Ever Any ‘Light at the End of the Tunnel’? Asylum Seekers’ Coping Strategies

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Abstract
Asylum seekers in New Zealand traverse an elaborate and arduous immigration process to obtain official recognition as refugees or protected persons. Gaps in refugee policy compound their predicaments through forms of civic, social, and economic marginalisation. Successful asylum seekers do not have access to all government-funded resources available to their counterparts, the resettled (quota) refugees. In light of these challenges, our aim was to investigate how they cope.

We hypothesised (i) that asylum seekers are more likely to cope by endorsing maladaptive (negative) coping behaviours more than adaptive (positive) coping behaviours; and (ii) that coping behaviours differ significantly between those currently in the process of refugee status determination and those with approved or declined status.

A mixed methods research design was used. In the first phase, the Brief COPE scale was used to collect data about the coping strategies of 31 asylum seekers from Sub-Saharan Africa. In the second phase, semi-structured interviews were conducted with seven participants drawn from the first sample group to further investigate their perceptions and
experiences of the coping strategies. Data were analysed with SPSS in the first phase and manually in the second.

The findings indicate that (i) asylum seekers tended to endorse adaptive rather than maladaptive coping behaviours; and (ii) those still in the process of refugee status determination coped differently from those who had been approved or declined. We conclude that asylum seekers are endowed with strengths and resilience despite their challenges. These strengths could readily grow into assets with more timely interventions. Determination officers, lawyers, therapists, social and community support workers, and researchers could incorporate more of a strengths-based perspective to promote positive coping behaviours and to encourage change in areas of negative coping.

Introduction

This article investigates how asylum seekers cope with the process of refugee status determination (RSD) in New Zealand. Most refugees enter New Zealand from overseas via a systematic quota system (quota refugees). They are granted permanent residence visas on arrival and join a planned and supported resettlement process (Beaglehole 2013; Mortensen 2011). In contrast, asylum seekers flee persecution in their countries of origin and make their way to New Zealand. Once in the country, they must endure the official RSD process with minimal or no support. Despite the difficulties inherent in navigating the process, there is little relevant New Zealand-based literature. In addition, international research with this population group focuses largely on their negative experiences rather than their positive coping behaviours (Raghallaigh and Gilligan 2010). There are no studies about Sub-Saharan African asylum seekers in New Zealand.

For the reasons outlined above, a strengths-based approach was taken in selecting the research question and studying how Sub-Saharan African asylum seekers cope with the RSD process in New Zealand. The first research question asked what coping strategies they use most during this process. We hypothesised that they use more maladaptive than adaptive coping behaviours. The second question investigated differences in their coping behaviours at different stages through RSD. We hypothesised that they use different coping behaviours depending on whether they are still in the RSD process, or had been approved, or declined.

Asylum Seekers in the Context of New Zealand

An asylum seeker in New Zealand is a person who has applied for refugee or protection status and is awaiting a decision on the application
(Immigration New Zealand [INZ] 2015). The RSD is the administrative or legal process through which government authorities establish whether a person who has applied for refugee or protection status, is eligible or not (United Nations High Commissioner for Refugees [UNHCR] 2005). Three international refugee/protection instruments are included in New Zealand legislation for establishing asylum applications: (i) the United Nations 1951 Convention relating to the Status of Refugees, and 1967 Protocol relating to the Status of Refugees; (ii) 1984 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; and (iii) 1966 International Covenant on Civil and Political Rights.

An application for asylum is made initially to the Refugee Status Unit of INZ. If successful, the individual is recognised officially as a refugee or protected person (INZ 2015) and is also known generally as a convention refugee (Human Rights Commission 2017). If unsuccessful, the individual can appeal to an independent authority, the Immigration and Protection Tribunal (IPT) of the Ministry of Justice. Unsuccessful asylum seekers at the IPT level are liable for deportation, except when they are pursuing a further appeal and/or judicial review at the High Court (Spiller 2019) or other higher appellate courts. The RSD process takes several months to a year or more, from the lodgement of the application to the release of the decision by the Refugee Status Unit (INZ 2015); and approximately seven months in 2018 and 2019 at the IPT (Spiller 2019).

In marked contrast to other Western countries which have seen an unprecedented increase of asylum seekers over the last decade (UNHCR 2015, 2019), New Zealand has experienced relatively low figures, averaging some three hundred asylum applications annually from 2005 to 2016, and approving approximately half (Human Rights Commission 2017). Although there has been an increase in annual numbers recently, reaching, for example, 510 applications in 2018/2019 (INZ 2019), this is still very low compared with other Western democracies. New Zealand’s low figures are due to its distant location and an effective ‘advance passenger processing’ system at flight departure points to the country (Tan 2014). These prevent most potential asylum seekers from boarding flights to New Zealand.

Despite these low numbers, New Zealand’s refugee policy marginalises asylum seekers, thereby exacerbating stress and hardship both during RSD, and after formal recognition as refugees or protected persons. In contrast to quota refugees, asylum seekers are not entitled to state housing, tertiary education (except English language courses), and full employment support before official recognition. Although asylum
seekers granted temporary visas are eligible for limited social welfare (emergency benefit), they continue to face challenges accessing this entitlement from the government department in charge (Human Rights Commission 2017). They do not receive general settlement support available to quota refugees even after official recognition as refugees or protected persons (Bloom and Udamemuka 2014; Marlowe and Humphage 2016).

Research About Asylum Seekers

The research about asylum seekers in New Zealand and overseas is not commensurate with the media coverage of the rapid growth in numbers, and the political grandstanding and debate. Some of the few scholars who have covered the moral panic and the political grandstanding on asylum seekers in New Zealand, and by extension overseas, include Bogen and Marlowe (2017); Sulaiman–Hill, Thompson, Afsar and Hodliffe (2011); and West-Newman (2015). Research and reports on this population group also tend to focus on the number of refugee/protection status applicants; countries of origin; destination countries; approval and decline rates (e.g., Eurostat 2019; Spiller 2019; UNHCR 2019); and how policy/legislation affects them (e.g., Bogen and Marlowe 2017; West-Newman 2015). Studies that have explored the experiences of asylum seekers have focused mainly on challenges such as pre-migration and post-migration stressors; experiences of passing through the RSD; accessibility of services in host countries; mental health problems; and social inclusion (e.g., Bloom and Udamemuka 2014; Douglas 2010; Essex 2013), rather than coping and resilience (Raghallaigh and Gilligan 2010).

Negative Experiences

In New Zealand, asylum seekers live with great civic, social, and economic adversity, and face significant mental health challenges (Human Rights Commission 2017). They lack access to important information during the RSD, and experience exploitation in employment and discrimination in the social welfare sector (Bloom and Udamemuka 2014; Young and Mortensen 2003). Asylum seekers endure anxiety because of family members and loved ones left behind in the countries of origin, and difficulties reuniting with them during and even after a successful RSD (Poole et al. 2010; Upreti, Baswet and Rimal 1999). In addition, the RSD process is stressful, and the interrogatory style of refugee status interviews by determination officials can be re-traumatising (Schock, Rosner and Knaevelsrud 2015; Upreti et al. 1999).
Asylum seekers in New Zealand live in uncertainty for long periods, waiting on the completion of the RSD (Bloom and Udahemuka 2014). Their psychological well-being can be extremely fragile during these times (Human Rights Commission 2017). The negative experiences reported in New Zealand mirror findings from studies with asylum seekers in other western countries (e.g., Douglas 2010; Essex 2013; Tribe 2002).

**Positive Experiences**

There is little literature about the positive characteristics and experiences of asylum seekers in New Zealand. In a study by the Department of Labour (DOL), it was found that on average, compared to quota or family re-unification refugees, successful asylum seekers can read and write more languages; have higher levels of education, and better English language ability on arrival; are more likely to have work experience and have found work; and rely more on friends and government agencies for help (DOL 2004). Although this study highlights some positive attributes of successful asylum seekers, it is over 15 years old, does not focus on any specific population group, or provide insights into how these outcomes came about, thus limiting its practical usefulness. Besides, the study did not include asylum seekers who were still in process or declined. Bloom and Udahemuka (2014), and the Human Rights Commission (2017), have observed that asylum seekers receive positive support from community members and refugee-oriented organisations. These experiences are not unique to New Zealand. International research describes a similar lack of focus on facilitating positive experiences for asylum seekers around the world (e.g., Hartley, Fcay and Tyc 2017; Raghallaigh and Gilligan 2010; Shakespeare-Finch, Schweitzer, King and Brough 2014).

In sum, therefore, many of the studies on asylum seekers have not given broader consideration to their experiences and have tended to highlight mostly the negative experiences and challenges they face. Specifically, no study on asylum seekers in New Zealand has explored their experiences from a strengths-based perspective or focused on those from Sub-Saharan Africa. The few studies which have included positive experiences of asylum seekers do not focus on coping behaviours. There is also a dearth of literature overseas on the adaptive coping behaviours of asylum seekers. More generally, the dominant discourse on asylum seekers and refugees tends to conceptualise their adjustment process in non-coping terms (Pahud, Kirk, Gage and Hornblow 2009). Hence, this
research explores the coping strategies of asylum seekers, primarily from a strengths-based perspective.

**Definition of Coping Strategies**

Coping strategies are specific efforts, both psychological and behavioural, that humans use to endure, lessen, or minimise challenging events (Yusoff, Low and Yip 2010). They are said to have two primary functions: first, to manage problems that are causing stress to an individual; and, second, to govern the emotions that are related to these stressors (Lazarus and Folkman 1984). A coping response may be characterised as adaptive (positive) or maladaptive (negative). Adaptive coping response is when the behaviour aims to deal actively with the stressor or related emotions and leads to a greater likelihood of making more progress with the situation. Maladaptive coping responses aim to avoid stressful situations and are more likely to interfere with goal-directed behaviours, and subsequent levels of performance (Monzani et al. 2015).

**Methodology**

A mixed-methods sequential explanatory design (Ivankova, Creswell and Stick 2006) was used in the study. The data were collected in 2016. The first phase (quantitative) entailed using the Brief COPE scale to collect data on the coping strategies of 31 asylum seekers from Sub-Saharan Africa in New Zealand. The objective of this phase was to describe the participants’ major strategies for dealing with stress from the RSD. The second phase (qualitative) entailed semi-structured interviews with seven participants, drawn from the first phase sample group, to further investigate their perceptions and experiences of the coping strategies identified in phase one.

Numerous tools have been developed and used effectively over the years to assess coping strategies. The Brief COPE scale developed by Carver (1997) is one. It is a validated shortened version of the COPE Inventory (Carver, Scheier and Weintraub 1989), used when participants have little time (O’Brien and Leafman 2012). The scale has 28 items which assess 14 self-perceived coping concepts. The concepts are categorised generally into adaptive coping (active coping; planning; positive reframing; acceptance; humour; religion; use of emotional support; use of instrumental support), and maladaptive coping (self-distraction; denial; venting; substance use; behavioural disengagement; self-blame) (Monzani et al. 2015; O’Brien and Leafman 2012). In this study, however, we classified self-distraction as an adaptive coping
strategy for asylum seekers. Further explanation is provided in the qualitative results and discussion sections. Appendix 1 contains details of the Brief COPE scale, the sampling methods, and quantitative and qualitative data analysis.

Quantitative Results
Socio-Demographic Background
A total of 31 participants were recruited. Nine were from the Southern Africa region, eight from the Central African region, and seven each from the East and West African regions. They comprised mostly males (n=20). More than 80% were between the ages of 25 to 44 years. In terms of education and employment, 90% had at least a secondary school education, while approximately 50% were in some form of employment in New Zealand, which included full-time, part-time, and voluntary work. The number of participants who were still in the asylum process, those declined, and those approved, were nearly equal.

A Description of Patterns in Coping Strategies
The coping strategies most frequently reported by the participants were planning, active coping, positive reframing, religion, self-distraction, acceptance, use of instrumental support, and the use of emotional support. Each had mean scores greater than six out of a possible maximum of eight. These coping strategies are classified in this study as adaptive coping strategies. Venting, substance use, denial, and self-blame were reported at some moderate levels (mean=5). These coping strategies are classified as maladaptive coping. Behavioural disengagement (mean=3.9) and humour (mean=3.2) are the least reported coping strategies and are in the maladaptive and adaptive coping strategies, respectively. Substance use and religion have the most spread out scores with standard deviations of 2.8 and 2.1 respectively, demonstrating more variability in the sample than the other coping strategies. Table 1 shows the occurrence of the coping strategies. AC represents adaptive coping while MC is maladaptive coping strategies. It can thus be inferred from these descriptive statistics that, on average, the participants reported using more of the adaptive coping than maladaptive coping behaviours.

The Difference in Levels of Coping Among the Asylum Seekers
The participants were divided into three groups according to the status of their RSD (Group 1 = in process; Group 2 = declined; and Group 3 = approved). Kruskal-Wallis Tests were conducted for each coping strategy to evaluate the difference in coping levels between the three groups. The
results in Table 2 show that the ‘in process’ group was statistically significantly lower than the declined and approved groups in use of self-distraction, active coping, substance use, use of emotional support, use of instrumental support, positive reframing, and planning. These results suggest that the asylum seekers who were still in the process of RSD tended to cope differently from those who had been declined or approved.

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Qualitative Results

The qualitative results are presented in three broad themes: obstacles to adaptive coping behaviours; enhancers of adaptive coping behaviours; and changes in coping behaviours across the process of RSD.

Obstacles to Adaptive Coping Behaviours

Participants described having to go for many months (and in some cases more than two years) of the RSD process without a right to work and no social welfare, thereby being pushed to work illegally to survive, and being underpaid/exploited as a result. They experienced grave stress and anxieties from the determination process and were re-traumatised by the refugee status interview.

I was in the process for more than a year and was declined a work visa each time I applied. Before I finally got approved as a refugee, I was sleeping on couches and living as the beggar in my community. Before then, I was really helpless without the visa and sometimes I had no
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choice but to do the odd jobs under the table [work illegally] for as little as a koha [a gift or donation] in order to survive. (Male)

The process was extremely stressful and very, very frustrating and nightmares. Those are the things, crying and you know, anger but my anger was not in words but in action. I just wanted to be alone. ... Always talking to myself and sometimes I forget I am with people. Walking up and down in the house and not knowing what I set out to do. Sometimes I was so scared the people around me will think I am not normal. (Female)

On a more alarming note, two male participants narrated that they regularly consumed alcohol to cope with the stress from the RSD. Likewise, two female participants described how they could not sleep even after taking antidepressants. Three participants recounted that the stress from the process became unbearable that they contemplated giving up on the application and/or actually gave up on the claim by attempting suicide. A couple of the participants recalled a friend, a failed asylum seeker, who committed suicide in New Zealand in 2016. Another participant stated that she would sometimes direct her anger and frustration from the process towards her children by yelling at them.

Other challenges asylum seekers face that hindered positive coping with the RSD included non-recognition of overseas qualifications; discrimination in job screening processes and in workplaces; language and cultural barriers; and not being able to drive. Difficulties assessing health care services, social welfare (emergency benefit), and accommodation, as well as separation from family, friends, and loved ones, also made it hard for them to cope in a positive way.

**Enhancers of Adaptive Coping Behaviours**

The participants with longer periods in New Zealand, initial and ongoing instrumental support, social ties in the community, and some form of employment, tended to cope better than those without. More generally, social and community support workers, therapists, lawyers, and their friends were helpful and motivated them to work, suggested job opportunities, as well as liaised with potential employers and served as character referees. Notably, religious organisations (e.g., Christianity and Islam) served as centres for self-distraction, emotional and instrumental support, planning, positive reframing, meditation, and spirituality. Participants prayed regularly and participated actively in the choir,
groups, and conferences at church. This helped to keep them away from the stress from RSD.

My church members, those were the family. They were like family in the sense that apart from like providing and being of emotional support to me, they also supported me financially and materially. ... And in the church community, it is not only emotional support which is given to me, the spiritual side of it too, which I think is very important. When I cry, they are always there for me. (Female)

The asylum seekers who had lived at the hostel in Avondale, and the Mangere Refugee Resettlement Centre (MRRC), recounted benefitting significantly from the support and services of social and community workers of the Asylum Seekers Support Trust (ASST), and the MRRC; and therapists of the ‘Refugees As Survivors New Zealand’ (RASNZ). They described taking up paid and/or voluntary work such as helping others in the community and taking up extra shifts at work to stay busy and to keep their minds off the stress from the RSD. The nature of paid employment included full-time or part-time work as kitchen hands, support workers, factory workers, and fruit pickers.

Participants also reported engaging in social gatherings in the community; listening to music, singing, watching television, going to movies, reading; and indulging in physical activities such as walks, football, yoga, cycling, swimming, cleaning in the house, and cooking to keep the mind busy and, in so doing, forgetting about the RSD stress for a while. They described to a significant degree spending long times with family, loved ones, and friends on the phone and social media platforms such as Facebook, WhatsApp, Skype, Viber, and IMO, just to take their minds off the stress from RSD.

Hope emerged as one of the springboards of the participants’ positive coping. Most of the asylum seekers recounted that the main thing that kept them going during the voyage to New Zealand, and through the entire process of RSD, was the hope of a positive outcome and the hope of a better life in New Zealand.

You gotta have hope, and I think human beings we move on, we do things, we take chances is because we are hopeful of something better. (Female)
While in New Zealand, their hope was sustained by successful stories from other former asylum seekers. Spirituality was also fundamental in keeping their hope alive.

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

Hope was also described as a ‘candle in a dark room’ and a ‘light at the end of the tunnel’, which kept them alive through the arduous process of RSD in New Zealand.

There was some hope in me, but that hope was only like a candle in a dark room somewhere but I held on to it. (Male) Even though it is long and exhausting but I was hopeful there is like uh, you know, light at the end of the tunnel. (Female)

Changes in Coping Behaviours Across the Process of RSD

The participants described leaning towards different coping behaviours depending on where they were at in the journey of RSD (e.g., from the lodgement of the initial application for refugee status; through the refugee status interview; to responding to issues raised in the interview report; or a decision whether approved or declined; and appealing in the event of a decline). Factors which accounted heavily for the differences in their coping behaviours included: (i) emotional unawareness, lack of knowledge on instrumental support, and inadequate familiar emotional support in the early days of the claim; (ii) lack of familiarity with the Western notion of professional therapy; (iii) a false sense of resilience and mental preparedness on the journey to and while in New Zealand; (iv) a false sense of safeness and security upon arrival in New Zealand; (v) concealment of status as asylum seekers in the community; and (vi) feeling dispirited by self-stigma as asylum seekers/refugees.

Finally when I got here, I just felt relieved and I thought I was safe. I didn’t go for counselling and anything like that. I didn’t even think I will be needing emotional help. I thought I was strong and fine. It only dawned on me when it took a different turn and I wanted to kill myself. That’s when the psychologist came in. (Female)
In sum, the participants’ subjective description of their coping strategies assessed in the Brief COPE scale highlighted two general themes that supported as well as hindered their coping during the RSD. It also indicated that the participants used different coping behaviours depending on where they were in the journey through the RSD.

**Discussion**

The first hypothesis was that asylum seekers are more likely to cope by endorsing maladaptive coping behaviours than adaptive coping. This study demonstrates otherwise. It shows that they tend to use more of the adaptive coping strategies such as religion, self-distraction, acceptance, instrumental support, and emotional support, than the maladaptive such as venting, substance use, denial, self-blame, and behavioural disengagement.

The second hypothesis was that asylum seekers will use different coping behaviours depending on whether they are still in the process of RSD or refugee/protection status has been approved or declined. The findings confirm this hypothesis. The group ‘still in process’ scored significantly lower than the ‘declined’ or ‘approved’ in use of self-distraction, active coping, substance use, use of emotional support, use of instrumental support, positive reframing, and planning. Interviews revealed further that their coping behaviours change depending on the stage in RSD, and the asylum seekers in the early stages of the RSD struggled to cope more than those who had been in the process longer (the approved or declined groups).

*Adaptive and Maladaptive Coping Strategies*

Results from this study suggest that the Sub-Saharan African asylum seekers tend to use more of the adaptive than maladaptive coping behaviours (refer to Table 1). The asylum seekers who had early contact with refugee lawyers, social and community workers of the ASST and MRRC, and the therapists of RASNZ, benefitted significantly from emotional and instrumental support from these environments. Those who connected with and participated in religious communities in New Zealand benefitted in many ways. Their religious belief also helped them to hold out hope on the tedious journey of RSD. This emphasis on the importance of social and support networks is consistent with studies with people from refugee backgrounds in Australia (e.g., Correa-Velez, Barnett and Gifford 2015).

This would suggest that asylum seekers tend to thrive in environments where there are existing resources and staffing to help them from the onset.
and during the entire duration of the RSD. Unfortunately, the majority of the asylum seekers in the community do not currently have access to some of these basic services. There is a pressing need therefore, for service providers such as the ASST, RASNZ, the New Zealand Red Cross, and more importantly Immigration New Zealand, to deepen and broaden capacity especially regarding housing, employment, therapeutic professionals, and social work support for asylum seekers in New Zealand.

It should be pointed out that contrary to the general categorisation of self-distraction as a maladaptive coping behaviour (Meyer 2001; O’Brien and Leafman 2012), this study provides a new perspective on self-distraction as an adaptive coping behaviour. Self-distraction is considered a maladaptive coping strategy because it involves changing one’s focus from the problem to something else (Carver et al. 1989). This is usually when the strategy is used for a long period (Meyer 2001; Monzani et al. 2015). The use of the strategy for a brief period, however, can be beneficial (O’Brien and Leafman 2012).

Self-distractive activities were endorsed at length and in-depth by the asylum seekers in this study. This was mostly when they were in limbo, waiting for the outcome of their asylum applications, some without the right to work, others with the right to work but no job, and some who were able to work. During such times, they predominantly relied on social media platforms to engage with family and community in their home countries. Marlowe (2019) similarly observes that refugees use social media to participate in political life in their countries of origin. We argue that the use of social media in this way, as well as extensive participation in housekeeping, religious and physical exercise (though for long-term for self-distractive purposes), is adaptive coping. Hence, despite the stressful nature of the RSD and the limited resources available to the asylum seekers, the study participants used more adaptive coping behaviours than maladaptive.

Insights drawn from other studies that have used the Brief COPE scale in refugee (not asylum seeking) populations provide further context for the findings of this study. The first is an honours research thesis that investigated the stressors, coping strategies, and meaning-making of Liberian refugees living in a refugee camp in Ghana. This indicated that the most frequently endorsed coping strategies were in the adaptive domain (Sarfo-Mensah 2009). Similar results were observed in a study that explored coping among Bhutanese refugees in Nepal (Chase et al. 2013). The endorsement of adaptive coping behaviours by the asylum seekers in this study is not surprising, therefore. It affirms a position
already emphasised by the World Health Organization (WHO) and the UNHCR. Refugees are not just vulnerable people who only depend on hand-outs (WHO/UNHCR 1996). They are resilient, with many strengths and capabilities. If given appropriate interventions and opportunities, they will grow into assets to the country.

Even though the findings from this study seem promising, the results are not wholly optimistic. The incidence and form of maladaptive coping behaviours are concerning. For example, the asylum seekers frequently used venting, substance use, denial, self-blame, and behavioural disengagement (refer to Table 1). Participants’ accounts of the RSD process echoed stress, re-traumatisation, forgetfulness, fear, uncertainty, helplessness, anxiety, anger, frustration, dependence on substance, suicidal ideation and attempts, and self-harm. The depth of endorsement of these negative coping behaviours raises concerns as to the emotional and mental health of the asylum seekers. It points toward the critical need for therapeutic professionals in RSD and an adoption of an early interventionist approach in service delivery.

One does not need to look far afield to see that mental and emotional problems are prevalent among asylum seekers and refugees globally (McColl, McKenzie and Bhui 2008), and there is a growing concern over the mental health of asylum seekers and refugees in New Zealand (Human Rights Commission 2017; Mortensen 2011). Asylum seekers in New Zealand have been noted to use emergency psychiatric teams frequently (Young and Mortensen 2003), and to experience some emotional problems during their first six months in the country (DOL 2004). Against this backdrop, we hold grave concerns over the mental health of asylum seekers, and the discontinuation of the free comprehensive public health screening for asylum seekers living in the community in Auckland. We strongly endorse the recommendation of the Human Rights Commission’s (2017, 4) for the establishment of “an automatic and systematic mental health screening process for all asylum claimants.” It is more important now more than ever for researchers to investigate how the primary health care sector in Auckland is responding to the health needs of asylum seekers. There has not been a study on the health needs of this population in New Zealand in the last two decades.

Further, it is unfortunate that some asylum seekers are left for unreasonably long periods without any type of a temporary visa during the RSD. It puts them outside the confines of lawful means of livelihood in New Zealand, with significant downstream implications. Lack of a temporary visa only serves to bolster negative coping and vulnerability in the community. It pushes those in this category to unorthodox means of
survival including working illegally, and exposure to underpayment and exploitation, in sum, life on the fringes of New Zealand’s society. This has profoundly undesirable consequences on their coping behaviours and reputation as potential good citizens, as well as on their physical and mental wellbeing. It is essential that all asylum seekers are granted temporary visas (if not work visas, then interim visas in extreme cases) during the duration of the RSD, to augment positive coping.

The Difference in Levels of Coping Among the Asylum Seekers

Besides the results on adaptive and maladaptive coping strategies, asylum seekers still in the process of RSD (mostly those in the early days of the application process) tended to cope differently from those declined or approved (that is, those who had been in the process longer) (refer to Table 2).

This knowledge of the differences in the levels of coping among the asylum seekers is important as it sheds light on how asylum seekers cope as they traverse the RSD. It suggests that the stress of asylum seekers’ experience, and the coping strategies they use, fluctuate depending on the point they have reached in the journey through RSD. Asylum seekers may be stressed from the moment their initial application for refugee status is lodged, but the stress is likely to intensify at the time of their refugee status interviews. The stress is likely to increase further if their application for refugee status are declined and appeals have to be lodged. Hence, asylum seekers may tend towards different coping behaviours or different levels of coping depending on the level of stress they are encountering at the time. It is important for the determination officers, refugee lawyers, social workers, therapists, and helpers to understand the full impacts of the RSD, investigate asylum seekers’ levels of stress and probable coping behaviours, and offer interventions accordingly.

Several explanations were gathered from the qualitative phase of the study to account for the differences in levels of coping. Some of the reasons included internalised stigma as asylum seekers, and being new to New Zealand and unaware about the avenues and benefits of professional therapeutic support. There was a lack of information, mostly at the initial stages of the application process at the Refugee Status Unit. It was observed, as well, that the Sub-Saharan African asylum seekers who were still in the early stage of their claim had, arguably, a false sense of mental preparedness and safeness; were unaware that the RSD was already having a severe impact on their mental wellbeing; and were either unaware of, or unfamiliar with, the Western notion of professional therapy. As newcomers, even if they had desired some familiar forms of
social support, it was not possible since most of them did not have their family and friends with them.

Against such an environment of no family and friends (simply, no one to easily trust), the newly arrived asylum seekers tended more towards concealing from their communities that they were asylum seekers than the others who had been in the process longer. It would also not be too daring to contemplate that the negative stigmatising and discriminatory language, which occasionally appears in the media and public discourse (as discussed in Bogen and Marlowe 2017; Sulaiman-Hill et al. 2011; West-Newman 2015), amplifies the need for the asylum seekers to be reserved in their communities. Further, some asylum seekers may have lived in refugee camps and environments with close communal spaces; hence they could be afraid that if they tell someone about their mental distress and other difficult experiences, everyone else in the community would hear about their problem (WHO/UNHCR 1996).

While, on the one hand, the reason why asylum seekers may want to conceal their status in the community is understandable, especially if one considers the sensitive nature of refugee and protection cases, on the other hand, it is somewhat concerning when that secrecy becomes a stumbling block to help-seeking behaviours. The implication of concealment of their status as asylum seekers could include, as observed in Young and Mortensen’s (2003) study, that they may only seek help in the community at a later stage when things have become worse. Nevertheless, this should not be taken to mean asylum seekers overtly conceal their status. Researchers have observed that asylum seekers may even embellish emotional and traumatic experiences during interviews with determination professionals, lawyers, and concerned therapists, with the hope of attracting empathy and a positive outcome (Schock et al. 2015).

The fundamental question which remains to be answered from the foregoing is: how could the environment in New Zealand be made more welcoming so that asylum seekers feel free to seek help in the communities without the fear of being labelled or judged? We suggest a termination of the discrimination in policy in terms of resources available to convention refugees and quota refugees. It is equally important for lawmakers and journalists to limit or avoid negative discourse about asylum seekers and to use less stigmatising language. There is a need, as well, for the professionals who are in the business of first contact with asylum seekers, to build rapport and support them to seek medical help with early signs and symptoms of emotional and mental distress. It is helpful for the asylum seeker to be informed that in New Zealand and
Western civilisation, mental distress is not a curse or witchcraft, as is commonly perceived in indigenous societies.

Limitations

These results present an indication of the coping strategies of the asylum seekers, but cannot be generalised as the coping behaviours of Sub-Saharan African asylum seekers in New Zealand. The size of the sample was small, and the participants were not recruited from all over New Zealand where a representative sample would have been achieved. As discussed above, asylum seekers live in concealment of their status. They can be very sceptical about talking to anyone, including researchers in the community, about their status. Thus, it was extremely hard to recruit a representative sample.

Besides, the results from the qualitative phase may not have satisfactory transferability to all asylum seekers except those who meet the demographic characteristics of this study. In addition, the possibility of social desirability bias cannot completely be eliminated (Welte and Russell 1993). Given that the primary researcher is from the same cultural background as the asylum seekers, they might have withheld information on the coping behaviours that are generally seen as shameful in the African culture—for example, the smoking of cigarettes or cannabis by females or dependence on substance/drugs by males. That said, the depth and incidences of negative coping behaviours reported indicate that participants were honest in their response, and thus credibility may not have been compromised significantly.

It can also be argued that the Brief COPE scale might not have been an appropriate tool for assessing coping behaviours of asylum seekers as researchers have cautioned against using Western developed scales with non-Western populations (e.g., Mann and Fazil 2006; Shoeb, Weinstein and Mollica 2007). Sarfo-Mensah (2009) suggested that the most appropriate way to use a Western developed scale with refugees would be to translate and adapt the scale to the context of the given population. In the context of this study, the instrument was not translated. The breadth of the countries and languages that make up Sub-Saharan Africa made it practically impossible to translate the scale. Nevertheless, most of the participants in the study came from backgrounds where English is an official language, and Pidgin English is spoken extensively. The primary researcher is fluent in both languages. The Brief COPE scale was somewhat adapted by including social media platforms such as Facebook, WhatsApp, Viber, IMO, etc., to the list of self-distractive activities in it.
Social media is missing in the original scale. Future researchers may need to further validate this adaptation in a larger sample.

Even with the limitations above, the single most important factor that might have strengthened the results of this study was the use of triangulation. The use of both the quantitative and qualitative research methods has led to a broader and deeper understanding of the concepts of coping than would have been achieved if any one method was used alone.

**Conclusion**

This is the first New Zealand study to investigate the experience of asylum seekers from a strengths-based perspective, unlike the other studies that have focused largely on challenges. It is also the first study internationally that has used the Brief COPE scale to explore the coping strategies of asylum seekers. Results from the study indicate that the most frequently endorsed coping strategies are in the adaptive domain, although the frequency and nature of the use of maladaptive coping behaviours raise serious concerns as to the mental wellbeing of asylum seekers. The study further suggests that asylum seekers may lean towards different coping behaviours depending on whether they are still in the process of RSD or have been approved or declined. The implications of findings of the study for New Zealand are profound, even with its small scale. Notwithstanding the traumatic experiences that many asylum seekers have lived through, and the complex process that they must traverse to gain formal recognition as refugees or protected persons, they have learned to survive and cope with the deeply difficult situation. The professionals in this field could tap into their strengths to support them more effectively. There is a need for more broad research about strengths-based interventions to promote positive coping and encourage change in negative coping behaviours.

**Ethical Approval**

Ethical approval for the research was granted by the Auckland University of Technology Ethics Committee (AUTEC)—Ethics Approval Number 16/119.

**Appendix 1 The Brief COPE Scale, Sampling and Data Analysis**

Each item on the Brief COPE was rated on a four-point Likert scale, ranging from one (“I’ve not been doing this at all”) to four (“I’ve been doing this a lot”). The total scores on each of the coping concepts were calculated by summing the appropriate items for the concept. No items were reverse scored. The total scores on each concept ranged from two
(minimum) to eight (maximum). Higher scores indicated increased utilisation of that specific coping concept. There was no overall total score.

The Brief COPE scale was developed in the United States of America. It has been translated into several languages and used in multiple settings with Western, non-Western, and immigrant populations (e.g., in Baumstarck et al., 2017; Kapsou, Panayiotou, Kokkinos & Demetriou, 2010). It has been used to assess coping in Ghanaian and Nepalese refugees (Chase, Welton-Mitchell and Bhattacharai 2013; Sarfo-Mensah 2009), but not asylum seekers.

Sampling

Participants were recruited for phase one by advertising in community centres and word-of-mouth. Most were from communities in Auckland where asylum seekers have stronger social networks. For phase two, maximum variation sampling was used to select participants who had, in phase one, indicated a willingness to be interviewed individually. All of the participants had a personal lived experience of the RSD in New Zealand, were 18 years or older, and could communicate in English and/or Pidgin English.

Quantitative Data Analysis

The quantitative data was analysed using the Statistical Package for the Social Sciences—IBM SPSS Statistics 23 (SPSS). Descriptive statistics were conducted to analyse the levels of coping reported by the participants and investigate whether they used more maladaptive or adaptive coping strategies. In addition, the Kruskal-Wallis Test was used to investigate differences in the utilisation of the coping strategies among the participants who were still in the process of seeking asylum as opposed to those who had been declined or approved.

Qualitative Data Analysis

The interviews were audio-recorded, transcribed, and analysed by the first author. The analysis was conducted in three parts. In the first part, abductive reasoning (Folger and Stein 2016) was used in conjunction with deductive reasoning (Burns and Grove 2005) to explore the participants’ description of their lived experience of coping as assessed in the Brief COPE scale. In the second part, abductive reasoning was used in conjunction with inductive reasoning (Chinn and Kramer 1999) to explore the participants’ descriptions of the statistically significant differences observed between those who were still in the process of
seeking asylum against those who had been declined or approved. In the third part, the conventional approach to content analysis (Hsieh and Shannon 2005) was used to gain new insights from the data while avoiding the preconceived categories seen in the Brief COPE scale.

References


