	135	0	75	26.93	17.226	.790	-.251	.94	
Anxiety & Insomnia	170	0	21	8.58	6.436	.437	-.955	.92	.618
Depression	172	0	18	4.59	4.577	.918	-.209	.88	.515
Social dysfunction	170	0	21	8.147	4.246	.545	.129	.81	.381
Somatic complaint	166	0	21	7.210	5.671	.820	-.161	.88	.525
PCL-5	140	0	80	29.89	21.689	.608	-.683	.95	

NOTE. * = Mean inter-item correlation for factors with less than 10 items, *HWS = Health & Welfare Stressors, DS = Documentation Stressors, RUV = Refugees Uncertainty and Vulnerability*

8.5 Pre-migration Stressors of African Refugees in South Africa

Table 12 below shows the results from the Refugees Stress Scale (RSC) used to measure the pre-migration stressors of refugees. The table shows the percentage of participants who agreed and strongly agreed to statements as stressors at their home countries and the totals. The most common pre-migration stressors are a threat to life (62.2%), forced separation from family (57.1%), not having a clear vision about one's future (51.0%), limited freedom (50.5%) and follow-ups or beating from police or military (47.4 %). Other stressors that are stated by more than 40.0 per cent of the participants as pre-migration stressor include a threat to a family member, almost died due to threat, harassment by the police, and trouble getting a job.

Table 12

Pre-migration Stressors of Participants

	Stressors	Agree	Strongly Agree	Total (%)
1	I had a threat to my life	31.6	30.6	62.2
2	I had a threat to a member of my family's life	21.2	20.9	42.1
3	I almost died due to a threat	19.4	21.4	40.8
4	I was beaten and harassed	21.4	15.8	37.2
5	I had the death of a family member	17.9	20.9	38.8
6	I was forced to separate from my family members	25.5	31.6	57.1
7	I almost died	21.4	22.4	43.8
8	The police (or the military) were following/beating me	27.0	20.4	47.4
9	I was harassed by the police	24.0	18.4	42.4
10	I was hungry all the time	13.3	14.3	27.6
11	I didn't have food and water	12.2	11.7	23.9
12	I had no place to live	13.8	16.3	30.1
13	I had nothing	14.3	16.8	31.1
14	I had trouble with housing	18.4	19.4	38.2
15	I had trouble getting a job	21.9	21.9	42.8
16	I had trouble with my papers/ documents	16.8	14.8	31.6
17	I was not accepted because of my political orientation	20.4	16.3	37.7
18	Someone rape/assaulted me before age 18 years	4.1	3.6	7.7
19	I was forced to have sex for since years old	4.6	3.1	7.7
20	I was forced to sell my body for money or to cross borders	5.1	3.1	8.2
21	I was sexually harassed	5.6	4.1	9.7
22	I was physically assaulted	17.3	12.8	30.1
23	I was forced to join the military	12.2	10.7	22.9
24	I was serving/working without payment	10.7	8.2	18.9
25	I was forced to act wrongly against other people	5.1	10.7	15.8
26	I had limited freedom	25.5	25.0	50.5
27	I had no clear vision about my future	20.9	30.1	51.0

8.6 Post-migration Stressors of African Refugees in South Africa

The post-migration stressors of African refugees were measured using the PMLD and RDS. Table 13 below shows the major stressors of post-migration experienced by more than 50 per cent of the participants across the measures (agreed/serious problems & strongly agreed/very serious problems option). Participants either agreed or strongly agreed that they had experienced these stressors measured by PMLD; unemployment (67.3 %), discrimination (63.0 %), separated from family (62.1 %), unable to return home in an emergency (61.2 %) and fear of repatriation or fear of being sent home (60.8%). Similarly, a high number of refugees indicated that they are experiencing the following stressors measured by the RDS as serious and very serious problems; thoughts that

something bad can happen anytime is experienced by 75.4%, of this 44.5% strongly agreed to the statement. This shows the disturbingly high level of insecurity experienced by most African refugees in South Africa. Other major stressors that bother the African refugees are: children losing important cultural values, e.g. respect for parents and elders (70.0%), children getting involved in risk behaviours, e.g. drinking, smoking, drug use, sexual activity (68.6%), and lack of job opportunity/ unemployment (63%).

Table 13

Post-migration stressors among African Refugees in South Africa (measured by PMLD* & RDS*).

Items	**Serious problem**		**Very serious problem**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
Stressors measured by PMLF						
Unemployment	55	28.9	73	38.4	127	67.3
Discrimination	45	28.3	74	39.2	119	63.0
Being separated from my family	60	31.6	58	30.5	118	62.1
Unable to return home in an emergency	49	25.4	69	35.8	118	61.2
Fear of repatriation (fear of being sent home)	56	29.6	58	31.2	114	60.8
Bad working conditions	54	28.1	60	31.3	114	59.4
Difficulty obtaining help from charities	49	26.1	57	30.3	106	56.4
Delay in processing my application	45	24.2	54	29.0	99	53.2
Stressors measured by RDS						
	Agree		**Strong Agree**		**Total**	
Having thoughts that something bad can happen anytime	59	30.9	85	44.5	144	75.4
Children losing important cultural values (e.g. respect for parents and elders)	43	22.6	90	47.4	133	70.0
Children getting involved in risk behaviours (e.g. drinking, smoking, drug use, sexual activity)	47	24.6	84	44.0	131	68.6
Lack of job opportunity/ unemployment	66	34.4	55	28.6	121	63.0
Fears for my livelihood (e.g. losing belonging or property)	56	30.3	57	30.8	113	61.1
Fears for my life or a family member's life	62	33.3	50	26.9	112	60.2

**Note*. Scale response options for PMLD 1 = No Problem, 2 = Slight problem, 3 = Moderate problem, 4 = Serious problem, 5 = Very serious problem; for RDS 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree and 5 = Strongly Agree.

8. 7 Major Psychological distress symptoms of African Refugees

The two successive tables below (tables 14 & 15) show the major psychological distress, measured by GHQ – 28 and PCL – 5, of African refugees. In this study, 43.7 per cent of the participants showed psychological distress that included symptoms of anxiety and insomnia, depression, social dysfunction and somatic complaints. The mean score of anxiety and insomnia (M = 8.58, SD =

6.43) was higher followed by social dysfunction (M = 8.14, SD = 4.24). Regarding prevalence, the psychological distress, 44.3 per cent of the participants scored above the mean score for anxiety and insomnia (M ≥ 9), 38.2 per cent for Social Dysfunction (M ≥ 9), 40.4 per cent for somatic complaints (M ≥ 8) and 36.6 per cent for depression (M ≥ 5).

The most common symptoms of anxiety and insomnia experienced by the participants are: constantly feeling under strain (41.8 %); finding everything getting on top (39.2 %), and losing much sleep over worry (37.8%); common symptoms of somatic complaints; headaches (37.8%) and feeling of tightness or pressure in the head (34.2%); and common symptoms of social dysfunction; being dissatisfied with the way in which tasks were carried out (33.7%) and unable to enjoy data-to-day activities (30.1%). Participants indicated also feeling worthless (22.5%) and suicidal ideation (22.4%) as common symptoms of depression.

Regarding the PTSD symptoms measured by PCL – 5, as depicted in Table 15 below, shows the response of participants to specific symptoms. The total percentage is the sum of participants' responses that listed *quite a bit* and *extremely* when rating symptoms of post-traumatic experiences. The most common post-traumatic stress symptoms were feeling very upset when reminded of stressful experiences (38.4%) and strong physical reactions when reminded of the stressful experiences (36.2%), both are re-experiencing symptoms. Other prevalent symptoms were avoiding external reminders of the stressful experience (35.5%); being super-alert or watchful or on guard (34%); having difficulty concentrating (32.4%) and trouble experiencing positive feelings (32%).

Table 14

Frequencies of supportive response options for psychological distress symptoms as measured by the GHQ - 28

Have you been	Rather more than usual		Much worse than usual		Total	
	N	%	N	%	N	%
Anxiety and Insomnia (M = 8.58, SD = 6.43)						
1. Lost much sleep over worry?	37	18.9	37	18.9	74	37.8
2. Had difficult in staying asleep?	37	18.9	30	15.3	67	34.2
3. Felt constantly under strain?	39	19.9	43	21.9	82	41.8
4. Getting edgy (tense/ nervous) and bad-tempered?	38	19.4	34	17.3	72	36.7
5. Getting scared or panicky for no good reason?	32	16.3	31	15.8	63	32.1
6. Found everything getting on top of you?	34	17.3	43	21.9	77	39.2
7. Feeling nervous and strung-up all the time?	30	15.3	32	16.3	62	31.6
Depression (M = 4.59, SD = 4.57)						
8. Thinking of yourself as a worthless person?	29	14.8	17	8.7	46	23.5
9. Felt that life is entirely hopeless?	19	9.7	19	9.7	38	19.4
10. Felt that life is not worth living?	24	12.2	12	6.1	36	18.3
11. Thought of the possibility that you might kill yourself?	17	8.7	7	3.6	24	15.7
12. Found that at times you could not do anything because your stress was too bad?	22	11.2	11	5.6	33	16.8
13. Found yourself wishing you were dead and away from all your problems?	20	10.2	13	6.6	33	16.8
14. Found the idea of taking your own life kept coming into your mind?	30	15.3	14	7.1	44	22.4
Social dysfunction (M = 8.14, SD = 4.24)						
15. Managing to keep yourself busy and occupied?	24	12.2	25	12.8	49	25.0
16. Taking longer over the things you do?	46	23.5	12	6.1	58	29.6
17. Felt that overall you were doing well?	36	18.4	21	10.7	57	29.1
18. Satisfied with the way you have carried out your tasks?	46	23.5	20	10.2	66	33.7
19. Felt that you are playing a useful part in things?	47	24.0	15	4.4	62	28.4
20. Capable of making decisions about things?	36	18.4	15	7.7	51	26.1
21. Able to enjoy your normal day-to-day activities?	47	24.0	12	6.1	59	30.1
Somatic complaints (M = 7.21, SD = 5.67)						
22. Feeling perfectly well in good health?	20	10.2	12	6.1	32	16.3
23. Feeling in need of a good health?	31	15.8	25	12.8	56	28.6
24. Feeling run down and out of sorts?	33	16.8	33	16.8	66	33.6
25. Felt that you are ill?	28	14.3	25	12.8	53	27.1
26. Getting any pains in your head?	39	19.9	35	17.9	74	37.8
27. Getting a feeling of tightness or pressure in your head?	36	18.4	31	15.8	67	34.2
28. Having a hot or cold spell?	24	12.2	24	12.2	48	24.4

Total General health (Mean = 76.72, SD = 20.451)

Scores	**Frequency**	**Valid percent**	**Cumulative percent**
22	4	3.0	48.1
23	6	4.4	52.6
24	5	3.7	56.3
25	4	3.0	59.3

Table 15

Frequencies of supportive response options for Post-Traumatic Stress Disorder symptoms

In the past month, how much were you bothered by:	**Quite a bit**		**Extremely**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
1. Repeated, disturbing, and unwanted memories of the experience?	19	10.3	31	16.8	50	27.1
2. Repeated, disturbing dreams of the stressful experience?	22	12.1	29	15.9	51	28.0
3. Suddenly feeling or acting as if the stressful experience were actually happening again?	19	10.5	33	18.2	52	28.7
4. Feeling very upset when something reminded you of the stressful experience?	32	17.3	39	21.1	61	38.4
5. Having strong physical reactions when something reminded you of the stressful experience?	37	20.0	30	16.2	67	36.2
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	28	15.5	29	16.0	57	31.5
7. Avoiding external reminders of the stressful experience?	28	15.3	37	20.2	65	35.5
8. Trouble remembering important parts of the stressful experience?	21	11.5	33	18.1	54	29.6
9. Having strong negative beliefs about yourself, other people, or the	23	12.7	32	17.7	55	30.4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	25	13.7	27	14.8	52	28.5
11. Having strong negative feelings such as fear, horror, anger, or shame?	29	16.0	25	14.0	54	30.0
12. Loss of interest in activities that you used to enjoy?	25	14.0	28	15.6	53	29.6
13. Feeling distant or cut off from other people?	30	16.6	27	14.9	57	31.5
14. Trouble experiencing positive feelings?	31	17.4	26	14.6	57	32.0
15. Irritable behaviour, angry outbursts, or acting aggressively?	21	12.6	16	9.6	37	22.2
16. Taking too many risks or doing things that could cause you harm?	22	12.2	16	8.8	38	21.0
17. Being super-alert or watchful or on guard?	30	17.0	30	17.0	60	34.0
18. Feeling jumpy or easily startled?	30	16.7	20	11.1	50	27.8
19. Having difficulty concentrating?	36	19.8	23	12.6	59	32.4
20. Trouble falling or staying asleep?	25	13.7	29	15.8	54	29.5

8.8 Resilience of African Refugees

CD-RISC was used to measure the resilience of the African refugees in South Africa. The result shows, as depicted in Table 16 below, the percentage of resilience items that participants agreed and strongly agreed on as it applied to them. The most common strategies of resilience used by three quarters and above of participants are: “I work to attain my goals” (79.8%); “I think of myself as a strong person” (78.7%); “sometimes fate or God can help” (76.1%); “I give my best effort no

matter what" (75.9%) and "When things look hopeless, I don't give up" (75.3%). These statements show that refugees mostly rely on themselves to overcome their challenges.

Table 16

Frequency distribution of positive response options of Resilience scores

		Often true		True nearly all the time		Total	
		N	**%**	**N**	**%**	**N**	**%**
1	I am able to adapt to change	54	28.0	57	29.5	111	57.5
2	have close and secure relationships	50	26.6	29	15.4	79	42.0
3	Sometimes fate or God can help	38	20.2	105	55.9	143	76.1
4	Can deal with whatever comes	36	19.4	56	30.1	92	49.5
5	Past success gives me confidence for new challenges	62	32.3	65	33.9	127	66.2
6	I see the humorous side of things	54	28.7	23	12.2	77	40.9
7	I feel obligated to assist others in need	69	36.5	68	36.0	137	72.5
8	I tend to bounce back after illness or hardship	58	31.4	58	31.4	118	62.8
9	Things happen for a reason	66	34.7	69	36.3	135	71.0
10	I give my best effort no matter what	61	32.6	81	43.3	142	75.9
11	I can achieve my goals	65	34.0	75	39.3	140	73.3
12	When things look hopeless, I don't give up	63	33.2	80	42.1	143	75.3
13	I know where to turn for help	56	30.1	40	21.5	106	51.6
14	When I am under pressure, I focus and think clearly	61	32.4	51	27.1	112	59.5
15	I prefer to take the lead in problem solving	76	40.4	52	27.7	128	68.1
16	I am not easily discouraged by failure	70	36.8	59	31.1	129	67.9
17	I think of myself as a strong person	70	37.2	78	41.5	148	78.7
18	I can make unpopular or difficult decisions	56	28.6	46	24.6	102	52.2
19	I can handle unpleasant feelings	64	34.6	41	22.2	105	56.8
20	I have a strong sense of purpose	73	38.4	62	32.6	135	71.0
21	I have few regrets in life	62	33.7	50	27.2	112	60.9
22	I like challenges	61	32.3	47	24.9	128	57.2
23	I work to attain my goals	65	34.6	85	45.2	150	79.8
24	I have pride in my achievements	71	38.2	54	29.0	125	67.2
25	My friends are willing to help me make decisions and listen to me	54	28.3	27	14.1	81	42.4
26	My family is willing to help me make decisions and listen to me	63	33.2	39	20.5	102	53.7
27	I find my job rewarding	34	18.3	19	10.2	53	28.5

8.9 Correlation between the measurements

To establish the relationship between the measurements of migration experiences, resilience and mental health outcomes, several correlation analyses were completed. The results are presented in three tables as the variables were too numerous for one table.

In the first set, table 17, shows the result of correlation analysis between refugees' pre- and post-migration stressor measures (RSS, PMLD, & RDS) and resilience measure (CD-RISC). The Pearson product-moment correlation coefficients indicate strong positive correlations between pre-migration stressors measured by RSS and Post-migration stressors measured by RDS ($r = 0.552$, $N = 102$, $p < 0.01$) with a shared variance of 30 per cent and medium positive correlation with PMLD ($r = 0.368$, $N = 103$, $p < 0.01$). There is also a strong positive association between the two measures of post-migration stressors; PMLD and RDS at $r = 0.629$, $N = 126$, $p < 0.01$ with a shared variance of 39.6 per cent. All the correlations outlined above are practically significant.

The table also shows correlation coefficients among the sub-scales of measurements. The RSS is positively strongly correlated with the subscales of RDS, with Refugee Uncertainty and Vulnerability ($r = .46$) and with Refugee' Insecurity ($r = .54$) at post-migration. The measures and sub-scales of both post-migration measurements showed a strong positive correlation. A sub-scale of RSS organised violence at pre-migration is strongly correlated ($r = 0.48$) with family stressors at post-migration. The association between sexual abuses at pre-migration was not practically significant with PMLD and its four sub-scales, however, sexual abuse at pre-migration shows a practically significant positive correlation with Refugee Uncertainty and Vulnerability at post-migration.

Regarding resilience, there was no practically significant relationship between resilience and pre and post-migration stressors. However, a weak negative relationship was found between resilience and sexual abuse at pre-migration ($r = - 0.18$, $p < 0.05$), this shows that those who experienced sexual abuse are less likely to show resilience. A positive significant correlation was also found between resilience and documentation stressors ($r = 0.215$, $p < 0.05$) and resilience and family stressors ($r = .206$, $p < 0.05$). This means high scores in documentation and family stressors is correlated with high scores of resilience.

Table 17

Pearson product-moment correlation between RSS, PMLD and RDS

	1	2	3	4	5	6	7	8	9	10	11	12	13
1**. RSS**	1												
2.OV	.836**	1											
3. AbB	.820**	.486**	1										
4. SexAb	.521**	.189*	.343**	1									
5.Oppression	.792**	.491**	.617**	.298**	1								
6**. PMLD**	.367**	.397**	.272**	.133	.125	1							
7. HWS	.324**	.363**	.294**	.089	.093	.857**	1						
8. DS	.047	.097	-.057	.093	-.069	.627**	.361**	1					
9. FS	.442**	.477**	.253**	.042	.333**	.591**	.348**	.329**	1				
10. AS	.321**	.287**	.264**	.126	.142	.864**	.637**	.368**	.426**	1			
11. RDS	.552**	.555**	.375**	.090	.363**	.629**	.518**	.304**	.378**	.569**	1		
12. RUV	.459**	.481**	.305**	.089	.279**	.524**	.409**	.307**	.326**	.446**	.952**	1	
13. RI	.529**	.480**	.348**	.139	.325**	.582**	.478**	.269**	.373**	.570**	.838**	.630**	1
14. **CD-RISE**	-.083	.057	-.096	-.181*	-.028	.0148	.142	.215*	.206*	.046	.248	.234	.175

Note.

**. Statistically significant $p \leq 0.05$*

*** Statistically significant $p \leq 0.01$.*

Correlation is practically significant $r \geq 0.30$ (medium effect)

Correlation is practically significant $r \geq 0.50$ (large effect)

OV = Organised violence, AbB = Absence of Basics, SexAb = Sexual Abuse, HWS= Health & Welfare Stressors, DS= Documentation Stressors, FS = Family Stressors, AS = Acculturation Stressors, RUV = Refugees Uncertainty and Vulnerability, RI = Refugees Insecurity,

Table 18 depicts the correlation among RSS, CD-RISC and areas of psychological distress (measured by GHQ-28 and PCL-5) and their sub-scales. RSS showed medium and positive correlations with GHQ (r = .43, N = 92, $p < 0.01$) and with PCL-5 (r = 0.49, N = 92, $p < 0.01$). RSS also showed significant positive correlation with the GHQ sub-scales Somatic complaints (r = 0.52, N = 108, $p < 0.01$). A very strong positive association is also recorded between the two psychological distress measure, GHQ-28 and PCL – 5, r = 0.78, N = 108, p < 0.001.

Regarding the subscales, organised violence at pre-migration is significantly positive and practically correlated with PTSD measured by PCL -5 (r = 0.39), with Anxiety and Insomnia (r = 0.32) and with Somatic complaints (r = 0.31) at medium effect, both Anxiety and Insomnia and Somatic complaints are measured by GHQ. Absence of basic needs at pre-migration is also significantly, positive and practical correlated with somatic complaints (r = 0.45) and PTSD (r = 0.35). There is also a significantly positive and practical correlation between Oppression and Anxiety and Insomnia (r = 0.29) and Oppression and Somatic complaints (r = 0.37). It is noteworthy that Somatic complaints have been found to be significantly positive and practically correlated with all subscales of pre-migration.

However, Resilience has not shown any practically significant correlation with major measures of psychological distress and most subscales except for a significantly negative correlation with Depression (r = -0.22). This means, the higher the depression score, the lower the resilience level.

Table 18

Pearson product-moment correlation between RSS, CD-RISC, GHQ-28 and PCL

	1	2	3	4	5	6	7	8	9	10	11	12
1. RSS	1											
2. OV	.836**	1										
3.AbB	.820**	.486**	1									
4. SexAb.	.521**	.189*	.343**	1								
5.Oppression	.792**	.491**	.617**	.298**	1							
6. **CD-RISC**	-.083	.057	-.096	-.181*	-.028	1						
7. GHQ	.436**	.291**	.389**	.286**	.279**	-.079	1					
8. A & Inso.	.392**	.318**	.288**	.213**	.286**	-.098	.882**	1				
9. Depression	.246**	.124	.186*	.259**	.164*	-.219*	.726**	.526**	1			
10. SD	.311**	.276**	.233**	.128	.164*	-.013	.730**	.527**	.413**	1		
11.SC	.520**	.350**	.456**	.222**	.373**	-.045	.851**	.721**	.443**	.582**		
12.PCL	.494**	.386**	.350**	.249**	.250**	.082	.785**	.679**	.511**	.599**	.670**	1

Note.

**. Statistically significant p ≤ 0.05*

*** Statistically significant p ≤ 0.01.*

Correlation is practically significant r ≥ 0.30 (medium effect)

Correlation is practically significant r ≥ 0.50 (large effect)

OV = Organised violence, AbB = Absence of Basics, SexAb = Sexual Abuse, A & Inso. = Anxiety and Insomnia, SD = Social Dysfunction, SC = Somatic Complaints.

Table 19 below shows the results of post-migration stressors measured by PMLD and RDS and psychological distresses measured by (GHQ-28 and PCL-5). The PMLD showed a positive, practical significant correlation with GHQ (r = 0.37) and similarly with PTSD (r = 0.48) with a medium effect, RDS also showed a positive, practical significant correlation with both psychological distress measures; with GHQ-28 (r = 0.38) and PCL – 5 (0.53). This shows refugees Uncertainty and Vulnerability is strongly correlated with PTSD, more than other psychological distresses such as anxiety and depression.

Regarding the subscales, PTSD showed a practical positive significant correlation with post-migration stressors, i.e. with Health and Welfare stressors (r = 0.41), with Family stressors (r = 0.40) and with Acculturation stressors (r = 0.39). Furthermore, Acculturation stressors also showed a positive correlation with Anxiety and Insomnia (r = 0.36) and with Social Compliance (r = 0.31).

Table 19

Pearson product-moment correlation between PMLD, RDS, GHQ-28 and PCL

	1	2	3	4	5	6	7	8	9	10	11	12	13
1.PMLD	1												
2.HWS	.857**	1											
3.DS	.627**	.361**	1										
4.FS	.591**	.348**	.329**	1									
5.AS	.864**	.637**	.368**	.426**	1								
6.RDS	.629**	.518**	.304**	.378**	.569**	1							
7.RUV	.524**	.409**	.307**	.326**	.446**	.952**	1						
8.RI	.582**	.478**	.269**	.373**	.570**	.838**	.630**	1					
9.GHQ	.378**	.272**	.106	.337**	.387**	.380**	.339**	.393**	1				
10.A & I	.324**	.192*	.108	.339**	.368**	.420**	.378**	.392**	.882**	1			
11.DP	.148	.117	-.041	.136	.149	.136	.139	.195*	.726**	.526**	1		
12.SD	.301**	.223**	.092	.259**	.270**	.342**	.364**	.338**	.730**	.524**	.413**	1	
13.SC	.344**	.241*	.057	.317**	.342**	.238**	.255**	.367**	.851**	.721**	.443**	.482**	1
14.PCL	.485**	.415**	.291**	.402**	.398**	.531**	.483**	.470**	.785**	.679**	.511**	.599**	.670**

Note.

**. Statistically significant $p \leq 0.05$*

*** Statistically significant $p \leq 0.01$.*

Correlation is practically significant $r \geq 0.30$ (medium effect)

Correlation is practically significant $r \geq 0.50$ (large effect)

HWS= Health & Welfare Stressors, DS= documentation Stressors, FS = Family Stressors, AS = Acculturation Stressors, RUV = Refugees Uncertainty and vulnerability, RI = Refugees Insecurity, A & I = Anxiety and Insomnia, DP = Depression, SD. = Social Dysfunction, SC = Somatic Complaints

8.10 Differences between demographic groups regarding Psychological Distress

Table 20 below shows the result of chi-square analyses that tested whether there is a significant difference in psychological distress measured by GHQ-28 among categorically demographic groups. The psychological distress measured by the GHQ-28 were categorised as no psychological distress and psychological distress (using the cut off criteria 23/24, as outlined in Goldberg & Williams (1988). Then, the Chi-square of Independence tests were used to explore the relationship between categorical demographic variables, i.e. gender, age, educational level and marital status groups and the psychological symptoms. The result shows there is no significant difference between the demographic variables regarding psychological distress symptoms, except between males and females. For the 2 X 2 table, a Chi-square test for independence (with Yates Continuity Correction) indicated a significant difference between gender groups and categories of psychological distress, X^2 (1, n = 135) = 3.007, p = .045, *phi* = - .188. This means the females (56.3%) were more likely to be psychologically distressed than the males (36.8 %). However, it seems there is no association between demographic characteristics (age, education level, marital

status, refugee status in South Africa, English language competency in speaking and understanding) and psychological distresses.

Table 20

Chi-square of Independence results for Psychological distress symptoms among different demographic groups

	GHQ				*P*-Chi-square		df	Continuity corr.		Effect Φ & φ_c
	No distress		Distress		Value	Asymp. Sig		Value	Asymp. Sig	
	N	%	N	%						
Gender										
Male	55	63.2	32	36.8						
Female	21	43.8	27	56.3	4.765	.029	1	3.007	0.045*	-.188
Age										
Young	12	54.5	10	45.5						
Middle age	32	61.5	20	38.5	1.041	.594	2			
Older age	28	51.9	26	48.1						.090[a]
Marital status										
Married	40	55.6	32	44.4						
Never	31	67.4	15	32.6	5.519	.063	2			.204[a]
Others	5	33.3	10	66.7						
Status in SA										
Refugee	39	59.1	27	40.1	.124	.725	1	.031	.7860	.031
Asylum Seekers	37	56.1	29	43.9						
English understand										
Not Understand	7	41.2	10	58.8						
Understand	69	58.5	49	41.5	1.807	.179	1	0466	1.172	-.116
English speaking										
Not speak	10	47.6	11	52.4	.861	.353	1	.473	.492	-.081
Speak	65	58.6	46	41.4						

Note. *. Sig. $p < 0.05$, P = Pearson, Asymp.sig = Asymptotic significance, corr. = correlation, Cramer's V = $\boldsymbol{\varphi_c}$ [a]

Further, a one-way between-groups analysis of variance (ANOVA) was conducted to explore if there is a mean score difference in psychological distress measured by GHQ – 28 among demographic groups of refugees. Table 21 below shows statistically significant results only. There were statistically significant differences in the mean scores of demographic groups (country of origin, kind of job at home and level of education) on psychological distress. There was a statistically significant difference in the mean score for psychological distress between the four origins of countries: F (4, 135) = 3.566, p = 0.001. Here, the Welch Robes test of equalities of means is considered as the assumption of the homogeneity of variance is violated. The post-hoc comparison using the Tukey HSD test indicated that the mean score of refugees from DRC (M =

30.51, SD = 17.98) was significantly greater than Zimbabwe (M = 17.60, SD = 7.81). However, there was no significant difference among the other nationalities. Regarding the kind of job at home, participants who had irregular jobs at home scored significantly higher mean scores on the GHQ than professionals, skilled workers, students and the unemployed. Regarding the education level, those who identified themselves as only having a primary school qualification obtained significantly higher mean scores than those who had secondary and tertiary qualifications.

Table 21

Significant ANOVA results for psychological distresses measured by GHQ-28

Measure					95% CI		ANOVA	df	F	Post-hoc comparison
	Groups	N	Mean	SD	LB	UB				
Origin of country	1. Burundi	20	26.20	18.46	17.56	34.84	0.001[a]	4	3.566	3 > 4
	2. Eritrea	17	20.29	13.64	13.28	27.31				
	3. DRC	71	30.51	17.98	26.25	34.76				
	4. Zimbabwe	20	17.60	7.81	13.94	21.26				
	5. Others	7	35.57	20.76	7.84	54.77				
Job at home	1.Trained Professional	36	23.64	16.07	18.20	29.08	0.042[a]	5	3.686	5 > 1, 5 > 2, 5 > 4, 5 > 6
	2. Skilled worker	12	19.75	14.23	10.70	28.79				
	3. Self-employed	12	33.67	22.20	19.56	47.77				
	4. Student	30	27.33	14.86	21.78	32.88				
	5. Irregular jobs	9	45.00	21.35	28.58	61.41				
	6. Unemployed	11	20.45	10.94	13.10	27.81				
Level of education	1. Primary	6	42.00	15.59	25.63	58.36	.019[a]	2	5.401	1 > 3 & 1 >2
	2. Secondary	43	31.18	19.45	25.20	37.17				
	3. Tertiary	86	23.76	15.20	20.49	27.02				

Note. [a.] Welch Robes test of equalities of means.

8.11 Mean group difference of psychological distress groups and measures

The independent sample *t*-tests were conducted to determine whether refugee with and without psychological distress have different mean scores on the RSS, PMLD, RDS, CD-RISE and PCL-5 measures and their subsequent subscales. As table 22 below shows, there is a statistically significant mean score difference on the RSS, PMLD and PCL–5 measures and most of the subscales. Regarding pre-migration stressors, there is a statistically significant mean score difference between no distress group (M = 61.36, SD = 19.28) and distressed group (M = 77.75, SD = 20.98; t (88) = -3.858, p = .000) on RSS. The magnitude of the difference is also tested using eta-square (η2) and was found to be of moderate effect size (0.14). This result indicates that refugees in the distressed group have higher pre-migration stressor (RSS) scores than refugees in the no distress group. Similarly, refugees in the psychologically distressed group scored higher in

response to organised violence, absence of basics, sexual abuse and oppression during pre-migration than the psychologically no distressed group.

Regarding post-migration stressors, there was a statistically significant difference in the PMLD mean score between the no distressed group (M = 69.74, SD = 18.63) and distressed group (M = 80.18, SD = 19.49; t (109) = -2.878, p = .005). This shows that refugees in the distressed group have higher scores of post-migration stressors and similarly a difference was also found in scores for the subscales, i.e. Health and Welfare stressors and Acculturation stressors, but not for Documentation and Family stressors. There was a statistically significant difference in the total scale of RDS and the two subscales between the two groups for psychological distress.

Table 22

Independent-sample t-test results for measures and subscales for Psychological distress (No distress and Distress groups)

	No distress		Distress		t	df	p-value	95% CI		Eta-square $\frac{t2}{t2+(n1+n2-2}$
	Mean	SD	Mean	SD				LL	UL	
RSS	61.36	19.28	77.75	20.98	-3.858	88	.000***	-24.830	-7.947	0.144
OV	29.05	10.09	33.05	10.31	-2.013	107	.047*	-7.938	-.060	0.036
AbB	16.70	7.48	22.13	7.95	-3.873	121	.000***	-8.206	-2.654	0.110
SexAb	5.84	2.95	7.61	3.99	-2.836	122	.005**	-3.003	-.534	0.062
Opp.	11.91	5.61	14.52	5.25	-2.499	118	.014*	-4.489	-.520	0.050
PMLD	69.74	18.63	80.18	19.49	-2.878	109	.005**	-17.634	-3.250	0.071
HWS	22.96	8.58	26.89	8.73	-2.519	123	.013*	-7.021	-.842	0.049
DS	13.55	5.18	14.29	4.66	-.837	127	.404	-2.482	1.007	0.005
FS	9.73	3.27	10.73	3.36	-1.728	131	.086	-2.143	.145	0.022
AS	23.20	7.91	28.02	8.33	-3.226	117	.002**	-7.782	-1.861	0.081
RDS	52.79	13.71	60.55	11.39	-3.144	107	.002**	-12.658	-2.868	0.085
RUV	33.14	10.20	38.35	8.06	-3.058	112.5	.003**	-8.587	-1.834	0.077
RI	19.30	5.03	22.40	4.57	-3.500	120	.001**	-4.860	-1.348	0.072
CD-RISE	74.88	20.95	69.88	17.18	1.259	96	.211	-2.878	12.866	0.0016
PLC -5[a]	17.97	14.16	43.24	19.33	-7.498	78.77	.000***	-31.980	-18.563	0.367

Note.

**Significance at ≤ 0.05 level, **Significance at ≤ 0.01, ***Significance at ≤ 0.001,*

[a] = equal variance not assumed, CI= confidence interval; LL= lower limit; UL= Upper limit.

Eta square (Cohen, 1988); .01 = small effect, .06 = moderate, .14 = large effect

OV = Organised violence, AbB = Absence of Basics, SexAb = Sexual Abuse, HWS= Health & Welfare Stressors, DS= documentation Stressors, FS = Family Stressors, AS = Acculturation Stressors, RUV = Refugees Uncertainty and vulnerability, RI = Refugees Insecurity

Lastly, the psychological distress group scored a much higher level (M = 43.24, SD = 19.33) on PTSD than those in the no distressed group (M = 17.79, SD = 14.16; t (106) = -7.498, p = .000), with medium size effect (0.36). However, no significant difference was detected for the two groups of distress on their mean scores for resilience.

8.12 Predictors of Psychological distresses and PTSD

To understand the predictors of psychological distresses measured by GHQ-28 and PCL- 5, standard multiple regression analyses were undertaken.

8.12.1 What are the best predictors of Psychological Distresses as measured by GHQ-28?

To identify predictors for each psychological distress (Anxiety and Insomnia, Depression, Social dysfunction and Somatic complaints) measured by GHQ-28, four separate standard multiple regression analyses were carried out. Each model contains ten independent variables: the sub-scales of migration stressors measured by RSS, PMLD and RDS. The subscales are organised Violence, Absence of basics needs, Sexual abuse, Oppression, Health and Welfare stressors, Documentation stressors, Family stressors, Acculturation stressors, Refugee Uncertainty and Vulnerability, and Refugee Insecurity. The analysis also examined the unique ability of each of the independent variables to explain the variance in the dependent variable over and above the other independent variables. The table below shows only the variables that made a unique signification contribution to the models.

The full model for Anxiety and Insomnia with the ten variables were able to explain 28.2 per cent of the variance that was significant at p < .000 (ANOVA). From the ten variables, Acculturation stressor i.e. post-migration stress indicator made a unique contribution that was significant at p = 0.045 (p < .05). The full model with the same ten variables was also able to explain: for Social dysfunction 19.2 per cent (p < .001) of the variance, and for Somatic complaints 30.3 per cent (p < .000) see table 23 below. For Social dysfunction, Defenselessness' sub-scale namely Uncertainty and Vulnerability (p = 0.040) made a unique, significant contribution, while for Somatic complaints pre-migration indicator, i.e. Absence of basics (p = 0.013) made a significant unique contribution. However, the model was insignificant for predicting depression.

Table 23

Results of the standard multiple regression in predicting Psychological distress measured by GHQ-28

	R-square	ANOVA	Df	B	t	Sig.	95,0% CI for B		Part
							LB	UB	
Anxiety and insomnia									
(Constant)	.282 (.222)+	.000	10		4.906	.000			
AccSt.				.232	2.024	.045*	.004	.347	.157
Social Dysfunction									
Constant	.192 (.125)+	.003	10		.057	.954			
RUV				.234	.2.077	.040*	.005	.207	.170
Depression									
Constant	.123 (.049)+	.094	10		-.274	.784	-4.468	3.380	
Sex.Ab				.249	2.655	.009*	.085	.581	.227
Somatic Complaints.									
Constant	.303 (.245)+	.000	10		-2.067	.041	-8.857	-.191	
Absence B.				.273	2.533	.013*	.041	.336	.028

Note. +. Adjusted R Square; * . sig < .05.
AccSt. = Acculturation Stressors, RUV = Refugees Uncertainty and vulnerability, SexAb = Sexual Abuse; Absence B. = Absence of Basics.

8.12.2 Predictors of Post-Traumatic Stress Disorder symptoms measured by PCL -5

To examine how well demographic characters and migration stressors predict PTSD, a standard multiple regression was carried out. The model contains twelve independent variables, the sub-scales of migration stressors measured by RSS, PMLD and RDS and gender and educational level as demographic characteristics. The subscales are organised violence, Absence of basics needs, Sexual abuse, Oppression, Health and Welfare stressors, Documentation stressors, Family stressors, Acculturation stressors, Refugee Uncertainty and Vulnerability, and Refugee Insecurity. The analysis also examined the unique ability of each of the independent variables to explain the variance in the dependent variable over and above the other independent variables. The full model with the twelve variables was able to explain 43.6 per cent of the variance that was significant at $p < .000$ (ANOVA). From the twelve variables, gender, being

female ($p = 0.024$) and the post-migration stress indicators, namely the Refugee Uncertainty and Vulnerability and Family stressors made unique contributions that were significant at $p = .050$ and $p = 0.035$ ($p < .05$) respectively, see table 24 below.

Table 24

Results of the standard multiple regression in predicting PTSD.

	R-square	ANOVA	Df	B	t	Sig.	95,0% CI for B		Part
							LB	UB	
(Constant)	.436	.000	12		.056	.956	-32.598	34.481	
Gender				-.187	-2.298	.024*	-16.014	-1.178	-.170
L. edu.				-.112	-1.300	.197	-10.867	2.263	-.096
OV				.051	.480	.632	-.317	.519	.036
AbB				.128	1.199	.233	-.222	.901	.089
SexAb				.071	.822	.413	-.639	1.544	.061
Oppression				-.064	-.612	.542	-1.039	.549	-.045
HWS				.167	1.587	.115	-.099	.890	.118
DS				.068	.772	.442	-.446	1.015	.057
FS				.203	2.134	.035*	.093	2.534	.158
AS				-.090	-.790	.431	-.802	.345	-.058
RUV				.204	1.986	.050*	.001	.942	.147
RI				.121	1.087	.280	-.419	1.434	.080

* . Sig < .05.

Note. L.edu. = Level of education, *OV = Organised violence, AbB = Absence of Basics, SexAb = Sexual Abuse, HWS= Health & Welfare Stressors, DS= documentation Stressors, FS = Family Stressors, AS = Acculturation Stressors, RUV = Refugee Uncertainty and Vulnerability, RI = Refugee Insecurity.*

8.13 Chapter summary

This chapter presented results from different statistical techniques used to describe and infer from the data collected among African refugees in Durban, South Africa. First, the socio-demographic characteristics of the sample were described using frequency and descriptive analysis. Then factors of the measurements were determined using principal component analyses to explore the factor structure of the measures. Then using descriptive analysis (mean, standard deviation, skewness, kurtosis) the measurements' distribution and normality of the data was checked. Then the refugees' major pre- and post-migration stressors, psychological distress and resilience were described using frequency and description. Pearson rho correlation was used to examine the relationship between the various measurements and their subsequent subscales. Chi-square and t-tests for independence were used to determine demographic group differences in psychological distress. Then to identify predictors of psychological distresses standard multiple regression analyses were applied.

Chapter Nine

Quantitative Results Discussion

9.1 Introduction

This chapter deals with the discussion of the quantitative results, with the integration of relevant literature and theoretical perspectives. The demographic information of the participants is firstly discussed, followed by factorial analyses compared with other relevant studies in the field and examined for information on the experiences of refugees. The psychometric properties of the measures and descriptive statistics are discussed. Finally, the results from the chi-square, t-test, correlation and regression analyses are compared and discussed.

9.2 Socio-demographic background of the participants in the study

The majority of the participants are from the DRC. This might indicate that they are among the largest refugee communities in Durban, South Africa. In 2016 they were the largest group to request asylum in South Africa (UNHCR, 2017). They also seem to be seeking more support from NGOs and community institutions like the church, which makes them accessible as a group for research participation. Further, the Congolese have been experiencing continuous civil war and violence in their home country, resulting in large scale displacement and migration (IRC, 2007; UNHCR, 2017). Comparatively, refugees from other communities, for example, the Somalis, Ethiopians and Eritreans, most of them are self-employed in a small and medium-sized business, and rarely seek support from NGOs which makes them more difficult to access for research studies.

Almost half of the participants in this study had been granted refugee status at the time of the study. However, the number of asylum-seekers is greater than refugees in South Africa. In a recent report, the DHA (2017) stated that there are more than a million asylum-seekers and close to eighty thousand refugees in South Africa (DHA, 2017). The majority of the participants have a tertiary level qualification, and before their migration, 30 per cent were working as qualified professionals in their home countries. However, only 15 per cent are now employed professionally in South Africa indicating that even though qualified and experienced, the labour market is not considering refugees mainly due to systematic exclusion of refugees from entering the labour market (Kavuro, 2015). Kavuro et al. (2015) argued how policies that are designed to protect the historically

disadvantaged South Africans had overlooked the countries duty to respect refugee rights, including a right to employment. This might also support the argument that South Africa is not benefiting as much as it could, from qualified and experienced refugees due to its own policies and directives of exclusion. The number of refugees who identified themselves as self-employed at pre-migration increased from 18 per cent to 47 per cent at post-migration. This seems to suggest that many of the professionally qualified employees turn to self-employment.

9.3 Factors structure and Psychometric properties of the measures

The results from the factorial analysis for each scale that measured migration stressors, resilience and psychological distress and their psychometric properties are discussed below.

9.3.1 Migration Stressor Measurements

The developer of the ***Refugee Stress Scale*** divided it for the purposes of analysis into three subscales (Idemudia et al., 2013). However, factor structures of the scale were not reported on. The subscales were 'human rights abuse' (violence and police victimisation), 'poverty' (lack of resources), and 'sexual and physical abuse' (Idemudia et al., 2013). The scale was originally developed with 22 items (Idemudia et al., 2013); however, this study included five more items that identify experiences of oppression under totalitarian regimes. These were included as identified by the qualitative study and were not on the original scale. The subscales are replicated in this study and named as organised violence, absence of basic needs and sexual abuse, respectively, in addition, the newly added items as a fourth factor were named 'oppression'. This shows the similarity in pre-migration stressors among African refugees. Furthermore, the four factors were consistent with the most common pre-migration stressors among African refugees, as outlined previously in the qualitative study and the current literature.

The inter-item reliability coefficient was excellent for the total RSS in this study ($\alpha = 0.93$). This adapted instrument demonstrated higher internal consistency in this sample than the original scale that scored $\alpha = 0.90$ (Idemudia et al., 2013).

The data collected using ***Post-Migration Living Difficulties (PMLD)*** resulted in four factors. The four factors are meaningful as they were able to separate items that measure common stressors at post-migration, namely, Health and Welfare, Documentation, Family and Acculturation stressors. In this study, the fourth factor, Acculturation stressors, collated the fourth and the fifth factors of

the original instrument by Silove et al., (1998). Even though the instrument is often used, there is no other study that has reported the factor structure of it. Furthermore, the factors are common themes of post-migration stressors in different studies reported in the literature (Crush & Tawodzera, 2014; CoRMSA, 2011; Jinnah, 2013; Smit & Rugunanan, 2015).

PMLD obtained an excellent inter-item reliability coefficient with a Cronbach's alpha of 0.92. Even though the measurement has been used previously in similar contexts, among Sudanese refugees in Australia (Schweitzer et al., 2006) and other multi-cultural refugees including Africans (Aragona et al., 2012; Aragona et al., 2013), none of the studies reported the internal consistencies. The four sub-scales also obtained good reliability coefficients ranging from alpha 0.71 to 0.91 in this study.

The newly developed ***Refugee Defenceless Scale*** (RDS) measured personal and family experiences of uncertainty and vulnerability as well as insecurity. As mentioned earlier, the development of the instrument was informed by the qualitative results of this study and is one of the contributions of this study to the body of knowledge as there has not been an instrument developed to specifically measure refugees' personal and family's experiences of insecurity and vulnerability during the last stage of the migration process. The two factors identified, distinguished the items that measure Refugee Uncertainty and Vulnerability and Refugees Insecurity. The instrument obtained an excellent internal consistency coefficient $\alpha = 0.90$, and the two subscales also obtained a Cronbach's alpha of $\alpha = 0.88$ and $\alpha = 0.78$, respectively.

9.3.2 Resilience Measurements

The ***Conner-Davidson Resilience Scale (CD-RISC)*** factorial analysis resulted in a one-dimensional factor. This instrument has been showing inconsistency regarding the factors structure in studies across different contexts (Compbell-Sills & Stien, 2007; Jorgensen & Seedat, 2008; Singh, 2010). The one-dimensional factor explained variance of 37.6 per cent and is consistent with findings of Burns and Anstey (2010) in a large community survey in Australia that reported a one-factor solution.

The Cronbach's alpha reliability coefficient for the CD-RISC in this study was $\alpha = 0.93$. A similar Cronbach's alpha, 0.93, was reported among South African adolescents (Jorgensen & Seedat,

2008), however, a lower reliability coefficient, Cronbach's alpha of 0.88, was reported among Congolese refugees in Uganda (Ssenyonga, Owens & Olema, 2013).

9.3.3 Psychological distress measurements

The result of the factor analysis of the ***General Health Questionnaire (GHQ- 28)*** replicated the same four factors as the original measurement (Goldberg et al., 1997). This shows the suitability of the instrument for use in multi-culture samples as it is able to identify symptoms of psychological distress among African refugees. However, the ***Post-Traumatic Stress Disorder Checklist (PCL – 5)*** showed a complicated two-factor solution, and the only one-factor solution was retained as discussed in the results. It is likely that the scale is not culturally compatible with African refugees' understanding of their symptoms related to PTSD. Furthermore, recent studies have also been reporting inconsistent factor solutions from the original scale. For example, Armour et al. (2015) reported a seven-factor hybrid model among two independent samples, USA veterans and university students. Similarly, Ashbaugh et al. (2016) reported the seven-factor hybrid model as the best fit for the English and French version of the instrument for use among trauma-exposed undergraduate university students in Canada.

The GHQ-28 obtained an excellent reliability coefficient with an alpha of 0.93. Similarly, a reliability coefficient of $\alpha = 0.91$ was also reported among Zimbabwean refugees in South Africa (Idemudia et al., 2013). However, Haidula et al. (2003) reported a slightly lower Cronbach's alpha coefficient of 0.86. The four sub-scales obtained reliability coefficients ranging from $\alpha = .81$ to $\alpha = .89$.

The PCL -5 obtained an excellent internal consistency reliability coefficient, alpha 0.95. The older version, with 17 items, had also achieved an excellent Cronbach's alpha coefficient $\alpha = 0.97$ among Congolese refugee in Uganda (Rees et al., 2013), and a similar version also scored good inter-item reliability coefficients $\alpha = .80$ among Zimbabweans refugees in South Africa (Idemudia et al., 2013).

9.4 Major Pre-migration Stressors

In this study, the pre-migration stressors as measured by RSS, forced separation from family, not having a clear vision about ones' future, limited freedom and police or military follow-ups or beatings are reported as the most common stressors by the participants. Other pre-migration

stressors prevalent among the participants include threats to family members, near death due to threat, harassment by the police, and unemployment.

These stressors, mainly caused by civil war and state organised violence, are commonly reported push factors for refugees to flee their home countries (WHO, 2008; UNHCR, 2017). Consistent with the findings of this study, several studies among African refugees across the globe have been reporting life threats, violence and separation from family caused by war and violence, as the most common pre-migration stressors (Abraham et al., 2017; Kroll et al., 2011; Lindert & Schinina; 2011; Nakash et al., 2014). Other studies among African refugees in an African context also reported murder of family members or being forcefully separated from family, being close to death, being in a combat situation, the lack of resources to meet basic needs, imprisonment, rape and sexual violence as key reasons for forced migration (Fox & Tang, 2000; Mhlongo et al., 2018; Onyut et al., 2009; Rassmussen et al., 2010).

Similarly, Khawaja et al. (2008) reported that losing loved ones, violence and threats to life, lack of basic necessities and difficulties in carrying out daily activity due to war were the main pre-migration stressors among South Sudanese refugees in Australia. In this study, the war and violence-related stressors experienced by African refugees in South Africa are not as high as reported in studies among refugees living in camps as mentioned earlier (Akinyemi et al., 2012; Fox & Tang, 2000; Rassmussen et al., 2010). For example, similar experiences but higher stress rates were reported by Rassmussen et al. (2010), among South Sudanese refugees living in a refugee camp in Chad. The related economic stressors (lack of basic resources and unemployment) are also similar reasons for the flight of Zimbabweans found in the work of Idemudia et al. (2013) as mentioned in the earlier discussion pertaining to the qualitative data.

Most of the time refugees in camps are the immediate victims of war and violence, and their memories of traumatic experiences are fresh. However, those who travel beyond neighbouring countries could be relatively less traumatised and affected by the violence as they could live in relatively better conditions, or it could be that the length of time leads to the lessening of the impact of some traumatic experiences. Systematic reviews among refugees have shown decreasing symptoms of PTSD as time goes by (Fazel et al., 2005; Porter & Haslam, 2005; Steel et al., 2009).

In this study, sexual violence (i.e. forced sex, rape, sexual assault and harassment) was reported by less than 10 per cent of the participants, suggesting that these stressors are lower among the

African refugees in South Africa by comparison with most other destinations. The study by Morof et al., (2014) reported a higher rate of gender-based violence including physical violence, sexual violence, forced sex and attempted sex among urban-based women from Somalia and the DRC in Uganda (Morof et al., 2014), post-displacement experiences of sexual violence seems higher. Studies argue low rate of sexual violence reported could be due to the fear of the stigmatisation that might have impacted women's decisions not to share these experiences in the interviews. However, in the qualitative interviews out of four female participants, one shared her experience of sexual violence (rape), and another one witnessed a rape of her sister. So, it seems women are sharing their experiences of sexual violence, and the low rate indicated in the study could be the actual figure among refugees in South Africa.

In addition, the restriction of freedom and a lack of a future vision was also reported as pre-migration stressors by about half of the participants. State organised violence that includes the lack of freedom for speech, movement and faith, arbitrary detention and conscription can be as traumatising as war and violence and therefore viewed as gross human rights abuses (Abraham, Lien & Hanssen, 2018; Idemudia et al., 2013), and recently similar experiences of gross human right violation were also reported among North Korean refugees in South Korea (Chu et al., 2016) as indicated in the qualitative discussion. However, these kinds of stressors that are not specifically related to war are not yet fully researched among refugees. The effect of lifelong inhumane and deprivation human rights experiences on the mental health of refugees' needs further exploration, as it seems not receiving adequate attention, to better understand and promote wellbeing among the group.

9.5 Major Post-migration Stressors of the participants

Both the PMLD and RDS are used to examine post-migration stressors. Defenceless stressors such as "thoughts that something bad can happen at any time" is experienced by three-quarters of the participants that show a disturbingly high level of uncertainty, insecurity and sense of vulnerability experienced by most African refugees in South Africa. Such daily experiences of defenselessness may refer to xenophobic threats and criminal attacks, as suggested earlier in the discussion of the qualitative findings. This finding is consistent with the wider literature that indicates refugees' experiences of xenophobic violence on a daily basis (Crush, 2008; Harris, 2002; McConnell, 2008; Mothibi et al., 2015; Neocosmos, 2010). Furthermore, the high level of vulnerability and insecurity

are grounded in everyday life experiences as many local South Africans view African migrants as a threat and as being problematic, and therefore they have to be excluded (Moyo et al., 2017). These views are also similar to the argument put forward by Soloman and Kosaka (2013) who state that there is a negative perception among locals about foreigners generally, as a threat to economic and national identity and as a threat to individual rights. This is also supported by the findings of this study that showed more than sixty per cent of the participants experience discrimination based on who they are. This could be in accessing public health services (Crush & Tawodzera, 2014; Zihindula et al., 2016) and discrimination in accessing employment (Smit & Rugunanan, 2014).

Furthermore, refugees' consistent feelings of insecurity could also be due to the high crime rate in South Africa, especially in poor communities where crime ravages livelihoods specifically in inner-city areas with poor socioeconomic conditions where refugees mostly reside (Olumide et al., 2014; Rees et al., 2017), also discussed in the qualitative study.

Other prevalent post-migration stressors among refugees include the lack of job opportunities/ unemployment, fear of repatriation due to problems with obtaining documentation, worries about their children - losing important cultural values and involvement in risk behaviours, separation from family and being unable to return to their home countries for emergencies. For a long time, unemployment has been identified as a major post-migration stressor among refugees in South Africa (Kavuro, 2015; Smit & Rugunanan, 2015; Tshishonga, 2015). The reasons for unemployment was discussed in more detail in the qualitative discussion chapter as the findings of the quantitative study confirm those in the qualitative phase.

Furthermore, as a result of the xenophobic violence of 2019, it has been announced that the ministry of small businesses is developing legislation that will ban migrants from being involved in certain businesses (Sidimba, 2019), in order to strengthen the protection of locals. Similarly, the acting head of Health in KwaZulu-Natal issued a circular to health care facilities in the province to suspend employing foreign health professionals particularly doctors in order to accommodate young South Africans doctors trained in Cuba (ILO, 2019).

Almost 60 per cent of the participants also reported poor working conditions as post-migration stressors. This is consistent with the Tshishonga's (2015) study that reported experiences of exploitation and coercion of refugees. Therefore, most refugees have not yet been able to improve

their economic conditions in South Africa and are still suffering from the lack of basic necessities (Tshishonga, 2015). This situation is further exacerbated by a lack of proper documentation that creates further stressors, and also negatively affects their access to public services.

It seems that most refugees find their difficulties in obtaining legal documentation as a stressor. They report experiencing delays in the processing of applications, fear of repatriation and the inability to return to their home countries for an emergency. Similarly, Rugunanan and Smit's (2015) study among the Congolese and Burundians in South Africa found experiences of inaccessibility and exploitation with endemic corruption at Home Affairs as the main obstacles when trying to secure documentation (Landua, 2006; LHR, 2015; Vigneswaran, 2008). Document-related stressors are higher among asylum-seekers as their permit is subject to renewal on a six-monthly basis.

Documentation problems are institutional restrictions, as the theory of Structuration (Giddens, 1984) states, in the form of policy. Furthermore, it has been reported that because of the structures, implicit or explicit social norms within the hosting countries, refugees have been exposed to poor health services, housing and exploitation at work (Murray, 2010). For example, the discrimination within the health care system is evident in the Health Promotion Policy and Strategy 2015-2019 of the Department of Health (2014), where it does not make any provision for refugees (Zihindula et al., 2016). Recently, in this regard, the previous South African Health Minister Dr Aaron Motsoaledi, has been criticised by media for his xenophobic speech regarding migrants creating pressure in the health system (Editorial, 2019). In its editorial the Business Day asserted that the "*Health minister's prejudiced utterances encouraged illegal, discriminatory practices against foreigners*".

Another key stressor that refugees face (more than two-thirds) are issues pertaining to their children such as the poor living conditions, the fear that they would lose important cultural values and that they might engage in risk behaviours, e.g. risky drinking, smoking, drug abuse and sexual activity. Refugees parents' concern is rarely explored in the literature, except for the qualitative study of Smit and Rugunanan (2015) where mothers, in particular, expressed their concern about the wellbeing of their children because of the insecure living conditions and physical threats to refugee women in Gauteng. The women showed a constant fear and distress due to the lack of income to provide for themselves and their children (Smit & Rugunanan, 2015). In relation to

Bronfenbrenner (1979) bioecological theory, the condition of the children and concern of the parents could be explained as a result of reciprocal interaction of the context they found themselves in and individual factors that could lead them to misbehave and delinquency. Refugees are away from their cultural norms and values that could influence the children. In post-migration, institutions, even the family system, that keep and protect the children from delinquency are wiped out, and secondly, due to the poor socio-economic neighbourhoods that they find themselves in, as previously mentioned, the crowded inner-city areas, where risk behaviours and crime are widespread (Olumide et al., 2014; Rees et al., 2017).

In South Africa, adolescents who abuse substance arouse complex emotional problems in the family, break family values and promote family dysfunction (Winters, Botzet, Dittel, Fahnhorst & Nicholson, 2015). The parents worry about the wellbeing of the substance-abusing youth and fear as they are or may become involved in criminal activities even stealing valuables from their homes and become threats to their parents and siblings (Mash & Wolfe, 2010). A study among migrants from Latin America in the USA by Smokowski, Rose, Bacallao, Cotter, and Evans (2017) reported that parents are psychologically distressed by acculturation to fear that the American culture might weaken the family bonds, and they restricted the adolescents' 'social freedom', this leads to adolescent developing risk behaviours such as aggression and delinquency. The study also indicated that parents worry, and parent-adolescent conflict often coexist (Smokowski et al., 2017).

These overwhelming stressors among refugee parents' regarding their children, which are not only away from their home and culture, but also staying in poor socioeconomic conditions have not received more specific attention.

9.6 Psychological Distress among the participants

Psychological distress symptoms, as measured by the GHQ-28, are experienced by about half of the participants in this study. The prevalence of psychological distresses was determined using the cut-off 23/24 suggested by Goldberg and Williams (1988). The GHQ-28 also categorises psychological distress pertaining to anxiety and insomnia, social dysfunction, depression and somatic complaints. Anxiety and insomnia are found as the most prevalent psychological problems, 44.3 per cent of the participants scored above the mean (M = 8.58, SD = 6.43) followed by social dysfunction, somatic complaints and depression. Several studies, among African refugees, have consistently rated anxiety, depression and PTSD to be major mental health

conditions experienced by refugees (Bogic et al., 2015; Crager et al., 2012; Porter & Haslam, 2005; Steel et al., 2009).

However, studies have been showing inconsistency regarding the prevalence of psychological distress (Al-Smadi et al., 2017; Lindert et al., 2009; Morof et al., 2014), that is seen in the review by Bogic et al. (2015) that reported a wide range of prevalence, for example, anxiety ranging from 20.3 – 88 per cent, and depression (2.3 – 80 per cent) among refugees.

The prevalence of mental health conditions is relatively lower in this study when compared to other studies among African refugees. For example, Fox and Tang (2000) found a very high presence of anxiety with (80%) and depression with (85.5%) among Liberians and Sierra-Leoneans refugees in the Gambia, Morof et al. (2014) also reported a notably high prevalence of depression (92 %), and PTSD (71.1%) among Congolese and Somali women refugees in Kampala, Uganda. The lower rate of psychological distresses could be attributed to long time resettlement and the comparatively better socioeconomic opportunities in South Africa compared to other African countries that might also have played a role. However, the meta-analysis by Lindert et al. (2009) and a study by Tekin et al. (2016) among Iraqi refugees reported a similar prevalence of anxiety (40 %) and major depression (39.5%) respectively.

The finding of this study, regarding the prevalence of PTSD, is within the range that has been reported among African refugees, 25 – 71 per cent (Karunakara et al., 2004; Kolassa et al., 2010; Neuner et al., 2004; Onyut et al., 2009; Onyut et al., 2004; Ssenyonga, Owens & Olema, 2013). In a systematic review conducted by Steel et al. (2009), it was reported that the highest prevalence of PTSD occurs among African refugees when compared to all other refugee groups.

The most common symptoms of PTSD among the refugees are the re-experiencing of trauma, including feeling very upset when reminded of the stressful experiences and the showing of strong physical reactions when reminded. Other common symptoms are trying to avoid external reminders of the stressful experiences and arousal symptoms like being watchful or on guard and experiencing difficulty in concentrating. These PTSD symptoms: re-experiencing of trauma and showing of strong physical reactions were also found as main symptoms of PTSD in the qualitative findings of this study that shows consistency between the findings.

9.7 Resilience of the participants

Generally, the African refugees showed good resilience (M = 72.26, SD = 19.227) measured by the CD-RISE. Almost 80 per cent of the refugees indicated their resilience using self-reliance statements such as 'work to attain my goals' and 'consider myself as a strong person'. Other most common resilience strategies include relying on fate or God for help, giving their best efforts no matter what, and not giving up even when things look hopeless. The resilience strategies refer to coping mechanisms that seem to be a more individual inner resource in nature, i.e. self-reliance, to overcome their challenges. However, this is contrary to the African view of resilience based on collective culture (Theron, Theron, & Malindi, 2013). This might be attributed to the broken social supporting networks. Secondly, most refugees are at the same level or are experiencing similar stressors and therefore little material assistance can be expected from fellow refugees, they, therefore, prefer to rely on themselves rather than burdening family networks and communities for their needs as also shared in the qualitative interviews by some refugees. Further, another reason can be dissatisfaction with or giving up on the traditional collective means of support. In South Africa, refugees do not get any form of support from the government, and the support they obtain from NGOs and community institutions are very basic, can be unreliable or inconsistent and where it is given, only for a short period of time. This supports the findings of the qualitative study where refugees are described inner resources (psychological capital) as a main coping mechanism, in addition to faith and religiosity.

In this study, the resilience of refugees is higher (M = 72.26; SD = 19.227) than what was reported among refugee adolescents in Australia (Ziaian et al., 2012). However, it is similarly to what Connor and Davidson (2003) reported among primary care patients (M = 71.8, SD = 18.4), and psychiatric outpatients (M = 68.0, SD = 15.3).

9.8 Demographic and Measurement differences in Psychological Distress

An attempt is also made to examine whether an association between demographic characteristics and mental health exists (either no psychological distress or some psychological distress) among the refugees. The chi-square analyses results show that there is no significant difference between most of the categorised demographic characteristics regarding psychological symptoms, except with gender, females are found to be more prone to psychological distress than males. However, the study by Rassmussen et al. (2010) reported higher depression among male refugees from South

Sudan in Chad. Similarly, Onyut et al. (2009) reported a higher prevalence of arousal PTSD and anxiety among male refugees. This was attributed to the familial role where men are expected to be breadwinners according to their tradition whoever, and they were restricted in the camps from working and providing their families (Rassmussen et al., 2010). However, Idemundia et al. (2013) reported no gender differences in psychological distress among Zimbabwean refugees. Regarding other demographic groups, it seems that age, marital status, refugee status in South Africa (refugee or asylum-seeker) and English language mastery has no influence on the mental health of African refugees in South Africa. This suggests that all reported similar levels of psychological distress irrespective of demographic differences.

However, there was a significant mean score difference on psychological distress regarding refugees' country of origin, kind of previous employment in the home country and level of education. In these study refugees from the DRC significantly reported higher mean scores than Zimbabweans on psychological distress. This shows that Congolese refugees are suffering more psychological distress than Zimbabweans. The Congolese refugees fled from a war-torn country, while most Zimbabweans are economic refugees. Refugees from war zones have consistently been showing to suffer from more psychological problems than economic migrants (Crager et al., 2012; Lindert et al., 2009). Similarly, Onyut et al. (2009) found a higher prevalence of PTSD among the Somalians who experienced higher traumatic experiences than their counterpart Rwandese. Further, Smit and Rugunanan's (2015) study among refugee women in South Africa found Zimbabweans better employable as they are fluent in the English language than in comparison to Congolese or Burundians. Therefore, a lack of masters in the English language decrease employability that may impact the extent of psychological distress among refugees from the DRC. As it was mentioned in the qualitative discussion, cultural similarity and language helped Zimbabwean refugees to cope better than other counterparts, and this might also contribute toward a lower level of psychological distress than the other groups.

Regarding the kind of previous employment in the country of origin, those who were working at irregular jobs in their home country showed higher psychological distress than other employment categories except for self-employment. This shows that refugees who had irregular jobs at home might have migrated with expectations of a better job opportunity accompanied by higher family

responsibility. Their expectations for jobs remain unrealised and responsibilities unfulfilled, and this might worsen their mental health conditions as they face a lifetime of unemployment. Studies have found lower levels of mental health among refugees whose social status decreased during post-migration, e.g. when their socioeconomic status decreased in post-migration (Bogic, Njoku, & Priebe, 2015; Chen, Hall, & Renzaho, 2017). However, there seems not to be a study that recorded the mental health of refugees who were unemployed or who had irregular and/or precarious jobs in their home countries prior to migrating.

Regarding education levels, refugees with higher levels of education are found to experience lower psychological distress, and this is consistent with a study that reported education as a protective factor in mental health problems (Karunakaral et al., 2004). The refugees' higher level of education could be linked to higher self-esteem and hope for employment or self-employment initiatives and could facilitate adapting to a foreign language easily and thereby help to reduce psychological distress. As it is found in the qualitative study, those who migrated with tertiary education qualification background opted to further their education in order to increase their employment opportunities rather than working for lower-paid jobs and stagnate, and this personal progress and meaning might have improved their confidence that positively affected them.

The experience of higher migration stressors and lower levels of resilience seemed to have impacted the mental health of the participants negatively. This finding is congruent with the literature that reported higher psychological distress among refugees who are overwhelmed by migration stressors (Bogic et al., 2015; Idemundia et al., 2013; Onyut et al., 2009). Evidence was also found for the comorbidity of psychological distress as outlined by Nickerson et al. (2017) as those with psychological distress have also shown notably higher PTSD symptoms than those without psychological distress.

However, there was no difference in resilience between the two groups of psychological distress that means resilience is less likely to influence psychological distress. This finding is in contradiction with studies that indicate resilience as a protective resource from psychological distress (Arnetz, Rofa, Arnetz, Ventimiglia, & Jamil, 2013). Furthermore, inconsistent results were also found regarding family stressors and documentation problems, and participants showed no

difference in mental health. This means irrespective of their stressors the participants reported similar levels of psychological distress. Separation from family and documentation problems are general stressors across the participants. Therefore, they might all have been similarly psychologically affected.

9.9 Association between Migration Stressors, Resilience and Psychological Distress variables

The study investigated associations among migration stressors, and between migration stressors and resilience and psychological distresses of refugees. The results of the correlation analyses are discussed below.

9.9.1 Association between Pre- and Post-Migration Stressors

In this study, significant and positive associations were found to exist between pre-migration stressors measured by RSS and post-migration stressors measured by the RDS and PMLD. This implies that refugees who experienced higher pre-migration stressors are more likely to experience high post-migration stressors. Earlier literature supports this finding that refugees who experienced and witnessed traumatic violence and conflicts are more likely to be overwhelmed by host country stressors such as family and acculturation stressors (Kunz, 1981; Miller & Rasmussen, 2010). These could be due to several reasons as refugees in most instances had to flee their home countries from life-threatening violence without any preparation and also might still be suffering from their traumas making them more vulnerable to be overwhelmed by the realities of the post-migration phase. The issues they have to face, e.g. the host country's cultural barriers, hostility from the host community and policies towards refugees, may exhaust their resilience. Generally, South Africa is known as a hostile community for migrants, politically motivated hatred, regressive refugee policies including documentation processes marred by corruption (Gordon, 2016; Moyo et al., 2017; Sutton et al., 2011; Tshishonga, 2015). It should also be noted that most of the refugees have lost their primary supportive social networks and therefore the resettlement process might become very difficult resulting in them suffering from longing, alienation and loneliness (Chen et al., 2017; Schweitzer et al., 2006).

The strong association between pre- and post-migration stressors are explained in the theory of refugees by Kunz (1981) that argues that post-migration stressors could be traced back to refugees' experiences, dependence on and identification with the population in their home country. Further,

he also asserted that host country factors such as cultural compatibility, population policy and social attitudes are crucial for refugee integration. Not only that, but these factors also determine the association between post-migration stressors and refugees' adaptation to the new culture that will expose them to psychological distress including isolation and withdrawal from interaction (Kunz, 1981).

The RSS showed a strong positive correlation with the subscales of RDS, refugees' uncertainty and vulnerability and refugees' insecurity in the post-migration phase. This shows that refugees who experienced a threat to their lives, who have been forced to separate from their families, with no clear vision about the future and who have been followed or beaten by the military in their home countries are most likely to experience defencelessness in host countries. This could be due to the traumas and experiences of continued vulnerability and threats developed as a result of the hostility in South Africa (Moyo et al., 2017; Schippers, 2015; Soloman & Kosaka, 2013). Further, in this study, it is found that sexual abuse in the pre-migration stage was significantly associated with experiences of insecurity and vulnerability in post-migration, and this strongly supports the argument that these experiences are more likely to result in developing a perception of defencelessness and greater vulnerability.

After the recent xenophobic attacks, refugees are demanding third country resettlement which shows the extent of experiences of insecurity and desperation for a foreseeable solution from the South African government (Evans, 2019). As discussed earlier, refugees' poor precarious socioeconomic conditions also contribute to the feelings of uncertainty, insecurity and vulnerability. The findings also show that the pre-migration stressors are more likely to play a significant role in perpetuating experiences of vulnerability and insecurity, in addition to the challenged of post-migration and related stressors.

Furthermore, organised violence at pre-migration stage showed a strong positive correlation with family stressors at post-migration, an indication of refugees' overwhelming concern for their families back home. This could be unbearable to refugees who personally experienced traumatic violence at home and who know that they are targeted as a group (e.g. as a tribe) particularly if the situation and threats they have escaped still prevail. There are several studies that reported a high level of worry among refugees whose families are living under violent conditions back home (Nickerson et al., 2010; Porter & Haslam, 2005; Steel et al., 2009). For example, Nickerson et al.

(2010) revealed high levels of psychological distress among refugees whose families are living in war-torn regions or in areas where they experience perpetually violent situations. Refugees might also feel guilty for abandoning their families in risky life conditions, as found in the qualitative results of the study.

Regarding the post-migration measurements, a strong association was found between post-migration stressors PMLD and RDS. This shows the cumulative effect of stressors, e.g. a refugee with documentation problems, is less likely to be employed and able to access public services than others. The use of both measurements has helped to identify common stressors. Furthermore, the RDS is used as a complementary measurement in identifying additional stressors missing in the PMLD, e.g. parents' worries about their children as a common stressor. This suggests the consistency of the new measurement, the RDS, with the already existing measurement of post-migration stressors; however further refinement is necessary.

9.9.2 Association between Migration stressors and Psychological distresses

The study also examined the association between migration stressors and psychological distresses. Generally, the pre-migration stressors showed a positive association with psychological distress measured by GHQ-28 and PCL-5, indicating African refugees who experienced stressors such as traumatic violence including sexual abuse, oppression, and absence of basics needs are more likely to experience psychological conditions such as anxiety and insomnia, somatic complaints and PTSD. This shows, the likelihood of pre-migration stressors to impact the mental health of refugees, even after resettlement, and even more so when they have had not any access to psychological support in the early stages of post-migration. The findings are consistent with the wider literature among African refugees (Mhlongo et al., 2018; Neuner et al., 2004; Onyut et al., 2009) and other refugees across the globe (Crager et al., 2012; Porter & Haslam, 2005; Steel et al., 2009). For example, Mhlongo et al. (2018) reported a strong association between traumatic war experiences and PTSD among African refugees in South Africa.

Regarding the psychological distress, somatic complaints showed a stronger association with pre-migration stressors that implies, refugees who experienced high pre-migration stressors are more likely to suffer from somatic complaints than other psychological distresses. Particularly, the absence of basic needs (food, water and shelter) before migration is strongly associated with

somatic complaints. This indicated forced displacement as a result of war or violence involves and/or leads to a lack of basic needs and related psychological distress (Miller & Rasmussen, 2016). However, it is noteworthy that somatic complaints are also associated with all pre-migration stressors. This can be related to the common explanation of psychological distresses using physiological symptoms such as headaches, feelings of tightness or pressure, feeling ill and in need of better health. There are several studies among African refugees that found somatisation as a common explanation for mental health problems (Geltman, Grant-Knight, Ellis, & Landgraf, 2008; Fenta, Hyman, Rourke, Moon, & Noh, 2010). Rohlof, Knipscheer and Kleber (2014) reviewed studies that examined medically unexplained physical symptoms among refugees. They suggested four explanations for somatisation among refugees namely; somatic complaints could be for yet unknown somatic illness, or psychological conflict resulting from physical complains without somatic diseases, or it could also be culturally accepted explanations for non-western cultures that are not familiar with terminologies, nor have similar words in their home language to refer to the western conceptualisation of psychological distress or as explained that somatisation may arise from the inability to express emotions (Rohlof et al., 2014).

The subscales of the RSS, i.e. organised violence and absence of basic needs, in particular, are associated with PTSD, somatic complaints and anxiety and insomnia. There are various studies that support these findings reporting a strong association between experiences of violence and PTSD and other mental conditions (Morof et al., 2014; Neuner et al., 2004; Ssenyonga et al., 2013). For example, Mhlongo et al. (2018) reported an association between higher traumatic experiences and higher risk for PTSD, and Karunakara et al. (2004) reported the high level of developing PTSD symptoms with increased witnessing of traumatic events among African refugees.

In this study, refugees who were sexually abused in their home country showed a strong association with depression and PTSD. This study provides evidence that experiences of violence are associated with higher risks of PTDS and depression, and it is consistent with previous studies among refugees (Ellis, MacDonald, Lincoln & Cabral, 2008; Morof et al., 2014; Ssenyonga et al., 2013) particularly sexual trauma is highly associated with PTSD among women (Mhlongo et al., 2018; Vu et al., 2008). Also, a likely explanation for the gender difference found where women were more vulnerable to psychological distress in this study.

Another stressor, oppression by authorities at home is found to be positively associated with anxiety and insomnia and somatic complaints. The finding explains the reality of people under oppressive regimes who are forcefully subjugated under totalitarian states. Totalitarian regimes apply physical and psychological coercion as their primary methods of ascendency. It also creates an atmosphere of continuous internal and/ or external threats (Abed, 2004). Those situations lead inevitably to human rights violations including religious and political persecution, disappearances of citizens and the use of torture (Abed, 2004; Abraham et al., 2018; Lee et al., 2016; Nakash et al., 2014). Consistent with the findings of this study anxiety and insomnia was found to be higher among North Koreans (Lee et al., 2016; Lee, Shin, & Lim, 2012) and Iraqis (Abed, 2004) who had experienced state violence and repression before migration. However, research in this regard is very limited, as mentioned earlier.

The above findings showed the extent of stressors from the home country, affecting the psychological wellbeing of refugees. There is no consistent argument regarding the duration of the traumatic experiences and their effect on psychological well-being even after re-settlement. For example, longitudinal studies among Bosnian and Kosovar refugees by Mollica et al. (2001) and Roth et al. (2006), respectively, have shown that PTSD reaction may continue and even increase over time. On the other hand, meta-analyses have shown that with prolonged migration time there is a reduced risk of mental health problems among refugees (Fazel et al., 2005; Porter & Haslam, 2005; Steel et al., 2009).

Furthermore, African refugees' post-migration stressors measured by the PMLD and the RDS showed significant association with psychological distress (measured by GHQ and PCL -5). This means refugees' experiences of post-migration stressors that include health and welfare, family, acculturation, insecurity and vulnerability are associated with increased psychological problems. This is consistent with several studies (Idemudia et al., 2014; Maharaj et al., 2016; Pamaray, 2014; Womersley et al., 2016). For example, Akinyemi et al., (2013) found poor quality of life as a major determinant of poor mental health, Maharaj et al. (2016) reported a significant association between not having enough to eat and eating less with anxiety and depression, and refugees who experienced discrimination are found to be more at risk of psychological distress (Thela et al., 2018). It should be noted that the association between the RDS and health and welfare and acculturation stressor subscales might suggest criterion validity for the newly developed RDS.

Furthermore, the RDS particularly showed a strong association with PTSD that means refugees' who are experiencing insecurity and vulnerability problems are more likely to suffer from PTSD, more than other psychological distress conditions. This is consistent with studies that reported the absence of safety as a significant contributor to psychological distress (Maharaj et al., 2016; Rassmussen et al., 2010) among African refugees.

Similarly, post-migration stressors; health and welfare, separation from family and acculturation stressors also showed a positive association with PTSD. In their study among African refugees, Thela and colleagues (2017) reported an association of acculturation stressors such as discrimination as well as separation from a family with a high risk of PTSD symptoms and depression. However, in this study depression is not associated with any post-migration stressors. Furthermore, refugees troubled with acculturation stressors are more likely to experience anxiety and insomnia and social complaints. The results show that post-migration stressors among African refugees clearly impact psychological distress (Maharaj et al., 2016; Neuner et al., 2004; Rassmussen et al., 2010) that may further complicate the settling process in the host country.

More importantly, a strong positive association ($r = 0.78$, $p < 0.01$) was found to exist between the two measures of psychological distresses the GHQ–28 and the PLC–5, i.e. anxiety, depression, social dysfunction and somatic complains are strongly correlated with PTSD. These indicate comorbidity of psychological distress conditions. It is therefore highly likely that refugees who are experiencing either anxiety, depression, social dysfunction or somatic complaints to also suffer from PTSD or comorbidity with the other psychological distresses. Similarly, Nickerson et al. (2017) reported a high prevalence of comorbidity among multiracial refugees.

9.9.2 Association of Resilience with Migration stressors and Psychological distress

Another research question of the study examined the association between resilience, migration stressors and psychological distress among African refugees. The resilience of the refugees, as measured by the CD-RISE, does not seem to protect against the migration stressors (full scales of RSS, PMLD and RDS), and mental health distress. This is generally inconsistent with studies that revealed migration stressors (pre- and post-migration) negatively impact the resilience levels among refugees (Bhui et al., 2012; Siriwardhana et al., 2014; Ziaian et al., 2012). Further studies reported a positive association between mental health and a high level of resilience among refugees (Siriwardhana & Stewart, 2013; Siriwardhana et al., 2014; Ziaian et al., 2012).

However, the significant negative association between resilience and sexual abuse (the sub-scale of the RSS) indicates that the refugees who were sexually abused in their home countries reported lower levels of resilience than the others. A study among Congolese women refugees resettled in the USA found that the women had carried their sexual violence experiences and were continuously disturbed, suggestive of an impaired ability to cope as the experiences continue to re-emerge with ease (Wachter et al., 2016).

An unexpected finding is the significant positive relationship between resilience and worrying about family in the home country and documentation problems (both post-migration stress indicator). This is inconsistent with studies that reported a negative association between documentation problems and worries about families and resilience. As discussed earlier, the finding also seems in contradiction with literature that suggests family is supporting networking and source of resilience (Chung, Hong, & Newbold, 2013; Lenette, Brough, & Cox 2013), for example, Sherwood & Liebling-Kalifan (2012) claimed that family and social support are resilience strengthening factors among African women refugees from a war background who resettled in England. However, the findings in this study can be explained in that refugees who are highly concerned about their families in their home countries require of them to be more resilient and hopeful for better future as they are looked up to as a support to the families at home as y in poor condition, as it is found in the qualitative study. Regarding their documentation issues, despite the uncertainty, they cannot give up and have to stay positive (resilient) and survive the precarious conditions until they are able to effect some positive change. Similar explanations were stated by Smit, and Rugunana (2015, p. 197) to the resilience found among African refugee women - 'survival with impairment', despite their poor socioeconomic and documentation problems in South Africa, the focus is on 'doing what they can do'. Therefore, resilience in this context does not mean only to bounce back to normality but is suggestive of demonstration of perseverance in adversity and consistent efforts to overcome the challenges.

Furthermore, looking closely at the findings of resilience as a coping strategy in this study, as discussed earlier, refugees rely on and believe more in themselves and personal efforts to cope rather than on other strategies besides relying on God. However, they showed less reliance on social support as a coping strategy. This concurs with the above finding that shows refugees who are separated from their home and unable to return at any time are more likely to rely on

themselves. In other words, having no immediate family close by might also encourages self-reliance and a stronger focus on personal inner resources. This could be a nuanced finding on the literature of resilience that needs further investigation in order to capacitate and enhance self-reliance-based resilience where family and social support is less likely to occur due to separation and displacement. This argument does not sideline the existence of a community bond; however, as it is indicated in this study, participants preferred to rely on themselves as their community members are experiencing the same poor economic conditions as themselves.

In this study, resilience has not shown a significant correlation with measures of psychological distress except a negative correlation with depression. This shows that it is difficult to demonstrate resilience if you are depressed. The consequences of depression include negative mood, interpersonal difficulties, negative self-esteem, ineffectiveness, headaches, loss of appetite, crying, abdominal pain (DSM- 5, 2013; Ziaian et al., 2012). This is consistent with studies that found an association of low level of resilience with refugees suffering from depressive symptoms or behavioural problems (Hjemdal et al., 2011; Ziaian et al., 2011). For example, Ziaian et al. found a higher level of resilience associated with less depressive symptoms among multinational adolescent refugees in Australia (Ziaian et al., 2012).

There is a need for further examination of the resilience scale and research to gain a better understanding of what constitutes resilience for the refugees, particularly, the resilience of African refugees. This will enable the appropriate interventions to be recommended to enhance the resilience of refugees. Even though the instrument obtained an excellent reliability coefficient, it might still not fully address all the resilience dimensions of African refugees, particularly for those who settled in South Africa. It is also possible that this would differ for refugees who settle in different African countries as the context and integration process might be totally different. In particular, when considering the conceptualisation of resilience on availability of external support, it is clear the availability of supportive structures and prospects for altering your current condition is a critical element of resilience as inner personal resources will be depleted in contexts of continued fear, vulnerability and struggle for a livelihood as found among refugees in this study.

9.10 Predictors of Psychological distress and PTSD

Standard multiple regression was used to assess the ability of migration stressors (sub-scales of RSS, PMLD and RDS) to predict psychological distress – anxiety and insomnia, depression, social dysfunction and somatic complaints.

In finding the predictors of anxiety and insomnia, the whole model significantly explained 28.2 per cent of the variance and only acculturation stressors made a significant unique contribution. The acculturation stressor includes communication difficulties, unemployment, discrimination, poverty, loneliness and isolation. Lindencrona, Ekblad, & Hauff (2008) in a study among refugees in Sweden and Strong, Varady, Chahda, Doocy, & Burnham (2015) among elderly refugees from Syria, found anxiety strongly associated with poor financial status, lack of friends, and poor living conditions. These are consistent with the findings of this study as unemployment leads to poor financial status, with poverty, discrimination and mastery of language show poor quality of life, furthermore, loneliness is as a result of poor or absence of friendships. Lower level quality of living is often associated with a high level of anxiety (Al-Smadi et al., 2015; Buhmann, 2014; Strong et al., 2015). However, Al-Smadi et al. (2015), in his study with Iraqi refugees in Jordan, found anxiety and unemployment as the main predictors of low-level quality of living. In this study, it seems that acculturation stressors, as outlined above, predicted anxiety and insomnia. However, further investigation of the interaction between migration stressors and anxiety is needed.

The standard linear regression model that examined the predictors of social dysfunction significantly explained 19.2 per cent of the variance. From the ten variables used, the RUV (Refugees Uncertainty and Vulnerability) was found to make a significant, unique contribution in predicting social dysfunction. The RUV, a post-migration stressor, indicates unsafety, discrimination, parents' worries about children's uncertain future and feeling of failing to fulfil parenthood, and lack improvement in living condition. Common symptoms of social dysfunction are inability to keep oneself occupied, taking a long time to complete things, dissatisfaction with carrying out tasks, feeling useless and lack enjoyment of day-to-day activities. Most studies on the mental health of refugees seem to ignore social dysfunction as psychological distress because most studies report on anxiety, depression and PTSD. Therefore, there is no literature to make a comparison of social dysfunction and its relationship with stressors. But a metal analysis by Hou et al. (2019) found general daily stressors that include housing/neighbourhood problems, unemployment, and inaccessibility to social services to be positively associated with functional

impairment (Hou et al., 2019). Based on the findings of this study it can be argued that refugees who are leading a precarious living condition and over-worried by the uncertainty of their future and that of their children's, seems expected to emotionally dissatisfy at carrying out tasks, feeling inadequate and to lack enjoyment for daily activities. It seems that social dysfunction should be further studied to gain a better understanding of how social dysfunction may impact the resettlement process in the last stage of migration.

In this study absence of basic needs was found to make a unique contribution in predicting somatic complaints while full model explained 30.3 per cent of the variance. This indicates the role of pre-migration stressors such as a lack of food, shelter and means of income in predicting somatic complaints by refugees. Somatisation is explained as physical symptoms that suggest a plea for help and the hope to be supported and cared for the disease on injury while there is no clear physical cause for the shared symptoms (Engel & Katon, 2008). The main somatic complaints were headaches, tightness around the chest and pressure in the head, feeling in need of better health or illness and fatigue. Previous studies, however, found traumatic experiences as a common cause of somatisation (Guarch-Rubio & Manzanero, 2017; Perron & Hudelson 2006). Refugees from Yugoslavia described their somatisation as a result of past traumatic experiences and current experiences of uncertainty about the future and fear of expulsion (Perron & Hudelson, 2006). Similarly, refugee women, in a refugee camp in Sahrawi, Morocco, explained their somatisation predominantly to loss of hope because of their extended stay in the camp (Guarch-Rubio & Manzanero, 2017). However, a study by Obimakinde, Ladipo, Irabor (2015) among patients from a general population in Nigeria, found somatisation to be correlated to belonging to a lower socioeconomic status. As discussed earlier, somatisation is also a common explanation for psychological distress among African refugees, and therefore the absence of access to basic needs is likely to be a leading factor for somatisation.

However, the fourth model that examined migration stressors' ability to predict depression was not significant. Even though the whole model failed to predict depression, sexual abuse seemed to have made a significant unique contribution to explain depression, a finding that is consistent with studies that show strong correlations between depression and sexual abuse, as discussed earlier.

Lastly, using the standard multiple regression, migration stressors and demographic characteristics as predictors of PTSD. Even though the full model was able to explain 43.6 per cent of the variance significantly, only gender (being a female) and refugees' feeling of uncertainty and vulnerability (RUV) made unique contributions to PTSD. As discussed earlier, there is no consistency in research findings literature that shows females specifically to be more likely to experience PTSD symptoms than males, except for the fact that they may be more vulnerable for psychological stressors in general as previously outlined. The RUV subscale of the RDS measures insecurities (e.g. thinking that bad things can happen any time), parents' concerns about their family, particularly their children, their poor living conditions and discrimination. This finding is supportive of the impact of the daily stressor effect on psychological distress (Farhat et al., 2018; Schweitzer et al., 2006). For example, among Syrians, transit and post-migration stressors are found as a source of pain and suffering more so than their past war experiences (Farhat et al., 2018). The importance about these findings highlight the predicament that the refugees face – there is not a way out considering their poor socio-economic conditions and hostile hosting community as well as the structural violence they are confronted with, e.g. migration policies and recent amendments. Even though the literature suggests that with a prolonged migration timeline there is reducing the risk of mental health problems including PTSD among refugees (Fazel et al., 2005; Porter & Haslam, 2005; Steel et al., 2009), however, other studies indicated PTSD reaction might continue and even increase over time (Mollica et al., 2001; Roth, Ekblad & Agren, 2006). Hence, as this study's findings indicate insecurity and livelihood vulnerability (precarious socio-economic condition) could be the reason for continued psychological distress in general inclusive of increased PTSD symptoms after resettlement.

9.11 Chapter Summary

This chapter presents the discussion of the findings from the quantitative cross-sectional survey data and the integration of relevant literature. The majority of the participants were from the DRC; almost half of the participants had refugees' status and had tertiary education. Before they fled, 30 per cent were working as qualified professionals in their home countries. This was reduced by 50 per cent to 15 per cent in post-migration. The results of factorial analyses of most of the measures distinguished the items into meaningful factors, except PLC-5 that resulted in

complicated factors. It was then decided to maintain one factor, and however, CD-RISC resulted in a one-dimensional factor.

Threats to life, forced separation from family, not having a clear vision about ones' future, limited freedom and violence were reported as the most common pre-migration stressors, while defenceless stressors such as "thoughts that something bad can happen at any time" is experienced by three-quarters of the participants during post-migration. In this study, 43.7 per cent of the participants showed current symptoms of psychological distress measured by the GHQ-28. The prevalence of mental distress is relatively lower in this study when compared to other studies among African refugees elsewhere. Almost 80 per cent of the refugees indicated using self-reliance statements such as "work to attain my goals" and "consider myself as a strong person" to report their resilience.

In this study, significant and positive associations were found between pre-migration stressors and post-migration stressors. There was also a strong positive correlation between stressors and psychological distress, indicating stressors such as traumatic violence including sexual abuse, oppression, and absence of basics needs are more likely to induce psychological distress such as anxiety and insomnia, somatic complaints and PTSD. Regarding demographic characteristics, females and those who were working irregular jobs in their home countries showed higher psychological distress than their counterparts. From the migration stressors, the absence of basics to fulfil their needs made a unique contribution to predicting somatic complaints, and acculturation stressors and Refugee uncertainty and vulnerability were found to predict anxiety and insomnia and social dysfunction respectively. Being female and experience of uncertainty and vulnerability are linked to predicting PTSD.

Chapter Ten

Summary, Conclusion and Guidelines for Mental Health Promotion Interventions

10.1 Introduction

This chapter has three main sections. In the first section, the benefits of the research design and methods used in answering the research questions are discussed followed by an integrated summary of the qualitative and quantitative findings and a brief integrated discussion that overlaps to some extent with previous discussions. Recommendations for a community-based mental health promotion intervention, for refugees within the Durban area, is put forward. In the last section, recommendations for policy developers, related stakeholders and suggestions for further research followed by a discussion on the limitations of the study and a final conclusion.

10.2 Through the lens of the Research Design and Theoretical Framework

This study is one of the few that attempts to explore the migration experiences of refugees, i.e. the experiences from the home country throughout the transition to the current post-migration experiences of refugees in Durban, South Africa. In that sense, this study depicts the migration stressors, and the psychological distress as well as the coping strategies of refugees throughout the different migration stages. To attain this, the study applied a sequential exploratory mixed-method design to answer the research questions. Qualitatively, the study explored the lived experiences of refugees, and the quantitative cross-sectional survey design examined and quantified the experiences of migration, stressors, psychological distress, resilience and other coping mechanisms.

The study provides an in-depth understanding of the total migration experience from the initial forced migration stage to the resettling in a host country and the related mental health impacts. Previous studies have attempted to answer partial experiences of the migration process using either quantitative or qualitative designs. Furthermore, by studying the migration experiences in the different stages, the study helps to understand the particular context-related stressors and mental health outcomes thereof as well as those that transferred across the different stages. Naturally, migration demands a simultaneous change in context that will involve cultural and socioeconomic challenges.

As the bioecological theory of Bronfenbrenner can be used to explain how contexts, as well as personal characteristics, play a significant role in refugees' experiences as they travel to the host country of settlement. Then, the reciprocal interaction between the context and personal characteristic, the proximal process, - determines the mental health outcomes of refugees. The process includes grand events, such as war and severe economic depression. For some refugees, their personal characteristics and psychological capital are sufficient to maximise resources or conditions within the environment to buffer the impact of the stressors of migration and may therefore be better able to manage the mental health outcomes. For example, a refugee with personal generative characteristics (Bronfenbrenner, 1995), can initiate and engage in activities, alone or with others, and can be responsive to initiatives by others. These, combined with personal assets such as knowledge, skills, abilities, intelligence, and experiences, would enable a refugee to overcome the contextual challenges. This can result in the positive management of mental health, or an individual might flourish in post-traumatic growth (Calhoun & Tedeschi, 2006). However, refugees whose personal life is characterised by distractibility, difficulties in maintaining control, being inattentive, unresponsive, showing a lack of interest in the surroundings and having feelings of insecurity, might be more likely to be overwhelmed by contextual challenges and subsequently more likely to experience psychological distresses (Bronfenbrenner & Morris, 2006; Siriwardhana et al., 2014).

Besides the challenges that can emanate from the push factor stressors such as war and oppression, the contextual systems during transit and post-migration stages can be supportive by virtue of accessibility and availability of supportive resources while negative if not accessible, available or absent. In other words, throughout the migration process, the systems (contexts) influence the direction and strength of refugees' mental health, as part of the proximal processes. Family networks other support networks can determine the psychological outcomes of migration stressors among refugees as well as the coping mechanisms. For example, support from family and a strong social network ease the traumatic experiences and other stressors of individuals (Siriwardhana et al., 2014). This can only be possible if there is a functional family or social support network to share the burden of the stressors and enhance their resilience. As a result, the refugee might have manageable levels of psychological distress. However, when that structure is not available, mostly in transit- and post-migration, as several studies argue, the resilience of refugees weakens and they are most likely to be vulnerable to psychological distresses (Miller, Hess, Bybee, & Goodkind,

2018). However, it is important to understand, that according to the bioecological theory (Bronfenbrenner & Morris, 2006), the proximal process which is the reciprocal interaction between the person, context and events, is the determining factor for mental health outcomes. Individual characteristics and personal resources might be weakened by the direct influence of context or events, or the individual might overcome the stressors.

However, the absence of a supportive social system may lead to developing other coping mechanisms in the absence of family and social networks. Refugees might rely on their inner resources, as the findings of this study indicated. However, the literature of resilience and coping support collective and common self-copying strategies (Goodman, 2004), and separation from family and prolonged displacement are found to negatively impact on resilience (Siriwardhana et al., 2014). In post-migration, refugees are vulnerable to psychological distress not only because of an absence of influential mesosystem aspects, such as family but they also encounter other stressors such as the lack of safety and basic needs in refugee camps and socioeconomic problems in urban settlements. Further, as refugees are challenged by the new culture and contextual systems dynamics, their openness and proximity towards the people around them might become less meaningful in terms of social support, or it may enhance their resilience. Hence, they opt to rely on themselves and may distance themselves from social contact.

On the other hand, it seems there are refugees who experience psychological wellbeing and resilience or are not severely affected by psychological problems and stressors in adversity, i.e. they overcome stressors without significant mental health distress. Therefore, the critical issue is to identify the protective factors that could be either individual, contextual or the interaction thereof. Every context (place) has contextual as well as personal factors that promote or constrain mental health. In other words, there are stressors that altered depending on the context, e.g. migration policy, can be minimized and magnified by contextual and personal factors that promote or inhibit mental health, respectively. Therefore, the research questions and the design applied in this study helped to deepen our understanding and identify contextual factors (stressors) and related mental health outcomes as well as coping mechanisms (see figure 3 below). This insight is necessary to develop an effective mental health promotion intervention for this group of refugees.

Furthermore, the study approach allowed for a thorough exploration of the migration experiences as a whole and to understand the synergy of the past and present stressors that influence the mental

health of refugees. In this sense, refugees as travellers have gone through different stages that present diverse challenges. The experiences from those situations, the ways of navigating the current stressors and ways of coping are likely to influence the individual's mental health. Most of the refugees have experienced life-threatening violence in their home countries and have either witnessed or personally experienced similar incidents during post-migration, e.g. xenophobic attacks, thus had recurring exposure to violence or any other stressors. This may have compounded the effects of their previous traumatic experiences, worsens their psychological stress and/or weakens their ability to cope. It is possible that they have become more resilient by finding meaning in these experiences and better ways of dealing with stressors.

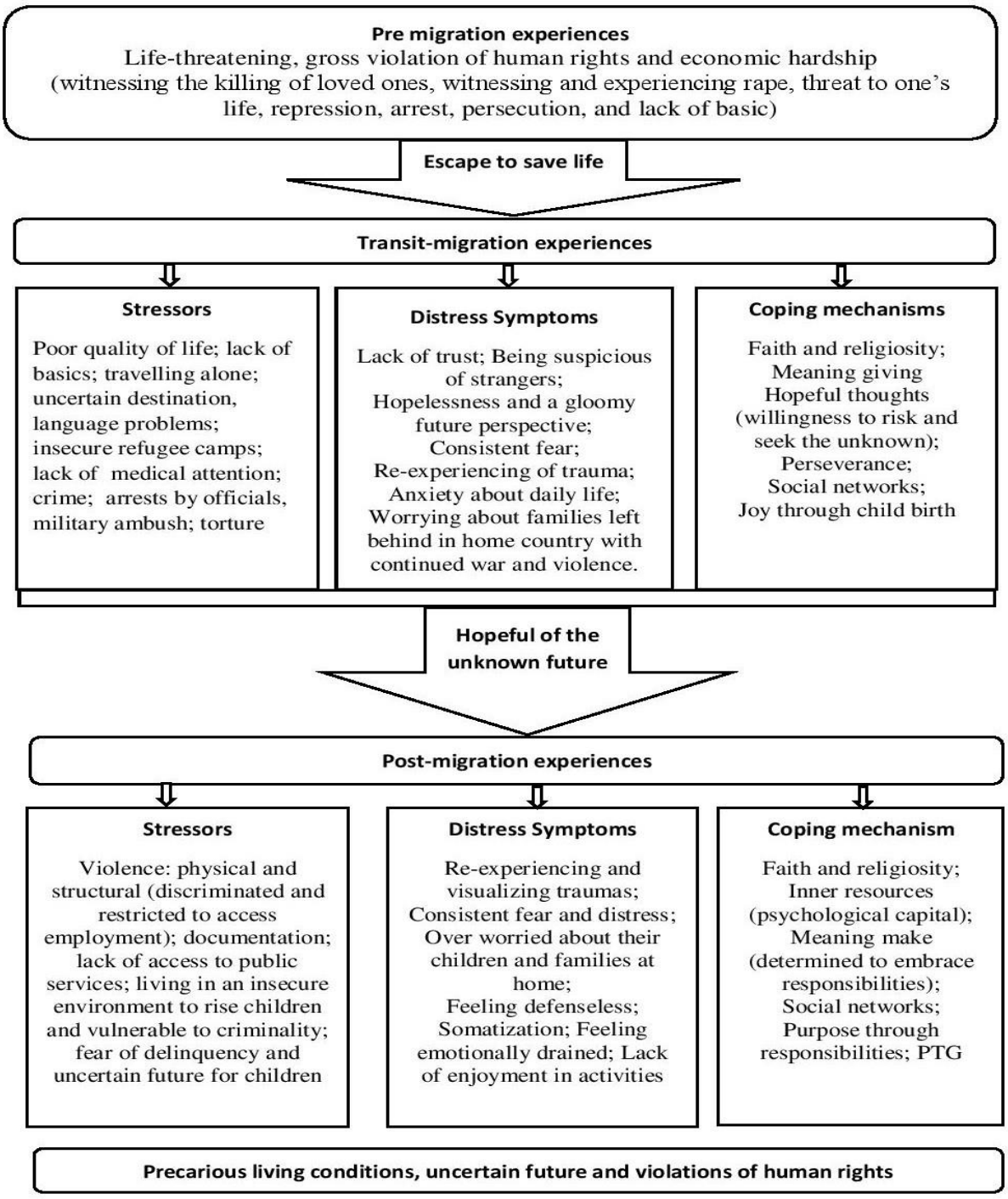

Figure 3 - *African Refugees Migration Experiences: Stressors, Symptoms of distress and Coping mechanism*

10.3 Summary of the Experiences of Migration: Stressors and Psychological distress of participants

The qualitative and quantitative results concurred in many ways, for example, refugees' main post-migration stressors were found to be uncertainty, insecurity and vulnerability. This showed that refugees are always under threat and overstressed by thoughts about things/events that can endanger their life or hurt them - *Anything can happen anytime* and are overly worried about their children.

Generally, the migration stressors refugees experienced were a life-threatening, gross violation of human rights and daily struggles for a livelihood, i.e. economic hardship. Those stressors could be caused by war or state organised violence, attacks from gangs or rebels or could be xenophobic violence or criminal attacks and exclusion from socioeconomic activities, particularly in post-migration. The common migration stressors were witnessing the killing of loved ones; witnessing and experiencing rape; threats to one's life; repression and harassment; violence; and a lack of basic needs; travelling alone without knowing where the final destination would be; lack of access to public services; feelings of insecurity; vulnerability; and poor living conditions. These findings are similar across the two studies and also consistent with the current literature pertaining to the most common migration stressors among African refugees.

Many of the participants did not plan their escape, and they were fleeing from war and persecution to save their lives. To most, it was a desperate journey. They also feared possible persecution in the neighbouring countries through infiltrators, particularly noted among Burundians. This prevented refugees from seeking assistance from their fellow countrymen, as they lost trust and became suspicious of others. They, therefore, travelled as far as they could to feel safe and to secure their lives. As participant 8 said, '*I would have travelled down further South if there was no sea*'. During their journey, the most difficult thing for most of them was not knowing where they were going and having to trust strange people they met along the way for assistance and information.

While previous studies mainly focused on war and conflict that refugees experienced, this study shed some light on state repression as stressors and its impact on the mental health of this group of refugees, an area that lacks the desired attention. Refugees from repressive regimes experienced gross human rights violations for extended periods and included arrests, torture, and abuse due to

their dissenting political or religious opinions. This means that their traumatic experiences are not the results of sudden events only, but of endured repeated traumas. Their hopeless situation and the gloomy future in their home countries forced their decision to leave for a better future.

Studies have found that their experiences are as psychologically distressing as those who experience war traumas (Getnet, Medhin, & Alem, 2019; Lee et al., 2016; Lee, Shin, & Lim, 2012, and this study). Refugees from repressive countries showed mental health distress, consistent fear of being attacked and re-experience the violence they experienced, e.g. torture in dreams were common. However, research regarding the psychological effects on refugees who have lived for a long period under a repressive regime, where their human rights were violated and lived constantly with fear and threat, has not as yet been studied sufficiently, as highlighted earlier in the discussions. These experiences seemed to have resulted in extreme fear and mistrust, impairment to their self-concept, self-efficacy, and as well as pervasive feelings of anger, resentment, humiliation, and betrayal (Nickerson & Richard, 2014). In this study, those refugees showed fear, hopelessness and confusion as indicated in the discussion chapters.

In transit migration, refugees who travelled for a short time experienced less trauma than those whose journeys were longer. Most of the reasons for a prolonged journey were a consequence of the difficulties encountered on the way. Those refugees, who travelled with partners and family members, took a long time and experienced more difficulties than those who travelled alone, as those who travelled alone could take more risks and be more flexible in deciding to go on or to stay. However, male partners had to take risks to seek a safer journey and a preferred destination for their wives and family and often had to leave them at a relatively safe place while he continued the journey. Those who crossed borders illegally had to pay money to dealers who arranged the journey with forged documents and by bribing border officials. Refugees have generally exposed to higher risks of such arrangements fail – a participant mentioned that he was imprisoned for three months for forged documents.

In transit-migration, refugees are beset with different stressors. The findings indicated that refugee women were particularly vulnerable due to little or no access to medical services, e.g. giving birth without proper medical attention or suffered a miscarriage, while those who sought safety in refugee camps had challenges with camp insecurity and sickness as a result of hunger and unhygienic food and unsafe water. Because refugees in transit are assumed to have money and/or

have other valuables, they fall easy prey to gangs, vandals and to smugglers who deceive them with false information to rob them of their money. Some refugees were even trapped by rebel ambushes. For most, the journey was psychologically desperate, and most felt that they had no other choice. They experienced hopelessness and powerlessness and left the outcome of their lives to fate, findings that are similar to those reported by Eleftherakos et al. (2018) among Syrians in the Balkans.

Mentally, transit migration could be the most stressful part of the migration journey, as refugees were leaving behind their country and family in danger. They are traumatised, and travel with very little hope, as they do not know where exactly they are going. They also experience different stressors, including a lack of basic needs and life-threatening violence along the way. Only a few travel with hope and knowledge of their destination where they would be received and supported by family or friends. These participants have shown better mental health outcomes as those who did not have any idea as to what the post-migration future might hold for them. The re-experiencing of traumatic events was worst among those who had no one to receive them in the host country and who suffered from hunger and sickness due to a lack of basic support.

Some of the experiences for migrants in transit in the 21st century include being held as a hostage for money ransom, being enslaved or being dismembered for body parts exchange. It was also reported by the UNHCR (2018), that 3139 refugees in transit lost their lives in the year 2017 in attempting to cross the Mediterranean Sea after crossing the Sahara Desert on their way to Europe. In light of the study findings above and elsewhere, a need exists for specific interventions by the UNHCR and other concerned partners around safety for refugees in transit.

The salience of the current difficulties during post-migration and hoping for some assistance from the researcher might have contributed to the extensive sharing of their experiences and stressors, also because current experiences might be more memorable, than past experiences. In the post-migration stage, refugees' feelings of being defenceless arise from 'thoughts that something bad can happen anytime'. Similar to previous studies, the results of this study show disturbingly high levels of insecurity and a sense of vulnerability experienced by most of the refugee participants similarly to study findings of African refugees also in South Africa (Smit & Rugunanan, 2014, 2015). This is aggravated by a lack of support and political will from authorities and public service workers in finding permanent solutions for key refugee challenges such as daily experiences of

xenophobic threats and criminal attacks; the concurrent uncertainty regarding documentation; struggles for a daily livelihood and related precarious socio-economic status and concerns for their children's future. The perceived poor quality of policing in regarding fairness and arrests of perpetrators of violence and crime as well as preventive actions against future attacks increase their feelings of insecurity. These concerns were earlier raised in the work of Crush (2008) and later by Gordon (2016). The result is that they have lost trust in the police and stopped to report incidents to the police fearing further harassment by perpetrators. While the corruption linked to the documentation at the DHA cannot be seen as separate from the endemic culture of corruption the country is suffering from, it however further threatens the security of refugees (CW, 2016; Smit & Rugunanan, 2015).

Since the amendment of the International Migration Policy (DHA, 2017) followed by the Refugee Act amendment (2017), the DHA is seen to apply specific tactics that discourage refugees from coming to South Africa by denying asylum to those who have already entered the country. The Lawyers for Human Rights stated, in their report to the South African Human Rights Commission, that there is a 96 per cent rejection rate for refugee applications and described the DHA as 'institutionally xenophobic' (Postman, 2018). This is evidence of a deliberate and systematic way of discouraging refugees from remaining in South Africa and preventing new asylum-seekers. Refugee documentation has been problematic, even though it permits refugees to study and to work, and widely criticised (Belvedere, 2007; Sutton, Vigneswaran & Wels, 2011). While private and public institutions employed some of the earlier refugees to South Africa, in the past ten years there have been no employment opportunities for refugees. Some departments and organisations do not acknowledge refugee documents, and their institutional directives exclude refugees, e.g. asylum-seekers, to open a bank account unless a refugee has the Section 24 Identification Document (I.D).

African refugees' expectations of a better life in South Africa have not been realised, i.e. a wish for a peaceful and secure life, not to be troubled by war and violence and for some economic prosperity. They thus questioned their ability to secure a decent life and future for their children. Concerns for the wellbeing and future of refugee children serve to discourage those without children to have children, particularly because of the levels of crime and xenophobic violence in South Africa. Similarly, Idemudia et al. (2013) found Zimbabweans frustrated with the lack of

economic opportunities to provide food and housing for themselves, and when they were fortunate to be employed, they experience coercion, discrimination and exploitation (Idemudia et al., 2013). Smit and Rugunanan's (2015) findings among African female refugees attested to the fact that they were to be in constant fear and distress due to insecure living conditions and a lack of income.

African refugees' living experiences in South Africa can thus be described as 'precarious' a situation that is likely to be exacerbated by an announcement by the Minister for Small Business Development, Khumbudzo Ntshavheni's, in response to the 2019 xenophobic violence. She indicated that her department is developing legislation that will ban migrants from being involved in certain businesses (Sidimba, 2019) to strengthen the economic protection of South African citizens. This legislation will further threaten a sustainable livelihood, lead to greater economic deprivation and undermine their humanity as most migrants in South Africa make a living from being self-employed in small businesses. This can thus be argued to constitute a gross violation of human rights, bordering on inhumane actions, where asylum-seekers are allowed to stay in the country but are prevented from making a living through either formal or self-employment. This is also in contradiction of South Africa's local integration approach, i.e. progressive self-reliance of refugees to establish sustainable livelihoods without expecting support from the state. Refugees have recently demanded to be relocated to another third country as they are not able to survive nor can lead a decent life in South Africa. In Cape Town, refugees have been occupying a shopping centre close to the UNHCR office and demanded resettlement to a third country, however, over a month camping has not yet brought them any positive outcomes (Hendricks &Yaguer, 2019).

Most of the participants long for the life they had back home before they were forced to migrate and to be with their families and culture that they grew up with. Most of them worry about their families back home who are still living under the same untenable conditions, e.g. conflict and oppression that impact negatively on the socio-economic conditions in the country. Refugees yearn to go back home; however, the continued instability in their home countries might mean that they have nothing to return to, and this leaves them with no choice but to stay in South Africa. Furthermore, refugees' poor socioeconomic conditions in South Africa also prevent them from fulfilling their families' expectations in terms of some kind of financial support. The consequence is that they are always under pressure and sustained psychological distress, as outlined above.

In this regard, it is important to note the strong association of pre- and post-migration stressors found in this study. Their disillusionment when they encountered the reality in South Africa left them mentally confused and distressed, further compounded by their previous traumatic experiences. The lack of support from formal bodies or government, the high unemployment rate and xenophobia further limit refugees' ability to heal from their traumatic experiences encountered during the different migration stages, i.e. pre-, transit - and post-migration phases.

Another significant stressor reported on in this study is refugee parents' concern for their children. For some, giving birth to a child, or to have a family for support, brought relief from psychological traumas. This is also true to the value of family and meaning it gives to life, particularly in the African culture. However, at the same time, failing to provide adequately for their families and being unable to offer them a future but rather subject them to hardships like discrimination and xenophobic violence, seem to result in the sense of guilt. Guilt, in itself, has a negative impact on mental health (Su & Hynie, 2019). The raising of children in the poor socioeconomic, crime-ridden communities in which they are exposed to common risky behaviours, e.g. substance abuse and sexual activities is a major concern. Negative contextual influences on adolescent risk behaviours are well documented (Desmond et al., 2019; Meader eta al., 2016). These concerns are heightened due to the perceived restrictions posed by the South African 'Rights of the Child' and 'Child Protection Policy' as it is seen to conflict with their traditional child-rearing practices such as corporal punishment including spanking at home. The school's role in creating awareness about the legislation and the increased tensions between parents and their children result in parents feeling little control over their children's lives. These concerns and helplessness exacerbate their mental health vulnerability and increase their distress and a key reason why the refugees do not want to settle permanently in South Africa.

As mentioned earlier, physical discipline is widely accepted as a child-rearing practice among refugee parents (Larriee, Tourigny, & Bouchard, 2007; Lashley, Hassan, & Maitra, 2014). Other studies have also confirmed that there is a conflict between refugee parents' cultural values and hosting countries' child-rearing practices, mainly based on Western views (Hassen et al., 2011). This leads to conflicts between children and their parents and also to disinvestment of parents in their children's upbringing, particularly if such practices de-values the authority and culture of parents (Lashley, Hassan, & Maitra, 2014).

It would therefore be important to engage refugees in dialogue to improve their insight and knowledge regarding the aims of the Children's Amendment Act (2007) and the Rights of the Child and the Child Protection Policy of South Africa. It is essential to highlight the preventive aims of the legislation, i.e. the prevention of child abuse and to prevent violence in later years by embedding patterns of violence as justified. In addition, the refugees seemed not to fully understand the difference between punishment and discipline and should benefit greatly to a better knowledge of child-rearing in a technologically advanced society where children grow up much faster than in other contexts. Similarly, culture awareness for practitioners is important to understand refugees' cultural values to minimise unnecessary psychological distress due to misunderstandings.

Further, the development of the Refugee Defenceless Scale (RDS) is one of the contributions of this study to the body of knowledge as there was no instrument that measured refugees' and their families' experiences of being defenceless, i.e. uncertainty, insecurity and vulnerability. The instrument allows for the exploration of parents' concerns for their children and the future as one of the major stressors affecting refugee mental health, as detected in the qualitative study. The sub-scale of the RDS, Refugees uncertainty and vulnerability is a predictor of social dysfunction and PTSD. Moreover, the RDS also identified major stressors that are not included in the PMLD, such as insecurity and vulnerability stressors. On the other hand, the measure also showed association with stressors, i.e. unemployment and discrimination as measured by the PMLD. More refinement of the measure is required, particularly how it relates to the PMLD and the likelihood of criterion validity for the RDS.

This study shed light on the mental health experiences of refugees because of forced migration across the different migration phases and the related stressors that influence mental health through multiple interconnected factors. Even though psychological distress presented in this study is due to forced migration experiences, voluntary migration in itself is considered a major stressor (David & Nadal, 2013) and may influence mental health due to the changes in the contextual systems and the entering into an unfamiliar context as explained by the bio-ecological conceptual model of the study. The participants' mental health descriptions in the qualitative study were also supported by the quantitative study and showed emotional and psychological distress that results from the

immediate current stressors and from stressors that continue to have an impact from the pre- and transit-migration phases.

Generally, the lower prevalence of psychological distress reported in this study compared to other studies among African refugees as outlined earlier is possible because of the time-lapse since the pre- and transmit migration stages and the physical distance from the initial push factors, i.e. threats of war. However, refugees are still experiencing structural and psychological violence that undermines their humanity. They may have found better ways of coping or able to repress or numb their traumas. In addition, the conceptualisations of mental health might also differ among the study samples that resulted in lower scores than elsewhere. On the other hand, some participants complained about the length of the questionnaire and did not complete it fully.

The study found that the psychological distress, particularly PTSD, was high among the participants who recently (less than a year ago) experienced traumatic events and are experiencing poor socioeconomic conditions in the post-migration environment. This signals a need for immediate psychosocial support specifically for newly arrived asylum-seekers in South Africa. Furthermore, this study provides evidence that experience of violence, including sexual violence, is associated with a higher risk of PTSD and depression. Even though there is inconsistency in the literature regarding the psychological effect of time duration from the initial trauma and recovery, this study showed an association between initial traumas, e.g. violence and current psychological distress possibly because of the multitude of resettlement stressors. In this regard, the RDS showed a strong association with PTSD implying that those experiencing uncertainty, insecurity and vulnerability problems are more likely to suffer from PTSD than from other psychological distresses.

The result of the quantitative study indicated a feeling of insecurity and vulnerability predicts social dysfunction that includes feelings of dissatisfaction with carrying out tasks, feeling desolate and no enjoyment in daily activities. This is a narrow mindset generated by negative emotions as the Broaden and Build Theory of Fredrickson (2004) states; however, positive emotions such as joy and interest broaden an individual's thought repertoire and actions, consequently built the individual's personal resources including physical, mental and social resources. Thus, participants with negative emotions, show a lack of interests and enjoyment in daily life, implying more focus on the daily struggles to secure a livelihood. Zihindula et al. (2016) reported that they sometimes

have to miss important health care appointments, e.g. accompanying partners for clinical screening during pregnancy or for HIV testing because they cannot be absent from their informal work arrangements

The local integration, non-encampment policy of the DHA overlooks the need for psychosocial support for asylum-seekers, a humane and efficient asylum-process and cultural orientation to the host community. In most instances, new asylum-seekers are expected to find their own way. In most cases, they lack the basic needs and necessary information regarding documentation resulting in feeling lost and psychologically distressed. Time and support for healing from initial traumas might be necessary for preparation for a new life in a new country.

The adoption of the non-encampment local integration policy stems from the argument that there are many impoverished South Africans and establishing a refugee camp and providing socioeconomic support for refugees would undermine and undervalue the needs of citizens who would need to compete for the limited resources (Khan & Lee, 2018). Hence, refugees must integrate themselves into the communities without burdening the state resources as mentioned above. Therefore, refugees do not have any welfare support from the South Africa government and the UNHCR. While this approach might be viewed as reasonable in light of the South African economic challenges such as the high unemployment rate, the consequence of neglecting the psychosocial needs of the refugee communities brings unnecessary human suffering. While South Africa adopted policy documents that pertain to social services, particularly to health services for refugees, such as the International Refugee Act (1998), UN Declaration of Human Rights (2006) and UNHCR (2009), various studies indicate a wide gap between policy and implementation (Petersen & Lund, 2011; Zihindula et al., 2017). As mental health services remain largely ignored among the general population in South Africa (Petersen & Lund, 2011), the lack of provision of mental health support for refugees in the South African National Mental Health Framework and Strategies, is no surprise (Zihindula et al., 2017). There is thus a need to re-look at the Framework and related policies and practices with cognisance of the humanitarian obligation of the host country for refugees, particularly pertaining to their mental health. It should be noted that the forced migration experience is a destabilising process that may leave individuals defenceless, particularly when they have to bear the stressors of ensuring their own livelihood. The struggle for survival, i.e. basic needs, will take priority over issues of their health and mental health. Ironically,

by neglecting the health and specifically mental health, refugees will find it more difficult to find alternative and new ideas to make a living.

Moreover, it is important to note that some African countries have a more accommodating approach, even though they are economically poorer than South Africa. For example, Uganda hosts the highest number of refugees in Africa (1.2 million), the refugee management approach of Uganda has been "… hailed as one which is not only progressive and compassionate but also smart" (Watera, Seremba, Otim, Ojok, Mukhone, & Hoffman, 2017, p. 8). The UN general secretary, Antonio Gutierrez, in 2017 admired Uganda for its efforts to rehabilitate South Sudanese refugees. Within a year of his visit, refugees were no longer in camps but in resettlement villages where they were farming plots of land and able to access public services and find jobs like other citizens (Watera et al., 2017).

Furthermore, as discussed earlier, the resettlement of refugees within local communities could be contributing to xenophobic attitudes and violence as traditional leaders or local administrative structures are not adequately involved in this process. Greater involvement would, in all likelihood, have resulted in better relationships with the host communities rather than refugees remaining isolated outsiders and vulnerable to criminality and violence.

It is important to mention the role of previously arrived kin members, faith-based communities and incapacitated NGOs to bridge the gap created by the policies and processes. Even though their support is not sufficient, it provides temporary relief for those few fortunate to receive the support. In this study, participants who were received by close family members had fewer worries about their basic needs and documentation processes than the others. Clearly, this seemed to have contributed positively to their mental health status.

Therefore, to ameliorate the plight of refugees, the state and the refugee agencies should play a greater facilitating role by connecting asylum-seekers to communities, faith-based organisations or NGOs who can offer them support. This might entail capacitating the refugee communities', e.g. faith-based communities in assisting them in creating centres for information and psychosocial support for asylum-seekers. Churches play a critical role as revealed in this study, in welcoming and accommodating newcomers to South Africa.

However, they could also play an important role in addressing stigma regarding mental illness as the general causal explanations of mental illness by most African communities is religious and spiritual (Molsa et al., 2010; Piwowarczyk et al., 2014). A mental health intervention could be best when making it available at religious institutions, viewed as central institutions of support. It might also be useful to offer the refugees information and education programmes in collaboration with religious institutions as these study findings clearly indicate that it is easier for refugees to seek support from institutions of religion rather than outsiders. However, one should be attentive not to isolate refugees but to involve them with various local organisations and other South African citizens to build their social capital and foster positive relationships.

It can also be argued psychosocial support should also address the basic needs as poverty leads to mental health problems and mental health problems cannot be treated without paying attention to the addressing the basic needs. Access to mental health services is another aspect that should receive attention, with focus at improving the awareness of refugees on the importance of seeking mental health services and attempts to destigmatise it.

10.4 Coping mechanisms and Resilience among African refugees

Through their migration journey refugees employed different strategies that corresponded with the adversities they faced. This is in direct accord with the theory of stress and coping proposed by Lazarus and Folkman (1984) and can also be explained by the bioecological framework.

Coping mechanisms employed by refugees are highly influenced by the availability and functionality of the bioecological processes, i.e. the context, the individual characteristic and the reciprocal interaction between them. In the case of migration, the context of the relationship between the microsystem and mesosystem, for example, is disturbed, and this forces refugees to recreate or to redefine the ecological systems. For example, in their home country, the family was the immediate and primary source of support and individual reactions to the stressors was highly likely to be influenced by the extent of family and community support. However, once they left this system, the family influence might have disappeared or been replaced by other structures. People with common backgrounds (e.g. experiences, culture, religion and language) will then become a source of support and replace the traditional systems. For example, prison mates were a source of support and provided hope for a refugee who reported being imprisoned and tortured in

his country. Others mentioned their faith, religious communities and fellow compatriots that played a supportive role.

In this study, cross-border truck drivers seemed to have been a significant support to some participants who would not have made it to South Africa if it were not for the drivers. They informed them about South Africa and offered them free transport. For those who escaped from war and persecution, hearing about a safe place and receiving assistance to reach the destination, transformed the sense of worthlessness and feelings of insignificance to feelings of hope and optimism and possibly convinced to come to South Africa. This might also have assisted some to regain trust in humanity.

When arriving in Durban, the church assisted them for a few months until they were able to get an alternative way of surviving (as outlined above). Further, the church assisted newcomers by connecting them to the community with the same language and culture. The church as a support system plays an important role in the mental and social wellbeing of refugees, particularly among newcomers. As outlined above, the church or other religious institutions as a support system can play a more prominent role in the mental health of refugees.

In addition, those who utilise available and trusted structures might cope better with resettling than their counterparts. In the absence of specific support structures, refugees have to rely on themselves to overcome their struggles, often of a financial nature. Strong personal resources inclusive of psychological capital (Luthans et al., 2007) and other characteristics, at times, need to replace unavailable systems or supplement the available and accessible social systems. Therefore, the fostering of inner resources inclusive of psychological capital and other strengths among refugees is important. These include the individual's curiosity, tendency to initiate and engage in activities, responsiveness to initiatives by others to pursue long-term goals all that are linked to resilience as well as knowledge, skills, abilities and experiences, even gender and age might play meaningful roles (Bronfenbrenner & Morris, 2006; Fergus & Zimmerman, 2005).

Furthermore, coping strategies such as internal motivation to do more to get out of their current unsatisfactory situations and a belief that things can be changed were used. Modest achievements in education or financial income encourage them to persevere and to further develop their self-efficacy in their ability to change their circumstances (Bandura, 1999). Further, discovering one's

passion, encourage them to be more open to others and by interacting with people with common passions seems to be a hope-giving experience.

The study found that almost 80 per cent of the participants agreed that they work to attain their goals and believe in themselves as being capable of overcoming stressors. Their perseverance, in not giving up when things seem hopeless, and to take the lead in problem-solving without becoming discouraged by failure, demonstrates their resilience in adversity. This shows how these refugees have to draw on their inner resources when there is less support from their networks or from other resources.

Throughout the migration stages, faith in God and religiosity stands out as the most common coping mechanism, and more than 70 per cent stated, 'All is from GOD', they depended on prayer and faith in God as a leading and decision-making 'omnipotent' force.

When faced with threats to their lives in their home countries, refugees acknowledged their realities through reflective thinking and realised that it would be unlikely for them to survive unless they acted. For most, escaping the immediate threat was the first way of dealing with the situation, the realisation of the existing danger they faced and its consequences, motivated this action. Refugees have shown flight and fight reactions in their migration experiences. They had to escape the threat. However, they also fought the challenges they had faced along the way. These reactions demonstrated their willingness to take risks with unknown outcomes and a determination not to give up and continue to look for alternative solutions. They seemed to have found meaning in the fact that they acted for 'self-preservation' and hope for a better life, but each little challenge that they were able to overcome seemed to have built more self-efficacy. While it might seem inexplicable, seeking to have a family and particularly children, to create meaning and to give direction to their lives, also served their goal-directedness, determination and discipline.

Psychological counselling as a coping mechanism is used in few cases, even though refugees are aware of private, professional counselling, they are largely constrained financially to utilise them. Rather the church community initiatives, where they talk openly about their experiences with people of similar experiences and cultural backgrounds seems more feasible.

10.5 Mental Health Promotion Interventions

In this section, some guidelines for a mental health promotion intervention for refugees are outlined and discussed. The guidelines are grounded in the results of the study with cognisance of the global literature regarding refugees. As discussed in previous chapters, there are two main intervention approaches; the trauma-focused individual psychotherapeutic approach and the psychosocial or multi-model approach. Both intervention approaches have advantages and limitations when used independently; however, this study advocate for an integrated psychosocial intervention that is grounded in community-based psychosocial interventions, including individual psychotherapy and socioeconomic support for needy asylum-seekers. The mental health of refugees is embedded within the physical health, socio-cultural, economic, and political spheres, as these factors are argued to complement and are interdependent to influence mental health either positively or negatively (Friedli, 2009; Green, Richard & Potvin, 1998; Jane-Llopis et al., 2011).

Newly arrived asylum seekers should receive physical and mental health screening to address their immediate health and wellbeing needs before they are integrated into the Public Health Care (PHC) for primary health care. Since mental health is neglected in the public sector, it is important to ensure that acute psychological distress through trauma counselling and where necessary psychotherapy is provided with follow-up and continued community-based psychosocial support. The declaration of Human Rights (2006) and the UNHCR (2009) advocate for health screening for asylum-seekers on arrival, South African health documents seem not to refer to this issue, and no provision is made in this regard. Further, the South African health system might not have the necessary capacity for health screening as it lacks health infrastructure and medical supplies (Zihindula et al., 2017). However, studies argue that refugee could pose a health risk if they remain unscreened and it will be costly if they seek health service when they become severely ill (Morries et al., 2009; Zihindula et al., 2015). This suggestion is in line with health promotion and bioecological perspectives (Eisenbruch, de Jong & Put, 2004; Goodkind, 2005; Goodkind et al., 2014).

Therefore, an intervention for newly arrived refugees must assist them in the local PHC system to follow-up treatment were relevant after screening and for general medical care, and refer them to mental health care professionals. This is based on the argument that refugees whose basic needs are not satisfied might not be responsive to only a psychological intervention. Similarly, refugees

with a debilitating physical illness might not positively respond to a mental health intervention. For example, Nickerson and his colleagues (2010) outlined a multi-model mental health intervention among refugees that included socio-economic support such as advocacy, assistance in documentation, family reunion, housing, access to social services and medical care. Concurring with this, Goodkind et al., (2014) adopted a six-month intervention among African refugees, designed to be culturally appropriate and to strengthen the refugees' cultural values, in a non-stigmatised environment and focused on the social determinants of mental health. The study highlighted the importance of addressing socioeconomic determinants of mental wellbeing as being vital for refugees' psychological health. Further, Miller and Rasmussen (2010) argued that dealing with social and material needs would make it easier to identify people with specific psychological needs. As indicated in the discussion, some participants attested the importance of material needs - attaining some financial income improved their psychological health.

Health promotion advocates increasing control of health determinants by individuals or communities. Therefore, an intervention with the aim of promoting the mental health of refugees should be designed to enable refugees to increase their control of the determinants of mental health. In previous chapters, the discussion highlighted the contextual systems that determine the mental health of refugees. Therefore, the intervention that is designed to promote the mental health of the refugees should enhance the capacity of refugees to increase their control of the determinants of optimum mental health.

The guidelines developed from the findings of this study and global research for refugees in Durban is specifically tailored to their experiences and needs. The advantage of community-based intervention is to engage community member (representatives of communities) equally in all phases of the intervention programme, from defining the research problems to planning the intervention and implementation, to evaluation (Cargo & Mercer 2008; Minkler & Wallerstein 2003; Vaughn et al., 2017). This process gives participants a sense of ownership, strengthen the relationship with the researchers, build trust due to the transparent process, and has greater mental health benefits (Afifi et al., 2011; Vaughn et al., 2017). In addition, it is also the first step in normalising mental health needs and in the de-stigmatising of psychological distress and related help-seeking.

An important issue worth considering is the politics of finance and policies when proposing and designing an intervention for refugees. It is also key to give due regard to the socio-economic condition of the hosting community or country. The LMICs are challenged to fulfil the physical health needs of their citizens with the result that mental health is a neglected form of basic health care (Petersen & Lund, 2011; WHO, 2013). However, various initiatives are underway to improve mental health services in LMIC (Petersen & Lund, 2011). Moreover, countries prioritise the needs of their population, then proposing an intervention that demands state funding or integration within the health system of the country, might not be viable. However, every possible avenue must be considered.

A review by Thom (2000) in mental health service in Southern Africa suggested a de-centralised and community-based approach. Peterson and Lunda (2011) systematically reviewed mental health services research studies to identify progress and challenges. The majority of the studies indicated some progress on the de-centralising mental health care services. Further, the review outlined that the common mental health disorders (CMDs) remain undetected and untreated in the primary healthcare system (Petersen & Lund, 2011) mainly due to a shortage of specialists and economic constraints. Furthermore, individual-based psychotherapy interventions in African countries seem to be not feasibly generally, considering a large number of non-refugees in need of such services. The WHO (2011) reported that there is approximately one psychiatrist per 2.5 million people, one psychiatric nurse per 500 000 people and one psychologist per 2 million people in Africa.

A task shifting approach that involves training primary health care staff in mental health; to identify CMDs, and to manage and refer where appropriate is suggested (Peterson & Lunda, 2011; WHO, 2008). Secondly, harnessing trained community care workers to deliver manualised psychosocial interventions for specific conditions is highly suggested (Thom, 2000; Peterson & Lunda, 2011). For example, in an intervention conducted with general health workers in the health care systems, who were trained in counselling and supervised by specialists based on a specific mental health programme (Kakuma et al., 2011), several potential advantages were reported: improved access to care, reduced stigma and opportunities for integrating physical and mental health care. This approach has been found effective worldwide, particularly in the LMICs in

closing the treatment gap for CMDs (Araya et al., 2003; Bolton et al., 2003; Chatterjee, Pillai, Jain, Cohen, & Patel, 2009).

10.5.1 Community-based psychosocial intervention

In light of the above argument, community-based psychosocial intervention is suggested as the best alternative as it has various advantages. Refugees migrate with their religion, language, cultural values and beliefs, including health beliefs (Bhui, Warfa & Mohamu, 2010; Ruiz, & Bhugra, 2010) and they exercise them in their micro-communities. These already existing communities are contextual proxy systems that refugees seek out and are referred to for support and guidance when they first arrive in South Africa and onwards. The familiar contexts provide a safe space as a common language, trust and similar beliefs are shared, an ideal context for addressing psychosocial challenges. A psychosocial intervention should be directed at strengthening community capacity to provide psychosocial support to their members through task-sharing programmes. The intervention should focus on enhancing the determinants that positively impact on both resilience and mental health. For example, Siriwardhana et al. (2014) conceptualised a resilient mental health framework based on a systematic review and outlined 'supportive' factors that include a sense of coherence, strong family and social support and networks, religion and belief systems, all factors that were identified in the study which can be harnessed in communities for members. Related to the sense of coherence, anxieties, value to elicit positive emotions etc. the consideration of including mindfulness training is a worthwhile endeavour.

Mindfulness is defined according to Kabat-Zinn (1994) as a compassionate and non-judgmental moment-to-moment awareness of one's experiences. Mindfulness-based interventions are reported to be effective at reducing symptoms of anxiety, PTSD and depression among general population and refugees (Khoury et al., 2014; Kuyken et al., 2016; Van der Gucht Glas, De Haene, Kuppens, & Raes, 2019). Such interventions aim to reduce reactions and avoidance to cognitive, emotional and physical experiences and encourage openness and acceptance of these experiences. It also encourages individuals to engage in valuable and meaningful actions, even those that might have been avoided previously. Mindful interventions involve training in mindfulness meditation skills and targets to enhance individuals' attention, awareness, and compassion, not only to others but also to the self (Crane et al., 2017).

There are various studies that report the role of spirituality and religiosity in positive mental health (Areba, Duckett, Robertson, & Savik, 2018; Oman & Thoresen, 2005; Pandya, 2018; Vitorino, Lucchetti, Leão, Vallada, & Peres, 2018). Moreover, several studies have shown that high religiosity levels were associated with decreased levels of depression, and sometimes prevented depression in populations at risk, and were used as a coping strategy (Pandya, 2018; Pargament, Feuille, & Burdzy, 2011; Vitorino et al., 2018). For instance, a review of 444 quantitative studies (1962 – 2011) examined associations between religiosity, spirituality and depressive symptoms. From these studies, 178 were methodologically robust, and 119 (67%) of these showed a negative relationship between religiosity/spirituality and depression (Bonelli, Dew, Koenig, Rosmarin, & Vasegh, 2012). Panya's (2018) study examined the role of spirituality and spiritual education in promoting mental wellbeing among 4504 refugees in 38 camps in nine European counties. The post-test result showed a higher score of optimism and on the mental health inventory. In addition, voluntary participation, full attendance of the programme and a willingness for self-practice were found to be some of the other predictors of refugees' mental health.

In terms of a social capital perspective, three aspects are important to develop, i.e. bonding, bridging and linking (Putnam, 1995, as cited in Lomas, 1998). Strengthening Social capital that includes social cohesion and supportive networks, have benefits in offering support, protecting difficulties, improving health and increase opportunities through supportive relationships within the group as well as external groups (Becares & Nazroo, 2013). Social bonding assists in connecting and integration of newcomers into their new environments. Church communities already fulfil many of these roles with positive outcomes for the refugees under the leadership of the religious leaders, i.e. pastors and others as addressed earlier. Care should also be taken to develop the bridging and linking aspects of social capital as well (Lomas, 1998) implying positive health influence through health-related behaviours, access to services and facilities. In the absence of bridging and linking social capital, refugees might become so close-knit that may bring further isolation of refugees and alienation by the host communities, including services. Meyer-Weitz, Oppong-Asante and Lukubeka (2019) reported on the alienation of refugees from the DRC in Durban to health services due to very high levels of social bonding among them. By attending to bridging and linking social capital, the integration into the host communities will be facilitated as well as accessing available resources hold by external agents such as NGOs and faith-based and other organisations.

Further, programmes to strengthen communication and interaction should be carefully designed to demystify misinformation and reduce hostility. The program should also focus on improving awareness of local communities on the plight of refugees. It should also address the lack of refugees' involvement in community issues. A cohesive society is built on consistent engagement and sharing of experiences in an open and transparent way.

Another factor worth considering among African refugees is the stigmatisation of mental health. For example, Piwowarczyk and colleagues (2014) found that stigma and fear of disclosing personal information posed major barriers for mental health care. Idemudia et al. (2013) found it difficult to discuss psychological distress with a group of Zimbabwean refugees. The refugees from Zimbabwe failed to acknowledge the psychological and emotional problems even though they openly described their stressors. Furthermore, it should be noted that mental health services available in the Western world are underutilised for several reasons, mostly, because the services are not responsive to refugee needs and the stigma associated with seeking mental health services as well as problems experienced due to limited language proficiency (Weine et al., 2000) as discussed earlier. Therefore, community based mental health intervention that integrates the social fabric of refugee communities would be viable for promoting mental wellbeing of refugees.

Further, productive interventions designed for refugees' mental health should include strategies that recognise and strengthen social affiliation and the potential of refugees. It is key to identify the passion of refugees and to recognise the social network they want to associate themselves with and to develop their potential. This is the untapped strategy of mental growth with a high possibility of enhancing the mental health of refugees through discovering and developing their passion and resilience. For example, in this study participants mentioned that becoming activists helped them to open their world to share experiences and to commit themselves to justice. Another example of a social group is faith-based groups, i.e. the Rastafarian or church groups.

10.5.2 Guidelines for Mental health Intervention

Psychological First Aid developed by WHO and UNHCR can be used to enhance the capacity of the community in dealing with mental health problems, through sharing skills. This would make the service accessible and develop the capacity of the community to ensure greater sustainability, i.e. based on the results of this study and relevant literature (Goodkind et al., 2014; Miller &

Rasmussen, 2010; Slobodin & De Jong, 2015) the following guidelines are recommended for intervention for mental health promotion and psychological wellbeing of refugees. For some interventions, all the guidelines outlined below might not be necessary, or they could be adopted according to relevance to identified and expressed needs of the refugees.

Situation Analysis: This is a critical phase of intervention development to ensure relevancy and also to foster ownership of the intervention. Therefore, an engagement and research process should be undertaken to understand psychological distress, immediate socioeconomic stressors and ways of coping, including the existing community structures used as a proxy for support. The research methodology may include basic survey type screening tools complemented by focus group discussion, in-depth interviews with stakeholders, including refugees and even youth and community-based surveys as outlined by Miller and Rasmussen (2010).

There is always a dilemma of whether or not interventions should address the mental health consequences of pre-migration stressors first or prioritise post-migration stressors. Such decisions on refugee mental health interventions would benefit from understanding the immediate needs of the refugees and from identifying stressors strongly associated with poor mental health and functioning. Further, identifying refugees with minor and major psychological problems who might need clinical intervention is also important; hence screening could be conducted as part of the research. Studies have shown that traumatic experiences are associated with psychological distress immediately after exposure and may improve over time for a majority of refugees (Song et al., 2017), therefore, time duration after the distress and help-seeking is an important aspect in understanding the likelihood and extent of psychological distress, but this should, however, be verified for the individual refugee. Secondly, the research helps to define the priorities of the refugees, daily stressors, including lack of basic needs, are major determinants of mental health, as indicated in this study. Further, it is important to understand refugees' issues at individual, family and community levels, particularly parents concern of their children.

The research should help to identify and familiarise the reader with the refugees' micro-communities. As mentioned above refugees migrate and have micro-communities in which they practice their culture and beliefs. These are already existing communities that need to be recognised and capitalised on for maximum impact of the intervention. It has been found that western based mental health services are underutilised by refugee communities, this is mainly due

to the disparity between the setting and refugees' culture, belief systems and language (Delbar et al., 2010; Slobodin & De Jong, 2015), let alone the difference in psychological views between Western and African-based psychological practices. Therefore, identifying and integrating psychosocial interventions into community settings that are familiar with refugees where they practice their culture and beliefs in their own language, is essential. In this study, such communities are found to be centres of psychosocial support where new asylum-seekers were accommodated and provided with basic needs and supported spiritually which ameliorated some of their distresses. It is also important to access such groups through gatekeepers (community or religious leaders). Most of the time, gatekeepers (e.g. pastors) are knowledgeable about the needs of their community as they interact with them on a regular basis as members approach them for support. They would thus be key informants that could also assist in the situation analysis phase.

Prioritise the basic needs of refugees – these might include food, shelter, medical care and documentation issues. As indicated in this study and other studies, lack of basic needs is major daily stressors that exacerbate psychological distress. In this study, refugees who lacked basic needs and who had recently experienced traumatic events are profoundly distressed; further, they are likely to be also subjected to other stressors such as crime, discrimination and documentation problems. Therefore, addressing their basic needs is a pre-requisite for psychological wellbeing and will influence the effectiveness of psychological intervention.

Provide training and mentorship to community mental health facilitators (CMHF) from the refugee community supported by professionals. Trained facilitators from the community have many advantages – as the members of the community have intimate knowledge of the culture, values and beliefs of the community and have a general familiarity with the community, key success factors of such an intervention. Community mental health facilitators may ensure greater refugee interaction and participation. Secondly, trained community members are likely to enhance the sustainability for the intervention as there will be someone who will look after the community after the departure of the initial implementers. This will also reflect the health promotion approach, i.e. bottom-up approach instead of a top-to-bottom approach (Laverack & Labonte, 2000). This can be accomplished by offering training on psychological first Aid and basic counselling skills for the CMHF through task sharing. The training manuals developed by WHO or UNHCR for such a purpose can be adopted. Mentorship by the research team and professionals should be provided

until the community peer facilitator reaches a sustainable level of skill in conducting the intervention. However, professionals need to oversee and support the CMHF. Mentorship could be based on direct observation, constant discussion with the facilitators and evaluation of the intervention. In this regard, confidentiality might be problematic if people do not want to share personal experiences with the person they know well; therefore, a referral to another trained CMHF or a professional should be organised. Training in ethics for the CMHF will be essential to understand their role and the importance of upholding confidentiality. In addition, CMHF will need to have personal development as part of the training so that they may address their own stressors and problems and to be regularly engaged in debriefing sessions with professionals to prevent burnout and to help them deal with challenges, mentoring and reflection on their own progress and impact of the intervention.

Networking with service providers. It is important to network a community-based intervention with non-profit organisations that render basic needs support, language and skills training, legal and counselling services. Those organisations that offer counselling services should also be an important resource for the mental health intervention programme both in training but also rendering the on-going professional support to the CMHF. Additional services such as clinical psychologist will also be required. For example, refugees with major psychological problems can be referred to counsellors or to a clinical psychologist etc.

General awareness. A need exists to develop mental health awareness and to reduce mental health illiteracy among the refugee communities. This awareness programme should involve the wider refugee communities to enhance their mental health literacy, i.e. "*the possession of knowledge and skills about mental disorders which aid their recognition, management and prevention*" (Atilola, 2014; p. 94). This awareness programme is not separate from the psychosocial intervention, however, as the literacy level of refugee community is low, there must be an ongoing programme to increase the interest of the community in mental health. Further, this programme can use be used to bridge the gap between African and Western practices of psychology by adapting relevant theories and practice of the West to Africa.

10.6 Recommendations and suggestions

In this section, recommendations regarding the mental health of refugees for policymakers and organisations dealing with refugees are outlined, followed by suggestions for further study.

Recommendation for policymakers and organisations

The result of this study concurred with other studies that showed refugees' experiences of prejudice, intolerance and discrimination, on a daily basis from locals. Increasing negative attitudes among local South Africans towards migrants is increasing (Schippers, 2015; Tshishonga, 2015). Studies indicated that the South African government maintains and exacerbates the xenophobic violence (Hanekom & Webster, 2009; Misago, 2019). There exists institutionalised discrimination against refugees at public and private institutions through policies (Hanekom & Webster, 2009; Neocosmos, 2008; Tella, 2016). The documentation process at DHA for asylum-seekers is getting worse progressively over time. These factors are negatively associated with the mental health of refugees. Therefore, the following recommendations are outlined for consideration among policymakers and related organisations in addressing refugees' challenges.

- There is a need for inclusive policy and services in general. Health practitioners, including mental health practitioners, should familiarise themselves with the cultural backgrounds of refugees and develop a spirit of partnership in a client-centred approach to all who seek their services, especially refugees. This will help in providing the mental health needs of refugees in a more effective and compassionate way.
- The DHA should focus on better management of the asylum processes instead of delaying documentation that leads to an increasing number of undocumented migrants. Accessibility should be ensured, and unnecessary time delays addressed. There seems to be the view that a deliberate strategy is used by the DHA to discourage the entering of asylum-seekers to South Africa. However, Polzer and Landau (2008) and Smit and Rugunanan (2014) asserted that it is impossible to curtail migration. Thus better administration could benefit both refugees and host communities. Further, even though asylum-seekers are denied services when they approach the RRO, many of them have been held liable for being illegal migrants. This is in addition to their inability to access any service without documents. Support from the UNHCR for better administration of asylum-seekers documentation process could assist in this process.
- There are private and some public institutions which do not acknowledge the asylum-seekers and refugee documents. This shows a discrepancy between the government, who is authorising documents and institutions that are denying recognition of legal documents.

Many refugees have been excluded from services or jobs because of these discrepancies. The DHA needs to clearly communicate with service providers and enforce the legitimacy of the permits.

- A policy-driven intervention aiming at decreasing discrimination and promoting social cohesion among the communities must be consistent instead of being implemented sporadically or when xenophobic attacks are staged. These programmes need thorough designing and collaboration in which both communities play a major role as equal partners to the interventions. Furthermore, the South African government, local and international refugee agents should coordinate their resources for better outcomes as separate efforts have not been fruitful.
- Insecurity and feelings of vulnerability are found as the major factors for deteriorating mental health conditions among refugees in South Africa. The security apparatus has been dismally failing to protect refugees from threats and violent attacks. Recently, refugees were violently attacked, and their properties were looted in the presence of police officers. The police have been accused of non-cooperation with refugees when approached for services regarding crime. Hence refugees are discouraged from reporting any issues to the police, which increases their vulnerability. The Justice Department has a duty to attend to matters related to security and crime whoever the perpetrators or victims are.
- There is a need for reconsidering the way in which refugees have to settle and integrate into local communities. This should be assisted by DHA or related agents to ensure that refugees resettle among communities with the acknowledgement and guardianship of local and traditional leaders. This would help facilitate the legitimacy of refugees within local communities, and it also opens the door for communication and interaction of the communities with each other. In addition, a mechanism should be provided to newly arrived refugees where they will be able to make contact with refugees' networks or centres of similar nationalities. This process will assist refugees in integrating with less anxiety and uncertainty.
- South Africa ratified Resolution *61.7 of the 61st Annual World Health Assembly* on the Health of Migrants, which calls on member states to promote equitable access to health promotion, disease prevention and care for migrants (WHO, 2008b). While refugees have access to health care, discrimination and subtle refusal of health care services speaks to the

need for diversity training for health care workers to offer an unbiased and client-centred service to benefit not only refugees but all who seek public health care.

Suggestions for further research

The following suggestions for further research were underlined by the study findings and would be important, particularly for the development of mental health promotion interventions:

- There is a need for the refinement and further development of mental health instruments for the African continent, i.e. screening instruments. Even though Africa is not culturally homogenous, studies mentioned earlier report on similarities regarding the aetiology of mental health across African cultures. Aspects such as causation and idiomatic explanations of mental health issues need further clarification. In this regard, there is a need to refine the instrument Refugee Defenceless Scale (RDS) developed in this study. Refining the instrument can assist whether it can be part of the existing scale as another component (sub-scale) or new scale in its own.
- More research should also look at the Likert versus other rating scales. Which of the rating scales obtains better results in a multicultural context? Respondents seem to have difficulty with the nuances of the different response options. A rating scale might be able to address this shortcoming.
- Further, there has been very little attempt to study refugees' families as a unit. This could increase the general understanding of family and individual stressors that emanate from the migration phases and related family dynamics. These insights would be necessary for family-centred interventions that enhance the psychological wellbeing of the family.
- Further studies have to look also at refugees' post-traumatic growth. As it is evident from this study, few participants are actively experienced PTG. Thus studies should explore PTG among refugees as the potential for mental health promotion.
- This study has not focused specifically on how individual characteristics may impact mental health among refugees and plays an important role in mental health as outlined by the bioecological model. Research in this regard will further assist the development of interventions for refugees.

10.7 Limitations of the Study

The study has few limitations either inherited from the methodology or technical limitations that need careful consideration when interpreting the results of the study. A few interviews were conducted through an interpreter; thus, some information might have been lost in translation, even though adequate training was given to the interpreter.

The quantitative part of the study used a cross-sectional design, i.e. data were collected on one occasion from participants; therefore it is affected by limitations inherited from the design; the design provides an estimation of knowledge, as its correlational, causality cannot be determined. It is important that the accuracy of remembering detailed past experiences, especially traumatic experiences, might be in some instances, questionable. However, some corroboration with other studies among refugees suggests some level of validity and reliability.

Further, a limitation of the design is convenience sampling, and the small number of participants in this quantitative study means that the results cannot be generalised to all refugees in Durban, South African. This small number was mainly due to language barriers, work patterns of refugees, lack of interest in research studies, and financial constraints of the study that would have otherwise increased the number and representation of the refugee community. As only refugees who were able to read and understand English, French and Swahili were eligible to participate. The questionnaire should also have been translated into other African languages such as Amharic (Ethiopia), Tigrigna (Eritrea), |Somali (Somali) and Lingala (DRC).

The last, limitation of the design is minimal social desirability bias; respondents might have responded to what they thought was expected instead of communicating their true experiences, irrespective of the fact that it was emphasised to respond truthfully. Methodological factors might as well have been partly responsible for bias, and Likert scale measurements often tend to overestimate the prevalence.

10.8 In Conclusion

Refugees in South Africa had to flee as they experienced life-threatening stressors in their home countries, escaped death but had to leave loved once and travelled with their traumatic experiences through the transit migration difficulties. They continue to hope for a better life and future in an unknown place while experiencing feelings of loss, grief and worthlessness.

Refugees reached South Africa with hope and aspiration for safety and economic opportunities and faced the immediate challenges of acculturation the need to become self-sufficient. However, they were disillusioned with the realities of insecurity, a lack of economic opportunities and the challenges and humiliation to fulfil basic needs with no possibility to ever making a decent living. Further, the quality of their lives compromised through highly regulated restrictive and punitive policies and practices.

The shock of what they encountered in South Africa left them deeply disappointed, confused and mentally distressed, which hinder their ability to heal from their traumas but rather exasperate their previous traumatic experiences. Further, recent policy developments and amendments as well as media statements by officials, are highly likely to further worsen daily living conditions and impact negatively on the physical and mental health of refugees in South Africa. Their basic human rights enshrined in the UN's Refugees Convention (1951), South African Constitution (1994) and in the Refugee Acts (1998) are perceived to be carefully and deliberately undermined. Systematically, they are restricted from being employed under the pretext of reformative actions, while further restrictive measures have been drafted to limit refugees from engaging in self-employment in some small and medium-sized businesses. This is a gross violation of human rights bordering on inhumane actions, whereas refugees are accepted and allowed to stay in the country but simultaneously being prevented from formal and self-employment. This also seems to contradict the local integration approach of refugees in South Africa that of progressive self-reliance of refugees to establish sustainable livelihoods without expecting support from the state.

Recently, refugees have been banned from involving themselves in vaguely articulated political activities related to South Africa and their countries of origin. This seems to be another detraction from the existing policy that allowed refugees membership of non-violent civil society organisations. These increasing restrictions placed on refugees results in greater hopelessness among these marginalized groups. The question that comes to mind is whether refugees are destined to live in limbo or of being stateless as they are not able to settle humanly in South Africa nor able to go back to their home countries embroiled in war and conflict. Their frustration and desperation are evident in the large groups of refugees recently demanding to be resettled in another country. However, the UNHCR stood by their policy of the individual case-based

resettlement programme and also being silent about the violation of human rights and life-threatening xenophobic occurrences in South Africa.

Against the background of the study findings, increasing restrictions that threaten their livelihoods and the public evidence of desperation among refugees that questions their hopes for a just climate, it is clear that urgency is required to support and alleviate the mental distress of refugees.

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APPENDIX 1

Ethical Clearance for the Study

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

10 January 2020

Mr Aron Tesfai 214581706
School of Applied Human Sciences
Howard College Campus

Dear Mr Tesfai

Protocol reference number: HSS/2072/016D
New Project title: Exploring Migration Experiences and Mental Health among Refugees and Asylum-seekers in Durban, South Africa: Guidelines for mental health promotion interventions.

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 27 Decemner 2019 has now been approved as follows:

- Change in title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

Best wishes for the successful completion of your research protocol.

Yours faithfully

[redacted]

.....
Professor Urmilla Bob
University Dean of Research

/dd

cc Supervisor: Prof Anna Meyer-Weitz
cc Academic Leader Research: Dr Jean Steyn
cc School Administrators: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee
Dr Rosemary Sibanda (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
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Website: www.ukzn.ac.za

APPENDIX 2

Gatekeepers letter for Data Collection

REFUGEE SOCIAL SERVICES
NPO : 062 971

N242 Diakonia Centre
20 Diakonia Avenue
Durban
4001
Republic of South Africa

Tel: (031) 310 3578
Fax: (031) 310 3576

3 November 2016

Mr. Aron Hagos Tesfai
School of Applied Human Sciences
College of Humanities
Howard Campus
UKNZ
Email: aribanov@gmail.com

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct a research among Refugees and Asylum-seekers who are clients of the Refugees Social Services in Durban, South Africa. The research project is for Ph.D. and permission is granted provided the Ethical clearance is granted from the Human and Social Sciences Ethical Clearance Committee of UKZN. This permission is also written after thorough discussions about the aims and objectives of the study with the researcher and his supervisor Prof. Anna Meyer-Weitz.

We noted the title of your research project is: **Exploring Mental Health issues among Refugees and Asylum-seekers in Durban South Africa: Guidelines for Mental Health Promotion Intervention.**

It is noted that you will be collecting qualitative and quantitative data by purposefully selecting samples for interview and handing out questionnaires to those identified as relevant. Please ensure that the following is noted by the participants before the interview. The information should also appear on your questionnaire:

- Ethical clearance number;
- Research title, aims and objectives of the research;
- Consent form (handed/attached to questionnaire)to be signed by participants before the interview and before he/she fills in questionnaire;
- Gatekeepers' approval by the RSS.

Data collected must be treated with due confidentiality and anonymity.

Yours Sincerely

[redacted]

Yasmin Rajah
Director

APPENDIX 3.1

Informed Consent for Qualitative Interviews Participants

Discipline of Psychology
School of Applied Human Sciences
College of Humanities
University of KwaZulu-Natal

Purpose of the study

My name is Aron Tesfai, under the supervision of Professor Anna Meyer-Weitz. I am conducting this study for a doctoral thesis in philosophy. The main purpose of this study is to explore migration experiences of adult refugees and asylum-seekers in Durban and to develop a guideline for intervention to promote mental health among the group. Therefore, the interview is intended to generate rich information on the lived migration experiences; stressors/ difficulties, mental health issues and coping mechanisms at pre-, transit- and post-migration. You are approached to participate in this study because you are a refugee or asylum-seeker, an adult 18 years and older.

Participation in the study is **completely voluntary** and you are allowed to **withdraw** from the study at any time. Refusal to participate in the study, or withdrawal from the study, will not involve any penalty or loss. The interview will be ***audio recorded*.** Participants will not be asked to provide their name and all information you provide will be kept ***confidential*** and ***anonymous***. If you decide to participate in this research study, you will be asked to sign this consent form after all your questions regarding the study and interview process is answered.

Risk and Discomfort

We anticipate minimum risk associated with participation in this study. However, if you do experience any discomfort, the researcher and counsellor are available to talk with you. In addition, the RSS provides psychosocial service that is available for refugees at their request.

Benefits of the study

This research will help to develop guidelines for a mental health intervention for refugees and asylum-seekers and promote psychological wellbeing among the group. The study is expected to make a policy recommendation, widen the understanding of refugees' stressors and mental health problems, and the study will call for deserving attention on refugees' mental health issues across sectors. However, as a participant you might not have any material benefit.

Questions - If you have any question or concerns and feeling discomfort about participation in this research, please contact:

Researcher: Mr. Aron H. Tesfia

School of Applied Human Sciences, Psychology.
Howard College, University of KwaZulu-Natal
e-mail: aribanov@gmail.com
Tel: 0743534306

Supervisor: Professor Anna Meyer-Weitz

School of Applied Human Sciences, Psychology
Howard College, University of KwaZulu-Natal
Email: meyerweitza@ukzn.ac.az
Tel: 031 260 7618

University of KwaZulu-Natal Ethics Committee
Ms Mariette Snyman
Research office: HSSREC – Ethics
Govan Mbeki Building
Private Bag X54001
Durban, 4000
Tel: +27 31 260 8350
Fax: +27 31 260 3090
Email: snymanm@ukzn.ac.za

Declaration of Informed Consent

- I have been informed about the nature, purpose and procedures for the study: Exploring Migration experiences (Stressors, Psychological outcomes and coping) among Refugees and Asylum-seekers in Durban South Africa: Guidelines for Mental Health Promotion Intervention.
- I understand that I am free to withdraw from the research at any time, should I so desire. The information that I provide will be anonymous and confidential and will only be used for research purposes.
- I have also received, read and understood the written information about the study. I understand everything that has been explained to me and I consent to take part in the study.
- I also given my consent for audio recording of the interview.

Participant signature Date

APPENDIX 3.2

Informed Consent for Quantitative Interviews Participants

Discipline of Psychology
School of Applied Human Sciences
College of Humanities
University of KwaZulu-Natal

Purpose of the study recruited

My name is Aron Tesfai, under the supervision of Professor Anna Meyer-Weitz. I am conducting this study for a doctoral thesis in philosophy. The main purpose of this study is to explore migration experiences of adult refugees and asylum-seekers in Durban and to develop a guideline for intervention to promote mental health among the group. In this questionnaire, you will be asked to complete some questions that will assess your general mental health, pre- and post-migration difficulties you have been experiencing, and for which you have been using coping mechanisms. You are being asked to participate in this study because you are a refugee or asylum-seeker, an adult 18 years and older.

Participation in the study is **completely voluntary** and you are allowed to **withdraw** from the study at any time. Refusal to participate in the study, or withdrawal from the study, will not involve any penalty or loss. Participants will not be asked to provide their name and all information you provide will be kept ***confidential*** and ***anonymous***. If you decide to participate in this research study, you will be asked to sign this consent form after all your questions regarding the study is answered and understood what will happen to the information you provide

Your participation will be highly appreciated, and it will not take more than 30 minutes of your time to complete the questionnaire. Please feel free to contact either me or my supervisor for any further clarification regarding this study.

Researcher: Mr. Aron H. Tesfai

School of Applied Human Sciences, Psychology
Howard, College, University of KwaZulu-Natal
e-mail: aribanov@gmail.com
Tel: 0743534306

Supervisor: Professor Anna Meyer-Weitz

School of Applied Human Sciences, Psychology
Howard College, University of KwaZulu-Natal
Email: meyerweitza@ukzn.ac.az
Tel: 031 260 7618

If you have any questions about ethical issues as a participant, please contact Phumelela Ximba in the research office at the University of KwaZulu-Natal on 031-2603587 or email: ximbap@ukzn.ac.za.

Declaration of Informed Consent

- I have been informed about the nature, purpose and procedures for the study: Exploring Migration experiences (Stressors, Psychological outcomes and coping) among Refugees and Asylum-seekers in Durban South Africa: Guidelines for Mental Health Promotion Intervention.
- I understand that I am free to withdraw from the research at any time, should I so desire. The information that I provide will be anonymous and confidential and will only be used for research purposes.
- I have also received, read and understood the written information about the study. I understand everything that has been explained to me and I consent to take part in the study.

_____

Participant signature Date

APPENDIX 4

Qualitative Interview Guide

Demographic information

1. How old are you?
2. Gender: 1. Female _____ 2. Male _____
3. When did you arrive in South Africa?
4. Where is your Country of origin?
5. What is your marital Status?
6. What is your level of Education?
7. What is your status in South Africa? Refugee_____ Asylum-seeker_____

Open-ended Questions on Migration Experiences

1. Can you please, as much as you can, describe how your situation was at your home country before you have decided to leave?" or
- In as much detail as possible, tell me what it was like living in your home country before you left?
- What are the factors that made you decide to leave your home country?
- Can you explain to me what happened after you made the decision to leave your country?

1. If there was, what were the most stressful experiences you have witnessed or experienced in your home country (this applies also for transit and post-migration)?
   - What were the most difficult issues to deal with?

2. How were/are you coping with difficulties that happened in your migration or in your life?
   - How were/are you dealing with your experiences?"
   - Through all these difficulties that you went through, what kept you going?
   - Have tried to seek a professional help/ assistance to deal with those negative experiences?

3. How do you describe your psychological and emotional experiences during your migration?
   - Can you please describe your migration journey, psychologically and emotionally?
   - Do you find yourself at a time reliving/ re-experiencing negative experiences?

4. Please explain to me how was your journey to South Africa?
    - What happened when you arrived in South Africa?

5. How would you describe your life in South Africa? Or what is it like to live in South Africa?
    - What are the most challenging things you have been experiencing in South Africa?
6. If you have to give someone advice about managing difficulties in life, what would you tell them?
7. How was your expectation and the reality you are experiencing on a daily basis?

8. Are you feeling like building your future and do you see South Africa as your home?
    - How do you see your life in South Africa and how do you see your children's future in South Africa?
9. Do you think about to go back to your home country? How does this impact your life?

10. If you want to add something you feel you should talk about refugees and asylum-seekers in South Africa?

APPENDIX 5

Questionnaire for Quantitative Data Collection

Instruction

Firstly, I would like to convey my gratitude to you for been willing to participate in the research. Please be reminded that the outcome of this research study depends on your willingness to honestly share your views.

Please follow the instructions for each section closely as they differ from section to section.

Section A: Demographic information
Please provide your answer in the given space (write or tick on the space provided).

1. Age: _____

2. Sex: 1. Female ☐ 2. Male ☐

3. Arrival date in South Africa _____

4. Country of origin: _____

5. Home Language/s: _____

6. Skills in English language

	Not at all	A little	Moderate	Very well
a) How well can you understand English				
b) How well do you speak English				

7. Religion: _____

	Never married	Married	Divorced	Widow	Engaged	Other (please explain)
8a. Marital status						

8b. If you have a partner: do you live with or close to your partner				Yes ___	No _____
9. How many children do you have?	0 ____	1 ___	2____	3___	4 or more __
10. Are all your children with you in South Africa?		Yes __	No, only some ___		No children __
If some are with you in South Africa, how many are there? _____					

11. What is the level of your Education?

No education ____ Primary school _____ Secondary school _____ Tertiary _____

12a. what was your job/occupation before you came to South Africa?

_____

12b. what is your job/occupation now? _____

13. What is your main source of income now? _____

14. What is your status in South Africa? Refugee _____ Asylum-seeker _____

15. When did you first apply for asylum? _____

16. How many times have you been renewing your document? _____

17. Have you been in a Refugee Camp before arriving to South Africa? Yes □ No □

If Yes, in which country/s? _____

For how long? _____

Section B

2. RSS (Refugee Stress Scale)

Instruction: We should like to know your past experiences while you were at your home country.

Indicate to what extent you disagree or agree with the statements below.

(1 = Strongly Disagree), (2 = Disagree), (3 = Neutral), (4 = Agree) and (5 = Strongly Agree).

	Questions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I had a threat to my life	1	2	3	4	5
2	I had a threat to a member of my family's life	1	2	3	4	5
3	I almost died due to a threat	1	2	3	4	5
4	I was beaten and harassed	1	2	3	4	5
5	I had a death of a family member	1	2	3	4	5
6	I was forced to separate from my family members	1	2	3	4	5
7	I almost died	1	2	3	4	5
8	The police (or the military) were following/beating me	1	2	3	4	5
9	I was harassed by the police	1	2	3	4	5
10	I was hungry all the time	1	2	3	4	5
11	I didn't have food and water	1	2	3	4	5
12	I had no place to live	1	2	3	4	5
13	I had nothing	1	2	3	4	5
14	I had trouble with housing	1	2	3	4	5
15	I had trouble getting a job	1	2	3	4	5
16	I had trouble with my papers/ documents	1	2	3	4	5
17	I was not accepted because of my political orientation	1	2	3	4	5
18	Someone rape/assaulted me before age 18 years	1	2	3	4	5
19	I was forced to have sex since 18 years	1	2	3	4	5
20	I was forced to sell my body for money or to cross borders	1	2	3	4	5
21	I was sexually harassed	1	2	3	4	5
22	I was physically assaulted	1	2	3	4	5
23	I was forced to join the military	1	2	3	4	5
24	I was serving/working without payment	1	2	3	4	5
25	I was forced to act wrongly against other people	1	2	3	4	5
26	I had limited freedom	1	2	3	4	5
27	I had no clear vision about my future	1	2	3	4	5

3. PMLD (Post Migration Living Difficulties)

Instruction: Please read the following concern carefully and circle the number which best fits the extent of your concern for each problems below. The response options are:

(1 = No Problem), (2 = Slight problem), (3 = Moderate problem), (4 = Serious problem), (5 = Very serious problem)

Indicate the extent to which you are troubled by any of these concerns (in south Africa):	No Problem	Slight problem	Moderate problem	Serious problem	Very Serious problem
Protection Concern					
1.My family in my home country	1	2	3	4	5
2.Being separated from my family	1	2	3	4	5
3.Fear of repatriation (fear of being sent home)	1	2	3	4	5
4.Unable to return home in an emergency	1	2	3	4	5
5.Interviews by immigration officers	1	2	3	4	5
6.Conflict with immigration officers	1	2	3	4	5
7. Delay in processing my application	1	2	3	4	5
8. Being in detention	1	2	3	4	5
Access to health and welfare					
9. Difficulty in obtaining government welfare	1	2	3	4	5
10. Bad working conditions	1	2	3	4	5
11. Difficulty obtaining help from charities	1	2	3	4	5
12. Worry about not getting treatment for health problems	1	2	3	4	5
13. Poor access to emergency care	1	2	3	4	5
14. Poor access for long-term health problems	1	2	3	4	5
15. Poor access to dental care	1	2	3	4	5
16. Poor access to counselling or mental health care	1	2	3	4	5
Resettlement experiences in south Africa					
17. Communication difficulties	1	2	3	4	5
18. Unemployment	1	2	3	4	5
19. No permission to work	1	2	3	4	5
20. Discrimination	1	2	3	4	5
21. Loneliness and boredom	1	2	3	4	5
22. Poverty	1	2	3	4	5
23. Isolation	1	2	3	4	5
24. Lack of access to preferred foods	1	2	3	4	5

4. RIVS (Refugees Insecurity and Vulnerability Scale)

Instruction: Please read the following concern carefully and circle the number which best fits the extent of your concern for each problems below. The response options are**:**

(1 = Strongly Disagree), (2 = Disagree), (3 = Neutral), (4 = Agree) and (5 = Strongly Agree).

	Recently, I am bother by:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	Not having food for my family	1	2	3	4	5
2	Lack of job opportunity/ unemployment	1	2	3	4	5
3	Fears for my life or a family member's life	1	2	3	4	5
4	Fears for a friend's life	1	2	3	4	5
5	Fears for my livelihood (e.g. losing belonging or property)	1	2	3	4	5
6	Discrimination against me	1	2	3	4	5
7	Being made to feel ashamed that I am a refugee (foreigner)	1	2	3	4	5
8	Discrimination against family members/children	1	2	3	4	5
9	Lack of a better future for children here	1	2	3	4	5
10	Lack of educational opportunity for children	1	2	3	4	5
11	Unconducive living environment to raise children in	1	2	3	4	5
12	Children losing important cultural values (e.g. respect for parents and elders)	1	2	3	4	5
13	Children getting involved in risky behaviours (e.g. drinking, smoking, drug use, sexual activity)	1	2	3	4	5
14	Not being able to discipline children as previously	1	2	3	4	5
15	Lack of improvement in my living condition	1	2	3	4	5
16	Having thoughts that something bad can happen anytime	1	2	3	4	5

5. CD - RS (Connor-Davidson RS)

Instruction: Please read the statements carefully and indicate to what extent it applies to you by circling the number which best applies to you (Fits with your views). The options are:

(0 = Not true at all), (1 = Rarely true), (2 = Sometimes true), (3 = Often true), (4 = True nearly all the time).

	Not true at all	Rarely true	Sometimes true	Often true	True nearly all the time
1. I am able to adapt to change	0	1	2	3	4
2. I have close and secure relationships	0	1	2	3	4
3. Sometimes fate or God can help	0	1	2	3	4
4. I can deal with whatever comes	0	1	2	3	4
5. Past success gives me confidence for new challenges	0	1	2	3	4
6. I see the humorous side of things	0	1	2	3	4
7. I feel obligated to assist others in need	0	1	2	3	4
8. I tend to bounce back after illness or hardship	0	1	2	3	4
9. Things happen for a reason	0	1	2	3	4
10. I give my best effort no matter what	0	1	2	3	4
11. I can achieve my goals	0	1	2	3	4
12. When things look hopeless, I don't give up	0	1	2	3	4
13. I know where to turn for help	0	1	2	3	4
14. When I am under pressure, I focus and think clearly	0	1	2	3	4
15. I prefer to take the lead in problem-solving	0	1	2	3	4
16. I am not easily discouraged by failure	0	1	2	3	4
17. I think of myself as a strong person	0	1	2	3	4
18. I can make unpopular or difficult decisions	0	1	2	3	4
19. I can handle unpleasant feelings	0	1	2	3	4
20. I have a strong sense of purpose	0	1	2	3	4
21. I have few regrets in life	0	1	2	3	4
22. I like challenges	0	1	2	3	4
23. I work to attain my goals	0	1	2	3	4
24. I have pride in my achievements	0	1	2	3	4
25. My friends are willing to help me make decisions and listen to me	0	1	2	3	4
26. My family is willing to help me make decisions and listen to me	0	1	2	3	4
27. I find my job rewarding	0	1	2	3	4
28. I feel I am in control of my life	0	1	2	3	4

6. General Health Questionnaire (GHQ – 28)

General Health Questionnaire (GHQ-28) is not publicly available, therefore, it cannot be attachd for publication. For accessibility and further information on use, please use this link. https://www.gl-assessment.co.uk/products/general-health-questionnaire-ghq/.

7. PCL-5

Instructions: Below is a list of problems that people sometimes have when they have had very stressful experiences. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by the particular issue in the past month.

(0 = Not at all), (1 = A little bit), (2 = Moderately), (3 = Quite a bite) and (4 = Extremely)

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderatel*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, and the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behaviour, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm? E.g. drinking	0	1	2	3	4
17. Being super-alert or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4