

# The coping processes of adult refugees resettled in New Zealand

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## Abstract

A significant proportion of worldwide research concerning adult refugees has investigated clinical perspectives and emphasised the impact of pre and post-migration experiences as key factors affecting their mental health status. Nevertheless, a clear understanding of their mental health problems and psychiatric morbidity is difficult to obtain due to major prevalence variations and discrepancies between studies. Further, recent studies in New Zealand have underlined the limitation of health providers' abilities to meet refugees' mental health needs.

On the other hand, despite the acknowledgment of refugees' endurance abilities to overcome traumatic events during both their pre-migration flight and in their first asylum countries, relatively less is known about their capacities to show positive adaptation to life's tasks in the course of resettlement in a final host country and how this impacts on preventing mental health problems. The current study, therefore, was undertaken to develop a theoretical understanding to describe and explain adult refugees' coping processes in overcoming resettlement difficulties and adjusting to life in New Zealand. This was achieved by using the grounded theory methodology where qualitative data were collected from twenty-six former refugees coming from war torn countries namely Afghanistan, Burma (Myanmar), Ethiopia, Kurdistan region and Somalia who are now living in Christchurch and Nelson.

Participants described the basic social process of obtaining a social position as being the main goal which motivated them to develop their coping skills and behaviour. They explained that this was underpinned by the inter-relationship of their personal resources and gradual personal achievements which were influenced by encouraging external support from resettlement services providers and "caring" New Zealanders. Data collected during this study suggest that this dynamic process, in which personality and environmental factors interacted in a reciprocal and transactional relationship, appeared to be the condition *sine qua non* to negotiate and manage resettlement challenges. Indeed, participants frequently emphasised that if this interaction was not activated they faced greater difficulties in coming to terms with their new environment and in their adjustment to life in New Zealand, thus leading potentially to adverse mental health outcomes. Additionally, quantitative socio-economic data were collected so as to describe participants' characteristics.

The study's findings underline the complexity of adult refugees' coping processes as well as some of the institutional constraints hindering their adaptation progress which can result in mental distress. These issues require responses which are beyond the health sector on its own. The implications of supporting the development of personal abilities so as to guide pragmatic support and encourage multisectoral collaboration are outlined and discussed. Areas for further research are highlighted as well as strategic issues which need to be addressed for improving the current situation of refugees resettled in New Zealand.

## Glossary of terms

*The inclusion of this glossary was considered as important so as to enable understanding of the research to be achieved by non-academic readers, as indicated in Appendix C, item n° 10, a full copy of the research will be given to the Canterbury Refugee Council.*

**Ability:** refers to competence in doing, skill and proficiency that has already been acquired. It is what we can do in the present (Bandura, 1994).

**Acculturation:** the process by which a member of an ethnic or racial group adopts the values, customs and behaviour of another. It refers to changes in behaviour, attitudes, values and identity that occur when individuals from one cultural group are in continuous contact with people from another cultural group.

**Acculturative stress:** the reduction in the health status (including, psychological, somatic and social aspects) of individuals who are undergoing acculturation and for which there is evidence that these health phenomena are related systematically to acculturation phenomena (Berry et al., 1987).

**Capability:** refers to a feature or a faculty capable of development. It is future orientated (Bandura, 1994).

**Consumers Price Index (CPI):** measure of the price change of goods and services purchased by private New Zealand households. Often used as a measure of inflation, it covers prices for: food, clothing, housing, household contents and services, health, transport, communication, recreation and culture, education, miscellaneous goods and services. The CPI is produced quarterly from prices gathered in a range of surveys at 15 urban areas (Source: Statistics New Zealand, 2008).

**Coping:** “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, as cited in Harrop et al., 2006, p.5).

**Coping processes and behaviour:** “the process by which an individual appraises and responds to environmental and social stressors in an effort to reduce the demands imposed by stressors and to prevent and minimise stress related illness” (Cockerham & Ritchey, 1997, p.22).

**Coping strategy:** an action, a series of actions, or a thought process used in meeting a stressful or unpleasant situation or in modifying one’s reaction to such a situation.

**Culturally appropriate:** refers to activities or services that allow for the expression of particular cultural values and ways of acting.

**Culture shock:** physical and emotional discomfort experienced when arriving to live in another country or place differing from the place of origin. It often relates to the inability to assimilate the new culture, causing difficulty in knowing what is appropriate and what is not.

**Empirical:** describes observations or research which is based on evidence drawn from experience. It is distinguished from something based solely on theoretical knowledge or on some other kind of abstract thinking process.

**Emotion-focused coping:** “coping strategy in which the person tries to control his or her emotional response to a stressor” (Straub, 2003, p.167).

**Health determinant:** “factor or characteristic that brings about a change in health, either for the better or for the worse” (Reidpath, 2004, p.9). Health determinants include the range of personal, social, economic and environmental factors that determine the health status of individuals and populations.

**Human capital:** those features of individuals (such as age, formal skills, cultural skills, language proficiency etc.) that can facilitate labour market integration in the host country. Those features are termed as “capital” because they can be “reinvested”.

**Immigrants:** in New Zealand, immigrants are defined as people who were born overseas and entered New Zealand under an immigration programme. Currently, New Zealand’s immigration programme comprises three main streams: Skilled/Business, Family Sponsored, and International/Humanitarian.

**Integration:** the process by which newcomers contribute to the dominant society’s social and economic well-being while retaining their own cultural identity. It is a two-way process involving the participation and cooperation of both newcomers and members of the dominant receiving culture.

**New Zealand Deprivation Index (NZDep):** a census-based small area index of deprivation, derived by principal component analysis of nine socio-economic variables from the New Zealand census, using mesh blocks (small areas with a median of 100 people).

**Mental health :** the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and to deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of equity, social justice, interconnections and personal dignity (Edwards 1999, as cited in Building on Strengths, Ministry of Health, 2002).

**Post Traumatic Stress Disorders (PTSD):** delayed and/or protracted response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (WHO, 2007, ICD-10 F43.1).

**Problem-focus coping:** “coping strategy for dealing directly with a stressor, in which the person either reduces the stressor's demands or increases his or her resources for meeting its demands” (Straub, 2003, p. 168).

**Protective factors:** “elements that modify, ameliorate, or alter a person’s response to some environment hazards that predisposes a maladaptive outcome. Protective factors do not have any affect on the individuals in the absence of stress” (Grizenko, 1998, p.289).

**Refugee:** “a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of persecution because of his or her race, religion, nationality, membership of a particular social group or political opinion and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear and persecution” (Article 1 of the 1951 Refugee Convention, UNHCR, 2007, p.7).

**Resettlement:** is seen as both a process and an outcome. It involves the selection and transfer of refugees from a State in which they have sought protection to a third State which has agreed to admit them – as refugees - with permanent residence status. The status provided should ensure protection against *refoulement* and provide a resettled refugee and his/her family or dependants with access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals. It should also carry with it the opportunity to eventually become a naturalized citizen of the resettlement country (UNHCR, 2004, p.2).

**Risk factor:** a clear defined behaviour or constitutional (e.g. genetic), environmental, or other characteristic that is associated with an increased possibility or likelihood that a disease or disorder will subsequently develop in an individual.

**Self-efficacy:** people’s beliefs about their capacities to produce designated levels of performance that exercise influence over events that affect their lives and their beliefs in their capabilities to mobilise the motivation, cognitive resources and courses of action needed to exercise control over tasks' demands (Bandura, 1994).

**Settlement :** transition process in which migrants and refugees progress from dealing with the immediate challenges of finding somewhere to live, getting a job and adapting to unfamiliar systems and customs, to becoming active participants in the social, civic, economic and cultural affairs of their new homeland. It is a two-way process, which requires learning, adaptation, acceptance and respect by migrants and refugees and by host communities.

**Skills:** the function-driven capacities acquired over time, practice and experience.

**Social capital:** “networks together with shared norms, values and understandings which facilitate cooperation amongst groups” (OECD, as cited in Spoonley et al., 2005, p.93).

**Social desirability:** manner of presenting oneself in a favourable light (Crowne & Marlowe, 1960, as cited in Beere et al., 1996).

**Social support:** “the companionship from others that conveys emotional concern, material assistance or honest feedback about a situation” (Straub, 2003, p.190).

**Socio-economic determinants of health:** the social and economic conditions such as poverty, social exclusion, unemployment, and poor housing strongly influencing health. They contribute to inequities in health, explaining why people living in poverty die sooner and get sick more often than those living in more privileged conditions (WHO, 2008).

**Socio-economic status:** “classification of an individual, household or family according to occupation, income, education or some other indicators of economic or social status” (Wilson, 1985, p.210).

**Socio-economic position:** “descriptive term for a person’s position in society, which may be expressed on an ordinal scale using criteria such as income, educational level obtained, occupation, value of dwelling place, deprivation of area of residence, etc.” (Salmond & Crampton, 2002, p.36).

### Methodology glossary

**Basic social problem:** “refers to what, in the view of the people being studied, is their main concern or problem” (Punch, 2005, p.215).

**Basic social process:** “refers to what, essentially, people do in dealing with a basic problem” (Punch, 2005, p.215). It is a particular type of core category which by contrast to the other categories is processural in nature (suggesting change and movement over time) (Glaser, 1978).

**Category:** a classification of concepts. The classification is discovered when concepts are compared one against another and appear to pertain to a similar phenomenon. Thus the concepts are grouped together under a higher order, more abstract called a category. (Strauss & Corbin, 1990).

**Concept:** the mental image that symbolizes an idea, an object, an event, a person (Babbie, 2001).

**Conceptualisation:** “the mental process whereby fuzzy and imprecise notions (concepts) are made more specific and precise” (Babbie, 2007, p.124).

**Deductive approach:** deductive reasoning works from the more general to the more specific. Sometimes this is informally called a "top-down" approach (Trochim, 2006).

**Dimensions:** “variations of a property along a range” (Corbin & Strauss, 2008, p.45).

**Heuristic:** “serving to indicate or point out, stimulating interest as a means of furthering investigation” (Flexner & Hauck, 1987, p 898).

**Inductive approach:** inductive reasoning works from specific observations to broader generalisations and theories. Sometimes this is informally called a “bottom up” approach (Trochim, 2006).

**Middle-range theory:** “set of techniques to analyze reality and allowing to produce theoretical accounts that engaged with that reality in order to communicate with others, whether policy-makers or scholars from other disciplines; and providing ideas for future work” (Merton, 2002, p.386).

**Properties:** “characteristics or components of an object, an event or action, which give specificity to and define an object, event and/or action” (Corbin & Strauss, 2008, p.46).

**Open coding:** first analytical step in grounded theory which pertains specifically to the naming and categorisation of data through their close examination and questioning.

**Rigour:** the term used in qualitative research to describe trustworthy research that carefully scrutinizes and describes the meanings and interpretations given by the participants

**Semi-structured interviews:** guided conversations where broad questions are asked, which do not constrain the conversation and new questions are allowed to arise as a result of the discussion. This is different from questionnaires and surveys where there are very structured questions that are not deviated from. A semi-structured interview is therefore a relatively informal, relaxed discussion based around a predetermined topic. The process of a semi-structured interview involves the interviewer presenting the context of the study and its objectives to the interviewee or interview group (such as a family or household). The set of questions are prepared but open, allowing the interviewees to express opinions through discussion. Questions are generally simple, with a logical sequence to help the discussion flow.

**Theoretical sampling:** “the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses data and decides what data to collect next and where to find them in order to develop the theory as it emerges. This process of data collection is controlled by the emerging theory” (Glaser & Strauss, 1967, p.45).

**Theoretical saturation:** It is the point in analysis when all categories are well developed in terms of properties, dimensions and variations. “Further data gathering and analysis add little new to the conceptualisation, though variations can always be discovered” (Corbin & Strauss, 2008, p.263). Theoretical saturation refers to the end stage of theoretical sampling in grounded theory research, when new data are not showing new theoretical elements, but rather confirming what has already been found.

**Theoretical sensitivity:** the means by which the researcher can guard against potential bias that can threaten the rigour of the study.

**Theory:** a system of ideas utilising researched evidence to explain certain events and to show why certain facts are related.

**Symbolic interactionism:** “a school of sociological research oriented by the proposition that human behaviour is determined not only by the objective facts of a situation but also by the meanings that people attribute to them through the use of symbols” (Calhoun, 2002, p.475).

## Chapter I

### 1. Introduction

Quote:

*"Before coming to New Zealand, I have been in a lot of troubles. I was persecuted because it was the war, I have been in jail, I survived many years in refugee camp where I saw a lot of people dying because they were too weak, children were very sick. I have learned how to be strong and how to survive and manage with life. I have experienced the worst and I have learnt how to hope. When I arrived nine years ago, I was sent to Mangere with my child for six weeks. I was very worried because of my family left behind and my child was so sick. I was crying a lot and was very, very down. I did not expect a lot. I was looking for protection and peace and I found it here.../... From the level that I come from, I have achieved a lot; I am like a Kiwi now. You know, I am still alive and still today for me this is the big thing" (participant # 15)*

This statement highlights some of the psychological distress endured by refugees which is linked often to life threatening past events, family separation and dislocation but also great uncertainty on arrival in the host country. Nevertheless, after a period of respite individuals are usually able to recover from severe traumas and structure a new life, but how is this transition made possible?

Indeed, a common belief is that former refugees, because of their past experiences, are at particular risk for developing mental disorders. Worldwide research on refugees' mental health is inclined to see psychopathology as an inevitable consequence of pre-migration traumas responsible for their emotional difficulties when resettling (Colic-Peisker & Tilbury, 2003; Watters, 2001). Nevertheless, the relationship between the level of trauma suffered and subsequent distress experience is complex. Today, the burden of mental disabilities affecting former refugees resettled in a third country is difficult to interpret because of conflicting findings due to methodological errors and limitations as well as cultural differences when interpreting emotional suffering (Fazel et al., 2005; Hollifield et al., 2002). In that respect, over the past decade, research investigating the cultural and social aspects of refugees experiencing resettlement in a third country, has demonstrated the influence of such factors on individuals' behaviour and subsequently on their mental well-being.

The predominance of the clinical perspective, however, tends to understate the impact of those socio-cultural aspects, as well as the impact of resettlement barriers (i.e. lack of social status, unemployment) on former refugees' stress which is recognised as likely to be as powerful as the events prior to the flight from their country of origin (WHO, 2001). Such facts highlight the ongoing challenges for health professionals to address emotional difficulties of a multicultural group which generally go beyond the competence and capacity of the health sector on its own.

Similarly, in New Zealand, "the mental health concerns of refugee populations are of serious concern" (New Zealand Immigration Service & Department of Labour, 2004, as cited in Nam & Ward, 2006, p.5), however, empirical evidence is missing. While recent clinical reviews have identified specific needs (Briggs & Macleod, 2006; MacLeod & Reeve, 2005), it appears that available clinical responses are limited in terms of cultural sensitivity which often leads to unsatisfactory results in contrast to those expected over a course of intervention (Briggs & Macleod, 2006; Guerin et al., 2004; Jackson, 2006). Additionally, although a consistent body of literature describes resettlement obstacles and adult refugees' weaknesses and vulnerability (Ministry of Health, 2001; Nam & Ward, 2006; Schmidt, 2007), relatively less is known about their coping processes in overcoming major adjustments and adapting to unfamiliar life tasks.

This study, therefore, was undertaken to address some of the above mentioned gaps by describing and explaining adult refugees' coping processes in a time of adversity whilst resettling in New Zealand. Preference has been given to that group because of the lack of literature surrounding these processes amongst adult refugees' in contrast with young refugees (Ministry of Education<sup>1</sup>, 2006). Grounded theory was the qualitative methodology chosen to develop a theory that explains this phenomenon for which there is, as yet, no strong theoretical framework. It could generate explanations of "why" and "how" adult refugees are able to overcome resettlement challenges and to adjust adequately. The research questions, specific aims and expected outcomes of this study are described in Chapter III, section 1.

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<sup>1</sup> The Ministry of Education (2006) has reviewed international literature on refugee children who had experienced severe trauma and adaptation mechanisms to adapt to new educational settings and practice of a second language. It has looked at different models, methods and appropriate school-based interventions for supporting children relocated in New Zealand.

Twenty six adult refugees (14 men and 12 women, quota refugees and family reunification refugees) from Afghanistan, Somalia, Ethiopia, Burma and Kurdistan region living in Christchurch and Nelson agreed to participate in this study. They were interviewed individually using the semi-structured interview technique. As the research progressed, interviews became more specific and focused on emerging findings as part of the methodological process.

Participants' input could help the understanding of adult refugees' coping processes in the face of adversity and thereby add to existing literature. It could contribute to improve capacity to address refugees' emotional needs and to prepare them better for a positive future in their host country. Moreover, participants' perspectives about "*what works*" could enable stakeholders to reinforce those multisectoral collaboration which are critical to complete a successful adaptation, thus preventing the deterioration of former refugees' overall well-being.

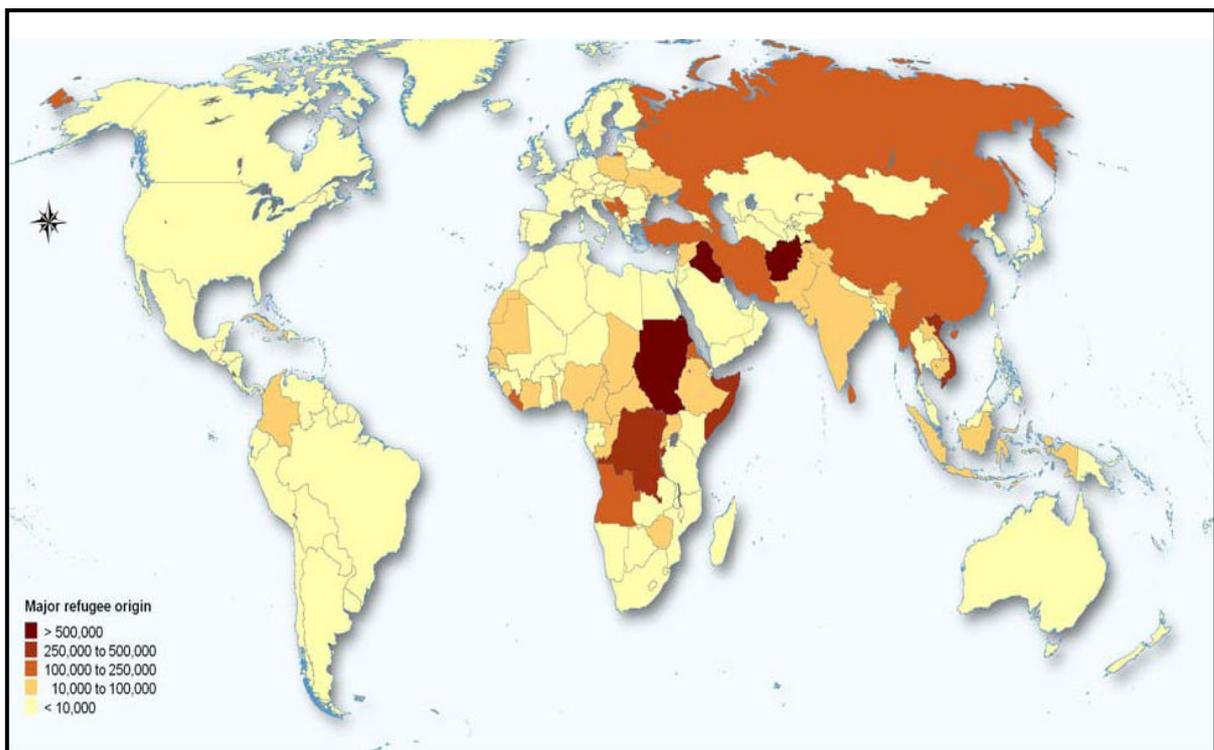
## **2. Refugee Background**

### **2.1 Who is a refugee?**

The 1951 United Nations Convention relating to the Status of Refugees is the key legal document which establishes refugees' rights and the legal obligations of signatory states. Article 1 of the Convention defines a refugee as "a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of persecution because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear and persecution" (UNHCR, 2007, p.7). This very specific definition covers only people who have fled their homelands and sought sanctuary in a second country for humanitarian protection.

Millions of people worldwide face similar desperate circumstances but do not legally qualify as refugees and are therefore not eligible for official relief or protection. This includes: (i) Internally Displaced Persons (IDPs) who may have been forced to flee their home for reasons similar to refugees, but who have not crossed an internationally recognised border, (ii) returnees who return to their country or usual place of residence and, (iii) stateless persons who are not considered as nationals by any state. By the end of 2006, the United Nations High

Commissioner for Refugees (UNHCR) stated that IDPs worldwide were estimated to be more than 23 million. They were located mainly in Eastern and Central Africa, South America<sup>2</sup>, Middle East and Central Europe. It was estimated that stateless persons globally were 15 million, however, reliable data were not available. The international refugees figure stood at 9.9 million. Most of them had to flee their country of origin because of personal persecution, death threats, internal conflicts and wars in Central Africa and Great Lakes area (Rwanda, Burundi, Democratic Republic of Congo), Northeast and Horn of Africa (Sudan, Somalia, Ethiopia), West Africa, the Middle East (Iraq, Kurdistan), Afghanistan, South-East Asia, South America and Eastern Europe as shown in figure 1.



**Figure 1: Main source countries of refugees in 2006<sup>3</sup>**

## 2.2 Refugees are not migrants

According to the United Nations, the term migrant can be understood as "any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to that country"<sup>4</sup>. In that respect, this should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned,

<sup>2</sup> Colombia has one of the largest IDPs population in the world with more than 3 million people internally displaced.

<sup>3</sup> Source: UNHCR, 2006.

<sup>4</sup> Source: UNESCO: migration, glossary, migrant.

for reasons of personal convenience and without intervention of an external compelling factor. Further, the term "migrant" is often applied to "migrant worker" which refers to "a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national"<sup>5</sup> (United Nations, 1990).

This definition indicates that the term "migrant" does not refer to refugees as indicated earlier. Indeed, because of the forced nature of their flight from their homeland and the specificity of their humanitarian needs, refugees are eligible for internationally endorsed rights as stipulated in the 1951 United Nations Convention and its 1967 protocol<sup>6</sup>. Unlike migrants, refugees do not have any alternative other than to flee their own country because they have been victims of serious human rights violations. When leaving, they seek crucial safety and **protection**, including that of their family, in another state, usually a neighbouring country whose capacity to be able to meet their survival and protection needs is frequently limited<sup>7</sup>. They often have to live there for decades, possibly for the rest of their lives, in precarious conditions aggravated by socio-economic marginalisation and chronic poverty. To those to whom resettlement is proposed this is their last option when either potential repatriation to their homeland or local integration in the first asylum country has been ruled out. This aims to grant protection and promote durable solutions for those whose safety is at risk. Resettlement also means that states who agree to accept them share responsibility for the world's refugees. Nevertheless, resettlement remains an accessible solution for a minority; in 2002, less than one per cent of the world's 10.4 million refugees were resettled<sup>8</sup>. Indeed, refugees do not have a right to resettlement and states are not obliged to offer it. Another fundamental difference is that refugees do not have any influence on their resettlement destination. For example, in the case of quota refugees, UNHCR conducts close investigation of eligible candidates before submitting their files to possible host countries. In New Zealand, cases are submitted to, and re-assessed by, the New Zealand Immigration Services so as to ensure that they meet the country's resettlement requirements.

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5 Convention on the Rights of Migrants, 1990.

6 It removes the geographical and time limitations written into the original Convention under which mainly Europeans involved in events occurring before 1 January 1951, could apply for refugee status.

7 The majority of countries hosting large numbers of refugees are low-income countries e.g. Democratic Republic Of Congo, Zambia, and Ecuador. The report of the High Commissioner to the General Assembly on "Strengthening the Capacity of the Office of the High Commissioner for Refugees to carry out its Mandate" indicates that from 1997 to 2001, low-income countries hosted two thirds of the global population of concern to UNHCR.

8 Source: ICAR: Information Centre about Asylum and Refugees in the UK. <http://www.icar.org.uk/>

Feller (2005) emphasises strongly these distinctions between both groups because of the current trend to subsume refugees as a sub-strata of the broader class of migrants (often of illegal migrants) with asylum policies being integrated in the broader migration control framework thus transcending refugees' protection needs. This point is especially relevant in the current environment whereby global security and concerns about international crime and terrorism following 11th September 2001 make states cautious about migration movements. Because of the misunderstanding and/or ignorance of those major differences, the confusion between both groups persists amongst the public as well as amongst some support organisations which frequently mix the needs of refugees with those of migrants. Moreover, the media tend to convey harmful and negative stereotyping when placing emphasis when law-breakers had been refugees. This fuels debate on state security which contributes to increased suspicion. Whereas some refugees might be involved in criminality, the majority should not be damned with the few. Apart from the above, the following table 1 categorises other variations existing between the two groups, refugees and voluntary migrants.

Table 1: Differences between migrants and refugees

|   | Refugees <sup>9</sup>  | Migrants   |
|---|--|--|
| <b>Preparation before leaving their country</b>         | <ul style="list-style-type: none"> <li>• Unprepared emotionally because of emergency to escape: no time to bid farewell to relatives, have to abandon most of their belongings, property.</li> </ul> | <ul style="list-style-type: none"> <li>• Prepared emotionally for their departure and travel: have time to bid farewell to loved ones.</li> </ul>  |
| <b>Contact with the resettlement country</b>            | <ul style="list-style-type: none"> <li>• Involuntary: little choice about their destination.</li> <li>• Arrive with very little; rely on the country's assistance.</li> </ul>                        | <ul style="list-style-type: none"> <li>• Voluntary: able to select a host country.</li> <li>• Arrive with personal belongings and financial resources.</li> </ul>  |
| <b>Mental well-being on arrival in the host country</b> | <ul style="list-style-type: none"> <li>• Debilitated by a loss of previous life, worries, traumatic events.</li> <li>• Know very little about their new country.</li> </ul>                          | <ul style="list-style-type: none"> <li>• Motivated to settle in a new country.</li> <li>• Have information on culture, employment, education.</li> </ul>   |
| <b>Personal documentation</b>                           | <ul style="list-style-type: none"> <li>• Travel with insufficient or no personal documents.</li> </ul>   | <ul style="list-style-type: none"> <li>• Travel with personal documents.</li> </ul>  |
| <b>Family/relatives</b>                                 | <ul style="list-style-type: none"> <li>• Family members left behind, dead or missing.</li> </ul>   | <ul style="list-style-type: none"> <li>• Usually emigrate with their families.</li> </ul>  |
| <b>Relation with homeland</b>                           | <ul style="list-style-type: none"> <li>• Unlikely to return because of safety and protection reasons.</li> </ul>   | <ul style="list-style-type: none"> <li>• Can return to their homeland for visits or return if they cannot settle.</li> </ul>   |
| <b>Perception by the host society</b>                   | <ul style="list-style-type: none"> <li>• Negative stereotypes: perceived both as victims or threat and as burdening the welfare system.</li> </ul>   | <ul style="list-style-type: none"> <li>• Less negative attitudes because they may come from a similar country and culture.</li> <li>• Do not pose a threat to the host country in terms of education, health, or other costs.</li> </ul> |

*Adapted from: "Refugees health care: a handbook for health professionals", (Ministry of Health, p.5, 2001).*

<sup>9</sup> Some of these characteristics can be found also amongst Internally Displaced People (IDPs).

### 3. New Zealand and refugees

#### 3.1 Trends and origins

New Zealand's first major involvement in refugee support began in November 1944 with the arrival of nearly 900 Polish civilians (mainly children) from war-torn Europe. Since then circa 40,000 refugees have been resettled in response to humanitarian crises (i.e. war, personal persecution, ethnic cleansing). For the past two and a half decades, refugees have been coming from war zones: Cambodia, Vietnam, Laos, in the 1980's, Horn of Africa (Somalia, Ethiopia), Eastern Europe in the 1990's, and Iraq, Iran, Afghanistan and Myanmar in the 2000's as described in figure 2. This diversity of people coming from cultures and economic development far remote from that of New Zealanders reflects an increasingly multicultural society with varying needs and adaptational skills.

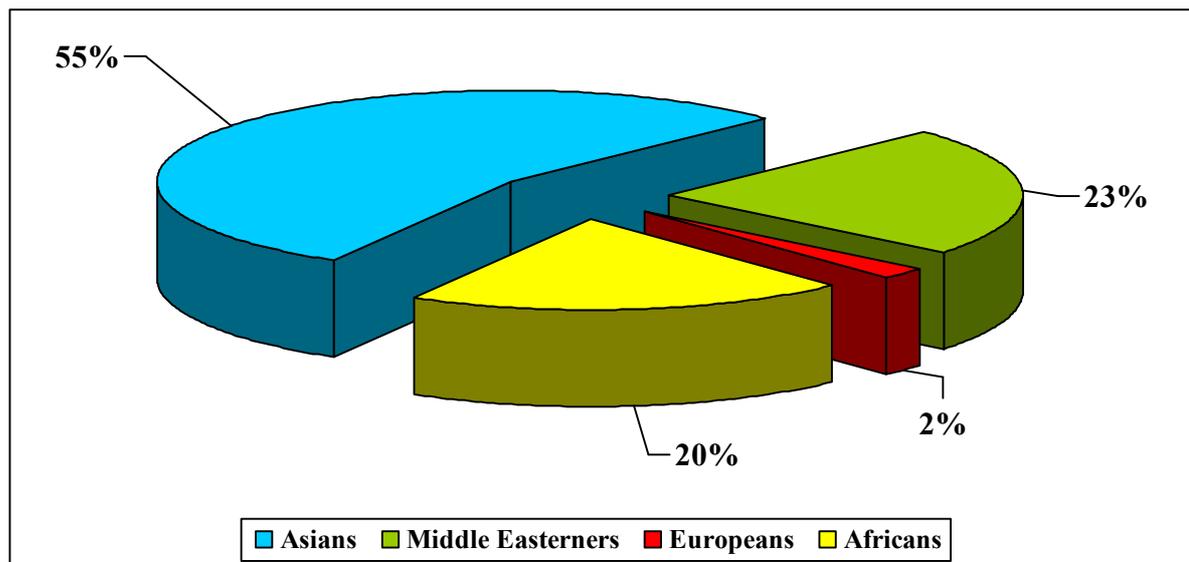


Figure 2: Main refugee groups resettled in New Zealand from 1979 to 2007<sup>10</sup>

#### 3.2 Refugees' classification

New Zealand is one of the 147 states adhering to the 1951 United Nations Convention and/or to its 1967 Protocol. It is therefore committed to consider all claims for refugee status made at its borders and must allow claimants to remain in its territory until their refugee status has

<sup>10</sup> Source: New Zealand Immigration Service, 2007. Despite not coming from the middle-East, this group includes Afghanis.

been assessed. Approximately, 200 to 500 asylum seekers<sup>11</sup> are given refugee status by the New Zealand authorities every year and are classified as **Convention Refugees**. They thereby become protected under New Zealand law and are entitled to the same rights and obligations as any other citizen.

In addition, New Zealand is one of the few states<sup>12</sup> committed to support the resettlement of **Quota Refugees** selected and referred by the UNHCR. Since 1997, this quota has been fixed at 750 persons annually<sup>13</sup> and is approved by the Minister of Immigration and the Minister of Foreign Affairs after consultation with refugee communities and resettlement stakeholders (government and non-government agencies). This category is restricted to a partner and children and is divided into the following three sub-categories:

- *Protection cases* (600 persons) including up to 300 places for family members. These are high priority refugees because they need protection from an emergency situation,
- *Women at risk*. These are women refugees (alone or with dependant children) at risk in a refugee camp, especially from sexual violence (75 persons), and
- *Medical and/or disabled cases*<sup>14</sup> (75 persons). These are refugees who have a medical condition or disability which cannot be treated in the country of asylum but can be treated in New Zealand.

The third category **Family Reunification Migrants** (also identified in the literature as "Family Reunification Refugees" corresponds to family members<sup>15</sup> who may come from a refugee background and who are sponsored by resettled former quota or convention refugees (resident or citizen in New Zealand) to come and live in New Zealand. In some years, the number of family reunification refugees can be equivalent to the size of Quota refugees.

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<sup>11</sup> Referred to as 'border' or 'spontaneous' refugees.

<sup>12</sup> In 2006, sixteen countries were involved in refugees' resettlement :Argentina, Australia, Benin, Brazil, Burkina Faso, Canada, Chile, Denmark, Finland, Iceland, Ireland, Netherlands, New Zealand, Norway, Spain and Sweden.

<sup>13</sup> The 1987 original quota was set at 800 places per annum.

<sup>14</sup> Medical screenings are not required for acceptance; medical cases are accepted as long as treatment is available in New Zealand.

<sup>15</sup> Parents, grandparents, siblings, adult children, grandchildren, aunts ,uncles , nieces and nephews.

### 3.3 Citizenship requirements

To obtain New Zealand Citizenship, former refugees must have been legally resident in New Zealand for five consecutive years<sup>16</sup>. They must understand and speak English (skills are assessed at an interview), be of "good character" and intend to continue to live in the country or work for a New Zealand organisation overseas. In 2006, application fees were NZ\$460 for adults, NZ\$230 for children under 17 and NZ\$200 for citizens by descent. The processing of a citizenship application generally takes between 4 and 6 months.

### 3.4 Government support

#### 3.4.1 Overview

Although refugees may come from similar backgrounds and situations, their access to services and welfare support can differ in accordance with the category to which they belong.

*Quota Refugees* have been granted refugee status in their first asylum country and thereby automatically become residents on arrival in New Zealand. They are sent for a six weeks orientation course at the Mangere Refugee Resettlement Centre in Auckland where they are provided with information on New Zealand culture, laws and regulations, English classes and medical screening including psychological services if required. When leaving the Mangere Centre, they are eligible to receive an Emergency Benefit available to unemployed New Zealanders plus a one-off Re-Establishment Grant of NZ\$1,200 for purchasing mainly household items. Additional assistance might be given to "special cases". A high proportion is resettled in Auckland, Hamilton, Wellington, Christchurch, Hutt Valley and to a lesser extent Nelson. The relocation depends upon whether family or friends are already established there as well as the presence of the lead Non-Government Organisation "Refugee Migrants Services- Refugee Resettlement" (RMS) involved in refugee assistance. RMS assigns New Zealander individuals or families as sponsor volunteers, for a minimum period of 6 months up to 12 months to assist newcomers with becoming more familiar with the host community. It also supports them in finding housing, accessing jobs, language classes, education for children, subsidized health care and welfare benefits.

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<sup>16</sup> Before 2006, eligibility for New Zealand Citizenship was possible after three years of residency. Since that date, the qualifying period from residence to citizenship has been extended to five years.

*Asylum seekers* who claim refugee status on arrival are eligible for government funded legal representation only. During the investigation process they are either kept in a detention centre until their identification is proven or in hostels funded by the Department of Labour where they must report to the authorities at specified times. If their claim is rejected, individuals must leave New Zealand. If it is confirmed, they are classified as *convention refugees* and thereby become entitled to the same services as quota refugees except for the re-establishment grant.

*Family Reunification Refugees* rely entirely on their sponsor family members who are responsible for providing them with accommodation for at least the first two years of residence in New Zealand. They might, however, be eligible for Housing New Zealand support. They do not receive government assistance on arrival other than English language support and must have two years continuous residence in New Zealand before becoming entitled to the Unemployment Benefit.

### **3.4.2 Access to health services**

Quota refugees on arrival are as eligible as any New Zealander for publicly funded health services. They are given the "community service card" entitling them to free outpatient treatment at hospitals plus the maximum subsidy for General Practitioner visits and prescription charges. In 2007, for adults and children aged 6-18, medical visits were subsidised respectively at NZ\$15 and NZ\$20. For prescriptions, they pay a government prescription charge of NZ\$3 per item (if the medicines are partially subsidised there will be additional charges). The card covers all close family members but it does not subsidise fees of alternative health providers unless they are also registered as GPs. Families continue to benefit from this support provided that they do not have sufficient income to afford health care.

In the Refugees' Voice report (New Zealand Immigration Service & Department of Labour, 2004), former refugees reported their general health as being good to excellent. Nevertheless, the survey did not indicate the reasons given by the participants to explain such a statement. Half say that their health had improved since they arrived because they felt safe and secure. The majority (97%) were registered with a General Practitioner. Most were satisfied with their doctor and regarded them as good, kind and approachable. One in ten indicated that they were not able to visit a doctor when they needed to. The main reasons were communication

barriers, expensive consultations, transport problems and the difficulty of obtaining an appointment.

#### **4. New Zealand Settlement Strategy**

Because of their past multiple traumatic and survival experiences refugees face problems similar to other ethnic minorities such as loss of identity and sense of ownership, separation from their land. Indeed, settling in a new country necessitates individuals dealing with the immediate challenges of finding a place in which to live, gaining employment, understanding and adjusting to foreign systems and customs. New Zealand government agencies and non-government organisations supporting refugees, therefore, have to facilitate their adaptation by promoting social harmony, mutual respect and cultural understanding.

Furthermore, in 2004 the government launched the New Zealand Settlement Strategy which focuses on a proactive approach that supports the settlement of new migrants, refugees and their families in this country. The implementation of the strategy, revised in 2007<sup>17</sup>, is under the leadership and coordination of the Department of Labour. It outlines how contributing government agencies, such as the Ministry of Health, Housing New Zealand or the Ministry of Justice and other stakeholders should support newcomers in achieving the following settlement outcomes, as set out in the strategy's seven goals (Department of Labour, 2007, p.11) as:

"Migrants, refugees and their families:

- are accepted and respected by the host communities for their diverse cultural backgrounds and their community interactions are positive,
- obtain employment appropriate to their qualifications and skills and are valued for their contribution to economic transformation and innovation,
- become confident using English in a New Zealand setting or are able to access appropriate language support,
- access appropriate information and responsive services that are available in the wider community,

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<sup>17</sup> The New Zealand Settlement Strategy launched in 2004, included six goals also present in the 2007 version. The main difference between the two versions is the additional goal that "newcomers accept and respect New Zealand".

- form supportive social networks and establish a sustainable community identity,
- feel safe within the wider community in which they live and,
- accept and respect the New Zealand way of life and contribute to civic, community and social activities."

The settlement challenges faced by newcomers in New Zealand, especially refugees, cannot be addressed through any single agency and require a collaborative and coordinated approach. The framework provided by the settlement strategy, therefore, has allowed the establishment of a national action plan and in some areas a regional settlement action plan (i.e. Auckland or Wellington) setting out what has to be done to implement the strategy including the allocation of responsibilities and a time-frame for action. Some of the findings developed in the Discussion Chapter IV will examine the current outcomes of the strategy in relation to the participants of this study.

## **Chapter II: Literature Review**

In this chapter, a review of refugee mental health status and related information in New Zealand, emanating from available literature, will be presented. This will be followed by findings from worldwide studies which have investigated the main sources of stress and mental disorders affecting former refugees during resettlement. Subsequently the refugees' coping abilities and mechanisms will be examined. It has to be underlined that because the study did not focus specifically on psychological concepts such as resilience or self-efficacy, they have not been investigated in the same depth as would otherwise be the case. Finally, grounded theory which is the qualitative method used to conduct this study, will be detailed.

### **A. Refugees and mental health**

#### **1. Mental health of refugees in New Zealand**

##### **1.1 Paucity of information**

Despite several publications stating that the mental health status of former refugees resettled in New Zealand remains of serious concern (New Zealand Immigration Service & Department of Labour, 2004), a comprehensive overview of the burden is difficult to obtain. Nam and Ward (2006), in an annotated bibliography on research and consultations relating to refugees' and migrants' needs, have confirmed this gap by underlining some of the main concerns reported by some stakeholders involved in refugee support. For example, the Mental Health Commission (2002) stressed the lack of public and professional attention to refugees from smaller ethnic groups. The New Zealand Immigration Service and the Department of Labour (2004) mentioned that reliable data on the mental health needs of refugees living in New Zealand are lacking. Crampton (2003), in evaluating the Hutt Valley refugee population reported the need of raising information and careful targeting of mental health issues in refugee communities. The Working with Muslim Communities (2004) reported that past trauma such as experiencing civil wars and living in refugee camps, isolation from family and friends and unemployment are having an adverse effect on the mental health and well-being of refugees.

Further, the Ministry of Women's Affairs (2006) in its report on women's status in New Zealand, stated that refugee women also "suffer from depression and post-trauma stress and

that dislocation from family is a major mental health issue for refugee families” (p.54). More recently, participants of the first Refugee’s Health Conference held in Auckland (30th May 2007), reiterated the importance of exploring refugees' mental health status and asked the Ministers of Health and Immigration to “provide resources and direction for carrying out evaluation studies of specialist services targeting refugee health and mental health needs” (Conference Recommendations Report, p. 4).

## 1.2 Identified needs

It is worth highlighting the commonly held view that being a refugee is associated with poor health, with greater risks of infectious diseases and psychological or mental problems. Evidence is lacking, however, to provide a representative picture to establish if they are more affected by mental disorders than other groups. The last national “New Zealand Mental Health Survey: Te Rau Hinengaro” (Ministry of Health, 2006), which gathered quantitative information regarding people experiencing mental health problems, has focussed on Māori, Pacific peoples and "other" New Zealanders without making a distinction between "other" groups or nationalities. During an informative seminar on this survey held in Christchurch on 8th March 2007, in response to a question about refugee inclusion, it was stated formally that refugee numbers in New Zealand were too "insignificant" to be included in that study.

An extensive study focusing on the resettlement experience of refugees, conducted in 2002 by the New Zealand Immigration Services and the Department of Labour<sup>18</sup> has revealed that:

- one in three refugees said they had experienced emotional problems prior to moving to New Zealand as well as after settling in New Zealand,
- 60% of whom had not asked for help to deal with these problems, and
- one third were willing to obtain some help relating to the stress they were experiencing.

The survey did not include questions about mental health "as there was some concern about the re-traumatisation of refugees if these questions were asked" and "the project team considered that this was a particularly sensitive issue to investigate in depth" (Refugee Voices, 2004, p.97). However, McLeod and Reeve (2005) in reviewing the files of refugees' health screening from 1995 to 2000, on arrival at Mangere Centre, found that:

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<sup>18</sup> Results published in "Refugee voices: a journey towards resettlement", 2004.

- 20% of the refugees had been subjected to some form of significant mistreatment (detention and/or physical ill-treatment) before arriving in New Zealand,
- 14% reported some form of significant psychological symptoms, and
- 7% were diagnosed as having suffered from Post-Traumatic Stress Disorder.

A major difference was established between women who reported psychological symptoms and men who reported ill treatment. Psychological upset represented one of the most common reasons for referral to secondary services from Quota refugees. However, details on the reasons why people were upset were not reported.

### **1.3 Main reported hindrances to access mental health-care provision**

Efforts have been made during the past decade to identify and meet refugees' mental health needs better. For example, quota refugees are provided on arrival in New Zealand with counselling, psychological support when necessary, as well as assistance in their towns of resettlement. Nevertheless, resettlement services providers (Auckland Regional Settlement Strategy, no author, 2004) have underlined that there is a lack of clear strategy to meet refugees' health needs. Current health policies appear to be only partially effective because of communication barriers and a lack of skilled staff possessing a cross-cultural background. There is a shortage of interpreters skilled in the health field and few former refugee health professionals are employed in the health sector or resettlement agencies because of the non-recognition of their professional or personal skills. As a consequence, former refugees who might be in need of mental health support usually do not approach health-care professionals.

This reluctance is also associated with a range of *practical factors* including a poor knowledge or understanding of accessing the New Zealand health system together with a lack of financial resources. Communication barriers with professionals, due to poor English, lack of interpreters as well as consultations which are too brief create additional difficulties for refugees who wish to explain complex health and social problems (Guerin, 2003; Ministry of Health, 2001). *Cultural obstacles* also hamper refugees' in seeking mental health care services because they are not used to sharing personal feelings openly due to cultural principles and/or fear of being stigmatized (i.e. being considered as "crazy"). Further, the individualistic Western medical approach often fails to consider patients' cultural beliefs and methods of healing. In that respect, the International Organisation for Migration (IOM, 2002) emphasised

that it is nearly impossible to define mental health comprehensively from a cross-cultural perspective. The multiplicity of components varies considerably from "subjective well-being, perceived self-efficiency, autonomy, competence, intergenerational dependence, and self-actualization of a person's intellectual and emotional potential" (p.1). However, it is agreed that mental health is broader than "a lack of mental disorders" and that mental functioning is fundamentally interconnected with physical and social functioning. With this in mind, this broad understanding of mental health is of significant importance in the context of refugees who come from places with different values and cultures. Such considerations represent ongoing challenges for health professionals whose available tools do not always accord with the needs and realities of a multicultural group which possesses other views on health concepts and cures.

This lack of cultural sensitivity has been underlined by Jackson (2006) from the Auckland Refugees As Survivors Centre who wrote "information about the effect of cultural difference in health-related interaction is limited.../...for mental health the situation is worse and for refugees worst of all" (p.33). In that respect, she has gathered information on some of the refugee communities' beliefs related to a poor mental health status aiming to support professionals dealing with refugees' distress. Other initiatives are starting to emerge such as the Wellington Regional Health and Well-Being Plan (Awad, 2006) which aims to develop culturally appropriate services by emphasising cross-cultural training and skills for organisations involved with refugees as well as to train and employ refugees. Further, the Refugee Council of New Zealand during the first National Refugee Health Conference (2007) confirmed those gaps and recommended that, "The rationing criteria for mental health services for refugees should not be restricted in relation to Western DSM-IV<sup>19</sup> diagnostic criteria. Culturally responsive mental health services should be available as of right in both culturally specialist and mainstream services for refugees." (p. 2).

#### **1.4 Limitations of the health sector**

Recent clinical research in New Zealand has started to provide empirical evidence of the above mentioned hindrances. Briggs and Macleod (2006) have revised 64 closed refugees' and migrants' cases, medically diagnosed and treated for major depressive disorders, anxiety

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<sup>19</sup> Diagnostic and Statistical of Manual Mental Disorders, fourth edition- American Psychiatric Association, 1994. This mental diagnostic instrument has been developed by the American Psychiatric Association during the 1970's and has been refined over the past decades.

or adjustment disorders with symptoms of low mood. They found that most of them did not make the gains that would be expected over a course of intervention. This was explained by non-compliance with a treatment regime and incorrect diagnosis linked to the challenge for mental health professionals to fit some of the patients' clinical symptoms within the DSM-IV international mental illness classification. It appeared that most of the patients were referred to a mental health specialist for somatic problems and that the term “demoralisation” could be an interim alternative to designate non-specific psychological distress among refugees attending mental health services. In-depth research in that field is on-going in New Zealand and Australia to understand better the cultural and clinical needs of refugees and migrants attending mental health services.

On the other hand, Guerin et al. (2004) have collected information on Somali conceptions and expectations concerning mental health. Indeed, the authors underlined that knowledge of their health practices is limited and that many factors contribute to barriers and difficulties between mental health professionals and Somali clientele. For example, the proper use of, and patients' compliance with the treatment is often compromised due to the non-existence in Somali language of terms to describe many Western mental illnesses. Additionally, Somalis place great reliance on general practitioners who do not always have the time, sufficient cultural skills and interpreters to support them. In that respect, the authors emphasised the need to develop and strengthen specialised mental health services and identified some possible areas for improvement. They assert that special attention should be given to a better handling of language and communication differences by giving interpreters appropriate health training. This could avoid misunderstandings especially during inappropriate situations (for example, having a male interpreter during a female consultation) or when referrals to specialists are required. Diagnoses, medication prescriptions and their consequences also should be explained clearly to, and understood by, Somalis. Finally, health professionals should be more involved within the refugees' community through home visits such as attending social functions and interacting with interpreters.

Such findings highlight that there is no common answer either to alleviate people's distress or to overcome the limitations of health professionals. This is acknowledged in New Zealand, which is developing diverse responses to meet the specific health needs of the Māori and Pacific people because of the dominant and not always appropriate Western medical approaches. Indeed, it appears that the DSM-IV diagnostic criteria, might be restrictive to

Western culture and therefore not always applicable in other cultures. Over the past decades transcultural psychiatric approaches, by questioning the validity of most cross-cultural research on constructs of mental illness, while at the same time, underlining some universal features, have promoted a more balanced approach as described in the following section 4.

Health policies, however, remain standardised and largely centralised, thereby giving little space to flexibility and diversity (Wright & Hornblow, 2008). Such issues, however, are certainly not exclusive to New Zealand and Williams and Westermeyer (1986), while investigating refugees' mental health in different Western resettlement countries, reported similar difficulties encountered by health professionals in the U.S.A, Canada, Europe and Australia.

In addition to the difficulties to meet former refugees' mental health needs, it is often reported that those needs are consequences of individuals' past traumas and the experiences of forced migration (Ministry of Health, 2001). Those which relate to socio-economic barriers during the period of resettlement and which also affect individuals' overall well-being, are often considered to be secondary. To highlight the complexity of refugees' adaptation process whilst resettling and potential risk factors for their mental well-being, the following paragraphs will explore some of the most common sources of stress faced by refugees worldwide.

## **2. Resettlement stresses**

In addition to pre-migration adversities, resettlement pressures such as socio-economic constraints trigger an on-going level of psychological distress. Studies and reviews on refugees' mental health (Pernice & Brook, 1996; Tribe, 2002, Watters, 2001) indicate that refugees' adjustment-stress in the host country may be as powerful as those events prior to their flight. Environmental changes create uncertainties and tensions in addition to uprooting because individuals do not always have the means to deal with unfamiliar situations. Refugees arrive with varying degrees of preparation for their new environment and the majority face similar adaptational problems regardless of their cultural, educational, political, professional and traumatic backgrounds (Berry, 1988; Hsu et al., 2004; Lin 1986; Ministry of Health, 2001). The interrelation of personal and external factors, which will be described below, might drive former refugees into social isolation caused by mixed feelings of inadequacy and

shame because of being unable to join and participate in the mainstream society. This increases individuals' vulnerability and impacts negatively on their mental well-being and could affect negatively their adaptation process and resettlement outcomes.

## **2.1 Loss and grief**

Refugees, regardless of gender and age, have been involved in a significant series of human and material losses. During the process of forced migration most of them have experienced the death or separation of family members and close friends, the dispossession of personal property and means of livelihood. Sometimes, they might also have lost their dignity, faith and even their will to live. All have lost their homeland and cultural values and beliefs. Frequently, they have been deprived of the possibility to participate in ritual mourning which would have enabled them to deal with events which were beyond their control. For example, Boehnlein (1987) found a number of clinical similarities between the symptoms of chronic grief of Cambodian refugees and Post Traumatic Stress Disorder and the importance of associating religious belief and ritual during ongoing medical treatment to alleviate patients' suffering. Indeed, not being able to mourn can result in prolonged and unresolved grief often exacerbated by a constant feeling of guilt and worry over relatives left behind and the preoccupation to be reunified. Lifton (1983) through his work with Hiroshima victims, wrote that in addition to their survival and traumatic experiences, survivors have "to endure the additional internal trauma of self-blame" (p. 172) because of being alive. He emphasised that the survivors' willingness to accept their helplessness under previous extraordinary circumstances and absolve themselves from guilt remains one of the key tasks in recovery.

Additionally, refugees have lost everything which represented their previous social status or role and usually are reduced merely to their physical selves. On arrival in the host country they are foreigners and can be perceived as intruders simply because they are labelled with the title of "refugee". Frequently, this administrative identity, which gives them access to welfare and social support, is viewed with suspicion and/or low social status by the mainstream society. The predominant image of a refugee, seen as a traumatised, government supported and dependent individual makes the development of social connections difficult. For example, Colic-Peisker and Walker (2003) reported that many Bosnian refugees in Australia articulated the feeling of uneasiness about being classified as "refugee" which they considered to be a status full of "opprobrium" and a socially disadvantaged and culturally distant social category from the rest of the society.

## 2.2 Fragile community of origin and community pressure

There is no agreed definition of community in sociological terms. For example, the sociologist Hillery (1971, as cited in Phoumimdr, 2007) sought to determine the common definitional components of community. He found that four common components occurred in 69 of the 94 definitions of community; people, common ties, social *interaction* and place. Interestingly the only component common to all 94 was people.

In a Western context, community is often understood to be a specific group of people living in the same environment, sharing the same interests and having the same cultural and historical heritage. It is also considered to be the place where individuals find cohesion, unity and solidarity. Following this logic, most of the resettlement policies give a special attention to the re-establishment of refugee communities. Relocation, therefore, is organised spatially by sending newcomers belonging to the same ethnicity to places where their peers are living in order to build a social network so as to facilitate and comply with the exigencies of resettlement. Such connectedness is seen as being a source of practical and emotional support, as well as restoring or maintaining a sense of belonging and cultural identity.

Some refugees, however, who try to establish links with their fellow countrymen, find that others often are too overwhelmed by their own problems to offer support. As a consequence of historical strife, continuous internal sub-group divisions (e.g. in Afghanistan, Somalia, Sudan), together with past or recent internal conflicts or wars, the refugees' sense of belonging to a homogeneous community often is disrupted and sometimes lost. This creates difficulties in sustaining contacts with their peers. Such contacts have been altered by individual or group "bad" experiences, life in camps and personal accusations leading to mutual suspicion. Occasionally, some former refugees may highlight their political, cultural and organisational allegiances more than hitherto. This can cause persistent tensions and consequently a failure of community bonding by alienating refugees from each other. This also can result in difficulties in selecting a leader or obtaining an influential representation when needed. On the other hand, some leaders do not have the real authority to represent the majority and can be used strategically by resettlement providers to comply with some policies targeting communities (Guerin, 2004). Some refugees, moreover, do not wish to rely too much on their group of origin because this could retard their progress in the host society and prevent them from having contact with others (Lin, 1986).

In Australia, Phoumimdr (2007) reported that the level and incidence of disputes in the Lao community, because of power conflicts, had reached a stage where there was a need to establish a special council to bring the community back together. He emphasised the danger of over-identifying with one's own ethnic group because it can lead to tension or factional disputes. Other recurrent issues persist such as competition amongst individuals by achieving a successful resettlement symbolised visibly by material acquisitions such as a good home, new car and satisfactory work (Colic-Peisker, 2003). Moreover, when community support exists, individuals may have to face pressure and control to comply with their traditional obligations.

Such realities make difficult the application of social policies targeting refugee communities which experience internal divisions characterized by the development of numerous associations unequally organised and credible when important issues occur. The services provided either by the government or funded to the community groups, therefore, may not reach the individuals in need of such support due to internal disunity linked to complex socio-cultural layers (Phoumimdr, 2007). In New Zealand, the 2005 Refugee Issues Forum in Wellington mentioned the need to build strong communities but stressed the lack of strategic direction and the deficient current 'silo' funding approach (as cited in Ward, 2006). Moreover, the concept of "community" varies from one culture to another and peoples' understanding and meaning. For example, immigrant women from Korea recently arrived in Canada associated community with a very small group limited to friends and sometimes neighbours (Graham & Thurston, 2005).

### **2.3 Unemployment**

One of the key indicators in obtaining social status and being integrated is employment since it is also an efficient way to reconstruct one's identity by regaining control over one's life. The majority of former refugees, however, have to wait years before being able to integrate into the host country's labour force.

In the South Island of New Zealand the Migrants Report issued in 2007 by the Christchurch City Council, stated there is evidence that discrimination impacts on the ability of some ethnic groups to access employment. Generally speaking, people aged 15 years and over from ethnic minority groups, including migrants and refugees, have a higher unemployment rate (8%)

than the total Christchurch population (5%). Further, in 2006, amongst the refugee groups, the Kurds had the highest unemployment figure of 30%, followed by the Somalis and Ethiopians at 19%. The Afghans had the lowest unemployment rate at 15%. The small refugee population numbers and low total labour force requires that care be taken when interpreting these figures, however, unemployment remains three to seven times higher compared to the rest of the population.

The barriers limiting refugees from accessing work opportunities and entering the workforce vary from a weak command of the host country's language, no formal education, to employers' reluctance to employ people from other cultures because of racism and/or discrimination. Additionally, the process of completing a job application developed in Western societies is foreign to most refugees. In many low-income countries people usually do not have to apply formally for jobs since networking via relatives and personal contacts is usually the norm. It is likely that the absence of easily available information and practical advice in the receiving society contributes to a higher level of stress. Furthermore, their previous work experience and /or professional skills are frequently considered as inadequate to meet the labour market's requirements. Middle or upper class urban professionals and those aged in their forties and over are affected particularly. They are employed frequently at a lower status than their previous education and/or professional background. This lack of recognition and loss of previous status, which are perceived as the main pillars of their identity, are recurrent causes of embarrassment and trauma. For example, Bosnian refugees resettled in Australia who were unable to work reported a sense of failure which they did not wish to expose to either their own community or to the host society (Colic-Peisker & Walker, 2003).

McSpadden (1987) in studying the psychological well-being of adult single male Ethiopian refugees resettled in the Western United States found that 100% of the participants put jobs as the most important factor for achieving a "satisfying happy life" and to become self-sufficient and independent. Stress levels of those who were employed were much lower and were also linked to perceived acceptable work status, with decent wages. Those educated with a good command of English but who did not find suitable employment presented more psychological distress as well as expressing their fear of "falling down". Similarly, Flakerud and Nguyen (1988) found that satisfactory employment for Vietnamese refugees resettled in the U.S.A

correlated more highly with emotional well-being than either pre-migration stress or family separation.

Such findings highlight that being unemployed adds to refugees' insecurity by increasing their feeling of being both hopeless and useless, as well as their sense of stigma and discrimination. This affects their ability to plan towards improving their situation and their idea of a better future. It also impedes their gradual adaptation in a new environment because they are unable to participate in its socio- economic life.

#### **2.4 Economic deprivation and poverty**

Consequent upon chronic unemployment and/or poorly paid work, refugees depend on the Welfare System. In New Zealand, the majority rely on government financial assistance including, for example, emergency benefits, unemployment benefits, accommodation supplement or disability or sickness benefit. The New Zealand Immigration Service and Department of Labour (2004) reported that seven out of ten refugees said that they did not have sufficient income to meet their everyday needs. In many cases, the reasons given were not having work, high household bills and expenses for their children and trying to keep in contact with and/or supporting families overseas. A report issued by the Christchurch City Council in 1997 (as cited in MacGibbon, 2004) found refugees to be the most disadvantaged people: 60% struggled to meet their accommodation costs compared to 39% of the rest of the population and 51% experienced problems affording food either for themselves and/or for their family. In 2006, people from Africa and the Middle East resettled in Christchurch had an average annual income of NZ\$ 16,400 and NZ\$ 12,700 respectively. This was lower than the 2006 personal median yearly income for full time work of NZ\$23,400 before tax.

Chile (2002) in examining the socio-economic status of African refugees in New Zealand established that out of a sample of 68 respondents only 34% were in full time employment and 39% were unemployed. The remainder were employed part time or were studying. This limited economic sufficiency impacted negatively on their capacity to save, to access appropriate housing and food, to participate in socio-cultural activities and to remit money to their families overseas. Additionally, most had debts contracted during both their forced immigration and relocation adding to their chronic economic deprivation. The author emphasised that when the issue of debt was not addressed the individual and family were

caught up in the foreseeable cycle of poverty. These refugee groups were characterised by social problems leading to frustration, loss of self-esteem and social isolation because of their inability to meet both their New Zealand and overseas family needs. Women reported their struggle to find employment because of their linguistic, dress and customs differences. The majority were afraid to complain about discrimination because of their lack of language skills and/or knowledge of the bureaucratic complaint process. They also believed that they would not be taken seriously or could face further prejudice when applying for residence, citizenship or family reunification. Chile concluded that all these factors contribute to impoverished communities because of their exclusion from participating in the mainstream society.

Guerin and Guerin (2002) confirmed that many life-style problems amongst Somali refugees resettled in Hamilton, New Zealand, resulted from insufficient income, such as buying cheap, fatty and sweet food, not being able to participate in social activities or enrolling children in "good schools". Income poverty could generate inter-generational conflicts because parents were unable to afford fashionable clothes or pay for leisure activities due to prohibitive costs. It appeared that the effects of current poverty on individuals' mental health inhibited self-help and long-term prospects, rather than prior war-related trauma. The authors concluded that the coupling of historical and resettlement poverty led to a variety of negative outcomes accentuating refugees' dissatisfaction with their host country. Similarly, Detzner (2004) has gathered forty life histories of Southeast Asian elderly refugees resettled in the United States over the past three decades. He reported that financial constraint was a recurring source of stress for almost all of them and mentioned that a survey conducted in 1990 in the state of Minnesota, found that 87% were living below the poverty level compared to 12% of the general elderly population. In the United Kingdom, one study of 30 refugee households found that all of them were food-insecure and 60% of the children were experiencing hunger (Sellen, 2002, as cited in Hargreaves, 2007).

Such findings reveal serious socio-economic inequities and social disadvantages which impede refugees from regaining control over their lives. This is exacerbated in a Western country where both the way of life and cost of living are particularly expensive. Moreover, individuals are unable to exploit their past coping mechanisms, survival techniques and behavioural patterns. There is a common assumption that economic misfortunes faced by refugees in their resettlement country cannot be compared to what they had experienced before. Economic poverty and welfare dependence, however, are genuine causes of distress

for those involved. Both compound a sense of worthlessness and inadequacy because financial dependence also creates a dysfunctional relationship with their host society.

## **2.5 Culture shock and adjustment to a new way of life**

When refugees have to adjust to a new way of life significantly different from their own, the stress induced by those changes is identified as culture shock (which often overlaps with acculturative stress, described later). Culture shock relates to difficulties in assimilating unfamiliar situations which can affect seriously a person's day-to-day ability to function. When arriving, former refugees might have the false assumptions that "the streets are paved with gold" and the pre-conception that the attaining of material possessions and success are easy. Images conveyed by the media such as cinema and television, tend to imply the authenticity of this impression which can lead to high and/or unrealistic expectations. People soon come to realize that living in a Western country, usually economically and technologically more advanced than their own, is a daily struggle. They have to acquire the command of a foreign language, modify and adjust to a new mode of housing, reduced mobility, changes in diet and climate and economic obligations such as paying bills and taxes regularly.

Additionally, they do not always know how to behave or what is expected from them. Daily tasks, such as shopping for food, asking for directions, using a lift or escalator, an internet connection, taking a bus, all represent obstacles involving not only the language barrier, but also the potential for deep cultural differences. They have to comprehend different political and socio-economic structures, religious beliefs and sets of relationships. Becoming aware of and endeavouring to assimilate foreign values, behaviour and practices also can create an accumulative stress especially where such principles are likely to be incompatible with their own culture and experiences. The move from a "communal" to an individualistic Western way of life can be critical in engaging in the process of recovery and resettlement. It is likely to contribute to various levels of fatigue and frustration (i.e. bitterness, resentment, homesickness) which can result in feelings of rejection or regression. Memories of their homeland, therefore, might become rose-tinted and nostalgic by remembering only the good things.

These feelings are usually temporary and diminish over time after which people tend to make significant improvements to their lifestyle. Stein (1986) when exploring the adaptation

experience of refugees in the U.S.A. described a “cross cultural adjustment” in four main steps. The first 3 to 4 months are usually characterised by personal contentment (often described as “the honeymoon phase”) followed over the next 9-12 months by confrontations with practical and cultural difficulties resulting in culture shock if efforts to succeed are unsatisfactory and what has been left behind cannot be replaced. The next one to three year period is usually the adjustment time. A mastery of the cultural differences should be acquired after five years. Refugees' degree of success in the host country, however, will depend on the variety and perceived intensity of the difficulties and their abilities to overcome cultural differences.

## **2.6 Acculturation**

Acculturation is the process by which a minority group assimilates the cultural values and beliefs of a majority community. The most common definition reported in the literature (Berry, 1988; Colic-Peisker & Walker, 2003) is the one of Redfield et al. in 1936 who defined acculturation as "culture change which results from continuous, first-hand contact between two distinct cultural groups". Thus, in the context of refugees' resettlement, both refugees and hosts have to accommodate those differences. The former are expected to adjust to the mainstream society which has to develop in turn some flexibility, understanding and acceptance of cultural diversity.

Berry et al. in various publications (1988, 2006) have proposed a four-fold model to describe immigrants' and host societies' acculturation attitudes which can be of use when conceptualising refugees' resettlement experiences. This model considers the extent to which immigrants modify their cultural identity and characteristics by adopting the new culture whilst retaining their own. The successful adoption of the host culture and retention of cultural roots leads to integration. Conversely, marginalisation occurs if this task is not achieved. A total adoption of the host culture with no retention of the home culture produces assimilation. The opposite leads to separation from the dominant group.

Similarly, the host society's acculturation attitudes determine the extent to which it adopts newcomers and maintains its own culture. When both cultural heritages are preserved, multiculturalism occurs. The acceptance of newcomers' culture will produce a melting pot whilst the opposite will generate segregation. Conversely, exclusion will arise when the host society

does not wish newcomers to "identify with either their heritage culture or the receiving culture" (MacLachlan, 2006, p. 46).

Cheung (1995) investigated the relationship between acculturation and minor psychiatric morbidity amongst 223 former Cambodian refugees resettled in Dunedin, New Zealand. Subjects who had chosen the integrated mode of acculturation presented lower psychological distress. The association between mental disorders and acculturation depended upon age, marital status, length of time in New Zealand, educational level, and socio-economic status. Those who were older, widowed, newly arrived, less educated and of lower socio-economic status, were less acculturated and presented the highest rate of psychiatric morbidity. This remained especially significant in women aged 31 to 50.

A study amongst former Bosnian refugees living in Norway conducted by Van Selm et al. (1997) showed that assimilation was related to the highest life satisfaction, while integration was related to the highest feelings of competence. Both were strongly related to positive reactions from the Norwegian host society. On the other hand, Colic-Peisker and Walker (2003) found that the first generation of Bosnian refugees, who resettled in Australia during the 1990's, chose relative separation from the mainstream society. This was linked to English language barriers, the difficulties of regaining their previous occupational status and Australian cultural insensitivity. Individuals, therefore, were more inclined to adhere to their own community and sought work and support through informal channels. The second generation, however, appeared to be integrating more rapidly, partly due to family resources and "sacrifices" directed towards educational and the professional success of children.

Because of the involuntary nature of contact with their host country and being part of a minority, refugees represent a "special" category undergoing acculturation. For many of them, this transition requires constant and significant efforts to engage with the mainstream society which can be perceived as a burden or challenge. Individuals' inability versus willingness to overcome cultural obstacles can result in inhibition and/or a withdrawal from the receiving society. Specifically, this can happen if they are estranged from their own community and are unable to anticipate and evaluate the mechanisms by which to identify with their host country (Kunz, 1981). As described in the previous paragraphs, studies on refugees have demonstrated that acculturation is a complex process influenced by individual characteristics, the nature and length of the contact between both groups including their similarities and dissimilarities, the

course of the process and the level (individual and group) at which it takes place. Adaptation outcomes, therefore, will depend upon refugees' resisting or accepting new relationships and the mobilisation of personal resources and achievements when dealing with a dominant group. On the other hand, these will be influenced strongly by the degree of tolerance and receptiveness of the host society.

## **2.7 Family changes**

For many refugees, their nuclear family has been destroyed prior to their flight from their country of origin because of the death of family members or the obligation of one parent to leave on their own. The numerous challenges of resettlement, therefore, will add to the difficulties for many families of recreating harmony in their host country. Such challenges can result in changing roles between husband and wife. Women coming from current war zone countries have frequently lived under the authority of a male relative (father, brother or husband). On arrival in a Western environment they may gain much more freedom which can be difficult and sometimes uncomfortable to manage because of their previous conventional role. Because of economic constraints and male job insecurity in the resettlement society, married women might be obliged to work which can create family tensions because the husband is no longer the "breadwinner". Indeed, the husband might not only lose his professional status but also his leading role as head of the family because his wife becomes the main source of income. Other family challenges are those faced by single mothers (widows, divorced or those with missing husbands) arriving in a host country. They have to learn very quickly how to become "head of the household", responsible not only for the family's economic sustainability but also its cohesion. Despite hardship, many women acquire self-confidence in handling new responsibilities, which is not always welcomed by their community of origin (Williams, 2004).

Such a shift in family roles and normative behaviour, due to a new way of life, has repercussions on self-image and impacts on relationships with children. For example, Degni et al. (2006) looked in-depth at the experiences of 21 Somali parents raising their children in Finland. The changes in the husband-wife relationships because of migration, reduction of the extended family size and gradual independence of the women was seen by men as a threat to the cohesion of the "Islamic Family". This was despite the men demonstrating a greater propensity in accepting women's opinions and decisions regarding family matters. This loss

of the men's lead status was exacerbated by the fathers' unemployment which obliged them to stay at home and be involved in domesticity. Additionally, both parents were dependant upon their children for translation with outside institutions and day-to day communication thereby diminishing their parental authority which had already been affected by a more permissive Western style of child raising. For example, Somali teenage boys readily adopted a Western teenage lifestyle ("hanging out at night", drinking and smoking) considered by their parents to be unacceptable behaviour and led to family conflict. In contrast, girls seemed to accept better the Somali cultural norms. In summary, adults saw changes in parenting practices becoming heavy and stressful and reported having difficulties in coping.

Such structural changes also affect single mothers who might face difficulties because of the lack of a paternal role model leading to children taking advantage of the situation or being expected to adopt adult roles (Centre for Multicultural Youth Issue, Australia, 2006). Furthermore, Tousignant (1992) when reviewing the impact of forced migration on individuals and family mental health confirmed that such changing roles could lead to inter-generational conflicts and role confusion, especially for non-Western refugees. He explained that in Canada, refugee children have access to the Western educational system which teaches and encourages individual autonomy, competition and new values. Thereby these children have access to Western practices in contrast to their parents who lack social networking in the host society and/or are strongly attached to their cultural beliefs. Whereas children are "empowered", parents might become "disempowered". This can conflict with parental control strategies which, if not accepted by the children, can result in rebellion and sometimes delinquency. In that respect, Green (1989) reported that children's frustration cannot easily surface at home and "most children find school one of the few places where their confusion, distress, rage and fear can be expressed" (p.127). Such schooling problems in a Western setting require the involvement of parents who might not understand how to resolve their children's difficulties. For example, Guerin et al. (2003) explained that Somali parents resettled in New Zealand were reluctant to be involved in schools because in Somalia visiting a school meant that their children were in trouble. Further, they also faced English language barriers when communicating with the teachers and trying to understand what they had to do. On the other hand, the authors stressed that despite the common assumption that children adapt more easily to change than adults, it must not be forgotten that they also face constraints by coming from a refugee background and thereby are also exposed to Western challenges, a situation of which their parents are not always cognisant. Similarly, Tousignant (1992)

recalled that refugee children might have to share the losses and traumas of their parents. The children might also be kept in ignorance of past events with the result that "families' secrets create a distance within the relationships between children and their parents"<sup>20</sup>(p.11).

Nevertheless, Shimoni et al. (2003) investigated in Canada the paternal engagement of 24 immigrant and refugee fathers coming from Asia, South Asia, Western Europe and South America. All expressed a deep commitment, concern and responsibility toward their children's future success in their new country. They viewed education as a predominant means to reach that goal and were positively engaged with their children despite facing the struggles of acculturation, language acquisition and employment. Fathers indicated that the most important help which they needed so as to assume their child raising responsibilities was intensive support for learning English and access to suitable work. Both were seen as major factors to cope with their new environment and develop respectful and supportive relationships with their children.

Another example of family change which is poorly documented relates to the family reunification experience in the host country. Rousseau et al. (2004) have investigated the family reunification process of Congolese refugees resettled in Canada. The adaptation to a Western way of life resulted for many Congolese in personal transformation such as independence, adoption of other cultural values and loss of cultural roots and changes in the family dynamics. Such changes were not always understood by reunified members on arrival and sometimes triggered family conflict because prolonged separation and uncertainty had made it difficult to deal with the breach in relationship so caused. The authors emphasised the importance of providing support to former refugees by viewing the ambiguous losses and changes associated with the separation and reunification process as part of family plans to re-establish family continuity and reduce emotional stress.

## **2.8 Summary of resettlement stresses**

The foregoing headings have highlighted some of the major sources of stress faced by refugees in a new environment. Such sources are strongly interrelated and reflect the reality that socio-cultural changes and socio-economic living conditions in the host country might

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<sup>20</sup> In French: "Tous ces secrets de famille créent certainement une distance dans le rapport des enfants avec leurs parents" Tousignant, 1992,p.11).

lead to prejudice and social isolation if they are not addressed. They have been identified as having a significant adverse influence on refugees' mental health and consequently on their adaptation process and outcomes. The following sections, therefore, will review some of the most reported mental health problems amongst refugees during the course of resettlement.

### **3. Common psychological distress and mental disorders**

A clear understanding of refugees' mental health status and psychiatric morbidity is difficult to obtain. The majority of research has given prominence to depression, anxiety and Post Traumatic Stress Disorders but results and interpretations can be contradictory. For example, Graig et al. (2006) reported major prevalence variations and discrepancies between studies because most had been of help-seeking populations. A critical review conducted by Hollifield et al. (2002) who extracted data from 394 articles on refugees' trauma and/or health status, found that the majority of research was either descriptive or included quantitative data from instruments having limited or untested validity and reliability. They emphasised the lack of theoretical bases to instruments and poor use and reporting of sound accurate measurement (such as poor case definition, unclear data collection and/or analysis) as well as translation and cultural differences in expressing mental health issues. That notwithstanding, a review of some research describing the most frequent mental health disorders reported among former refugees will be presented including current debates and health professionals' challenges.

#### **3.1 Acculturative stress**

Experiencing acculturation (a process outlined under section 2.6) can provoke some identity conflict characterised by changes in mental health status such as confusion, anxiety or, feelings of alienation. Such an adverse consequence is often referred to as acculturative stress, defined by Berry et al. (1987) as “a reduction in the health status (including, psychological, somatic and social aspects) of individuals who are undergoing acculturation phenomena and for which there is evidence that these health phenomena are related systematically to acculturation phenomena” (p.2). Several sources (Berry, 2006; Jackson, 2006; Ministry of Health, 2001) report that stress occurs when various psychosocial stressors create implicit or explicit demands on people to adjust and the intensity of their stress' response varies according to personal characteristics. For example, the elderly and women (especially those

without husbands or partners), those with a "poor" educational level<sup>21</sup> and those relocated from a rural to an urban environment are more prone to develop acculturative stress. Low self-esteem, rigidity, lack of prior inter-cultural experiences, unemployment, changing roles and loss of social position are additional predictors. Moreover, Cox stated that "the more radical and different the host culture is in comparison to the newcomers' native cultures, the more acculturative stress will be experienced" (as cited in Nwadoria & MacAdoo, 1996, p.1).

As described previously, refugees when moving to new countries have to deal with many unfamiliar situations which can provoke acculturative stress. For example, Mitchell et al. (2006) when investigating the resettlement of adult Dinka from Southern Sudan to Perth, Australia found that the adjustment in culture, language and lifestyle created stress and disorientation in performing their practical tasks. Settling into homes, finding work and enrolling children in schools was difficult. Children's acquisition of new attitudes that challenged parental authority also caused tension and dysfunction. In the United States, Nwadoria and MacAdoo (1996) conducted a study amongst 200 Vietnamese young refugees and their families to assess their psycho-cultural well-being by investigating the extent to which they experience acculturative stress as they attempt to adjust to a new culture. Specific attention was given to the effect of employment, effective spoken English, length of residence, gender and nationality on the level of acculturative stress. The findings of this study indicated that two major variables impacted upon levels of acculturative stress: employment and the aptitude to communicate in spoken English. Most of the participants (81%) who were employed indicated lower feelings of stress in contrast to those who were not employed. In that respect, the impact of employment on self-esteem and mental health appeared to be more pertinent to refugees whose identity and self-esteem were already threatened. Additionally, the more individuals could communicate in English, the fewer the feelings of stress they experienced.

Zangeneh et al. (2004) conducted a survey covering both areas of acculturation and mental health to adjustment amongst 100 newly arrived Iranian youth refugees in Canada. The survey aimed to identify the nature of acculturation and to understand how youth refugees coped with their immigration and acculturation transition. While many adolescents adjusted successfully, some had difficulty in coping and meeting challenges such as learning a new language,

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<sup>21</sup> Those with greater education seem to have more intellectual, economic and perhaps social resources to view acculturation as "challenges" and to be able to deal with changes.

finding new friends and continuing to perform well academically. In such cases, adjustment tasks were particularly challenging because teenagers were not only re-defining themselves as individuals, but had also to learn what it means to be a member of a non-dominant group. They had to negotiate the demands of this transition phase by finding a balance between their native and the Canadian culture and such experience could lead to an increased amount of pressures. Findings indicated that those who had difficulty in adjusting to the Canadian culture tended to be more likely to resort to risky behaviour in the form of drug use, such as barbiturates, tranquilizers and/or methamphetamines, to cope with stress.

### **3.2 Unexplained psychosomatic complaints**

Frequently reported mental health disorders of refugees include "somatisation", "medically unexplained symptoms" and "functional disorders" to describe physical symptoms (pain, fatigue, dizziness and dyspnoea being the most common) which cause excessive worry but for which no proper patho-physiological diagnosis can be found. It is assumed that distress in refugees, especially amongst those coming from a non-Western setting, is expressed with somatic complaints because manifesting emotion is not part of their cultural make-up.

For example, Young et al. (1987) reported that Asian refugees resettled in North America were reticent about indicating psychological symptoms and instead described bodily discomfort such as skin problems. Similarly, Nguyen and Bowles (1999) emphasised that in Vietnamese culture, a distinct way of dealing with problems is to express preoccupations indirectly under "the guise of physical symptoms such as headache, fatigue, insomnia". Indeed, somatisation is a culturally acceptable way of presenting emotional concerns when seeking help in times of pre-migration experiences and uncertainties. Similarly, Hakim-Larson et al. (2007) indicated that Middle Eastern former refugees (Iraqi, Lebanese, Palestinian) resettled in the U.S.A. perceived their emotional troubles as physical problems and sought help initially from their family and primary health care providers rather than mental health professionals. This finding coincided with World Health Organisation studies (as cited in Hakim-Larson et al., 2007) in collectivist Eastern societies which reported that depression was often described somatically in contrast to reports of low moods in most Western cultures. Indeed, whereas such "culturally" coded expressions of distress when facing a specific problem are understood within the ethno-cultural group, this is often not the case by outsiders (Jackson, 2006).

In recent research on medically unexplained physical symptoms, Feldmann et al. (2007) have contrasted the views of Afghan and Somali refugees resettled in the Netherlands with those of general practitioners (GPs). Whereas all acknowledged that past and present worries and bad experiences had a negative influence on health, the interpretation of physical complaints without an apparent medical explanation emerged as an important source of divergence between both refugees and GPs. On the one hand, refugees disagreed with the tendency of the GPs to associate too readily their physical complaints with psychological problems linked with their war backgrounds. On the other hand, GPs acknowledged meeting difficulties in managing unexplained complaints such as stomach ache or backache because of the patients' focus on physical discomfort while ignoring or suppressing the reporting of feelings which could reflect psychological problems. Whereas Afghans acknowledged that "nerves can play a role" and create psychological problems, Somalis did not understand such a concept because it is not part of their culture. However, both refugee groups described their concern and inability to re-establish their autonomy in their host country by using bodily symptoms and reporting being "ill" instead of using psychological terms. Such a lack of awareness of metaphors<sup>22</sup> and common wording to describe personal discomfort resulted often in patients' mistrust in the health-care setting because they perceived that they were not taken seriously. On the other hand, GPs who were unable to combine interest in the patients and also seek their agreement on possible explanations of their organic problems had mixed feelings of inadequacy and powerlessness.

During recent decades, somatic complaints have received greater attention from psychologists, sociologists and medical anthropologists because their scope encompasses more than a biomedical approach. It is widely recognised that somatisation is common in all ethno-cultural groups and societies despite differences in symptomatic presentations and meanings (Kirmayer & Young, 1998). For example, Grønseth (2001) reported that many Tamil refugees resettled in a fishing village along the arctic coast of Norway, tended to visit the local health centre because of diffuse aches and pains that practitioners found difficult to diagnose and treat. It appeared that most of the Tamils' physiological and psychological dysfunction resulted from their search for a community bond with which to deal with social challenges and daily struggle so as to adjust to their new environment. As biomedical

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<sup>22</sup> For example Sudanese people can describe heart pain for which no physical cause can be found but which can reflect psychological distress. Iranians can use the metaphors of general body pain, upper gastrointestinal pain and vitamin deficiency for depression and anxiety (Jackson, 2006).

approaches seemed insufficient in explaining these symptoms, and keeping in mind that in Ayurvedic<sup>23</sup> medicine the body and the mind are not separated, the author suggested a more complex understanding of somatisation. Instead of limiting unexplained pains to individuals' expression of emotional distress in the form of bodily symptoms, health should be viewed as embedded in social relations and cultural values which admit "that the body has a direct action and active perception of its surrounding" (p.509). The body, therefore, should not be seen as an object for the application of conventional Western medicine but rather "as a subject of sensation and experiences with the world" (p.509) which can provide ways to understand patients' complaints.

Such findings show some of the challenges faced by health professionals trained in Western thinking which differentiates clearly between the mind and the body. This is in contrast with many other cultures which do not subscribe to this duality and view both as a single entity with distress being interpreted as a physical ailment. On the other hand, although the notion that somatisation is more common, or is a characteristic of patients coming from a non-Western setting, particularly Asian or African (Kirmayer & Young, 1998), yet few data are available to describe the burden of somatic complaints and preoccupations amongst refugees.

This can be explained in part at least, both by the lack of cultural sensitivity of the health-care setting and the lack of "psychological culture" of many of refugees<sup>24</sup>, resulting in an under-utilisation of mental health services. Many are more likely to seek support from general practitioners when perceiving and interpreting their emotional concerns as "pains in their body". In New Zealand, Briggs and Macleod (2006) found that unexplained psychosomatic complaints have prompted the referral of many refugees to mental health services because of the difficulties of primary health-care organisations in dealing with this category of patient. Interestingly, comparable clinical presentations have been reported by Junod-Perron and Hudelson (2006) when investigating somatic complaints amongst refugees coming from former Yugoslavia and who were resettled in Switzerland. Most of the patients attributed the commencement of their health problems to past traumatic experiences. The persistence of their poor health was linked to current poor living conditions and uncertain legal residency

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23 Ayurvedic medicine is traditional medicine from the Indian subcontinent and deals with healthy living and therapeutic measures that relate to physical, mental, social, and spiritual harmony. Equal emphasis is placed on the body, mind and spirit to restore the innate harmony of the individual.

24 Many refugees come from countries where mental health care is still in its "infancy" and often unavailable because it is not viewed as a priority for multiple resources (human, financial, logistical) in a limited health environment.

status. They formulated their suffering in medical, social and legal terms, and sought help from physicians for those types of problems.

Conversely, Kirmayer et al. (2004) reported that Vietnamese males resettled in Canada could provide culturally based explanations for their own unexplained physical symptoms while their physicians could not. Although their justifications did not comply with biomedical theory, they were sufficient for some of them to give meaning to their distress (usually linked with psycho-social and stress-related difficulties) and seek help. This challenged the widespread assumption that unexplained symptoms are especially prevalent in cultures in which it is assumed that expression of emotional distress is inhibited. In that respect, Tribe and Summerfield (2002) highlight that refugees' distress in the absence of diagnosable organic disease too often is labelled under the category "psychosomatic", thus underestimating somatic symptoms and meanings that serve different psychological and social functions as reported by Kirmayer and Young (1998).

In summary, despite the widely accepted impact of past and present stress on body functioning in most cultures, the failure to find a satisfactory explanation of such clinical expression between people seeking help and care givers is frequent. A recent review of the epidemiology of somatisation disorder and hypochondriasis conducted by Creed and Barsky (2004) has underlined that the DSM-IV and ICD-10<sup>25</sup> definitions of such disorders have derived from clinical experiences in secondary and tertiary care and have criteria which appear to target a limited group of people with severe disorders. Such diagnoses might, therefore, not be applicable in a primary health-care setting. Additionally, the comparability of various studies suggests that somatisation and hypochondriasis cannot be regarded simply as psychiatric disorders. Although ethnographic research has helped to determine ways in which somatic presentations fit cultural codes, or idioms, of emotional suffering amongst different cultural groups, yet their clinical significance remains unclear. As described previously, the Western health model and psychological theories of somatisation focus on individual characteristics rather than on the fundamental social meanings of bodily distress. It appears that a better awareness of how refugee patients make sense of their suffering could support health professionals in improving their understanding of patients' expectations in order to meet their physical and emotional needs.

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<sup>25</sup> European guide for diagnosis of mental disorders.

### 3.3 Depression and anxiety

The literature reports repeatedly that former refugees are more likely to experience depression because of their past losses and uncertainty about the future in a foreign environment. For example, Westemeyer et al. (1984) have investigated the impact of acculturation on Hmong<sup>26</sup> refugees living in Minnesota, U.S.A. People rated themselves as experiencing very high levels of depression, anxiety and phobia at eighteen months after arrival. Men and the elderly expressed more depression whilst women expressed more fear. Both were associated with the loss of vocational and social roles plus the lack of English fluency. The same self-rating was repeated 3.5 years after arrival, when participants reported considerable improvement correlated with more time in the US, employment, English language training and acquisition of material possessions. Those who reported feeling depressed associated it with their poor English fluency and dependence on the welfare system. Interestingly, most socio-demographic characteristics such as gender, age, marital status and employment were no longer associated with self-reported psychopathology

In New Zealand, Pernice and Brook (1996) when investigating the mental health of Southeast Asian refugees, Pacific people and British immigrants also found that age, gender, marital status and educational level had little influence on emotional distress. On the other hand, discrimination through underemployment and perceived exploitation by employers were associated with high symptoms of anxiety and depression. Forty-three percent of the refugees<sup>27</sup> who experienced significant emotional disorders were unemployed. Not having close friends and spending leisure time only within their own ethnic group also contributed to depression and/or anxiety, or both. Similarly, Beiser and Hou (2001) conducted a 10 years longitudinal study on the risks-inducing effects of unemployment and the protective effects of language facility on the mental health of 1,348 Southeast Asian refugees resettled in Canada. They found that the prevalence of major depressive disorders declined from 6.5% on arrival to 2.3% ten years later. Language proficiency appeared to be a substantial predictor while unemployment was related significantly to depressive signs at the two time points. Noh et al. (1999) when investigating the relationship between perceived discrimination and depression amongst 647 South Asian refugees resettled in Canada found that those who had experienced racial discrimination presented increased levels of depression compared to those who had not.

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<sup>26</sup> Natives of Laos.

<sup>27</sup> n= 129.

On the other hand, Fazel et al. (2005) examined 25 eligible psychiatric surveys searching for serious mental disorder in nearly 7,000 refugees from four main regions (Southeast Asia, former Yugoslavia, Middle East and Central America) resettled in seven Western states<sup>28</sup>. Prevalence estimates for major depression amongst adults ranged from 3% to 80%. After considering and reviewing studies including 200 or more refugees, meta-analysis' findings suggest that one in twenty (5%) suffered major depression and one in twenty five (4%) from anxiety with a possibility that these disorders overlap in many people. In addition to those discrepancies, the exact burden of depression and/or anxiety remained unclear because many surveys did not record either functional impairment and/or treatment needs associated with those illnesses.

### **3.4 Post-Traumatic Stress Disorder (PTSD)**

Post-Traumatic Stress Disorder (PTSD) as defined in the DSM-IV diagnostic criteria is a psychiatric disorder describing "a range of psychological symptoms such as intrusive memories of the trauma (vivid flashbacks, nightmares), avoidance of circumstances associated with the trauma (keeping busy, feeling detached), no plan for the future, sleep disturbances, irritability, anger, lack of concentration and excessive vigilance". Its construct was originally developed on the basis of research and clinical experience of American Vietnam war veterans. Summerfield (2001) asserts that this diagnostic category is a legacy of this war and was established for the purpose of answering the socio-political and psychiatric needs of the American combatants.

A substantial body of research on PTSD has been accumulated over the past twenty-five years covering not only war-affected populations and victims of political violence such as torture but also survivors of terrifying events. Schmidt (2007) in reviewing some of the research on PTSD prevalence and refugees gathered the following figures from various studies<sup>29</sup>. Of 534 Bosnian and 993 Cambodian refugees resettled in the USA, 26% and 37% respectively suffered from PTSD (Mollica, 1998 and 1999). Nearly 50% of 842 refugees from Kosovo living in the U.K. were similarly diagnosed (Turner et al., 2003). A Norwegian clinical study of 231 out-patient refugees reported a figure of 46.6% (Lavik et al., 1996).

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<sup>28</sup> Australia, Canada, Italy, New Zealand, Norway, United Kingdom and the U.S.A.

<sup>29</sup> The bracketed names and dates are quoted by Schmidt, 2007.

Nevertheless, findings are mainly based on refugees attending clinics and explanations on such high rates of psychiatric disorders remain unclear. Additionally, information on the refugees' undergoing additional stress while resettling is insufficiently described. This raises the question of when or whether to address psychological issues in the presence of immediate fundamental needs. Furthermore, while it is believed often that rates of psychopathology amongst resettled refugees are higher than the general population, knowledge of their mental health prior to their trauma and migration to a third country is not available, thus limiting the relevance of such an assumption.

On the other hand, Silove et al. (2002) have assessed the long-term effects of trauma exposure on mental health and disability in Vietnamese refugees resettled in Australia. They found that only a small subgroup of individuals who had been exposed to high levels of trauma were at increased risk of mental illness and associated psychosocial disability after 10 years or more and who remained in need of specialized services. Furthermore, Fazel et al. (2005) in their meta-analysis review of psychiatric surveys (as cited in the previous section on depression and anxiety) on refugee adults and children reported also lower rates of PTSD. Whereas initially the prevalence of PTSD ranged from 3% to 86% for adults and 7% to 17% for children, revised data from studies consisting of a minimum of 200 participants dropped to PTSD levels of 10% and 11% respectively.

Although such findings demonstrate a great variation in PTSD prevalence, patients at the minimal end of the PTSD scale should not be ignored. However, uncertainty persists about the impact of past trauma on long-term mental well-being. A recurrent and central assumption in the literature tends to be that refugees are at high risk of Post-Traumatic Stress Disorder because of traumatic events such as family dislocation, physical and/or psychological ill-treatments, starvation, torture and insecurity. Nevertheless, some consider that PTSD has been overemphasised or taken for granted when working with refugees at the expense of other causes such as daily stress, family conflict, loss of social status (Guerin & Guerin, 2007; Hollifield et al., 2002). The World Health Organisation (2008) observes that PTSD is only one of a range of frequently co-morbid common mental disorders which tend to accompany other mild and moderate mental disorders. Indeed, such a focus creates "narrow" services that do not serve people with other mental problems and the low-level of help-seeking behaviour for PTSD symptoms in many non-Western cultures suggests that it is not the priority for many trauma survivors. This concurs with Miller et al. (2006) who question PTSD

applicability to non-Western survivors because cultural norms and individuals' understanding and sense of their experiences are insufficiently considered.

In New Zealand, Guerin et al. (2004) explained that Somali refugees associate key elements of PTSD such as headaches, rumination and insomnia with separation from their family and immigration bureaucracy regarding the bringing of their loved-ones to New Zealand rather than with their past experience. This was confirmed by Chapaman (2002) from the Wellington Refugees as Survivors Centre who reported that social workers were supposed to provide services based on the assumption that the refugee clientele needed trauma treatment. It appeared, however, that former refugees did not present with the need to resolve their past traumatic experiences and did not desire to revisit such issues. They asked the staff instead to assist them with resettlement matters which they perceived to be the causes of their current worries and problems.

#### **4. Applicability of western psychiatric concepts to non-Westerners**

The use of the DSM-IV or ICD-10 classifications and related psychiatric concepts as a diagnosis tool amongst people from diverse cultures, as well as in establishing the mental effects of war and displacement on refugees, have led over the past decades to ongoing debates (Briggs & Macleod, 2006; Creed & Barsky, 2004; Fazel et al., 2005; Kirmayer et al., 2004). This is especially valid in regard to PTSD, which remains the focus of most research and interventions amongst population groups affected by war or other traumatic events. For example, Summerfield (2000) wrote that " Although post-traumatic stress disorder is reported to be prevalent worldwide in populations affected by war, the assumption that a Western diagnosis entity captures the essence of human response to such events anywhere regardless of personal, social and cultural variables, is problematic" (p.233).

It is beyond the scope of this study to consider all the components of such a controversy. However, an important element is that many of those concepts follow the western biomedical and psychological models by establishing a diagnosis and therapeutic process based on predominant medical constructs regardless of the cultural perspective of individuals.

In that respect, Bracken et al. (1995) have underlined some of the common assumptions and limitations made by western psychiatry when approaching people in a non-western setting.

Firstly, the focus on the individual, as the main centre of attention, is not endorsed in many cultures because the notion of "self" and its relationship with others and with the outside world is different. In this way, various challenges are raised when studies on traumatic experiences have to be conducted amongst populations where the individual is conceived as a component of an extended family or group.

Furthermore, the representations of mental disorders found in the West often are considered to be similar to those found elsewhere. However, even though similar symptoms described in western psychiatric classification may exist in various cultures, they do not always have the same value and meaning. Similarly, western therapeutic methods often are considered appropriate for population groups worldwide suffering mental disorders, however, the exploration of inner thoughts focusing on a professional/patient healing relationship tends to disregard social, familial and political dimensions. The ignorance of such parameters might introduce inappropriate treatment models or strategies in attempting to support the rehabilitation of victims of various forms of violence and subsequent trauma (Bracken et al., 1995; Summerfield, 2000; Watters.2001).

The limitations around the universal applicability of western psychiatric concepts within non-western, traditional societies have been raised during the past decades by psychiatrists and anthropologists interested in "cross cultural psychiatry" which looks at whether psychiatric classifications of disorders are applicable to different cultures. In that respect, Kleinman (as cited in Kirmarcher, 2003) pointed out that culture in western psychiatry was incorporated in a very superficial way and that 90% of DSM-IV categories are culture-bound to Western Europe and North America. On the other hand, Schweizer et al. (2002) when reviewing some studies relating to the psychological treatment of refugees and asylum seekers living in Australia, found that one of the most significant barriers met by both groups was related to the cultural distinction between service provision and their own requirements and healing beliefs. This included the lack of cultural awareness by health professionals when assessing and interpreting symptomatology thereby limiting the design of appropriate interventions. The unfamiliarity and stigmatisation felt by refugees with mental health services were additional cultural factors resulting in poor services' utilisation because of their inadequacy in addressing key specific issues such as resettlement priorities and cultural bereavements.

Such cultural perspectives have helped professionals become aware of the hidden assumptions and limitations of western psychiatric theory and practice so as to identify approaches appropriate for supporting an increasingly diverse population seen in psychiatric services (Kirmayer, 2006). Nicholl and Thompson (2004) when reviewing some of the literature pertaining to psychotherapeutic treatment of adult refugees and asylum seekers<sup>30</sup> found that psychotherapy which includes cultural and personal beliefs is an option to reduce personal distress. "Testimony therapy" which consists of involving refugees in the telling of their trauma story in detail in their own language and making it known to others, is another form of "positive" therapy.

Furthermore, Bracken et al. (1995) reported that support given to victims of rape during the 1980's conflict in Uganda, has proved to be more effective through group meetings, which focused on development projects such as farming, rather than on women's experience of rape or post-traumatic symptoms. Similarly, Van Ommeren et al. (2005) recommend that health professionals encourage victims of trauma to engage actively in normal activities and participate within their community.

There is an increasing recognition that traditional beliefs and healers are often more important than the professional sector in the recovery process of victims of war and other violence. For example, Summerfield (2000) mentioned that in Cambodia and Zimbabwe, traditional healers have helped survivors to lay the war and its dead to rest. The importance for victims of war trauma to be able to conduct proper mourning is also highlighted by Igreja et al. (date unknown) who stress that the well-being of victims in Mozambique related strongly to the degree to which they could establish ceremonies and rituals surrounding grief. Carroll (2004) has studied how mental illness is understood, expressed, and treated among Somali refugees (17 adults) resettled in the U.S. and how these factors influence use of health services for mental problems. She found that most of the participants perceived that mental illness was a new problem they had to face and which did not exist to the same extent in Somalia prior to the war. Recurrent themes which Somalis used to explain the causes of their distress included the shock and devastation of war, dead, missing, or separated family members, and spirit possession or a curse. They explained that this led to three major types of mental problems: *murug* (sadness or suffering), *gini* (craziness due to spirit possession), and *waali* (craziness

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<sup>30</sup> It has to be underlined that research in the area of psychotherapeutic treatment of adult refugees and asylum seekers is very limited and in its infancy (Nicholl & Thompson; 2004).

due to severe trauma). Such findings contrasted with "Western teaching and emphasis on biological and physiologic origins for many common forms of mental illness" (p.9). Each type of problem was associated with specific behaviours and treatment strategies enlisting the services of a spiritual leader, religious/cultural doctor, group ceremony or reading the Holy Koran, talking to a trusted family member or friend, taking medications for physical symptoms. Findings showed that participants differed in their opinions about whether they would consult a doctor to discuss feelings of sadness or "craziness" suggesting that mental health care of refugees should address culture-specific belief systems in diagnosis and treatment.

However, despite discussions about the concepts, values and limitations of western mental health interventions, this does not mean that non-westerners do not have psychological insights or do not present symptoms associated with mental suffering ( Nicholl & Thompson, 2004; Summerfield, 2000). For example, Fedaku and Cleare (2008) mention that qualitative work from East and West Africa and South America has identified local terminologies of psychiatric disorders which are consistent with what would be considered for example as schizophrenia, anxiety or depression. However, what is in question, especially for population groups affected by war, is whether the suffering of war should be approached as a mental health problem and if so, how should it be done without tending to medicalise people's distress? Many sources cited in this section emphasised the need when supporting victims of war to address cultural and broader contextual issues as opposed to having a narrow clinical focus. Nevertheless, De Jong (date unknown) when working in war zones<sup>31</sup> stresses that sensitivity to culture must not be too rigid because it may result in doing nothing at all in response to significant needs when working with traumatised people. In that respect, the author underlined that any intervention in a population group by another implies the "meeting" of two different cultural worlds and subsequently a variety of understanding, views or values. Similarly, Bhui and Bhugra (2002) underline the importance for clinicians to obtain a better understanding of patients' experience and their explanatory model of distress. This should lead to a mutual influence enabling a pragmatic appreciation of the problems and ways to address them in concrete interventions while not neglecting or contravening beliefs which help people to cope with misfortunes of various kinds. Moreover, health professionals (Van Ommeren et al., 2005; Silove, 2005) emphasise that despite the ongoing debate, there is a considerable consensus acknowledging that a proper support to victims of trauma from

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31 Unpublished work for Doctors without Borders (Médecins Sans Frontières-MSF), humanitarian NGO.

various culture groups should not be limited to the mental aspects but should address also the social aspects of health.

## 5. Summary

The foregoing literature review has highlighted important research issues and concerns relative to refugees' mental well-being whilst resettling. These included information on refugees' mental health in New Zealand, some of the major sources of stress they encounter when approaching their host society and description of their main mental health problems reported worldwide. Although refugees are said to be at higher risk of mental disorders, the nature of the burden has yet to be investigated fully, with many conceptual and practical challenges. For example, refugees' mental health status prior to their trauma usually is unknown, thus making it difficult to establish the extent to which people are distressed because of their traumatic experiences. Furthermore, the inappropriate or overuse of psychological and psychiatric concepts in understanding the impact of war and displacement is problematic because it tends to medicalise peoples' distress.

The World Health Organisation (2007) emphasises that the assumption that the entire refugee populations are prone to mental disorders and are in need of psychiatric care has to be avoided. Available findings on former refugees' mental health disorders are not applicable to all since experiences vary from one person to another and do not necessarily induce severe and/or recurrent distress. They should, therefore, be interpreted with caution because they may contribute either to neglect or emphasise estimates which can convey false or incomplete impressions.

Further, critical issues such as peoples' perceptions and cultural meanings attributed to events including traumas are insufficiently considered. There is a need, therefore, for organisations and professionals involved with refugees to learn and understand more about the way they explain, express and cope with their suffering. In that respect, Halle (2004) while working with immigrants and refugees in Switzerland wrote: "Migrants are not *expert* in their suffering, health professionals are. However, migrants are *expert* on what their culture says about their suffering. Therefore, they must be used as an active guide and partner so as to

develop a new understanding of the problem"<sup>32</sup> (p.6). Moreover, if "traditional" support such as elders and religious leaders is available locally, it is important to collaborate with such networks. This can promote healing and adaptation when Western psychological concepts appear to be inappropriate because of their predominant biomedical orientation and tendency to medicalise mental suffering. Finally, in countries accepting former refugees for resettlement, greater attention should be given to people's resettlement difficulties which often are equal to, or greater than, the concern with mental health problems attributed to them (Miller et al., 2006).

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32 In French: " Le migrant n'est pas l'expert sur sa souffrance, c'est le soignant qui l'est. Par contre, il est un expert sur ce que dit sa culture de sa souffrance. Il faut donc l'utiliser comme guide et partenaire actif et structurer ensemble, en interaction avec lui, une nouvelle compréhension" .

## **B. Refugees' coping in the context of resettlement**

Whereas the literature reviewed so far relates to the acquiring of a greater familiarity with the research topic, it has also helped to generate further questions and the identification of gaps related to the adult refugees' coping phenomena under study. Building on this, research investigating refugees' coping processes to deal with unfamiliar situations was also reviewed to obtain some understanding about such phenomena.

### **1. Refugees' coping abilities and mechanisms**

#### **1.1 What is coping?**

Coping has to do with approaches, skills and abilities that allow people to face and manage life's difficulties. It is a process and not an outcome which helps to master a problem but does not necessarily mean the problem is mastered. The most widely adopted definition is that of Lazarus and Folkman (1984, as cited in Harrop et al., 2006, p.5) who identify coping as "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." The authors emphasise that coping is a dynamic process involving continuous interaction and adjustments between the environment and the person's attempts to cope. It fluctuates over time and life experiences (it is not a stable trait), thus obliging a person to appraise regularly both the demanding situation and available resources to deal with it effectively. Situations therefore are not inherently stressful since they might be appraised and approached differently between one person and another.

Faced with a challenge, individuals use their *coping resources* (internal and external) which refer to the personal and environmental factors that help lessen the negative points of stress in overcoming difficulties. *Internal resources* refer to personality characteristics such as optimism, self-esteem, locus of control, confidence, self-efficacy, knowledge and intelligence. They interact positively to master or minimise the adverse impact of events. Religion, spiritual beliefs and values also help people to find meaning in the face of adversity. By contrast, negative traits such as pessimism, low self esteem, poor confidence and emotional distress will have the opposite effect. *External resources* include environmental support emanating from family, social networks (friends, work colleagues), social and financial

support. A situation, which might have appeared uncontrollable initially, might become easier if the mobilisation of some of these resources results in positive outcomes.

Mobilization of internal and/or external resources leads to *coping strategies* which refer to specific efforts and behaviour which people develop to master, tolerate, reduce, or minimize stressful events. The two most commonly described are those used in the “transactional approach”, classified by Folkman and Lazarus (1980, as cited in Straub, 2003) into emotion-focused or problem-focused coping. In *emotion-focused coping*, people try to moderate and regulate distressful emotions by strategies such as seeking support from others, avoiding, minimising or reappraising the problems. They tend to rely on this style of coping when they believe little or nothing can be done to alter the stressful event, or they consider their coping resources to be insufficient to deal with it (Lazarus, 1993). In contrast, *problem-focused coping* refers to efforts to confront and eventually solve the problems directly by being proactive or reactive. People tend to rely on this style of coping when the stressor is appraised by the individual as being amenable to change. The nature (i.e. severity, importance) of the adversity usually determines the choice of strategy to moderate or buffer the stress effects. There is substantial evidence, however, that individuals use both problem-focused and emotion-focused coping (Caplan & Schooler, 2007, Harrop et al., 2006; Lazarus, 1993, Straub, 2003). Nevertheless, any situation in which constructive action is possible seems to enhance problem-focused coping whereas situations that have to be accepted are more likely to trigger emotion-focused coping.

There is no widely accepted and over-arching theory of how refugees cope with the challenges of resettlement. There is, however, a growing body of knowledge on coping strategies in general, which points to key factors in coping processes, including some work on coping by refugees. The following sections will review some of the most reported factors contributing to the development and/or the triggering of refugees’ coping processes to overcome resettlement difficulties and adjust to life in their new country.

## **1.2 Religion, spirituality and beliefs**

During recent decades a consistent body of research and literature has examined the impact of religion and spirituality beliefs and behaviour on health outcomes (Peach, 2003). This growing interest has different aspects varying from the importance of religion and spiritual beliefs in peoples’ lives to the limitations of modern sciences, including psychology and

medicine, to meet emotional and spiritual needs which people might experience in times of life-threatening and uncontrollable events (i.e. diseases, persecution).

The negative effects of religion and spiritual beliefs remain contested. They often refer to maladaptive processes such as attributing illness to sin, justifying physical or psychological abuse in the name of a spiritual discipline or, refusing potential life-saving treatment (Koenig et al., 2001). On the other hand, many people closely associate religion or spirituality's positive effects with personal well-being, an association supported by recent reviews (Koenig, 2007; Koss-Chioino & Hefner, 2006; Williams & Sternthal, 2007). In that respect, it is acknowledged that spirituality supports the personal quest for meaning, purpose, transcendence, connection with others and values, while religion organises the collective experience of a group of people into a system of beliefs and practices. Nevertheless, how they impact health remains unclear and both the positive and negative aspects fuel debate when considering both spiritual and religious resources as legitimate tools in the health care setting.

Clinicians working with war victims have emphasised that after a severe trauma the central point in the recovery process is to integrate this traumatic experience into a meaningful context in the life story of the affected person (Vanista-Kosuta & Kosuta, 1998). It appears that religion and spirituality can have that role as they have been found to be important coping resources in dealing with day-to-day living and protective factors against severe traumas and stressful situations (Brune et al., 2002; Tarakeshwar et al., 2003). In that respect, Pargament et al. (2000) have identified five functions which define religious coping methods and include: (i) *meaning* by offering frameworks for understanding and interpretation of life's misfortunes, (ii) *control* by helping to regain a sense of mastery over events, (iii) *comfort* by reducing personal apprehensions when facing uncertainty and adversity, (iv) *intimacy* by fostering social cohesiveness, solidarity and identity and, (v) *life transformation* by assisting people in finding new sources of significance whilst experiencing major life changes.

Recent studies and observations on refugees and their coping behaviour have perceived the importance of belief systems to overcome terrifying events and the challenges of exile. Brune et al. (2002) when investigating the outcomes of psychotherapy for 141 traumatised refugees resettled in Sweden and Germany, established that those with the strongest convictions, either religious or political, dealt better with their traumas and resettlement life. Dorais (2007) found that religion played an important part during the Vietnamese boat people's flight and

following their resettlement in Canada. It was an important source of hope throughout their migration process. It gave meaning to their dangerous sea journey and served as a remedy against the lack of activities during their long and uncertain stay in refugee detention centres. Soon after resettlement, religion helped the Vietnamese to preserve and reinforce their identity. It offered them a structured set of mental representations and practices so as to deal with major adjustments by preserving their original values and finding continuity in their lives. People were very active in organising their religious “being”, either by frequenting existing churches or for those who were non-Christians (i.e. Buddhism, Cao Dai<sup>33</sup>) by establishing places where they could meet for worship. Being involved in religious activities enabled them to meet others, to adjust gradually to their new environment and to demonstrate their capacities of organisation according to their needs. Similarly, Shoeb et al. (2007) found that faith and religion played a central role for the reconstruction of identity of Iraqis resettled in the U.S.A. regardless of their gender or religious affiliation (Muslim or Christian). Religious coping strategy was motivated by a search for meaning, intimacy and “self” and was often problem-focused because God was seen as “an emphatic Other”. Such findings suggest the positive associations between a full range of beliefs and coping methods, mostly religious, used by refugees to deal with psychological distress. Faith and related practices appear to answer individual spiritual needs such as hope, meaning, acceptance and transcendence and go beyond traditional measures of religious commitments such as church attendance because they raise fundamental philosophical and theological questions (Hornblow, 2007).

Moreover, most of the refugee studies cited above insisted that refugees’ migratory experiences must be understood as a *liminal* state corresponding to a transitional period where normal limits to thought, self-understanding and behaviour are relaxed. During that stage, individuals lack social status or rank, might be undetermined and to some extent have lost their sense of identity. This period often makes people turn to faith, either religious or another belief, as a source of emotional support to face difficulties, a form of social mobilisation and group identity to cope with the uncertainty. Mayer (2007) stated that for people who have been forced to leave their country, thereby losing their original citizenship, the retaining of their cultural identity through religious affiliation, despite a change of passport, provided a

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<sup>33</sup> Cao Dai is a synthesis of religions, trying to take universal truths and insights common to Christianity, Buddhism, Taoism, Confucianism, and Genism (all present in Vietnam), as well as Theosophy and Spiritualism. It later included Islam, Zoroastrianism and Hinduism in its research.

point of stability. In that sense, religious beliefs and practices and spirituality provide an alternative to a feeling of homelessness, being uprooted and being in exile by addressing individuals' dilemma of being caught between two worlds.

### 1.3 Resilience

The concept of resilience which originated from Physics is used to describe the quality of a material to be able to return to its original shape after being bent, compressed or stretched. Today, resilience spans several additional fields from ecology, engineering, economics to psychology. In the latter area, several longitudinal studies (Garmezy, 1993, as cited in Gakuba, 2001; Lindstrom, 2000 and Quinton & Rutter, 1988, as cited in Harrop et al., 2006) have been conducted in the field of child psychology to understand why and how some disadvantaged children and teenagers did not develop behavioural problems but managed to cope despite being exposed to chronic or severe stress (i.e. domestic violence, social isolation, poverty or discrimination). Findings revealed that many achieved a better level of functioning than expected and that some turned out to be competent and successfully adapted over time because of personal capacities and external support. Over the past twenty years, resilience has received increasing attention in developmental psychiatry (for example by Rutter in the U.K, Garmezy in the U.S.A. or Cyrulnik in France) because of multiple observations of people overcoming adversity in their daily lives that suggest resilience to be a "real phenomenon". This represented a switch from a deficit to a strengths based model approach by placing emphasis on individuals' coping skills and resources to withstand hardship rather than cataloguing risk factors and documenting negative outcomes.

Resilience, however, remains a complex concept which has resulted in multiple meanings and ambiguous terminology (Zimmerman & Arunkumar, 1994). There is no universally accepted definition of resilience although it is generally regarded as a person's ability to "bounce back" or adapt successfully after negative life experiences, lifespan transitions or difficult circumstances. Considerable variability in conceptualising resilience is reported depending on the specific research approach or the context of the study. It can be described as: (i) an individual *trait* such as, personal positive behaviour despite adversity, (ii) a dynamic *process* of adaptation in the presence of significant challenges or, (iii) an *outcome* facilitated by personal and environmental factors. In that respect, Zimmerman and Arunkumar (1994) pointed out that resilience "cannot be seen as a fixed attribute of the individual, because the circumstances in which it may occur are dynamic" (p.4). Should the situation change, so

might individuals be more or less resilient at different stages in their lives subject to a range of factors; they are not born with resilience, nor do they develop it as a stable personal characteristic. On the other hand, Masten, Best and Garmezy (1991, as cited in the Ministry of Education, 2006) conceptualized resilience as: “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (p.29). However, a recent integrative review on resilience conducted by Harrop et al. (2006) reported that some agreement is emerging amongst authors viewing resilience as a dynamic process which underpins mental well-being and quality of life in avoiding mental dysfunction or maladaptive behaviour in times of difficulty.

While a single definition does not adequately cover the complex meaning of resilience, yet there is a general consensus which considers that for resilience to be inferred, risk and protective factors need to be present. *Risk factors* refer to major, acute or chronic traumatic events (death of someone close, physical/psychological abuse or life crisis), life changes (moving, transition), cumulative stress, social disadvantages (unemployment, poverty and discrimination). *Protective factors* are usually divided into individual, family and community factors and refer to personal skills (communication, social) and temperament (positive attitudes and character) and environmental support (family members, school, working place, community at large and friends). All provide the resources with which to deal effectively with stress induced by the risk factors by altering or even reversing their negative outcomes. Protective factors, therefore, are fundamental elements in the conceptualisation of resilience because they increase the likelihood of overcoming difficulties by moderating or buffering the negative effect of risk exposure on an individual’s behaviour. Nevertheless, the dynamics of the interplay between these factors in supporting (or undermining) the process of recovery are not well understood. Moreover, it is worth underlining that those individual characteristics and environmental factors which foster resilience in one context may not lead necessarily to resilience in another. For instance, individuals can find themselves in a situation where they have limited or no access to external support and where their resilience capacities (such as working or social competences, problem solving, self-esteem or faith) might be of limited use.

Although refugees are often noted as exemplars of resilience, there are virtually no studies that have researched resilience in the context of refugee experience. Hollifield (2005, p.1605) stressed this gap by stating “that the resilience of refugees is all too often not honoured or included in research” and emphasises the inadequacy of methods in refugee research which

tend to focus on past trauma and/or resettlement obstacles and related behavioural dysfunction. Amongst the available information is that collected by Wilson (1995, as cited in Agaibi & Wilson, 2005) when reviewing studies on victims of war, torture, holocaust and natural disasters which identified similar manifestations of resilience amongst survivors in relation to trauma and Post Traumatic Stress Disorder. These include: (i) internal locus of control, (ii) acceptance of the trauma experience, (iii) a sense of group identity and "self" as a positive survivor, (iv) the perception of personal and social resources to cope in a recovery environment, (v) altruistic and pro-social behaviour, (vi) the capacity to find meaning in their past trauma and life afterwards and, (vii) connection-bonding and social interaction within the community of origin or friends and fellow survivors. This review summarised personal attitudes and skills and forms of coping that promoted the resilience function as a response to acute or prolonged forms of stress and its long-term positive adaptation. On the other hand, Gakuba (2001) investigated the contributing factors to develop resilience amongst young Rwandan refugees resettled either in Switzerland or France after the 1994 genocide. He found that despite severe past traumas and adaptational barriers in the host country (i.e. financial constraints, administrative issues or poor language skills) the umbrella of school or university was a critical protective factor and was seen by the majority as being essential to embracing the future. Studying not only gave young Rwandans the means to be "upgraded and valued" in their new society but also the perspective to be "useful" to their country of origin should their residency status in France or Switzerland be rejected after a few years.

Similarly, the Ministry of Education in New Zealand (2006) has acknowledged the role of school-based intervention in promoting positive adaptation outcomes for young refugees by facilitating the development of both personal and external resilience factors in their lives. This includes, for example, the availability of a caring adult or mentor, the promotion of self-esteem, understanding of maladaptive behaviour and offering other teaching options, including intervention in the form of therapy. More recently, Cone (2007) reviewed Russian immigrants and refugee resilience attitudes in the U.S.A. Personal characteristics such as flexibility, political and /or religious convictions, taking risks, complying with the resettlement requirements, maintaining their cultural roots through community events and strong hope and determination to succeed were powerful forces underlying the Russians' resilience.

Though little can be done about what has happened in the past in the lives of refugees, there is consistent knowledge about their resettlement difficulties and related needs. In that respect and despite considerable variation in how resilience is conceptualised, yet available information offers insight into understanding the challenges, the tasks and the "risks" faced by refugees during times of critical transition and cumulative stress. Available findings, either in the field of refugees or other groups, by describing or identifying people's abilities and available supports which promote resilience can help potentially to activate refugees' effective coping strategies. Interventions, therefore, which shift the focus from refugee pathology and medicalisation of their resettlement problems to individuals' strengths and reinforce the buffer role of social support, could sustain adult refugees in the accomplishment of a successful adaptation to their new environment (Muecke, 1992).

#### **1.4 Self-efficacy**

Self-efficacy refers to an individual's judgment of his or her skills and capacity (whether accurate or not), to execute actions so as to achieve an adequate performance required in a specific situation such as: "I know that I can solve that problem.", or, "I feel confident that I can answer that question". This construct, based on cognitive and behavioural concepts, was introduced primarily in the discipline of social psychology by Albert Bandura who defines perceived self-efficacy as "people's beliefs about their capacities to produce designated levels of performance that exercise influence over events that affect their lives and their beliefs in their capabilities to mobilise the motivation, cognitive resources and courses of action needed to exercise control over tasks' demands" (1994, as cited in Encyclopaedia of Human Behaviour, vol. 4, p.71). Additionally, this construct is domain-specific: indeed a person may possess self-efficacy in one area but not in another (for example, the ability to talk in public but the inability to jump a fence). It changes over time, meaning that it develops according to the context and through acquired experiences and requires the mobilisation of inner abilities. In that respect, personal attributes such as optimism, self-esteem, and self-determination or goal orientation are strongly related to high self-efficacy.

According to theory, self-efficacy beliefs determine how people feel, think, motivate themselves and behave (Bandura, 1994). To this end, self-efficacy influences individuals' behaviour by predicting their *goal setting* and subsequent task performance. It influences also their level of *motivation and persistence* in pursuit of those goals despite failures, *their sense of control* over the sources of stress and their *choice of behaviour* to face or avoid challenges

according to their perceived inner capacities. Individuals who are convinced of their being able to control personal or environmental challenges are more capable of taking direct actions so as to deal with the sources of stress. They will approach difficult situations as tasks to be mastered instead of risks to be taken and, therefore, will increase and sustain their efforts until achieving their goals. By contrast, those who consider themselves incapable of controlling adverse circumstances tend to focus on doubts and problems impeding their taking the correct course of action. In such cases where personal effort is not achieving rapid success, people are likely to give up and lose faith in their own abilities leading to stress or depression because of unfulfilled aspirations (Bandura, 1994).

Four major sources are reported to have a direct and effective influence in the development of a strong personal sense of efficacy (Bandura, 1994; Kaminski et al., 2007; Maddux, 1995). Firstly, the *mastery experiences* which refer to people's success in overcoming obstacles through perseverant efforts is reported to be the most effective, because, in contrast with failure, success builds a robust belief in personal control over events. Secondly, *vicarious experiences*, by observing people similar to oneself who are able to succeed in their tasks (modelling) encourages the "observers" to reproduce comparable activities because they believe that they possess the same capacities. Thirdly, *social persuasion*, also called verbal persuasion, which aims at convincing and strengthening people's beliefs that they are capable of performing a task and succeeding. The fourth way is through *emotional regulation* by reducing people's emotional proclivities during unusual and stressful situations which can impact negatively on their physical state thereby affecting their self-efficacy. For example, fearing to talk in public can lead to stomach ache, perspiration and heart palpitations and be perceived as a sign of one's own inability to master the situation. Those physical discomforts could be alleviated, for example through relaxation exercises.

Since Bandura's work, self-efficacy theory has been criticised because of the ambiguity existing between "self-efficacy expectancies" and "outcome expectancies" and also the similarity between self-efficacy and other concepts such as self-confidence (reported by Maddux, 1995). Nonetheless, a consistent body of research using the self-efficacy construct has been conducted in various fields such as education, management, business administration or public health so as to understand, assess or treat emotional and behavioural problems. For example, some research has highlighted the relationships between people's perceived self-efficacy and their ability to cope with stress induced by being unemployed (Luszczynska et

al., 2005; Salanova et al., 2006). Those with a high perception of self-efficacy appeared to invest more effort and to develop active coping by having a “winner spirit”. By contrast, those with lower self-efficacy tended to be more passive and to use emotion-focused strategies.

In the field of health, several research studies (Bandura, 1997; Palsdottir, 2008) have analysed the relationship between health promotion messages and individuals’ judgements about their capabilities in applying such information so as to manage their health in a successful way. Findings suggested that the enhancement of people's belief in their abilities to perform the necessary behavioural changes was a critical factor for effective health promotion. Health information, therefore, should contain more than advice about healthy behaviour and include persuasive messages underlining that people have the means to act upon it. A research team in Indonesia (Kanbaras et al., 2008) found that emotional support, such as encouragement and empathy which are two examples of social persuasion, positively influenced self-efficacy leading to active coping by diabetic patients and thereby to a reduction in daily stress because of their sense of control over the disease. Further, empirical studies of the application of the self-efficacy theory in understanding depression found there is strong evidence that low self-efficacy beliefs can cause depressive moods (Bandura, 1994; Maddux & Meier, 1995). Similarly, self-efficacy impacts on the handling of anxiety-related problems, especially when believing oneself to be unable to exercise control over harmful events which gives rise to increased anxiety (Williams, 1995).

Recent studies (Scholz et al., 2000) have investigated the understanding of self-efficacy in different countries and cultures (Asia, Arab Peninsula, Eastern Europe, South America) by testing the general self-efficacy scale, 10-item version, measuring the broad and stable sense of personal competence to deal effectively with a variety of stressful situations. Findings suggested that the self-efficacy construct tends to be universal despite cross-cultural differences. Although self-efficacy theory could be useful in investigating individuals' experiences in their mastery of adverse circumstance, yet no research on adult refugees and their self-efficacy competence whilst resettling could be found. Such a gap could be an area for further investigation. Indeed, articles regarding psychosocial determinants of recovery from diverse types of trauma (Benight & Bandura, 2003; Schwarzer et al., 2005) have underlined that people who believe they can defeat their trauma demonstrated proactive coping abilities to regain control over their lives rather than having their lives dictated by adverse circumstances. At the present time, research is being conducted on the measurement

of self-efficacy amongst former refugees, Kurds and Afghans, resettled in New Zealand and Australia (C.M.R. Sulaiman-Hill, projected finish date 2009) which should provide categorical data which are not currently available. Related findings should be of use in establishing if the self-efficacy construct could be a useful one to investigate and develop so as to strengthen refugees' coping resources when encountering resettlement impediments.

Indeed, it is acknowledged that a strong sense of self-efficacy is an important factor for positive psychological adaptation and adjustment as it determines that people are more likely to engage in tasks with which they feel comfortable and be less likely to participate in tasks with which they are not. As previously cited, Scholz et al. (2000) suggest that the self-efficacy construct tends to be universal despite cross-cultural differences. It might be of interest to develop interventions directed toward increasing resettlers' sense of control in specific situations could help to avoid emotional distress or "demoralisation which results in the belief that one does not have the capacities to control important life events and achieve valued life goals" (Maddux & Lewis, 1995, p. 46).

### **1.5 Social support**

There is considerable evidence that social support impacts positively on individuals' well-being because of its buffer role in decreasing social isolation. Although the concept is understood intuitively, yet attempts to define "social support" conflict when specific questions arise (Cooke et al., 1988; Simich et al., 2003; Young, 2001). However, it is often described as resources provided by other persons and refers to those support systems which provide assistance and comfort to individuals when encountering physical or emotional difficulties in order that they can cope better in times of adversity.

Social support ranges from multiple informal and formal sources including family members, friends, colleagues, peers or associations to government services such as the welfare system. The literature (Cooke et al., 1988; Liese et al., 1989; Wan et al., 1996) outlines four types of supportive factors, or behaviour, as potential forms of social support: (i) *emotional support* providing, for example, caring, empathy, trust, love, (ii) *instrumental support* providing aid in kind such as money, work or other practical help, (iii) *informational support* providing advice, suggestions, orientation or information and, (iv) *appraisal support* providing affirmation, feed-back and self-evaluation from others who have faced the same adversity. In

that respect, Cobb (1982, as cited in Cooke et al., 1988) has listed four key words to represent the subjective sense of those four forms of support which are potentially available from others, namely: love, esteem, security and appraisal.

Despite the large and diversified role which social support is hypothesised to play in refugees' lives, information, especially in terms of buffering the impact of stress on refugees, remains scarce or poorly explained. Nevertheless, Kovacev and Shute (2004) reported that classmates' support had a strong positive association with young Bosnian refugees' self-worth. Simich et al. (2003) found that refugees resettled in Canada viewed instrumental support such as access to information (health, English classes) and appraisal support as critical sources to adjust to their new lives. However, they encountered many barriers (such as language, no command of and/or access to the internet), preventing them from asking questions and/or obtaining suitable responses because of their inability to access information and also because of the non-existence of key informants. This resulted in refugees distrusting providers and choosing instead to turn to other sources of help such as friends or relatives. Sharing experiences with established refugees was one of the most useful supports because people could compare their own situation with others and thereby obtain confirmation that a successful adaptation could be possible. Interestingly, the availability of this appraisal support directed the newcomers to depart from the initial plans made for them and to relocate instead to areas where such support existed. This contrasted with the commonly held assumption that migrants' mobility is often motivated by economic opportunity. Not being able to access accurate and helpful social support, plus the absence of meaningful and supportive relationships, adversely impacted refugees' well-being thereby affecting physical and mental health such as heart problems or depression. In summary, the authors concluded that the immediate social support needs of refugees could be met most beneficially in partnership with established refugees who similarly had experienced exile and resettlement. Such significant relationships could be used as an alternative to current social services because newcomers tended to under-utilise health and social services when confronting resettlement stress.

The same research team (Simich et al., 2004) also investigated the meaning of social support amongst Chinese immigrants and Somali refugees in Canada. Both groups did not seek immediate help from government services because either it is delivered differently or does not exist in their country of origin. Both valued, above all, practical social support facilitating employment and social integration. In that respect the Chinese defined social support as a

responsibility of the government which they perceived in Canada as providing inadequate policies and direction. By contrast, the Somalis' view of social support was based on informal social networking. The majority of respondents were using informal channels to adjust to Canada (friends, community or religious associations) or, more likely they had to be self-reliant because of the lack of information about social services or discourtesy in the attitude of civil servants. Such an understanding of how newcomers were coping with settlement challenges and were or were not seeking help, highlighted some of the weaknesses of the formal supports, for example, in terms of income sufficiency, social inclusion and opportunities which jeopardised immigrants' and refugees' adaptation and well-being. Moreover, the authors emphasised that understanding social support arising from informal networking appeared to have important implications when designing programmes and services for meeting expectations and needs of new resettlers.

In Australia, Colic-Peisker and Tilbury (2003) have explored the process of resettlement of refugees living in Perth coming from former Yugoslavia and Africa. Refugees' locus of control and their ability to overcome practical and emotional difficulties depended on many factors, amongst which were personal resources (human and social capital) and support services provided upon arrival. This led either to an active or passive approach when dealing with resettlement issues. Those who chose an active style, categorised by the authors as "achievers" or "consumers", were more likely to have pursued particular professional or materialistic goals and possessed a generally positive attitude to their adaptational experience. They actively found solutions beyond government assistance by using their own abilities and family, ethnic community and other social networks. By contrast, those who reacted passively were categorised as "endurers" or "victims", perceiving their pre-migration experiences irrevocable and relied on small networks such as family and friends. In this latter situation, findings also suggested that this passivity was (though not deliberately) reinforced by the resettlement services "through their attempts to identify and deal with traumatic experiences" and "medicalise" the refugee experience. Although well intentioned, this "patronising" approach tended to focus on psychological help and clinical issues rather than supporting people in re-establishing a normal life and solving their daily problems. This created a gap between the caregivers who intended to help people presenting mental health problems and beneficiaries who used counselling services in anticipation that they would provide them with practical help (completion of administrative forms, contacting potential employers, finding a house).

Similarly, Young (2001) examined the buffering effects of social and personal resources of Salvadorian refugees living in Canada. Whereas personal locus of control and self-esteem played a significant role in facilitating optimal adjustment, yet social interventions providing a supportive approach to develop or strengthen such skills were deficient. Such findings highlight the relevance of extending the understanding of the reasons and resources that facilitate refugee adjustment rather than focusing only on the pathogenesis of the migration. Moreover, “affective support” also proved to be important by boosting self-esteem and providing emotional help and as a consequence alleviating refugees’ psychological distress (Gorst-Unsworth & Goldenberg, 1998; Shisana & Celentano, 1987).

One role of social support is its supposed ability to encourage adaptive coping responses by promoting self-esteem, confidence and a sense of control and also by providing information and guidance (Harrop et al., 2006). Nevertheless, Stanfeld (2006) when investigating the effectiveness of social support in reducing health inequities reported that social support " is influenced by social structural imperatives and becomes more than the sum of the individuals links of networks” (p.166). Previous cited studies have highlighted the significant role of both family and established community members in supporting newcomers both emotionally and practically thereby facilitating their adjustment in their new country in contrast to variable support from government resettlement services. Colic-Peisker and Tilbury (2003) reported that agencies, because of their own agendas or interests, might have a tendency to create or over- exaggerate former refugees’ needs in certain areas (mental health needs or counselling) in order to maintain their levels of funding and staff. This leads to the neglect of practical issues and finding effective solutions to housing, employment and family reunification impediments. This proclivity to reduce difficulties at the refugees' level, rather than at a structural level (labour market, discrimination) seems to be easier to deal with, however, it delays people’s inclusion and participation within the host society resulting in chronic disenchantment.

## **1.6 Conclusion**

The ability to cope and to activate effective coping strategies depends on a combination of external factors and individual characteristics. Special attention has been given here to social support, religion and faith because they represented important resources reported by the participants in this study as they manage and deal with resettlement challenges. Additionally,

the concepts of resilience and self-efficacy have been reviewed because participants identified inner resources and demonstrated similar characteristics as described in those psychological constructs. Given the breadth of the study, and that it was not focused specifically on psychological concepts such as resilience or self-efficacy, these topics have not been investigated in the same detail and depth as would have been the case had these concepts been the primary focus. Moreover, such psychological concepts, as with psychiatric concepts such as post traumatic stress disorder, cannot be assumed to have the same value and meaning across widely different cultures. Furthermore, other positive self-concepts could have been reviewed also such as internal locus of control, self-esteem, self-determination, and self-confidence. There is evidence that all interact with each other and are significant protective factors against the effects of adversity which by influencing and fostering active coping processes lead to a positive psychological adaptation and adjustment (Harrop et al., 2006).

Research on refugees during the course of resettlement tend to focus on clinical perspectives on their mental health problems or personal deficits and “current knowledge of refugees' coping strategies and their cultural determinants is still rudimentary and fragmented” (Lin, 1986, p.71). The review of literature presented herein is certainly not exhaustive, however, it was aimed at highlighting some of the former refugees' strengths and attributes contributing to and sustaining their successful adaptation to life's tasks in their host country. It has also helped in underlining the gaps in knowledge and the potential for further enlightenment in an area of growing interest together with the need to acknowledge individuals' capacities so as to overcome difficulties despite social disadvantages.

## **C. Quantitative and qualitative research**

### **1. Quantitative versus qualitative research**

#### **1.1 Philosophical paradigms**

Empirical research in the social sciences can be performed through both quantitative and qualitative methods which are based on particular philosophical paradigms referred to as a belief system or view of the world (Guba & Lincoln, 1994). While there are dangers in oversimplifying complex issues by contrasting quantitative and qualitative methods, there are nevertheless recognised differences between the two research approaches.

The quantitative paradigm is based usually on positivism which is characterised by the ontological position that there is only one Truth independent of human perception (Giddings & Grant, 2007; Sale et al., 2002). In that respect, quantitative methods are said to be objective because they seek precise measurements and analysis and the researcher remains detached from the data. By contrast, the qualitative paradigm is based on interpretivism and constructivism which are characterised by having multiple realities rather than a single Truth based on the thoughts and perception of each individual (Sale et al., 2002; Samdahl, 1999). Qualitative methods, therefore, are said to be subjective because the researcher is involved intimately with the subjects of the study and makes interpretations of their answers to the research questions. Both research traditions demand the highest ethical standards to protect participants and permit the application of meticulous methodologies to answer questions.

#### **1.2 Similarities, differences, strengths and limitations**

Quantitative and qualitative approaches have similarities, differences, strengths and limitations as well as different rigour criteria when presenting research findings (Alderson, 2001). The quantitative approach is more concerned with investigating and quantifying the relationships between variables in a population which can be observed and measured. It aims to answer questions such as "how much?", "how many?", "how often?", "to what extent" as well as "why", "what is happening here"? Collected data are usually structured in the form of numbers derived from subjects' responses which have been obtained through sets of questions. The data analysis permits the measurement of the frequency of a phenomenon of interest (such as the effect of a treatment on biological values). Hence, for an accurate

estimate of the association between variables, sample size and random selection of subjects are critical if results are to be generalised to a wider population of which the sample is considered representative through the use of statistical methods (Hopkins, 2001; Sale et al., 2002). One of the limitations of quantitative research is that it might focus on numeral description rather than detailed narrative and generally offers less information regarding human behaviour or perception (Hancock, 1998; Trochim, 2006; Weinreich, 1996).

On the other hand, the qualitative approach attempts to understand why things are the way they are in our social world and why people act the way they do (Hancock., 1998). It is more concerned with obtaining an in-depth understanding of human behaviour and of the motives which govern such behaviour. Therefore, it seeks to describe and interpret the meanings people attach to things and events so as to gain valuable insights and generate explanations and theories about the phenomenon under study (Hancock, 1998; Strauss & Corbin, 1998). Hence, research participants are asked, through in-depth one-to-one or group interviews, to describe their experiences and express their views in ways that are not structured as firmly as in quantitative research. Field observation can also be another option in the collecting of data so as to explore in more detail the reasons behind diverse aspects of behaviour. Furthermore, qualitative investigation usually centres on smaller groups who have experienced the phenomenon under study rather than on large samples. Indeed, the original research question may have sought an insight into a specific group within the population because of its difference from the general population and thus its uniqueness is the focus of the research (Hancock, 1998). The main limitations of qualitative research, however, are that it usually studies fewer people and thereby it might not be possible to generalise results to a population. It also makes it difficult to make comparisons especially if people give differing responses. Furthermore, it depends on the researcher's skills to conduct interviews and observations and results may vary greatly depending upon who conducts the research (Trochim, 2006; Weinreich, 1996).

Whereas quantitative research is thought to be more concerned with the deductive testing of hypotheses and theories, qualitative research is more involved with exploring a phenomenon through an inductive approach by moving from observations to the generation of hypotheses and theories. Indeed and as previously mentioned, qualitative research places emphasis on processes and meanings that are not rigorously examined or measured, in terms of quantity, intensity, or frequency. However, there is no superior or "best" approach and the two are not

opposites and the choice of one method in preference to the other depends on its appropriateness and effectiveness in answering the research questions. Despite variations and differences in the nature of the data, the data collection and the analysis methods, almost all researchers raise qualitative and quantitative issues during the research process. Qualitative researchers may use elements of a quantitative approach to check a theory, while quantitative researchers may be interested in interpreting subjects' experiences, which typically is more associated with qualitative research (Punch, 2005). Additionally, qualitative research can help to gain a general knowledge of a phenomenon and elaborate a theory which can be tested using further quantitative research.

### **1.3 Judging the quality of the research**

A further variation between quantitative and qualitative approaches is based on the different ways of judging the quality of the research. Quantitative research is usually judged on the common framework of validity and reliability (Babbie, 2001; Hopkins, 2000). Validity determines how well a variable measures what it is supposed to. It establishes "if the research truly measures what was intended to be measured and how trustful the results are" (Joppe, 2000, as cited in Golafshani, 2003, p. 599). Reliability reflects the replicability or repeatability of results and observations (Hopkins, 2001). It shows the extent to which results are consistent over time and provides an accurate representation of the studied population (Golafshani, 2003; Hopkins, 2000). On the other hand, qualitative research is judged on its trustworthiness in determining the degree to which the interpretations of the data are seen to illustrate accurately the phenomenon under study. It describes the ability of the researcher to persuade the audience that the results are worth paying attention to (Babbie & Mouton, 2001; Lincoln & Guba, 1985). The most widely used criteria to meet trustworthiness are those proposed by Lincoln and Guba and include credibility, transferability, dependability and confirmability which are explained in the following section 5).

### **1.4 Mixing qualitative and quantitative methodologies**

#### **1.4.1 Current debate**

The mixing of qualitative with quantitative approaches has become more and more common for *complementary* purposes in research whereby the researcher uses one method for one phase or aspect of the study, and the other for another phase or aspect. Such a combination,

however, is the subject of "hot debate" (Sale et al., 2002; Samdahl, 1999; Trochim, 2006) because working with both approaches raises "a range of issues above and beyond those encountered within a particular methodology" (Bazeley, 2002, p.2).

It is beyond the scope of this study to provide an in-depth discussion on the controversy of mixing quantitative and qualitative approaches, however, one of the fundamental disagreements remains philosophical. From a purist perspective, it is inappropriate to reconcile inherent philosophical differences at the paradigmatical level (Guba & Lincoln, as cited in Mactavish, 2000). Concerns persist about the appropriateness of linking quantitative and qualitative data without approaching the ontology (assumptions about the nature of reality), epistemology (knowledge of that reality) and methodology (techniques used to know that reality) foundations (Bazeley, 2002; Moon & Moon, 2004; Samdhal, 1999).

Another disagreement concerns the nature of the data; words in qualitative and numbers in quantitative research, which cannot be combined for triangulation, meaning that the results found from one of the methodologies cannot necessarily be confirmed by another. Trochim (2006), however, argues that all qualitative data can be quantitatively coded and stresses that recognising the strengths of combined information provides the researcher with new possibilities for interpretation that might otherwise be unutilised. Some authors (Giddings & Grant, 2006; Moon & Moon, 2004) raise the question of whether mixed methods research can be either a research paradigm or methodology which they link to the confusion resulting from the terms, quantitative and qualitative, commonly used to describe both methods and the methodology.

This having been said, Samdhal (1999) stresses that the quantitative-qualitative debate should be considered as a rhetorical question raising critical issues for reflection rather than as a question for which there is no answer. Moreover, the author states that such a debate "imposes an unfair dichotomy that does not capture all possible approaches to social enquiry" (p.5).

#### **1.4.2 Advantages and disadvantages of mixing methodologies**

Despite the arguments, there are, however, diverse advantages to mixing both qualitative and quantitative approaches. One of them being that both share the same goal of understanding the world in which we live, whereby the unification of their strengths adds richness to the understanding of a phenomenon of interest (Samdhal, 1999; Sale et al., 2002). Another

advantage is that the utilisation of both research methods is useful, especially in the area of nursing, because the complexity of the phenomena demands data from various perspectives so as to gain an insight into the phenomena under study (Clarke and Yaros, 1988, as cited in Sale et al., 2002; Giddings & Grant, 2006). Furthermore, mixed methods' research permits the collection of comprehensive information about a phenomenon which cannot be accommodated fully within a single approach, thereby guiding professionals in the taking of decisions regarding in their practice (Giddings & Grant, 2006; Mactavish, 2000).

As with all research approaches, combining methods also has its limitations and disadvantages. The study design requires time, extensive data collection and resources as well as the researcher's expertise in different methods. Because of the structural differences of the data (numbers and words) and the insufficient attention paid to philosophical issues, it is not always possible to corroborate findings resulting in a lack of clarity, depth and coherence of the study (Mactavish, 2000). Another disadvantage is that undertaking a mixed method study requires that careful consideration be given to the assumptions underpinning the research so that there is congruence between the chosen method and the research question (Giddings & Grant, 2006).

## **1.5 Summary**

With the above issues in mind, and consistent with the aims of this study, preference has been given to qualitative research as the main methodology of investigation. Indeed, the review of the literature, as presented in chapter II, did not reveal significant previous attempts at constructing a theoretical model of adult refugees' coping processes so as to overcome major adjustments whilst resettling. Therefore, an interpretive approach, seeking to understand and interpret the meaning which resettled refugees assign to their coping processes, was seen as the most appropriate approach to answer the research questions on a phenomenon which has received little attention in New Zealand.

Additionally, descriptive basic socio-economic and demographic data were collected so as to summarise participants' characteristics.

## **2. Qualitative methodologies**

Qualitative methodologies are being used increasingly in a number of disciplines, including health, so as to investigate the meaning of some of the behavioural aspects of given population groups (Marks & Yardley, 2004; Levy, date unknown). As mentioned previously, the qualitative approach can provide an in-depth understanding of a particular phenomenon by seeking explanations for which a quantitative approach is not particularly suited. To this end, researchers acknowledge participants' reality by using diverse data-gathering techniques, as well as asking them to verify that their information has been correctly portrayed (Sale et al., 2002; Samdhal, 1999). This contrasts with quantitative research where theories are generated from testing and refining of a previously constructed hypothesis.

Various methods, referring usually to techniques and procedures for gathering and analysing data, are employed throughout the research process. Data-gathering includes either individually structured or in-depth interviews<sup>34</sup>, or focus group<sup>35</sup> interviews, and the choice of selecting one type of interview over another will depend upon the richness or the limitation of interaction between participants to reflect on the research questions. It also includes close reading of the literature and, according to the type of research, observations. Data can be recorded on tape during the interview (with the permission of the respondents) and transcribed. If tape-recording is not possible, the interviewer instead takes detailed notes and draws on memory to expand and clarify rapidly the annotations after the interview. In both cases, field notes (also named memos) questioning the data are also developed so as to enhance the analytical process. This compels the researcher to clarify further each interview setting, as well as seeking additional information so as to maintain a balance between descriptive and reflective notes (Groenewald, 2004; Starks & Brown-Trinidad, 2007).

In much qualitative research, the analytical process is conducted during data collection as the data already gathered are analysed and guide the ongoing data collection (Pope et al., 2000). Furthermore, there is a variety of established procedures for analysing qualitative data regardless of methodological or disciplinary orientations. This involves, generally, the conversion of numerous raw data (e.g. audiotapes, interviews transcripts, observations) into partially processed data so as to extract key themes which relate to the phenomenon under investigation. These themes are then classified and grouped under a code (label) reflecting

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34 Structured interviews refer to interview in which a carefully worded questionnaire is administered and in-depth interviews are characterised by extensive probing and open-ended questions.

35 Small groups of between six to eight persons.

participants' meanings (Levy, date unknown; Starks & Brown-Trinidad, 2007). Once classification of data has been completed for all interviews, the researcher should reduce the data around central themes and relationships from which the final explanation of a phenomenon of interest can be drawn (Baptiste, 2001; Starks & Brown-Trinidad, 2007).

Various qualitative inquiry methodologies exist, each comprising distinct inquiry techniques, the main four reported in the literature being phenomenology, ethnography, case study and grounded theory. Despite differences which will be underlined briefly in the following section, all share the essential "ingredients" of qualitative research which include "the goal of eliciting understanding and meaning, the researcher as the primary instrument of data collection and analysis, the use of fieldwork, an inductive orientation to analysis and findings that are richly descriptive" (Merriam, 1998, as cited in Laws & McLeod, 2004, p.3)

## **2.1 Phenomenology**

Phenomenology originated in philosophy and Husserl (German Philosopher, 1859-1938) is regarded as being "the fountainhead of phenomenology in the twentieth century" (Groenewald, 2004, p.3). Phenomenological research aims to provide a comprehensive and accurate description rather than an explanation of a phenomenon of interest. It contributes to "deeper understanding of lived experiences by exposing taken-for-granted assumptions about these ways of knowing" (Starks & Brown-Trinidad, 2007, p.1373). However, it does not generate theories or models but rather raises awareness and increases insight into the phenomenon being researched for which clarification will be of benefit (Hancock, 1998). Because of the paucity of information concerning adult refugees' coping processes whilst resettling and because one of the expected outcomes of this research was the development of a theoretical explanation of such phenomenon, the use of a phenomenological approach was not considered as being appropriate.

## **2.2 Ethnography**

Ethnography has its roots in anthropology and sociology, and seeks to "fully describe a variety of aspects and norms of a cultural group to enhance understanding of the people being studied" (Byrne, 2001, p.1). One goal of ethnographic research is, therefore, to comprehend and describe how people's logic and practices make sense within their social contexts (Angus, 2005). To this end, it entails extensive fieldwork by the researcher which implies that she or

he remains within the group being studied for a relatively long period of time so as to understand better the group's behaviour and thought patterns (Byrne, 2001; Harris, 1997; Holmes, 2006; Osborne, 1994). It also requires the researcher to be sufficiently familiar with the social rules and language of the group being investigated, as well as a combination of historical, observational and interview methods (Genzuk, 1999). Data gathering involves a combination of various techniques, including extended periods of participants observations, formal and informal interviews, focus group discussions, the collecting of life stories enabling the learning of the meanings which people attach to their knowledge, behaviour and activities.

Additionally, the context (social, political and economic) surrounding the group is an important component when conducting ethnographic research thereby requiring prior knowledge about available information on the subject through, for example, a review of the literature, reports, correspondence (Genzuk, 1999). Such information can be gathered in the form of checklists with findings being verified subsequently in the group being studied. Moreover, Hancock (1998) stresses that in health-care settings, the ethnographic approach might increase cultural awareness of health professionals by underlining a common cultural parameter such as geographical, religious, tribal or shared experiences so as to explain certain beliefs or behaviour. Similarly, Genzuk (1999) mentions that ethnographers, through the generation of new insights, "may inform the others of their findings with an attempt to derive, for example, policy decisions or instructional innovations from such an analysis" (p.2).

In this study and despite the researcher's extensive cultural and political knowledge and personal experience of the participants' countries of origin, ethnographic research, however, was not considered as the methodology of investigation. The reasons underpinning this decision were (i) language barriers because of the researcher's inability to speak the participants' mother languages, (ii) the impossibility of the researcher being able to immerse with the participants for a long-term period, and on a daily basis, and (iii) participants' wide cultural diversities (five nationalities sub-divided into nine tribal or ethnic groups).

### **2.3 Case study**

Case study aims at understanding a bounded phenomenon through an in-depth examination of "a case" or multiple cases over time and place. It is difficult to define a case since almost anything can serve as such and may be simple or complex (Punch, 2005). For example, the

case may refer to a person, an entity (school, a university, or a classroom), a village, a country. It could also be a policy, a process, an incident. Conducting case study research requires detailed investigations of individuals, groups, institutions or other social units and the interpretation of descriptive data such as cultural norms, values and beliefs so as to gain a sharpened understanding of an event and what might become important to investigate in further research. Thus, this is one of those research approaches which can take a qualitative or quantitative stance because it lends itself both to test and to generate theories. When using this methodology, the researcher enters the field having a prior knowledge of existing theories on the topic under investigation so as to rebuild or improve a theory instead of approving or rejecting it (Babbie, 2007). Case study was considered as an option to explore the adult refugees' coping processes whilst resettling. It was, however, discarded because of the paucity of information relating to this phenomenon.

#### **2.4 Grounded theory**

One of the aims of grounded theory is to "build" a theory about a phenomenon for which there is as yet no strong theoretical framework (Levy, date unknown; Strauss & Corbin, 1998). It is not a description of a kind of theory, but rather represents a general way of generating theory (Clarke, 2005). Additionally, the final theoretical framework being "rooted" in participants' data appears relevant for them and for those interested in their experiences (Chamberlain et al., 2004).

In this study, the review of the literature has permitted the highlighting of some gaps in knowledge regarding adult refugees' coping processes whilst resettling, as well as the formulation of questions about a phenomenon which is insufficiently understood and explained. Grounded theory, therefore, has been the qualitative method of enquiry chosen because it was seen as being the most appropriate approach for researching this phenomenon about which little is known. Furthermore, and as acknowledged by Strauss and Corbin (1998) who underline the role of the researcher when using grounded theory, it was foreseen that the extensive experience of the researcher in conflict zones and with populations affected by war

or internal conflicts<sup>36</sup> would bring a considerable background of professional and disciplinary knowledge to this study .

Prior to the description of the various steps of data collection and analysis, as well as central findings of this study, a review of grounded theory tenets, techniques and procedures will be presented in the following sections.

### **3. Grounded theory: background**

Grounded theory originated and was developed 40 years ago by the sociologists Barney Glaser and Anselm Strauss (U.S.A.) in the area of health, especially nursing. While studying the interaction between health-care professionals and dying patients<sup>37</sup>, they developed a constant comparative method to generate theory directly from their data analysis. They presented their work in "The Discovery of Grounded Theory" where they defined their method as "the discovery of theory from data" (1967, p.1). This was in contrast to the traditional and dominant quantitative model used in the field of social sciences which relied heavily on hypothesis testing and verification techniques and assigned a minor role to qualitative research. Moreover, both wanted to react against what they considered to be a rather passive acceptance of all the "great men"<sup>38</sup> sociological theories too often based upon preconceived ideas and poor questioning of how they were developed. A grounded theory is developed inductively from the data and involves an iterative process that includes the raising of open questions, the collection of data and their sequential analysis that leads to the identification and formulation of a theory "rooted" (grounded) in the data to explain a given phenomenon.

#### **3.1 Philosophical roots**

Grounded theory's roots arise from symbolic interactionism which is one of the major theoretical perspectives in sociology. The researcher is interested in behavioural and social roles of individuals so as to understand how they interpret and react to their environment.

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36 The researcher has spent more than 20 years overseas working in conflict zones mainly with the International Committee of the Red Cross (ICRC), as explained in the following section 6 "Assumptions of the researcher".

37 Described in their publication "Awareness of Dying", 1965.

38 Glaser & Strauss (1967, p19) called "great men" Weber, Durkheim, Simmel, Marx, Veblen, Cooley, Mead etc. and mentioned that it is assumed that they have generated a sufficient number of theories on social life to last for a long while.

Blümer (1969, as cited in Fidishun, 2002) summarized symbolic interactionism based on three main premises:

- people act and re-act towards things and other people based on the meanings that things and other people have for them,
- these meanings are derived from social interactions and communications, and
- these meanings are established or modified through interpretation undertaken by each individual.

Thus, the notions of “with whom”, “with what”, and “how one interacts” become the major determinants of how the individual perceives and defines her/his own reality. Using this perspective, grounded theory aims to understand human behaviour and interaction with their environment. As the collection of data is usually done through individual interviews, multiple individual and social meanings are produced. It becomes, therefore, the role of the researcher to articulate their meanings and make sense from their experiences so as to reproduce their consensual experience and formulate a theory.

### **3.2 Which theory is generated?**

The methodology, via constant comparative analysis offers two types of theory, substantive and formal. Glaser and Strauss (1967) describe a theory as *substantive* for explaining phenomena for an empirical area of enquiry such as patient care, race relations, professional education, delinquency or research organisation. By *formal theory*, they mean a theory that is used for a conceptual area of enquiry such as stigma, formal organisation and socialization. Dey (1999) considers this distinction “hard to grasp” and underlines that a meaningful distinction between both might include time and space. From this perspective, he defines a substantive theory as having a specific subject observed in time and space (e.g. the evolution of the British welfare state in the postwar years) while a formal theory has general subjects which escape temporal and spatial boundaries (e.g. welfare states in general).

Both theories are grounded in the data analysis and are considered as middle-range theories which sit between micro-range and grand theories. First advocated by the sociologist Robert Merton in 1968, middle-range theories deal with delimited aspects of social phenomena and emerge at the intersection of research and practice. They lie “between the minor but necessary

working hypotheses that evolve in abundance during day-to day research and the all-inclusive systematic efforts to develop a unified theory that will explain all the observed uniformities of social behaviour, social organisations and social changes” (Merton, 2002, p.386). Unlike micro-range theories which are limited to particular populations or fields, narrow in scope and restricted in their focus, and grand theories which have a very broad explanation and do not easily lend themselves to testing, middle-range theories address specific phenomena and are more precise, testable and more applicable for practice yet abstract enough to be scientifically interesting (Van Sell & Kalofissudis, 2008). For example, a theory of pain alleviation represents a middle-range theory for nursing: it is broader than a theory of neural conduction of pain stimuli but narrower than the goal of achieving high level wellness (Chinn & Kramer, as cited in McKenna, 1997).

### **3.3 Evolution of grounded theory**

Since their first collaboration, Glaser and Strauss have developed the methodology independently and grounded theory has evolved in directions creating disagreements between them. Their central differences are both epistemological and methodological and have led to what is known as the “Glaserian” or the “Straussian” versions.

One divergence relies on the researcher’s *use of literature* review when entering the research. Glaser considered that pre-research literature review might compromise the final result because it can produce preconceptions concerning what to find and therefore should only be used at the theory “sorting” stage. Strauss and Corbin, on the other hand recommended using literature in the early stages of the research. Their separation became more explicit when Strauss and Corbin published in 1990 "Basics of qualitative research: Grounded theory procedures and techniques" and introduced a new *coding paradigm*. Whereas Glaser (1978, as cited in Charmaz, 2006) described two types of coding: open/substantive and selective, Strauss and Corbin distinguished between three: open, axial and selective thereby providing detailed analytic steps and procedures so as to enhance the development and building of a theory. Glaser considered this coding process to be too detailed and extensive because it forces the analysis of the data into forming the final theory rather than letting theory emerge from the data. Lastly, whereas Strauss and Corbin stated that grounded theory should be verified and influenced by the researchers' existing ideas, Glaser argued that a new theory should not involve verification merely because ideas are induced in the data (Dey, 1999).

Dey (1999) and Charmaz (2000) explain this "separation" in terms of the co-authors' different training backgrounds. While Glaser was trained in quantitative methodology in sociology, qualitative mathematics<sup>39</sup> (whereby mathematical expressions such as statistical formulas can be stated qualitatively) and in theory construction, particularly in theoretical coding, Strauss was trained in qualitative methodology influenced by the pragmatist symbolic interaction tradition. Glaser's approach is often described as being more "purist" because the researcher should be guided by the participants' realities thereby enabling the theory to develop and emerge from the data and not be influenced by the researcher's assumptions. In contrast, Strauss' approach is described as more "pragmatic" as he and Corbin proposed a set of analytical tools and guiding principles to develop the theory.

Furthermore and following the evolution of grounded theory over the last forty years, Clarke (2003) has introduced a new analytical concept that she entitled "situational analysis". The author stressed that because of the differences and complexities of human realities and social life, the concept of basic social process (the basic form of human action) developed in grounded theory is too structured to explain phenomena of interest. To address this gap, the author proposes to *supplement, but not replace* basic grounded theory approaches with a situation centred approach, whereby "the situation of inquiry is empirically contrasted through the making of three kinds of maps and following with analytic work and memos of various kinds" (Clarke, 2005, p,xxxv). Such an analysis relies fully on initial basic theory procedures as defined since 1967 (Clarke, 2005).

Firstly there are "situational maps" which lay out the human and non-human discursive elements of a situation. The second are the "social worlds/arenas maps" laying out the combined actors, key non-human elements and the fields of commitment in which individuals engage collectively in ongoing negotiations. The third are "position maps" which portray the variety and variation of positions taken or not taken by the persons on particular issues. The goal of situational analysis, therefore, is to open up the analytical process of grounded theory so as to provide researchers with other options in comprehending the complexities of social life and thereby understanding a situation of interest as a whole by avoiding the stopping of the analysing prematurely. To this end, the various maps are used to end the analysis process rather than being the tools to incite further investigation.

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<sup>39</sup> Source: Fernandez, 2005.

### **3.4 Which approach to select?**

Both strategies have their advantages and disadvantages. Buckley and Waring (2005) see that the freedom offered by Glaser can facilitate the generation of a concept but can present a very difficult challenge for novices as the methodology can appear abstract and hard to understand. In their view, the potential advantage of Strauss and Corbin's approach is that it is more structural and practical and includes procedural advice which can guide inexperienced researchers, however, it can also be confusing and complex.

On the other hand, grounded “theorists” such as Dey (2004), Goulding (1999) or Mansourian, (2006) emphasise that the methodology has evolved over 40 years. They tend to agree that regardless of which specific approach guides a particular study, there is a set of common fundamental principles and analytic tenets that remain. Indeed, grounded theory research starts by focusing on a selected topic followed by data collection, data analysis through coding, theoretical sampling procedures and conclusion of the research /writing of the final theory. During this process the researcher has to set aside preconceived theoretical ideas so as to allow the development of theoretical concepts and the theory to emerge through constant comparison.

### **3.5 Common criticisms and methodological mistakes of grounded theory**

Grounded theory has become very popular and has been applied successfully in different fields such as sociology, nursing, educational fields, political and social sciences. Several criticisms, however, often linked to a complex and sometimes “esoteric terminology” (Coyne & Cowley, 2006) are reported by people trying to understand the overall process. Bryman (2001) questions the lack of clarity on certain points such as the difference between concepts and categories because the term “categories” is being employed increasingly instead of “concepts”. He also highlights that: fragmented coding of data may result in the loss of what people say, some procedures (transcribing recorded interviews) are time consuming and it is difficult to establish when data are saturated so as to end the analysis and form the theory.

Indeed, the methodology has created considerable discussion since its conception, principally because of misuse of the method’s principles accentuated by the “separation” between its co-authors. As a result of a diluted use of the method’s essential tenets, together with an incorrect application, several mistakes and misconceptions have been reported. The most common

methodological errors identified by Wilson and Hutchinson (1996, as cited in Gage, 2005) are research (i) generating a description of a phenomenon rather than a theory (ii) mixing methods (iii) closing prematurely the methodological process resulting in under-analysis of data (iv) being too generic in analysis (v) using existing concepts and (vi) incorporating quantitative method into data gathering and analysis.

Recently, Suddaby (2006) when reviewing studies using grounded theory methodology stressed a profound misunderstanding of what constitutes grounded theory by underlining the following misconceptions:

- the ignorance of prior knowledge instead of using it correctly so as to prevent it from biasing the theory,
- the confusion between phenomenology and grounded theory approach,
- testing hypotheses and preconceived notions of what is likely to be observed,
- the mechanical application of analytical technique to data thereby producing poor results due to a logico-deductive process rather than an interpretive process,
- a fundamentalist tendency to develop a “rigid” grounded theory when the intention has been to provide a practical approach to help researchers understand complex social processes,
- a lack of commitment and involvement of the researchers within the research process as a member of the group,
- a poor description of the methodology used, thereby showing a lack of rigour and ignorance of the core procedures and,
- the non-acknowledgment of the dichotomy between Glaser and Strauss.

### **3.6 Summary**

The previous paragraphs have explained briefly the evolution of grounded theory over the past decades. This overview is helpful in understanding the historical development of the methodology including its complexity, debates and criticisms. That notwithstanding, and as underlined previously, there are core principles and analytical tenets to follow when applying grounded theory methodology in order to describe a phenomenon within the context of a situation and these will be described in the following sections.

## **4. Grounded theory methodology**

### **4.1 Sampling and data collection**

Whereas sampling in quantitative research is usually determined prior to data collection and analysis, sampling in grounded theory cannot be detailed and planned in advance because it is directed by the emerging theory. This is known as *theoretical sampling* which is an on-going process of data collection seeking pertinent data by identifying participants who have experienced and can describe the phenomenon under study.

The analysis of the first interviews allows the identification of broad incidents and events which are relevant to understanding and explaining the phenomenon. Participants' patterns (such as attitudes, situations, characteristic of being) are compared constantly and those which are similar are grouped together under common *categories* (see following section "Open coding" 4.4.1).

As the analysis progresses, variations, similarities and differences in data emerge thereby directing the researcher towards the topic or the individual who should be studied next so as to confirm and/or refine the developing categories. Thus, further information needs to be collected through the selection of new participants whose experiences are compared and contrasted with those already analysed.

Sampling will be completed when additional data do not provide any new insights into the developing categories meaning that categories are *saturated* because their properties, dimensions and relationships are explained theoretically (see following section 4.4.1). The purpose of theoretical sampling, therefore, is not to increase the size of the sample but to identify theoretically explained categories so as to develop a theory. In that respect, the final number of participants in the sample is determined when the outcome of the interviews become repetitive and that no new themes emerge.

### **4.2 Theoretical sensitivity**

Theoretical sensitivity refers to insight, a quality the grounded theory researcher develops through immersion in the data (Strauss & Corbin, 1990, 1998). This facilitates the researcher's ability to recognise what is important in the data so as to formulate a theory which remains true to the reality of the sensory facts under study. This means that the

researcher is apt to perceive relevant variables (categories and properties) and their relationships that explain the research question without being influenced by pre-conceived ideas. In that respect, theoretical sensitivity requires a level of flexibility and open-mindedness so as to gain understanding of the data rather than entering the field of research with prior perspectives which may lead into testing hypotheses rather than observing and gradually developing a theory. The researcher, therefore, should not be influenced by predetermined assumptions when investigating a phenomenon because seeking confirmation of established ideas can negate the emerging theory.

This, however, does not mean that existing expertise should be avoided totally. Indeed, theoretical sensitivity can be promoted by accessing and reading relevant literature as the research evolves and also by personal and professional experiences. The question is rather how to use knowledge properly so as to make sense of the data without influencing the final result (Dey, 1999). Some ways to prevent this from happening include being constantly aware of the possible influence of pre-existing conceptualisations of the subject under study and also by trying not to go beyond the research objective.

#### **4.3 The constant comparative method of data analysis**

As explained previously, grounded theory uses constant comparative method to generate theory directly from the data analysis. In that respect, constant comparison means comparing (i) peoples' opinions, actions, experiences (ii) incident with incident, (iii) data with developing categories, and (iv) category with category. The four stages and related procedures of constant comparison described in the literature (Dey, 1999; Glaser and Strauss, 1967; Pace, as cited in Mansourian 2006) consist of:

1. generating categories and their properties through coding procedures,
2. integrating categories and their properties through memo writing,
3. delimiting/developing the theory by reducing categories and thereby obtaining a "smaller set of higher level concepts" (Glaser & Strauss, 1967, p.110) and,
4. writing the theory when the findings are put together so as to form a coherent, understandable and informative theory.

These stages and procedures take place simultaneously during data collection and analysis which inform each other thereby allowing the researcher to move progressively from the concrete to the abstract.

#### **4.4 Coding process**

Grounded theory involves particular analytical *coding* described by Strauss and Corbin (1990) as “the operation by which data are broken down, conceptualized and put back together in new ways” so as to build theories (p.57). Coding commences at the beginning of data collection and is guided by further data collection via theoretical sampling. Numerous publications and articles (Charmaz, 2006; Dey, 2004; Moghaddam, 2006; Pandit, 1996) have been produced on coding procedures including the variations between its founding authors. All agree that independently of selecting Glaser or Strauss’ approach, the coding scheme permits the transformation of raw data into theoretical concepts thereby enabling the identification of categories and properties so as to establish the final theory.

##### **4.4.1 Open coding**

At the initial phase of the analysis, Glaser and Strauss (1967) and Strauss and Corbin (1990) call for *open coding* (or substantive coding) where data are broken down, examined, compared, conceptualized and categorized. It seeks to identify and label the key concepts reflected in the data (interview transcripts) that are relevant to explain the phenomenon under investigation. This is achieved through a meticulous reading of the transcripts where individuals’ stories are scrutinized and questioned (e.g. what is happening in that part, what does this incident indicate?). It enables the highlighting of the major concerns reflecting participants’ meanings. Similar statements are grouped together under a common code, usually named by using the participants’ own wording, termed *categories*.

As categories are developing, there is a need to describe more specifically, through theoretical sampling, how they are explained. This is achieved through the identification of their characteristics termed *properties* (or sub-categories) and *dimensions*. Dey (1999) describes dimension as the extension of a property in term of space (for example height, width, depth) and/or time (days, months, years). It can be measured by using a numerical scale (e.g. number of pupils in a classroom) or a more general description (e.g. big /small, long/short, many/few).

When no new categories emerge and their properties and dimensions are theoretically explained, there is a need to move on to the next analytical step so as to describe and understand how categories become integrated with others in order to develop a theory. It is beyond that point where Glaser and Strauss disagreed.

#### **4.4.2 Coding category relationships**

It is important to remember that grounded theory as a qualitative methodology and by contrast with quantitative methodology, does not infer causal relationships between variables. Indeed as a qualitative methodology, it does not aim at identifying which independent or explanatory variable increased the probability of a higher value on the dependent or "outcome" variable (Aus, 2005). It is more concerned in establishing which types of incidents, context, intervening conditions and consequences are relevant in explaining how social experience is created and given meaning (Denzin & Lincoln, 2000).

Such an inquiry is performed through some procedures to establish categories' relationships. In Glaser's view, the researcher at this stage has to go deeper into the analysis to see how categories cluster and connect together. In that way, transcripts and memos (see following section 4.5) have to be re-read carefully so as to review identified categories and properties. This examination helps to compare and reduce categories by linking the ones which are similar under common "coding families". At that stage specific categories are identified to enhance the emergence of the *core categories* that will form the final theory.

As an alternative, Strauss and Corbin have introduced for pragmatic reasons an additional codified operation termed "axial coding" which aims to develop the main categories and their properties in identifying their relationships. In practical terms, this process leads to a reduction and unification of categories in a way that allows the development of a *core category* which becomes "the central phenomenon around which all the other categories are integrated" (Strauss & Corbin, 1990, p. 116).

Charmaz (2000) and Dey (2004) agree that the step of grouping and reducing data (either through axial coding or coding families) supports the verification of the emerging theory because it leads to the selection of the core category that will theoretically explain the phenomenon. Charmaz (2006) indicates that the choice of how to reduce the data after open

coding will depend on the researcher's tolerance of ambiguity. She stated "Axial coding provides a frame for researchers to apply.../... students who prefer to work with a pre-set structure will welcome having a frame. Those who prefer simple, flexible guidelines and can tolerate ambiguity do not need to do axial coding" (p.61).

In summary, open coding allows the naming and grouping of categories and their properties and dimensions. It is followed by a coding procedure leading to the reduction and grouping of categories and defining their relationships. This progressive analysis leads to the next coding stage which is often referred to as *selective coding*.

#### **4.4.3 Selective coding**

This operation enables the identification and selection of *the core category* (also termed central category) which is a common pattern amongst participants that emerges with high frequency and thereby explains their behaviour related to the studied phenomenon. The third edition of "Basics Of Qualitative Research" by Corbin and Strauss (2008) describes a core category as:

- "it must be abstract, that is all other major categories can be related to it and placed under it,
- it must appear frequently in the data. This means that within all or almost all cases there are indicators pointing to that concept,
- it must be logical and consistent. There should be no forcing of the data,
- it should be sufficiently abstract so that it can be used to do research in other substantive areas leading to the development of a more general theory and,
- it should grow in depth and explanatory power as each of the other categories is related to it through statements of relationships" (p.105).

The identification and selection of the core category permits the development of a single storyline covering the phenomenon under investigation and around which all is related. It explains the behaviour of the participants in resolving their main concern; this process is referred to in grounded theory as a basic social process (or basic psychosocial process).

#### **4.4.4 Summary of coding process**

Via constant comparison, coding procedures support the identification and the reduction of categories by contrasting them so as to see how they either differ or connect together. This process helps to saturate the categories by describing and explaining their properties, dimensions and categories' relationships. It permits to identify and select gradually the core categories which will contribute to the final theory explaining the phenomenon under study.

#### **4.5 Memoing**

The overall analytical process is supported by *memos* which are "field notes" produced throughout the analysis so as to develop the theory. Memos can be anything written (varying from few lines to many pages) or drawn since they support recording the researcher's thinking process to logical conclusion as the study evolves. They help to crystallise ideas, establish impressions of what is going on within the data, note linkages between the categories and document the recurrent or new themes. Indeed, their purpose is to help the researcher to raise data to a conceptual level, to develop the properties of each category and to generate hypotheses about interrelationships between the categories (Strauss & Corbin, 1990). Early in the process, memos tend to be very "open"; as the analysis progresses they tend to focus on a core category and its possible links with the other categories. Whereas coding makes visible some categories and properties, memoing underpins the relationships which link the categories to each other.

Memos can be theoretical when they focus on the ongoing thinking process to identify specific categories and their properties and how they are interrelated. They can be methodological when there is a need to improve the methodology process such as theoretical sampling and coding procedures. Additionally, the construction of *diagrams* can help to comprehend the final theory by showing how categories relate to each other and the core category by visualizing their relationships through a graphic version.

#### **4.6 Delimiting and writing the theory**

Delimiting or sorting the theory is the connecting step between memo and theory writing. This is the opportunity for the researcher to compare field notes and underlines the uniformities and linkages in a set of categories leading gradually to a smaller set of higher

level concepts to formulate the final theory. Delimiting the theory provides the "skeleton" of the emerging theory, hence the preparation of the next stage "writing the theory". At that stage, the researcher should have enough explanations and justifications with which to address the original research questions so as to summarize and restructure the findings leading to the final results of the phenomenon under investigation.

## **5. Rigour/Trustworthiness**

As mentioned previously, the quality of qualitative research is not judged on the common framework of validity and reliability of the findings which are the standard criteria of quantitative research in the social sciences. Instead, the key issue in evaluating the rigour of qualitative research is judged by its level of trustworthiness which relates to the researcher's capacity to persuade her/his audience that the findings are worth paying attention to, or worth talking about (Babbie & Mouton, 2001, as cited in Modiba & Nolte, 2007). To this end, the most widely used criteria to meet trustworthiness are those proposed by Lincoln and Guba (1985): *credibility*, *transferability*, *dependability* and *confirmability* which are an alternative to more traditional quantitatively-oriented criteria of internal validity, external validity, reliability and objectivity.

### **5.1 Credibility**

Credibility refers to the believability of the research findings from the perspective of participants in the study. It is verified by: (i) "member checks" which is sharing the findings with participants so as to ensure that results are adequate representations of their meanings, (ii) developing trust between participants and the researcher, (iii) peer debriefing by discussing and sharing the methodological process and findings with experienced researchers so as to "explore aspects of the inquiry that might remain only implicit within the inquirer's mind" (Lincoln & Guba, 1985, p. 308) and, (iv) by presenting accurate and understandable data translating participants' views.

### **5.2 Transferability**

Transferability refers to the degree by which the study's findings can be transferred and applied to other investigated contexts and/or groups so as to develop knowledge about a given phenomenon. The researcher, therefore, needs to provide a "thick" description of the

phenomenon. This is achieved by (i) maximising variation in the data (e.g. participants' characteristics: age, education, socio-economic background, gender) and by considering similar and dissimilar (negative) cases which contradict prior observations and thereby provide a useful means of refining the emerging findings until categories' saturation is reached so as to ensure that a hypothesis accounts for all respondents and, (ii) detailing the research methodology, context and assumptions underlying the study.

### **5.3 Dependability**

Dependability refers to the consistency of the findings, meaning how these findings are stable over time if the phenomenon is studied by others. The researcher, therefore, has to show carefully and comprehensively the overall research process by describing and justifying what has been done at each step in arriving at the conclusions. This process is often described as an audit trail and necessitates that data collection and analysis, coding, sampling, interpretations, findings and recommendations should be detailed and made explicit so that another researcher could arrive at similar conclusions (Gage, 2005).

### **5.4 Confirmability**

Confirmability refers to the “neutrality” of the data such as the extent to which research findings are not influenced by researcher subjectivity and can be confirmed or corroborated by others. This is also achieved by documenting and tracing data from commencement until closure of the research (audit trail), by sharing ideas with others so as to have external perspectives on the results thereby avoiding bias or distortion. Indeed, confirmability reinforces the criterion of dependability as both aim to make full transparency of the data so as to permit the evaluation and acceptability of the findings by others.

Techniques used for establishing trustworthiness in this research are detailed and summarised in chapter III, section 5.5, and table 2).

## **6. Assumptions of the researcher**

Strauss and Corbin (1990) when describing grounded theory procedures and techniques stated that "throughout years of practice in a field, one acquires an understanding of how things work in that field, and why and what will happen there under certain conditions" (p.42). In

addition, grounded theory emphasises the researcher's involvement during the research process meaning that s/he should seek an empathetic understanding of the people s/he is studying (Sheppard, 2004). With this in mind I located myself as a foreigner in New Zealand, a nurse and a researcher.

As a newcomer in New Zealand, I was made aware of some of the adaptation difficulties faced by any person arriving in a new country. I had to adjust to a way of life which, despite having similarities with Europe, is also different in terms of values, customs and behaviour. Also I had to communicate in a language other than my own. As a nurse, my professional life was influenced by having spent nearly twenty years in some of the world's war/conflict zones (when working with the International Committee of the Red Cross (ICRC) in East, West, Central Africa, Asia, Afghanistan, South America and Eastern Europe). This provided me with unique war zone experience as well as extensive knowledge of individuals affected by war. It made me aware of the devastating damages of war on people's lives and on the different ways by which people can "talk" about their traumatic experiences (avoidance or silence being two of them). I could understand some of the situations which they had been through (threats, persecution and losses) because I have experienced or witnessed such events in the course of my work. I have been trained in how to deal with traumatised people so as to create both a confident and confidential relationship and thereby to seek, jointly, for an appropriate solution to alleviate some of their suffering. I also had the opportunity to work with people from different professional and cultural backgrounds. This has made me a party to different histories, perceptions, points of view and analyses.

These personal and professional experiences influenced my choice of research. I was interested in studying what happens to refugees who have been directed to resettlement in New Zealand, a completely unknown environment. I considered this to be a "logical progression" following on from my work. I was, therefore, encouraged to use my knowledge to comprehend how individuals, after having been forced to flee their homeland, could move on with their lives. I bore in mind that participants have their own experiences and cultural differences which I found they were willing to share. I discarded theoretical ideas and assumptions as much as possible. I ensured also that my experiences and feelings did not influence the analysis. My role in this process has been to examine, without preconceived opinion, participants' perceived barriers and factors contributing to their overcoming adversity so as to adjust to life in New Zealand.

## Chapter III: Research methodology and findings

### 1. Introduction

#### 1.1 Research questions, specific aims and expected outcomes

As mentioned in the previous chapter, a significant proportion of research on refugees' mental health whilst resettling has investigated clinical issues and often focused on their problems rather than on their successes. Despite a growing interest and attempt worldwide by trans-cultural psychiatrists to "de-medicalise" such an approach, relatively little is known about refugees' capacities to show positive adaptation to life's tasks when confronting post-migration or social disadvantages.

Such a gap in knowledge, therefore, has led to the formulation of research questions and specific aims so as to develop some understanding of the coping processes of adult refugees resettled in New Zealand.

The *research questions* were:

- Which factors contribute to adult refugees' coping processes to overcome resettlement difficulties and adjust to life in New Zealand?
- How do those factors impact on adult refugees' resettlement outcomes including their mental well-being during their adaptation process in New Zealand?

The *specific aims* were to:

1. investigate adult refugees' resettlement experiences, coping processes and resources to overcome adversity when resettling in New Zealand,
2. describe how refugees' coping processes and resources impact on their health including their mental well-being and consequently on their adaptation process in New Zealand,
3. explore the formal and informal support which adult refugees seek when facing emotional problems, and
4. provide information which can be used by stakeholders involved in refugees' support so as to address current gaps impeding effective responses to meet their emotional needs.

Consequently, the *expected outcomes* of the research were (i) to obtain a contextual and comprehensive knowledge of the coping process developed by refugees during the course of their resettlement, and (ii) to develop a theoretical explanation (middle-range theory) of adult refugees' coping processes to overcome major adjustment challenges whilst resettling.

## **1.2 Research proposal**

In the initial stages of this research, contacts were made with various government departments and organisations supporting refugees so as to understand the current difficulties and successes encountered by both refugees and stakeholders in New Zealand. Refugee associations were also approached to share their views on what had already been established as well as determining the relevance of conducting further investigation on refugees' coping skills and mechanisms. Feedback was enthusiastic and the Canterbury Refugee Council (CRC) agreed to support this study. Additionally, refugees contacted through informal channels showed a strong interest and were willing to participate in the research.

A research proposal was developed and constantly refined with the guidance of my supervisors. Application was made to the Upper South B Regional Ethics Committee for approval to conduct this study. The CRC Chairperson and Spokesperson together with one supervisor were present during the Ethics Committee meeting to support and answer questions on issues which were unclear. Outlined in the application was the purpose of the study including the chosen qualitative methodology (grounded theory), participants' information sheet and consent form and developed questionnaires<sup>40</sup>. The study was approved on 14th May 2007 (URB n° 07/04/012) with the stipulation that a twelve month progress report was due in May 2008 (see Appendix A).

## **2. Study design**

### **2.1 Descriptive quantitative data**

The study design included the collection of descriptive *quantitative data* through the completion of one questionnaire in the presence of the researcher. To this end, basic demographic/socio-economic data so as to describe participants' characteristics including age,

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<sup>40</sup> To avoid confusion, appendixes will be indicated during the research procedures.

gender, nationality, housing, employment, English language fluency, refugee status, size of family, community networks, length of residence in New Zealand and life-satisfaction level in the country were gathered. The form is available in Appendix B and related findings are detailed in the following section 4 and table 2.

## **2.2 Qualitative data**

Qualitative data were collected from different sources. Firstly, initial meetings were conducted with the Canterbury Refugees Council (CRC) Chairman and Spokesperson so as to validate the importance and relevance of the study amongst the various refugee groups resettled in South Island, New Zealand.

The CRC representatives have been closely involved throughout the research process. This collaboration has been critical in the development of a trustful working relationship between the various refugee groups and the researcher. Numerous meetings, varying from between two to four hours have been held on a bi-monthly basis either in their homes, or in the researcher's home. The researcher also attended various CRC meetings such as refugees' forum or the re-election of their Council Members. Additionally, the CRC Chairman and Spokesperson have been invited on several occasions to the University of Canterbury. Such meetings have been aimed at providing regular feed back on the ongoing research process, as well as to seek further clarification concerning questions or topics which had emerged during the study. Furthermore, the researcher supported the CRC in designing a survey questionnaire in relation to refugees' socio-economic living conditions in Christchurch which analysis has been undertaken by a master student from the Health Sciences Department of the University<sup>41</sup>.

Qualitative data were collected from adults' refugees through one-to-one in-depth interviews where they were invited to express their points of view on issues of importance relating to their coping processes in the overcoming of their resettlement difficulties and adjustment to life in New Zealand (see following section 5.1.1.1 "Interview procedures"). This was followed by a second meeting (follow-up interview) a few weeks later when participants were given the opportunity to share the findings of their statement analysis. Furthermore, following the "formal" interview, many participants invited the researcher to their homes or to special ethnic events so as to continue discussion around the research. Others did not hesitate to

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<sup>41</sup> Survey undertaken by Victoria Ravenscroft for which findings are expected around February '09.

telephone or seek to re-visit the researcher in her home thereby providing the opportunity to expand the researcher's knowledge.

Regular meetings also took place with various agencies involved in refugee resettlement (e.g. Department of Labour, Refugees and Migrants Resettlement Services (RMS), Christchurch City Council, ESOL<sup>42</sup> organisation and volunteers). This provided both the resettlement stakeholders and the researcher with in-depth knowledge of the current national policies supporting former refugees as well as with feed-back of the research. Frequent contacts were also made and meetings conducted with various New Zealand sponsor families involved in supporting refugees whilst resettling. Furthermore, the researcher has attended various refugee forums and a conference in Auckland on refugee mental health.

### **3. Inclusion criteria and recruitment procedures**

Former refugees who have arrived during the last past 10 years from Somalia, Afghanistan, Ethiopia, Kurdistan and Burma (Myanmar) were contacted through the Canterbury Refugee Council, Refugee Migrant Resettlement (RMS) families' sponsors living in Christchurch, participants' fellow countrymen, SEKA<sup>43</sup> and the RMS office in Nelson<sup>44</sup>.

The *inclusion criteria* for participants were that refugees:

- were from diverse countries,
- were males or females over the age of 18 with an acceptable command of English (with the possibility of having an interpreter of their choice if necessary),
- were from different educational and socio-economic backgrounds,
- had a variable length of residence in New Zealand of 12 months minimum, and
- were able to reflect on and share their experiences which related to the topics under investigation.

When potential participants were identified, they were contacted by telephone so as to organise a first meeting to explain, through the support of the participant's information sheet (see Appendix C), the aims and expected outcomes of the study as well as the details of their

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<sup>42</sup> ESOL: English for Speakers of Other Languages.

<sup>43</sup> SEKA: Somali, Ethiopian, Kurdish, Afghan, Canterbury Alternative Refugees Voice Association Inc.

<sup>44</sup> RMS Nelson is mostly involved in supporting Burmese refugees.

required participation. Participants were offered one week in which to consider if they wished to take part in the project. The subsequent contact (either by telephone or usually during a second meeting) was used to make an appointment and venue. This initial preparation required an average of between 3 to 4 hours work per participant in order to make sure that they understood the study and to feel comfortable in being a part of the research.

At the first interview, the participants' information sheet was read again and questions, if any, were answered. The participants' consent form (see Appendix D) was signed and a copy retained by the participant. The socio-economic and demographics questionnaire was completed and qualitative data collected. Participation was voluntary, personal and family details remained strictly confidential and every participant, therefore, was identified only with a study number. Because of the limited number of refugees in Christchurch and Nelson, it has been decided not to mention also participants' gender and age because of the possibility of personal recognition. A NZ\$30 food or petrol voucher was given to each participant (and interpreter when necessary) in appreciation of their time and input.

#### **4. Participants' socio-demographic characteristics**

The socio-demographic characteristics of participants are detailed in the following paragraph.

- Twenty six participants (n=26) were interviewed namely 14 males and 12 females. Twenty one participants were living in Christchurch and five (all Burmese) lived in Nelson.
- *Refugee classification*: sixteen participants arrived under the UNHCR quota system, nine came under the family reunification migrants' process and one was a former convention refugee.
- *The mean age* at the time of interview was 40 years for men and 34.5 years for women. The age for men ranged between 21 and 62 years, while that for women ranged between 18 and 45 years.
- *The mean size of the family* was 5 persons. Twenty participants had children under the age of 18 and some were under 5 years of age. Three of them had dependent children over eighteen who were studying at university.
- *The mean length of residence* in New Zealand was nearly 5 years. The minimum and maximum time spent in New Zealand ranged between twelve months and thirteen years.

Thirteen of the participants had lived in New Zealand for more than 5 years, five for between 2 and 5 years and eight for less than 2 years.

- *Occupational status:*

Employment:

- Although thirteen participants (50%) were working, yet only six were working full time (23%: 5 men and 1 woman); One participant had a senior position and two were working in the food industry. The three others had their own businesses.
- Seven participants were working part time (27%: 4 men and 3 women) for between 4 and 16 hours a week. One was employed as a "bilingual teacher" and the others in unskilled work such as cleaning, pushing trolleys or as part-time van drivers.
- None of those with overseas educational and/or professional qualifications (n= 8) such as teaching, pharmaceutical, mechanical had been able to obtain work in their fields of competence.
- The length of time to find stable work varied from two months up to five years regardless of participants' English proficiency.

Studying: two young female adult participants were enrolled full time at school.

Casual or no work: eleven participants (42%: 6 women and 5 men) did not have any employment or only worked a few hours "*from time to time*". Five of them (two women and three men) were actively seeking employment<sup>45</sup>.

Such findings are collated in table 2.

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<sup>45</sup> One male participant who insisted on finding work according to his educational background had been able to find such employment after the date of the interview.

**Table 2: Socio-demographic characteristics of participants**

|  |   | Total (n=26)                                   | Female (n=12)                                 | Male (n=14)                                    |
|--|---|--|---|--|
| Country of origin<br>N (%)                       | <ul style="list-style-type: none"> <li>• Afghanistan</li> <li>• Burma (Myanmar)</li> <li>• Ethiopia</li> <li>• Kurdistan region</li> <li>• Somalia</li> </ul> | 8 (30)<br>5 (19)<br>4 (15)<br>3 (11)<br>6 (23) | 4 (33)<br>3 (25)<br>2 (16)<br>1 (8)<br>2 (16) | 4 (28)<br>2 (14)<br>2 (14)<br>2 (14)<br>4 (28) |
| Refugee classification<br>N (%)                  | <ul style="list-style-type: none"> <li>• Quota refugee</li> <li>• Family reunification</li> <li>• Convention refugee</li> </ul>                               | 16 (61)<br>9 (35)<br>1 (4)                     | 9 (75)<br>3 (25)<br>-                         | 7 (50)<br>6 (43)<br>1 (7)                      |
| Place of residence in<br>New Zealand N (%)       | <ul style="list-style-type: none"> <li>• Christchurch</li> <li>• Nelson</li> </ul>  | 21 (81)<br>5 (19)                              | 9 (75)<br>3 (25)                              | 12 (86)<br>2 (14)                              |
| Age in years                                     | <ul style="list-style-type: none"> <li>• Mean (SD)</li> <li>• Maximum</li> <li>• Minimum</li> </ul>   | 38 (4)<br>62<br>18                             | 35 (9)<br>45<br>18                            | 41 (10)<br>62<br>21                            |
| Marital status N (%)                             | <ul style="list-style-type: none"> <li>• Single</li> <li>• Married</li> <li>• Divorced</li> <li>• Widowed</li> </ul>  | 5 (19)<br>16 (61)<br>3 (11)<br>2 (7)           | 2 (16)<br>6 (41)<br>2 (16)<br>2 (16)          | 3 (21)<br>10 (71)<br>1 (7)<br>0 (0)            |
| Family size (persons)                            | <ul style="list-style-type: none"> <li>• Mean (SD)</li> <li>• Maximum</li> <li>• Minimum</li> </ul>   | 5 (2)<br>9<br>1                                | 5,6 (1,7)<br>9<br>4                           | 5 (2,4)<br>8<br>1                              |
| Having children < 5<br>yrs N (%)                 | <ul style="list-style-type: none"> <li>• Yes</li> <li>• Maximum of children &lt; 5 yrs</li> <li>• Minimum of children &lt; 5 yrs</li> <li>• None</li> </ul>   | 14 (53)<br>2<br>1<br>12 (46)                   | -<br>-<br>-<br>-                              | -<br>-<br>-<br>-                               |
| Length of residence<br>in New Zealand<br>(years) | <ul style="list-style-type: none"> <li>• Mean (SD)</li> <li>• Maximum</li> <li>• Minimum</li> </ul>   | 5 (4)<br>13<br>1                               | 4 (2)<br>9<br>1                               | 5 (4)<br>13<br>1                               |
| Occupational status<br>N (%)                     | <ul style="list-style-type: none"> <li>• Full time work</li> <li>• Part time work</li> <li>• Casual* or no work</li> <li>• Studying</li> </ul>                | 6 (23)<br>7 (27)<br>11 (42)<br>2 (8)           | 1 (8)<br>3 (25)<br>6 (50)<br>2 (17)           | 5 (36)<br>4 (28)<br>5 (36)<br>-                |

\* "from time to time"

In addition, the following information was gathered:

- *Cause of flight*

All participants were forced to flee their homeland because of war and/or internal conflict. Thirteen were victims of personal threat including physical and/ or psychological ill-treatment.

- *First asylum country*

Twenty four participants had to find refuge or a hiding place in a first asylum country where they spent an average length of 6.5 years before being proposed to come to New Zealand. During that time, they survived because of international humanitarian assistance and/or support from family members or relatives. Some were able to find casual work. One of the participants spent nearly twenty five years in a camp and two were born in refugee camps. Only two participants and close family arrived in New Zealand directly from their country of origin.

#### **4.1 Additional information**

In addition to the descriptive quantitative questionnaire which aimed to gather basic socio demographic information, participants were eager to elaborate on other themes which appeared to be interesting and relevant.

- *Economic situation*

The research did not seek to establish participants' levels of income. Nevertheless, 80% of the participants were dependant on the welfare system (social benefits and/or supplements), thus indicating that the majority belonged to the low-economic strata.

- *Housing in New Zealand*

Eighteen participants were satisfied with their housing conditions, three "did not know" and five were not. The main dissatisfaction was that houses or flats were too small to accommodate the whole family and/or had poor insulation thereby they were difficult to heat.

- *Health services*

Eighty percent of the participants had a community service card and did not report major problems in accessing health services except for the common problem in New Zealand of a waiting list to access specialised health care. All participants were satisfied with the health care provision when experiencing physical disorders. The majority (92%, representing twenty four respondents out of twenty six), however, did not intend to seek support from the mental health care services when facing emotional difficulties. They explained the clear divergence between their cultural values and existing mental health approaches including the non-directive role of the health professionals and their individualistic approach in trying to solve people's distress.

Indeed, much of the psychological support and/or counselling requires the examination of thoughts and feelings which appeared incompatible with participants' non-Western beliefs in the avoidance of morbid thoughts and the repression of emotions. This contrasted with their desires for direction and "remedies" that offer immediate help and resolution of their current problems (e.g. family separation, unemployment, perceived discrimination) leading to the restoration and/or maintenance of personal harmony. The majority insisted that they did not want to elaborate on their past experiences because this created more harm than good and that "going back to these problems left behind" made them too sad. Their main resources in dealing with emotional concern were primarily religious beliefs and practices, followed by sharing feelings with family and close friends, reading, writing and physical exercising. Further explanation will be provided in the qualitative findings.

- *Life satisfaction*

Twenty one participants (81%) reported being satisfied with their lives, two were "not satisfied" and three reported that they "did not know". This "high" level of satisfaction appeared to be contradicted by some participants' statements described in the following

section of qualitative data findings. This could be explained by the participants' sensitivity to a "social desirability"<sup>46</sup> factor, which influenced their positive answers to this general question. Indeed, answering negatively could have been perceived by some respondents as a potential source of prejudice. This point was mentioned by Chile (2002) who found that African refugees resettled in New Zealand preferred not to talk about their daily problems such as discrimination and economic poverty because they believed that this could affect them or their family when applying for residence, citizenship, and work or seeking support.

## **5. Qualitative methodology: grounded theory**

The theoretical understanding of adult refugees' coping processes to overcome resettlement difficulties and adjust to life in a new environment is imperfectly understood and insufficiently documented. For that reason, grounded theory has been the qualitative method of enquiry chosen because it was considered as the appropriate approach for researching this *phenomenon* for which there is, as yet, no strong theoretical framework. With this in mind, it was expected that the methodology could help to generate explanations of "how" and "why" such coping processes contribute to maintain former refugees' overall well-being and reduced vulnerability to psycho-social problems.

Grounded theory provides an analytical process which, despite disagreements and debates on methodological components, has been used successfully in different science fields, including health sciences, since the 1960s (Charmaz, 2006; Dey, 1999; Strauss & Corbin, 1990). Moreover, grounded theory methodology generates a theoretical framework based on a set of plausible causal relationships among concepts thereby providing explanations of people's behaviour. This differs from other methods where often the information is presented with little comment (Barker et al., date unknown).

Because of the evolution and development of the methodology across a number of disciplines over the past four decades, such as social work, health, psychology and management, I have chosen to follow the recommendation of grounded theorists (Dey, 1999; Health & Cowley, 2004, as cited in Mansourian, 2006; Goulding, 1999; Kelle, 2005) that the novice researcher should follow the intrinsic elements of the methodology. This includes constant comparative data collection and analysis, theoretical sampling, literature review, theoretical sensitivity, and

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<sup>46</sup> Social desirability refers to a manner of presenting oneself in a favourable light (Crowne & Marlowe, 1960, as cited in Beere et al., 1996).

theoretical saturation (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Indeed and regardless of discipline or persuasion, Goulding (1999) states that “despite conflicting perceptions over methodological transgressions and implementation, there remain a set of fundamental nomothetic principles associated with the method” (p.8). These fundamental principles need to be followed if the study is to be recognised as a product of the methodology.

The concept of situational analysis developed by Clarke (2005) to supplement the traditional grounded theory approach (previously described in Chapter II, Part C on grounded theory, sub-heading 3.3) was not considered because no detailed research using that approach could be found<sup>47</sup>. Furthermore, *as a novice researcher*, I preferred and was advised to follow an existing methodology which has been proven to be successful and for which descriptive procedures are available (Strauss & Corbin, 1990, 1998).

Usually, the analytical process of grounded theory is explained in the literature through three phases (Chamberlain et al., 2004; Gage, 2005; Moghaddam, 2006) with each having a specific function and being interconnected with ongoing data collection and analysis. In phase 1, data are collected to commence analysis through open coding so as to enhance understanding and to find meaning in the data and thereby establish categories. The second phase involves further data collection and analysis in order to confirm and refine emerging categories to a more abstract level by describing and explaining their properties and dimensions. The third phase, which also involves further data collection and analysis, aims to identify categories' relationships in order to develop a "story line" of the phenomenon and to identify the "core category". The core category (also called central category) represents the basic social process (also termed basic psychosocial process), which refers to "what, essentially individuals do in dealing with their main problems in a particular situation" (Punch, 2005, p.215). Indeed, the core category is seen to explain most of the variability in participants' behaviour patterns and helps to integrate other categories which have been discovered in the data so as to describe how the theory ties together as a whole. These three phases are presented sequentially in the following paragraphs so as to enable them to be outlined clearly, however, it must be emphasised that they follow a constant progression and are not clearly separated.

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<sup>47</sup> The concept has been developed in 2003-2005.

## **5.1 Phase 1 of the data collection and analysis**

The first phase, named for example "Immersion and Initial Data Collection" (Gage, 2005), or "Generating the Initial Codes" (Chamberlain et al., 2004) refers to the initial data collection and analysis so as to open up the understanding of the information given by the study participants. It allows the building of a broad database (see Appendix F) leading to the generation of a set of categories (see Appendix E). I have chosen to describe that phase by outlining first the early data collection process which includes the recruitment, interviews and sampling procedures and data management followed by the initial data analysis termed "open coding".

### **5.1.1 Data collection procedures**

#### **5.1.1.1 Interview procedures**

Between May and September 2007, in addition to the initial selection and preparation of the interview, which required an average of between three to four hours work per participant, one-to-one in-depth initial interviews varying from one and a half hours to five hours were conducted. Interviews were recorded subject to the participant's agreement. Eight out of twenty six participants did not wish to be recorded, either because they considered their English to be inadequate or felt more confident without the tape recorder.

Interview questions were designed so as to permit participants to elaborate on their perceived difficulties since arrival in New Zealand, their coping resources to overcome such adverse circumstances and what could be done to improve their lives. General questions were asked so as to delineate a range of events from which initial codes could be established viz:

- what did you hope to achieve when you arrived? Did you achieve it? How do you feel about it?
- what were the 3 most difficult things you had to face when you arrived? How did you feel?
- what were the things which motivated you/helped you personally, in your family and around you to feel better?
- what are the things which motivate you/help you now personally, in your family and around you to feel better?

- do you think that your skills and strengths could be used better in New Zealand? How could that be? Do you think this could make you feel that you belong to New Zealand?
- what helps you when you feel sad, worried and/or upset?
- if there are 3 things that you can suggest to facilitate your life in New Zealand what would they be?
- what are your goals in 3-5 years?

During the follow-up interview, usually within one month and subject to respondents' or researcher's availability, each participant was given a copy of her/his transcript thereby providing them with the opportunity to refine or clarify some of their statements. These exchanges which lasted between two to four hours aimed at verifying how adequately their experiences were represented in the findings of the overall research. Because of participants' obligations, such as collecting children from school, and when it was felt by both participants and the researcher that additional discussion was needed, further meetings were conducted. It has to be underlined that no pressure or special request was placed on the participants by the researcher. This was in line with the pre-requisites of the research as well as to avoid bias. Moreover, the research process aimed to be a "pleasant" and constructive participation so as to elicit as much as possible participants' experiences, issues and concerns regarding their coping processes.

Furthermore, and as indicated previously, many participants were visited in their home or met during various special ethnic events (e.g. Ethiopian New Year) or family events such as birth celebrations, weddings, school graduation throughout all the research process (and after). Additionally, several participants continued to keep regular contact with the researcher after completion of the "formal" research procedures.

### **5.1.1.2 Sampling**

In respect of grounded theory principles, the sample size was not pre-determined before data collection because it was directed by the emerging findings. To this end, participants living in Christchurch and Nelson were sampled theoretically because they could explain their coping processes to overcome resettlement adversity in adjusting to New Zealand. They belonged to both quota and family reunification refugee categories, were from both genders and from

different sub-groups prevailing in their country of origin (e.g. clans for Somalia<sup>48</sup>, ethnic groups for Afghanistan<sup>49</sup>, Burma<sup>50</sup>, Ethiopia<sup>51</sup>). Theoretical sampling procedures will be explained in each of the varying analysis phases developed in further paragraphs.

### 5.1.1.3 Data management

Out of twenty six interviews, eight were conducted at participants' homes, five in the Nelson RMS office and thirteen at the researcher's home. This last option was considered when participants expressed their difficulties to speak freely or concentrate in their homes because of the presence of other persons and/or children.

Sixteen participants had a good to excellent command of English referring in this study to an individual's capacity to engage in a 60-90 minutes interview and being able to reflect their experiences without the support of an interpreter. Ten needed the support of an interpreter of their choice. Audio tapes were transcribed the day after each interview and a verbatim full transcription produced and printed. Each narrative was then checked against the recorded interview, saved and stored to flash drive and disk. Transcripts and quantitative data were stored at the University of Canterbury in secure filing cabinets provided by the Health Sciences Centre.

Qualitative data were analysed manually after consultation with Associate Professor Rosemary Du Plessis (Sociology Department of The University of Canterbury) who recommended that the use of a software programme (Nvivo 7) was not of great necessity or benefit for the research because:

- the sample was too small and learning the computerised programme was time consuming,
- the research involved only one interviewer meaning that a software programme could have been of use if the survey had been conducted in a variety of places and by different persons to verify the data collection and findings and,
- the researcher had sufficient professional experience with the participants' backgrounds and in conducting interviews and analysis.

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48 Somali people are divided into six major clusters of patrilineal clans, usually labelled clan families, that are internally segmented.

49 Afghanistan has four main ethnic groups: Pashtuns, Tajiks, Hazaras, Uzbaks. Minority groups include Aimaqs, Farsiwans, Turkmens, Brahusi, Balūches, Nuristanis.

50 Burma has a total of 135 different ethnic groups: major groups are Bamars (majority), Rakhine, Kayah, Kachin, Shan, Chin, Karen.

51 Ethiopia is a composite of more than 70 ethnic groups: Oromo representing 40% , Amhara, and Tigrean representing 32% .

A brief literature review was undertaken so as to outline the merits and limitations of computer aided analysis. Those in favour argue that it is less concerned with emotional experiences than structure, thus giving credibility in assessing the research findings (Richards & Richards, 1994, as cited in Goulding, 1999). They also mention the availability of flexible and varied tools which can facilitate coding, retrieval and the attachment of memos to indexing categories. Also, being able to change a category's content to support the emergence of the theory reduces effort and error thereby legitimising the findings. Those who are not in favour consider that a number of challenges persist when analysing data. For example, Denzin and Lincoln (1994) discuss the limitation of software packages because many remain limited to pure coding and retrieval procedures which do not have the ability to incorporate situational factors. Another perceived danger is the possibility of reducing field material to "codable" data only, thereby resulting in the loss of valuable sources of concepts and incomplete analysis.

Information was shared with my supervisors and the decision to opt for a manual interpretation of the data was taken. As a result, collected information was not only filed in specific electronic folders but also in written documents, coded and analysed.

### **5.1.2 Initial data analysis: Open coding**

#### **5.1.2.1 Categories' identification**

During the first phase of the analysis, open coding was used to break down the data into separate units to identify issues related to adult refugees' coping processes and categorise concepts emerging from participants. This involved repetitive and meticulous listening to the recording and reading of each transcript so as to become familiar with the data. Transcripts were scrutinized in order to identify words and phrases which highlighted an idea or theme of importance and enabled comparisons to be made. Sections of the narratives were assigned with a code and as the analysis progressed, similar concepts were grouped under a common category.

For example, participants started to describe what had helped them, personally, to overcome some of their past and present difficulties. The following are excerpts from the first five interviews:

- Participant # 1:

"My own experience and knowledge has helped me, because I was very social and I tried to know everyone, I was talking to everybody and asked everything I did not know. I ask people to explain to me. That's why I have crossed the bridge. I was not afraid, and asked and asked and asked. I was confident to ask the people, to ask for help. I am very confident about myself. If you are not confident you cannot achieve anything. You know, I respect myself first and then I respect the others. That makes it easy for me to contact the others".

- Participant # 2 :

"As an adult person, I had a little bit knowledge of the language and tried to find the best way to overcome the problems. This helped me. I have a family and have the experience of being a responsible person. I needed to defeat the difficulties in front of my children and found a positive way. To respect you is important to achieve your life. If you do the right things people respect you".

- Participant # 3 :

"I am a widow and I had 3 children to grow up. I was determined, I really wanted to have a better life for my 3 children. I needed to be strong because I understood that I had to live here and I have asked God to help me because a human being cannot do anything unless God guides you."

- Participant # 4:

"My brother was very bossy and told me that I have to learn English on my own. And I thought "okay" I will do it. My sponsor family also helped me a lot. I was asking them all the time when I did not understand and they talked to me all the time. I was showing them a book with pictures and ask how do you say spoon, how do you say this and that? I also prayed three times a day. You know when you read the Koran, when your feelings are very heavy, when you feel upset, reading the Koran makes you feel peace.../... I started also to be strong because I understood that I had to live here and that I have to learn the language and the culture."

- Participant # 5:

"The main point was my acceptance of the situation. People say that I am very tolerant as I accept what they want from me. I cooperate everywhere. This is what they said from me. Also, because our strong belief in our God, I thought that everything will be okay."

The category "personal resources" arose from analysis of these and similar narratives. Sentences and sections in which refugees referred to personal strengths were coded as such. The same analytical process was applied to identify and refine further categories leading to the development and establishment of twelve (12) categories as described in Appendix E.

### 5.1.2.2 Memoing

As described in the literature review (see chapter II, section 4.5), memoing was integrated fully during all of the analytical process to support the developing categories. On the one hand, methodological memos helped to improve the practical research process such as refining interview procedures or gathering impressions which could not be captured through recording. On the other hand, theoretical memos helped the ongoing thinking process to identify specific categories and foster further questions to be asked so as to maximise emerging findings. Additionally, diagrams were developed in support of the ongoing analysis. They helped to trace the emerging theoretical explanation by showing how categories relate to each other and to the core category by visualizing their relationships through a graphic version. Some of those memos and diagrams will be included in the following description so as to illustrate the analytical process done throughout the research.

When participants confirmed or contradicted what others had said, or produced new insights, memos helped to identify what should be investigated next. They were used also during the follow-up interview to provide feed-back to the participants so as check with them if the interpretation of what they had said corresponded to what they meant and to seek further clarification to refine emerging categories. For example, as the category “personal resource” was developing, it appeared that participant # 13 took a very pro-active role in order to overcome unemployment difficulties and the following note was taken after the interview:

*“Mr. Y arrived several years ago under family reunification. He did not speak English and did not have any recognised professional skills. However, he wanted to keep control over his personal life and consequently made considerable effort and said: “I knocked at every door to find a job, I was very careful and behaving correctly, I kept on time, I was respectful to everybody”. In comparison to some male participants, it seems that he had taken a very pro-active role so as to find his way in New Zealand because he did not benefit from any social support at that time”.*

During the follow-up interview, I explained to him my understanding of his situation and asked if he thought that being pro-active was appropriate to illustrate one of his coping behavioural patterns. After our exchange the following was noted in the transcript analysis:

*“Mr.Y agreed that he has been and is still very pro-active to keep control over his life. He insisted that “working hard” is the key to being accepted and included in the society. When I asked him why he did not ask for benefit, he laughed and said “you will die if you wait for that!”*

Similar observations, remarks and questioning were conducted after each transcript analysis and follow-up meeting. This facilitated the clarification of participants' meanings to confirm and refine emerging categories. Moreover, it facilitated concentration on the ongoing thinking process when categories were identified.

### **5.1.3 Summary of phase 1 of the analysis**

In summary, phase 1 of the analysis resulted in the design of a broad database of various concepts identified in participants' transcripts as described in Appendix F which permitted the grouping and coding under a common category of those which appeared to be similar in nature or related in meaning. The analysis of the first five interviews permitted the identification of broad events and incidents relevant to the research topic. This provided a guideline for selecting further respondents who could maximise the existing themes and also reveal new issues. Further data collection and analysis were conducted simultaneously so as to maximise variations, similarities and differences in participant's experiences. Emerging results were compared constantly against each other and directed further interviews in order to confirm and/or contrast the developing categories. This process strengthened the establishment of 12 categories usually labelled with participants' keywords (as described in Appendix E) until they became saturated meaning that their properties and dimensions were explained. Indeed, further data collection would have been a repetition of what was already known. At that stage, it was necessary to explain how categories were developed through the description of their properties (characteristics) and dimensions (category's extension in term of space and time). This will be detailed in phase 2 of the analysis.

### **5.2 Phase 2 of data collection and analysis**

The second phase of the analysis, to be headed for example, "Data Reduction" (Gage, 2005), or "Elaborating More Abstract Codes" (Chamberlain et al., 2004) aims to confirm the established categories in phase 1 of the analysis by describing and explaining their *properties* and *dimensions*. This was achieved by asking participants more specific questions so as to clarify relevant matters (meaning clarifying "the why?" of their responses) associated with each of them. Details from interviews which illustrate the categories of *personal resources*, *formal support and caring person* will be highlighted. The perspectives of participant # 3 have been selected as an example because she stressed several issues which needed to be

investigated further. Throughout the analytical process similar and opposing statements, research memos and notes will be presented to describe the decision process for developing properties of those three categories.

### 5.2.1 Category "Personal Resources"

In the third interview, I started to identify some specific themes mentioned by previous participants. Participant # 3 was a widow with three children who had arrived seven years ago in New Zealand under the family reunification refugee process. She insisted on her determination to have a better life compared to that which she had had in Africa. As the category *personal resources* started to emerge, related narrative sections and words were coded under specific properties as described in the following excerpts.

#### Participant # 3

"I was **determined**; I really wanted to have a **better life for my 3 children**. I needed to be strong because **I understood that I had to live here.**"

*Property: resilience characteristics (strong determination, aspirations, acceptance)*

"I **believe that everything is with God**. He is my first helper: "**first God and after the people** and I have asked **Him to help** me because a **human being cannot do anything unless God guides you.**"

*Property: religion/faith (dimension: strong and constant)*

"I have learned how to drive and could drive for a person who has a private business. I became very **interested in his business**. So, I thought "**why not to try to do business here?**" .You know **before coming here, I had a restaurant for 3 years and I did it all on my own. It worked very well and I was on my own with 3 children**. Here, I was **not afraid to take risk because I was able** to run my restaurant alone in Africa."

*Property: perceived self efficacy (experience, knowledge)*

"I have started my business one year ago and step by step it works. I **am able to communicate** a little with Kiwis and **this gives me a lot of confidence**.../...You know **I also enjoy helping people**. If someone is sick in my community I go to her/his home and help them with cooking, ironing. If they need money I try to help them too. I am like that; **if I have one cup of water and we are three and that this is the only cup, I will share it.**"

*Property: personal skills (communication, helping others)*

Participant # 3 described her personal abilities and clearly stated that she was able to mobilize her skills to earn enough money to provide for both her children and herself. As data collection and analysis progressed, participants' similar statements explaining and describing the category of *personal resources* were codified under the properties of *resilience characteristics, religion/faith, perceived self-efficacy, personal skills and family members* as shown in Appendix G, Part # 1.

## 5.2.2 Category "Formal Support"

### 5.2.2.1 Properties "Inadequate and adequate formal support"

At that stage of the interview, it was evident that participant # 3 managed to run her business despite her continuing basic command of English; a curious shortcoming because refugees are assisted with language classes. She mentioned very briefly at the beginning of our meeting that she went "a long time ago" to some government financed English classes but she had not liked them. Her opinion needed to be established and understood because *formal support* category (referring to social and resettlement services providers) had started to emerge and she was invited to elaborate. Her statement supported the initiation of the property of *inadequate formal support*.

"I went to English classes, but it was so different from home: **my level was too low I could not follow but also the level of the school was too low.** I went there for 2 years part time, but I missed the classes. **I did not like it and did not learn anything.** .../...You know they (*English courses providers and teachers*) have to understand the problems of the women students. For myself, **I think the problem is me** because my education was completely different in my country. They should emphasize on talking rather on reading and writing. **They give you papers that nobody understands but we should talk and talk and talk.**"

*Property: inadequate formal support (poor caring and supportive approach)*

This information coincided with some of previous participants' statements. Nevertheless, it was necessary to establish if it was shared by others (men and women, quota and family reunification refugees) leading to the following methodological memo in the research diary:

*"Participant # 3 mentioned the inadequacy of some formal support by citing the poor caring approach of English language class stakeholders. Previous participants talked about their perceived agencies' conflict of interest. I need to ask more specific questions about formal support perception in the following interviews and to seek participants who are satisfied in order to contrast the current statements."*

To this end, through theoretical sampling, quota refugees who were/are eligible for formal support as soon as they arrive in the country were recruited. Participant # 4 was a female "quota refugee" of a different nationality who had arrived six years ago with her two children. When asked what she thought about formal support, she said that she felt very satisfied and her statement initiated the property of *adequate formal support*.

Participant # 4

"When we arrived at the airport with other refugee families, there were 7 or 9 of our sponsors. They wrote our name in Farsi. I could recognize some faces as they sent us their photo when we were in Mangere. **I was very happy to see them.** And you know they did not know us and they seem very happy to see us! They bring us to this house, everything was here. I thought to myself they don't know us, they are not from our religion, culture but **they are close to us and make everything for us like parents for their children.../...The government helped us also very well for children to the school.**"

Property: *adequate formal support* (RMS sponsors volunteers, welcome, system is good for children)

This exchange created the awareness of the substantial differences between individuals in relation to the support provided by the resettlement services providers. Nevertheless, further investigation was needed in order to describe and confirm this disparity and the following was noted in the research diary:

*"Contrary to the family reunification refugees interviewed previously, participant # 4 is grateful for the formal support she has received; this confirmed information reported in the report Refugees' Voices 2004/Department of Labour. I have to compare her statement with other quota refugees and verify if there is a significant difference between quota and family reunification groups."*

During the interviewing process, similar positive declarations were collected, however, some quota refugees had contrasting views. For example, participant # 11 found that financial support was barely sufficient to cover her family's basic needs. She also objected to not being given the choice of decision on how to use the NZ\$1,200 resettlement grant which had made her feel dependant on her sponsor family. She also perceived that some government service employees did not understand refugees' difficulties and gave them inappropriate and sometimes rude answers. Participant # 16 shared the same view and added that resettlement agencies tend to highlight refugees' weaknesses in order to obtain funding.

As the research was progressing, positive and negative statements illustrated the variation of participants' personal experiences towards the formal support category by defining its *adequate* and *inadequate* properties as presented in Appendix G, Part # 2.

#### 5.2.2.2 Property "Inadequacy of mental health services"

The third specific aim of the research was to explore which formal and informal support adult refugees seek when facing emotional problems. Participants, therefore, were asked to describe and explain the cause of their problems and what was helpful to alleviate them. Those who had experienced severe traumas during their flight and in their first asylum countries were keen to tell their stories. The majority, however, linked their psychological distress to resettlement barriers preventing them from adjusting "smoothly" in New Zealand. The barriers described by participants included a poor command of English, bureaucratic procedures, unfamiliar way of life, non-recognition of their personal experiences and competences, family separation and limited access to the labour market. Many reported that this resulted often in bad headaches, stomach pain, sleeping and memory problems, sadness, anger, being lost, uncertainties and worries. The resources most cited to cope with those feelings were religion, sharing feelings with friends and family and being alone for a while. When asked to elaborate on support provided by the health services, the majority of participants stated that they did not seek such help because it did not solve their problems. Participant # 3 mentioned she did not trust the medical doctor or other professionals when facing distress and explained:

**"My worries are mine and I do not want somebody (e.g. interpreter) who I do not know to be aware about my personal problems. And you know, the GP he is nice but he is a normal "human being". Like me he knows something because he has learned, but he cannot understand what my worries are. It is beyond his capacities. He cannot help me as God can help me."**

Those who had experienced the health system for mental issues confirmed that statement but also did not perceive any improvement during the course of their medical treatment. For example participant # 4, who sought support because of her constant worries regarding her family left behind, expressed the following:

**"I went to see my GP because I was worried about my sister; she gave me tablets for it. This helped me with my children during the day because I was always angry when they asked something. I was very angry when my family asked me about my sister, because I could not do anything: I am not the immigration. I had terrible dreams all the night."**

Sometimes I took tablets sometimes not. But now, my sister's case seems to be okay, I feel better."

*Interviewer: What could have been done to help you?*

*Participant # 4: "What could have helped me was the immigration. .../... The tablets the doctor gives you it is good sometimes. People they should take it every day but this is not good for all the times. Maybe it helps for the brain, it stops thinking but it is not good for everything because the problem is still there. It is better to solve the problem."*

After six interviews, all participants, regardless of whether they had used the health services or not, shared the same opinion and the following memo was written:

*"05.06.07: It appeared that participants do not seek support from the health system when facing emotional difficulties regardless of their age, educational and English language level, adaptation level, gender, nationality, and religious beliefs. The most reported resource for alleviating mental suffering is religion and the least helpful seems to be the health care provision. The inadequacy of mental health services seems to be an emergent property of the category formal support. I need to investigate that issue with other participants who had experienced mental health services so as to contrast or confirm this inadequacy."*

To this end, participants who had used mental health services were asked to describe their experiences with the mental health care provision. For example, participant # 9 who requested that no personal details should be given for reasons of total confidentiality stated the following:

**"The system does not work; the professionals do not talk to us. They are up, we are down. There is no connection between them and us. They are not culturally sensitive."**

As interviews were progressing, similar comments were collected. For example participant # 15 stated:

**"I have taken anti depressors for a long time. This did not help. I had many side effects and this has affected my health. The main problem is that I am worried for my family left behind. You know if you know that you need your family to feel better and that you cannot have it, what can you do? I miss them a lot, but drugs will not help for that."**

By contrast, only two participants out of twenty six acknowledged that the health system had been helpful for solving some of their psychological distress. Participant # 14 was grateful for the counselling services which she had received to deal with family separation because people

were "very kind", listened to her and provided her with good relaxation exercises. Despite his poor command of English participant # 16 acknowledged the kindness of his General Practitioner who was "listening and talking" to him instead of merely prescribing drugs. On the other hand, most participants trusted their General Practitioners when having "pain in their body" and have an easy access to health services in comparison to their homeland. More generally, some mentioned that consultation fees were too expensive, that the results of their blood tests were not communicated or explained to them and that the waiting time for obtaining specialised health care was too protracted. At that stage of the analysis, specific aim # 3 which was to explore which formal and informal support adult refugees seek when facing emotional problems, was addressed. Findings suggested that religion and family members were the most reported resources for alleviating mental suffering while the least helpful appeared to be the health care provision.

### 5.2.3 Category "Caring Person"

Reverting to participant # 3, as the interview developed it became clear that it was necessary to enquire further into what had helped her to develop her business. Indeed, in addition to a poor command of English, she had not benefited from any financial aid with which to launch her "enterprise". The interpreter who assisted her mentioned earlier that somebody from her community had helped her to establish herself. Because *caring person* was an emerging category in phase 1, I was interested to learn more about her "friend's" role in overcoming her resettlement difficulties and developing her coping processes. Accordingly, she was asked: "What about Mr. B, do you think he has contributed to some of your success?". Her answer initiated some properties of this category of caring person.

"I was driving for my friend who has business and I was watching what he was doing. One day **I asked him if I could do the same. He said "why not?" he was very positive.** He mentioned that I had to ask first to a "Kiwi" lady who was in charge to give the permission to hire some space on the market place. **I asked her and she said yes.** So I rented some square metres, **my friend provided me with some craft to sell. He helps me to learn, he gives me advices.**"

Property: encouragement

Participant # 3 confirmed that her friend's support was a determining factor in the mobilisation of her personal strengths and skills. This was also the case of participant # 4 who talked spontaneously about the constant support that she had received from her sponsor

family beyond their original six months' commitment. It was acknowledged that previous participants had talked very positively about the help given by individuals and so she was invited to elaborate. Her statement permitted the development of the property empathy and confirmed the one of *encouragement*.

**"You know R and D they came to see me everyday because they knew I was alone at home. And then we were talking, and we went to the shop, they knew some Hallal meat and food. They encouraged me all the time. I was not afraid anymore; I was not alone any more. I was very happy with my Kiwi friends because they have been like a family to me. If R and D had not been there I could not have learnt English."**

*Properties: Empathy, encouragement (strong, constant)*

The following theoretical memo was written after this interview:

*"09.05.07: "Participants # 4 underlined that her sponsor family has been a major player in adjusting gradually to Christchurch. After four interviews, it became apparent that the support of New Zealanders or friends is critical. Is it because individuals in contrast to agencies are more available, recognise their capacities, are more "human" when approaching and supporting refugees during the resettlement process?"*

At the follow-up interview, participant # 4 agreed with this explanation and added that she felt more comfortable and "free" with her sponsor family because of their availability in comparison to agencies' staff. As the research was progressing many participants highlighted that "one" person had contributed significantly in boosting and nurturing their personal resources thereby facilitating their resettlement in Christchurch. Their statements corroborated the possible explanations noted in the research diary. For example, participant # 8 stated:

**"I have been lucky to have a very helpful Kiwi woman. She looks at the problems and she tries to find the solution and treat us as a New Zealander. She gave me a lot, she helps others by listening, encouraging me, us. She gave us good morale. If she was not there many people will have more problems than they have now. With groups this is very difficult. Last year, we have tried to have meeting with Mayor, refugee agencies, nobody responded to us, they did not send answer to our letter."**

*Property: treat us as equals, encouragement*

Similarly participant # 12 replied:

**"My actual boss has helped me a lot. Before working for him, I had my first job with a lady who was a bully. She did not have sympathy or respect for me.../... He gave me the chance and he could see the results! .../... After few months, he offered me to work full time with**

**responsibilities and challenges.** It was difficult during the first year, better the second year and now it has improved a lot. **I am really accepted and recognised** as a team member. "

*Properties: give the chance, recognition*

Participant # 12 also mentioned another person who taught him how to drive and said:

"One Kiwi friend **helped me and taught me how to drive** here. Usually you do not find this type of **vital help** amongst agencies. Mr. D. helped me to get my driving licence; **he was going out with me. He helped me to become independent.** Having a car here is important because **it helps you to have the practical control of your life.**"

*Property: practical help*

Participant # 15 confirmed previous opinions by saying:

"**My sponsor, she really helped me, helped us a lot.** She helped me **from her heart, she cared so much and she was suffering for me.** She was with me **all the time. She changed my life, she loved us and she was always very kind for us. She did a lot to find practical solutions with us.** It has been the most important support. **She is still helping us** a lot after all these years."

*Properties: empathy, practical help, encouragement (constant)*

This interview prompted the holding of further interviews to endeavour to establish what participants perceived as being the major roles played by caring individuals in their contribution to the development of adult refugees' coping processes in their adjustment to New Zealand. After fifteen interviews the following memo was written in the research diary:

*"30.07.2007: most of the participants have mentioned that the informal support they received from New Zealanders (either sponsor or anonymous persons such as participant # 2) was/is still a decisive factor in motivating adult refugees to mobilise their capacities by encouraging, helping them financially, caring and acknowledging their personal resources. No negative statements have been collected. The category caring person is established as well as its properties and dimensions."*

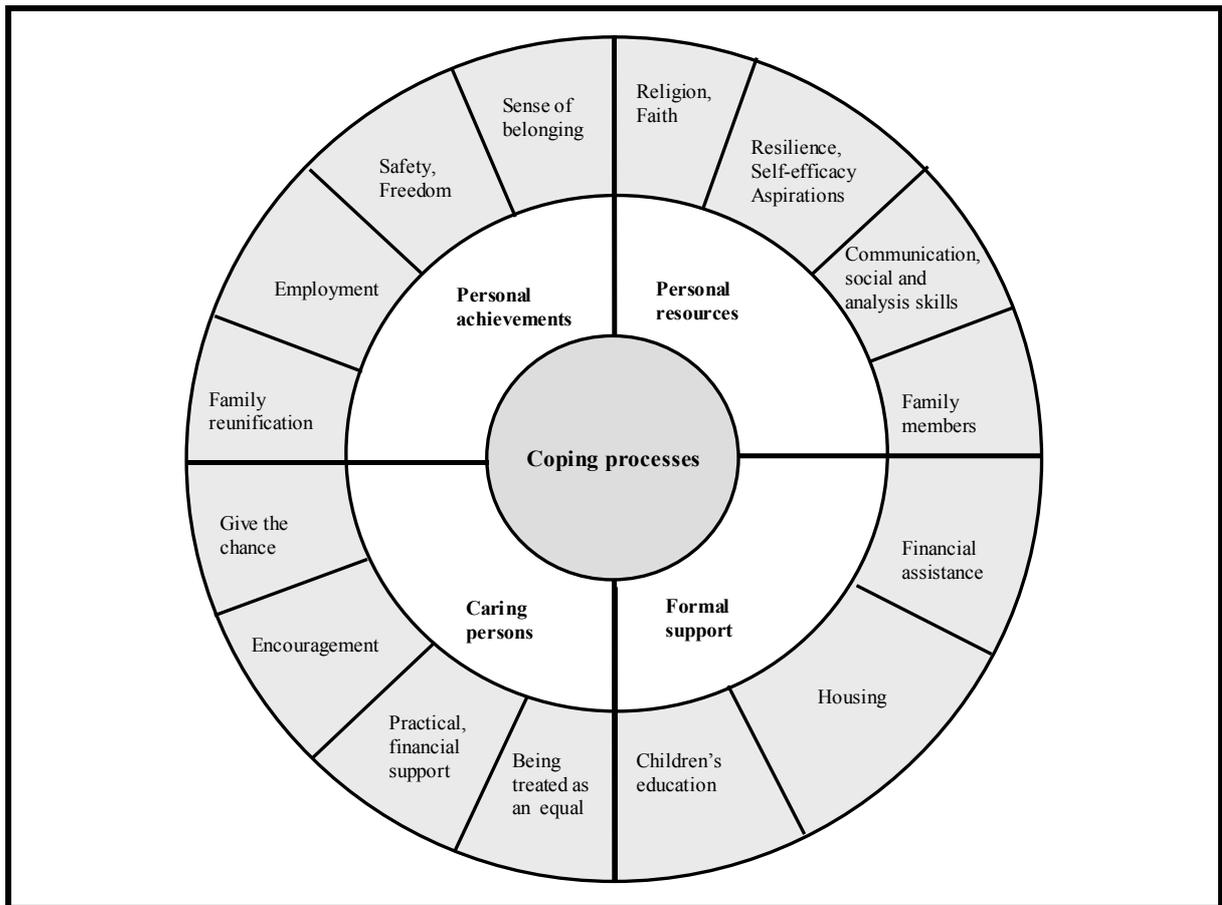
As data collection and analysis were progressing, information relating to the category *caring person* was assigned with the properties: *give the chance/recognition, empathy, treat them as equals, encouragement and practical help* as presented in Appendix G, Part # 3.

### 5.2.4 Factors adult refugees talk about as contributing to their coping processes

At that stage of phase 2 of the analysis, it appeared that the research question: "Which factors contribute to adult refugees' coping processes to overcome resettlement difficulties and to adjust to life in New Zealand?" had been addressed. The main factors which participants talked about as contributing to this dynamic included 4 main categories as indicated as follows:

1. *personal resources* which they described as social and analytical skills and varying personality traits amongst which the most cited could be associated to a certain extent to the Western concept of resilience (i.e. determination, flexibility, acceptance, hope, etc.) and perceived self-efficacy. Religion and faith as well as family members were reported by the majority of the participants.
2. *formal support* which they referred to financial assistance, housing, education for children,
3. *caring individuals* which they referred to people providing them with empathy, constant encouragement, pragmatic support and "give them the chance", and
4. *personal achievements* which they described especially as the obtaining of physical safety, satisfactory employment, personal and family integration, family reunification, material acquisitions (*to avoid repetition, this category and related categories will be explained in the subsequent section 5.3.1 "Categories relationships"*).

The combination of those factors and characteristics resulted in the figure 3 presented below.



**Figure 3: Factors adult refugees talk about as contributing to their coping processes**

Indeed, participants indicated that their acceptance of the situation and being determined to obtain a better life stimulated their personal efforts to solve some of their daily problems. The availability of a caring environment (financial assistance at the earliest stage of resettlement and supportive New Zealanders) acknowledging participants' strengths by encouraging them and giving them the chance to move forward was described by many as being critical in boosting their self esteem and capacities so as to challenge resettlement adversities.

Such a combination permitted participants to achieve gradually some of their initial expectations, physical safety and family reunification being the first ones. Nevertheless, other achievements especially obtaining work were described by all participants as a priority to achieve so as to cope with their new lives (as explained in the subsequent section 5.3.1, "Categories' relationships") as well as to engage with the mainstream society. Not being able to interact with the latter was identified by the majority as accentuating their sense of worthlessness and potential distress.

As the analysis progressed, data suggested that these four factors were interrelated strongly and contributed significantly to the development of adult refugees' coping processes. For example, the availability of a caring person encouraging participants appeared to influence the activation of their personal abilities. Being able to access work permitted participants to regain self-esteem and demonstrate their various skills. Indeed, participants frequently emphasised that if this interaction was not activated they faced greater difficulties in coming to terms with their new environment and in their adjustment to life in New Zealand, thus leading potentially to adverse mental health outcomes.

### **5.2.5 Summary of the identification process of categories' properties and dimensions**

As indicated previously in the literature review on grounded theory, the researcher has to show carefully and comprehensively the various steps s/he has taken in arriving at the conclusions. Indeed, this is part of the methodology procedures.

As an example, the identification of categories' properties and dimensions during phase 2 of the analysis, it was possible to ask more precise questions because of the increased understanding of the categories identified in phase 1 so as to define their properties and dimensions. When questions appeared to be poorly understood, drawings or examples were used to ensure participants' comprehension. They put a high degree of concentration and effort into endeavouring to respond adequately as well as to ensure that their views were understood. Additionally, regular guidance and feed-back was received from one of the supervisors, who had conducted research using grounded theory, for integration into the methodology process. For example, I had experienced confusion with the differing terminology found in the literature and wondered if properties and subcategories meant the same when approaching the phase 2 analysis. He commented as follows:

*“These terms are often used interchangeably so I would just suggest you be consistent with whichever term you use. Another term is “dimensions”. You will, of course, be starting to discover both similarity and variation in how participants describe and perceive phenomena of interest to you. These data help you to understand the different dimensions of your sub-categories. One thing about grounded theory is that there is a lot of jargon words to become familiar with. You will need to decide on the word/words you will use and not become distracted with the others.”*

This highlighted the importance of choice of words when illustrating the analytical process. It was essential to use identical terminology throughout so as to avoid confusion and to keep the research process understandable to the reader.

Regarding the elaboration of properties, I was concerned about the emerging category *fragile community* and the impression that participants did not seek or expect support from their peers because of existing tensions. I mentioned this issue to my supervisor because it contradicted the common assumption that community support is an external contributing factor to the coping processes of refugees whilst resettling. That was the reason for my choosing the establishment of this category rather than including it within a broader category. He concurred, but advised me to verify if this view was shared also by young adult refugees and how they cope because their input could provide new insights into this developing category. This was documented in the research diary as follows:

*"30.07.07: I have asked participants # 17 and # 18 how they currently perceive their communities of origin and if existing tensions affect their adaptation process in Christchurch. Although they recognise that divisions exist, yet they keep away from "negative" influences which they consider to be part of history or adult rivalry. Young adults try to communicate with everybody from any community and to help each other. They explain to their parents that they are living now in New Zealand and that continued "fighting" here does not make any sense. Their vision contrasts with adults, thus resulting in the identification of the property adult rivalry. "*

As the research progressed, varying participants' perspectives and experiences made me aware of the significance of theoretical sampling in order to maximise and illustrate the variation of adult refugees' coping processes during the course of resettlement. This was explained to the Canterbury Refugee Council (CRC) which was supporting the research. Nevertheless, after four interviews, I noticed the CRC tendency to refer some of their own relatives' members as potential participants in the research. I declined their offer and proposed another meeting with the chairperson so as to clarify the importance of having participants of different backgrounds and experiences to describe the phenomenon under study. This was very well understood and at the seventh interview the following was written in the research diary:

*"The CRC chairperson has understood well why participants have to be selected according to the emerging research findings. When I explained to him that so far most of the participants were not satisfied with the formal support they received, he said: " Do you need refugees who are happy with the support?" This is also understood by sponsor families who had put me in contact with potential respondents. "*

Another event which underlines the collaboration and understanding of the sampling process by the CRC occurred four months after the commencement of the research. At that time, the chairperson proposed extending the research to include Burmese refugees resettled in Nelson. He viewed their contribution as an added value because of individuals' different backgrounds (i.e. geographical, cultural and having arrived during the past two years in New Zealand). Consequently, he helped me to contact the RMS representative in Nelson who welcomed the proposal positively and recruited five Burmese former refugees according to the selection criteria. This information was shared with my supervision members who agreed with this idea. Over a period of two days at the end of August 2007, interviews were conducted in the RMS office with the support of an interpreter.

### **5.2.6 Conclusion phase 2 of the analysis**

Phase 2 of the analysis marked the transition from identifying categories in phase 1 to explaining and describing their properties and dimensions. This was achieved through theoretical sampling by selecting participants according to developing results. Participants' statements were compared and contrasted constantly so as to maximise data variation between participants as the analysis and coding were progressing. This required a close re-examination of transcripts and the categories' detailed points listed in Appendix F. Additionally, methodological and theoretical memos as well as diagrams supported this ongoing thinking concerning adult refugees' coping processes whilst resettling.

To help demonstrate how properties were determined from the data, Appendix G, Part # 1, 2 and 3 include sections of narratives to support the categories' "*personal resources*", "*formal support*" and "*caring person*". An identical process has been applied until all categories could be illustrated and saturated meaning that further interviews would not provide any additional information. This process led to the progressive reduction of the original broad database so as to identify 48 properties (see Appendix H) relating to the 12 categories as described in Appendix E.

## **5.3 Phase 3 of the analysis**

### **5.3.1 Categories' relationships**

Phase 2 of the analysis permitted the identification of the factors contributing to adult refugees' coping processes by describing categories' properties and dimensions detected in the

data and reducing them to a conceptual level. At that stage it was necessary to demonstrate how they related to each other so as to initiate a theoretically integrated explanation of adult refugees' coping processes in the course of resettlement. As indicated earlier, grounded theory as a qualitative methodology, by contrast with quantitative methodology, does not infer causal relationships between variables. It is more concerned in establishing which types of incidents, context, intervening conditions and consequences are relevant in explaining how social experience is created and given meaning.

In this study, categories' relationships were developed by questioning the established categories<sup>52</sup> during phase 1 of the analysis such as: "How resettlement difficulties impact participants' personal resources? Why and/or how having a caring person contributes to participants' coping processes?" Such a process aimed at supporting the development of a theoretical explanation on how adult refugees viewed and gave meaning to their coping processes to overcome resettlement adversities and adjust to life.

- *Initial expectations and resettlement difficulties*

As identified in phase 1 of the analysis, data indicated that resettlement difficulties included practical problems (lack of English, administrative regulations), socio-economic constraints (financial insufficiency, chronic unemployment), socio-cultural difficulties (culture shock, social isolation, stereotyping). A large proportion of participants reported having faced language barriers which they thought prevented them from obtaining employment. Those who spoke English and had professional experience mentioned that because they could not "confirm" their skills such as their previous professional experience or diplomas. They reported having been obliged to accept low-skilled and consequently low-paid work. This resulted in financial hardship and a strong dependence on the social welfare system or family members to cover their basic needs. Interconnected with these adverse circumstances were emotional difficulties, especially during the first 6-12 months, summarised by the participants as feeling like an alien, sad, uncertain, pessimistic, lost and inadequate because of their inability to engage with the mainstream society. Indeed, some of them described being caught between "two worlds": their original country to which they could not return and a new country which appeared reluctant to accept them.

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<sup>52</sup> For example: What is going on? When does this happen? How does the person react? When, why and how does the process change?.

During phase 3 of the analysis, participants explained how those difficulties had forced them to downgrade their initial expectations usually described by having a better life and challenged their personal abilities with the realisation that adjusting to New Zealand was more complex than they had anticipated. This progression was clearly expressed by participant # 12 who arrived six years ago in New Zealand. He explained how life in New Zealand was different from what he had expected. This caused him to reconsider his initial plans but that his personality traits had helped him to overcome a variety of problems as indicated in the following excerpt:

*Participant # 12:* “**I was thinking of going back to University** to study Anthropology or History to come up with a PhD, it was really a dream, but **it was unnecessary.**”

*Interviewer:* “*Why was it unnecessary?*”

*Participant # 12:* “I have studied all my life including philosophy. **This kind of study makes people unrealistic, misfit in the real world, pessimist and timid. It was my situation** due to my knowledge and also to my personal experience: I could not go along with people because of my intellectual background.”

*Interviewer:* “*Was that because you were at an intellectual level that people could not reach?*”

*Participant # 12:* “You know Nietzsche said that when someone is flying high and high and high, he becomes invisible. It was my case and this affected me because **I was isolated from the real world. It was not good for New Zealand which is a pragmatic country and I questioned myself a lot.** I was not proud of what I did and learnt before. I wish I would have been more useful in terms of Western life expectations.”

*Interviewer:* “*What do you mean and how did you manage?*”

*Participant # 12:* “. **I wanted anyway to find my right place,** not too low not too high. So **I was not assertive, and was very flexible at that time.../...I had a logical approach** and I decided to have achievable, realistically possible goals in New Zealand.”

Similarly participant # 19, who arrived 9 years ago after having spent many years in a first asylum country, explained that on arrival he had many “dreams” of earning a lot of money and “starting a new life”. After a few weeks, he mentioned realising that some of his aspirations had been over-optimistic because his lack of professional and English language skills inhibited employment. When asked what had continued to motivate him he emphasised that his strength of character and a revision of initial plans helped him to define “easy objectives”.

Conversely, some indicated having persisted with their initial expectations of gaining a "better life". They continued to believe in ultimate success simply because they thought that as they had experienced the worst which could befall them, then their capacities to deal with daily stress would be sufficient. For example, participant # 13 arrived thirteen years ago in Christchurch. He mentioned that his first priority was to use his knowledge and make personal efforts to be accepted by the mainstream society because (i.e. "behaving correctly, being careful to avoid misunderstanding because of my poor English", "working hard").

Participant # 15, severely traumatised prior to arrival resulting from persecution and years in camps, did not have high initial expectations. She stressed that her experiences, however, had taught her how to be strong and how to survive which she perceived as being an important factor which had influenced her behaviour in adjusting to New Zealand as indicated in the following excerpt:

"I have learned how to be strong and how to survive and manage with life. I have experienced the worst and I have learnt how to hope. Today, I feel alright, it has been so difficult before that I cannot complain too much. I cannot say that there is nothing for me here. I am fine. I had to change myself to adjust because you cannot be stucked in your own culture here; this is an interaction with the Kiwis, between people. "

As the analysis was progressing, participants frequently identified that their acceptance of their situation and "nowhere else to go" were important factors enhancing that appraisal process. Additionally, data suggested that when personal weaknesses and host society blockages were identified, participants started to put matters in perspective by reframing their priorities and concentrating on achievable goals in line with their perceived abilities so as to adjust to their new environment. Many acknowledged, however, that this was insufficient and that they needed external support to overcome resettlement adversities.

- *Personal resources, formal support and caring person*

Formal support, caring person and personal resources were three categories identified during phase 1. Data analysis suggested that the three influenced each other and were related with the process already outlined. Indeed, participants reported that when difficulties were appraised, they had to rely on their inner resources which they frequently identified as family members, resilience characteristics, self-efficacy, religion and/or faith. Additionally they sought external

support either through formal support and/or caring persons to resolve some of their adjustment problems and the stress associated with them.

In addition to personality characteristics (i.e. determination, flexibility, acceptance) the most personal resource to deal with daily hardship related to family members who helped them to find practical and emotional stability. Family reunification refugees reported that they relied heavily on their relatives for bureaucratic matters, financial assistance and provision of initial accommodation. On the other hand, quota refugees regarded being reunified with their family as the most vital factor in alleviating their emotional distress. For example, participant # 13 emphasised that by saying:

“You know I can see around me many people who are worried and cannot go ahead with their life because their family is left behind. That point is very important to consider because if people are reunified they are free in their mind and can integrate better.”

This was illustrated further by participant # 15 who described how the length and complexity of the immigration process over the past four years, when trying to have her estranged family reunited with her in New Zealand, had made her constantly worried and depressed. She associated her frequent asthma crises and consequent hospitalisations with this on-going preoccupation. At the follow-up interview, she mentioned that her family's immigration application had been accepted and that her relatives had arrived a few weeks previously in Christchurch. Her change in attitude was significant and when asked how she felt she answered: " Now, I am free, I can fly!" She pointed out that her doctor had been surprised about her health improvement which without doubt she attributed to this successful event. Similar examples were collected throughout the interviewing period. Family members were described by most of the participants as a major resource in coping with emotional problems. Moreover, all the parents indicated that their children were their main source of motivation in maintaining their morale and giving a meaning to their flight and to overcome resettlement adversity.

As the analysis was progressing, all participants reported being satisfied with the formal support given to their children, especially in terms of formal education which was seen as the key to their future success. This was not the case with the adults themselves who expressed varying opinions regarding the effectiveness of social and resettlement services providers. Information from services providers and orientation to social services was perceived

frequently as inadequate because it was either too complex (computerised information requires skills which many participants do not have) or unfriendly (lack of empathy by support providers). This accentuated the stress linked to language barriers and feelings of inadequacy. In that respect, many participants, regardless of their gender and refugee classification, explained that English classes were too complicated and did not provide them with the practical language skills with which to deal with their daily lives and/or obtain employment as indicated by the following statements:

Participant # 7: "Here nobody asked me what I can do. I think that they will not ask me because I do not know the language. I go to English classes, but this is not enough. I have homework but I cannot do it because nobody can help me. Often we do not understand the teachers. They ask us to find a word in a dictionary but it does not exist in Somali language. It is difficult when you do not speak English. But you know when I was in Ethiopia, I was able to talk the language and this helped me to work. To do business, it is important to understand the language to explain. For example if you have a shop with fruits and people ask you what it is, it is a problem if you cannot answer."

Participant # 12: "For the English classes, bilingual teachers are very good to support refugees and obtain successful results. Often, adults receive too many copies; teachers give them papers on Pukeko birds or about life in Antarctic instead of teaching them more practical vocabulary. Teachers do not involve themselves enough. Maybe it is beyond their capacity? They are indifferent of their progress or not. They just want the students to be happy. They over-exaggerate acceptable results and never underline the mistakes. This does not give any value to the work. In fact they encourage people to make them happy instead of correcting them."

Nevertheless, some acknowledged that due to their poor educational background, finding the right tools was not easy to achieve. To this end, participants attending English classes emphasised that the availability of bilingual teachers was highly appreciated.

Another recurrent concern in relation to the poor perceived effectiveness of the formal support was that many participants indicated that they were insufficiently represented and not involved in the decision making process concerning refugees' assistance and policy formulation. They resented not being given the opportunity to be employed by and within the resettlement services system and thereby not given the chance to use their own resettlement experience to help newcomers as indicated in some of the participants' statements:

# 8: "The agencies do not help us. As individuals they help but not as organisations. We miss coordination and miss voice representation. The forums are more for the agencies or NGOs'. They do not employ refugees to help others to create connection and develop network. They

have some refugees acting as interpreters but that is all but they do not involve refugees when decisions have to be taken."

# 9: "Former refugees should be involved in supporting each other and helping the newcomers. .../... You know, we need to be involved. One refugee said in a forum nothing about us should be without us! I am quite involved to make the Kiwi understand our difference, that as refugee we are not a burden and that we want to be seen a positive part of the country. That we want to have responsibilities, and that we are able to carry things on our shoulders too. We can add to the colour of the society also."

Financial hardship and insufficient income were also recurrent issues, however, data revealed a variety of opinions regarding governmental financial assistance. Quota refugees were, in general, appreciative of the financial and practical assistance they received on arrival because of their initial culture shock and vulnerability. Many mentioned that they were grateful to the New Zealand system because they had learnt or were learning English, had obtained a part-time job, had a good house and seen their children successful at school. By contrast, some "negative" cases were also identified. For example, participant # 11 agreed that welfare assistance was crucial on arrival but considered that further support to access job opportunities was inefficient and kept adult refugees dependant on unemployment benefits and isolated from the mainstream society. She ended by saying that "nobody" was detailed to keep track of them so as to ensure how they were coping. She was wondering, therefore, if she and her family should not move to Australia for a better socio-economic life. After analysing her transcript, the following theoretical memo was written:

*"Quota refugees are grateful for initial financial and practical assistance during their first months of resettlement. This earlier satisfaction with government and agencies' support seems to turn after few a months to frustration. Is that because of the lack of recognition by social services of refugees' previous experiences? Is that because former refugees' social needs are not considered?"*

At the follow-up interview she was questioned about these possible explanations and her response was documented in the research diary as follows:

*"Participant # 11 acknowledged that being a benefit recipient makes people regard themselves as different and helpless because they cannot demonstrate their capabilities. This affects their morale because they have to stay "at home". She stressed that agencies do not understand that refugees have survived difficulties greater than language or a cold climate but they are not given the chance to establish a life for themselves. In her situation, she did not see any major change in her life since her arrival six years ago and feels "sad" at being obliged to rely on the welfare system because financial assistance is too low to cover all her family needs (i.e. school uniforms, books) and not being able to work."*

Her statement confirmed that in addition to financial constraints, the lack of recognition of individuals' past experiences to survive and lack of gratification of personal competences were considered by many participants as causes affecting negatively their self-esteem and confidence. As interviews continued, participants confirmed the importance of formal financial and practical support to cover their basic needs. By contrast, most of them perceived this support as inadequate to cover their social needs which started to dominate after the initial 6-12 months period of resettlement. Poor support to access the labour market and consequently to engage within the mainstream society was considered by all participants as a major source of stress and impediment to their adjustment in New Zealand. Dependence on unemployment benefits after more than a year or two was identified by the majority of participants as a main cause accentuating their feelings of worthlessness because of limited financial resources and non-participation in meaningful activities. Many stressed that this affected also their future perspectives because they could not find opportunities and motivation in new contacts and experiences with which to develop life's objectives.

Interestingly, as interviews continued, some participants expressed similar dissatisfaction but stated that they could find unskilled work easily if they wanted. This contradiction resulted in the following memo:

*"People expressed clearly their frustration at being dependent upon government benefit because of the perceived stigma of unemployment and out of the main stream society. At the same time, some showed a reluctance to accept just "any kind of job". Is that because of language barriers, insufficient wages or because they see some types of work as being beneath their educational and/or professional capacities?"*

For example, participant # 16 had worked for eight months and was then made redundant because his employer had encountered economic problems. He disagreed that being on benefits impeded his engagement with mainstream society. According to him the minimum wage, more than English language barriers, discouraged acceptance of unskilled and often physical hard work and could explain why some refugees preferred to stay on the welfare system. Participant # 22 shared the same view and questioned the policy whereby as soon as people started to work, then benefits are reduced, thereby decreasing "real" household income because of additional costs related to transport to reach their work places and income taxation.

As identified in phase 2 of the analysis, the same inadequacy regarding health services was perceived when encountering emotional difficulties. Those who had to undergo mental health

care treatment felt a lack of connection with the health care providers and emphasised that drugs did not help them. The majority of participants mentioned that they mistrusted the health system because it “does not solve the problems” and subsequent distress which they frequently linked with the practical issues of resettling. They questioned the individualistic Western medical approach which is at variance with their cultural values and which excludes their family members and/or religious or influential community members during the caring process. Many mentioned their unwillingness to share, even with an interpreter, their mental difficulties which they considered to be private matters. They believed that understanding their emotional suffering was beyond the health care providers' competence. For many only God or Allah has that ability, so religion or faith was the first cited personal coping resource. When asked if medical or psychological support could help them to overcome their past trauma, they said they were disinclined to discuss any prior tragic events and preferred to “move forward” on their own.

In summary, data suggested that the reported inadequacy vis-à-vis formal support often resulted in bitterness and personal frustration because of participants' inability to interact socially with the New Zealand society. When asked what could be done to improve their current situation many participants highlighted that Christchurch society should be more open-minded and treat foreigners with tolerance and to acquire an acceptance of cultural differences. Interestingly, many respondents stressed that former refugees should also make more effort to comply with the resettlement requirements and not always to be blaming the system. For example, participant # 14 stated that the government was spending a considerable amount of money on support and that refugees should be “honest and work hard”. Participant # 18 stated that refugees should respect New Zealand's rules and give back to the host society because it should be a reciprocal relationship.

At that stage of the analysis, data suggested that the described and perceived limitations of resettlement and social services directed participants' choice to other types of support. Many, when having the opportunity, turned to caring individuals (often a New Zealander or a close friend) who were seen as a fundamental source of support in realising some of their objectives and improving their sense of well-being. This “personalised” assistance was identified frequently by the participants as being more effective than formal support because it provided them with encouragement, empathy and pragmatic solutions (as detailed in previous section 5.2.3). After seven interviews, four participants had highlighted that “one” person had

contributed significantly in boosting and nurturing their personal resources thereby facilitating their resettlement in Christchurch. This resulted in the following memo.

*"Sponsor family or anonymous New Zealander has been a major player for some refugees to adjust positively to Christchurch. After seven interviews, it appeared that the support of New Zealanders or friends had been critical in strengthening or developing participants' abilities to overcome their problems thereby contributing to their mental well-being. Is it because individuals, in contrast to agency staff, are more available and respectful, recognise their capacities, are more "human" when approaching and supporting refugees during the resettlement process?"*

As interviews were progressing, many participants underlined the importance of having "someone who upgrades you" (participant # 12) to re-establish their self-confidence by treating them as an equal and giving them the chance to demonstrate their abilities. To this end, all quota refugees indicated to be very appreciative of their New Zealand sponsor families. On the other hand, family reunification refugees who are not entitled to this support expressed their indebtedness for help given by "anonymous" New Zealanders. For example, participant # 2 declared that one "Kiwi friend" played a major role during his adjustment in Christchurch by explaining to him how to "behave", finding him a job and lending him sufficient start-up finance in order to launch a successful local business which he reimbursed a few months later.

Although some participants did have friends within their community of origin who had helped them, the majority reported that they did not rely on the support of their peers because "each family has enough difficulties in coping with its own problems and can hardly help others" (participant #12). Moreover, the majority of the participants indicated that they did not trust members of their "community" because of mutual suspicion and distrust linked with historical events, current conflict and/or cultural sub-group divisions as indicated for example by participant # 2:

"I get some support from a Kiwi friend but not from the Somali community. As you know, we have a problem back home and what's going on at home, war, is going on here. Therefore, my community did not help me at all, except few Somali personal friends. The Somali community does not exist at all. There is a kind of skeleton but it does not work anyway".

Additionally, some viewed negatively the funding of formal community bodies because of the "manipulation" by some of the community's leaders. They considered this could, paradoxically, exacerbate the split in their community. Others indicated that being successful

or trying to integrate into the host society sometimes caused jealousy and cultural blockages within their own group. This was the case for some single mothers who had taken a leadership role in raising their children and therefore became independent as indicated by participant # 15 who said:

"People are jealous if you succeed, if you have more than them. They judge you badly when you can manage because they do not understand, they do not know."

Nevertheless it appeared that some men started to accept this role change and supported their wives to learn English, to drive and to find a job. For example, participant # 21 was very proud that his wife worked as a driver because this would never had been possible in his country of origin. By contrast, young adults were willing to develop a good relationship with their peers and avoid community in-fighting. They indicated that this was made possible because they could mix with others while being at school compared to their unemployed parents who were unable to network except with other refugees.

- *Coping strategies (reducing emotional stress and/or solving the problems) and obtaining a social position*

Being economically self-sufficient and being regarded as a New Zealander were central and recurring concerns of participants who often associated both as essential pillars to reach "a good position within the society". To this end, data suggested that participants developed two main coping strategies, categorised in phases 1 and 2 of the analysis as: *reducing emotional stress and/or solving some of my problems*, these categories summarising participants' skills and behaviour to deal with resettlement adversity.

Data suggested that during the first months of resettlement, reducing emotional stress appeared to be the most frequent coping style when facing life changes. The most described behaviour included, first of all, praying and appealing for help and strength from Allah or God. This was followed by avoidance of, and/or distancing themselves from, resettlement barriers and pre-migration experiences, exercise and relaxation techniques and exchanging feelings with family and friends. Such behaviour was described frequently by participants when they had to deal with situations which they were unable to influence personally. This included, for example, immigration bureaucracy to bring in their family, culture shock and perceived inability to operate effectively within a new environment and life's crises such as

inter-generational problems or divorce. For example, participant # 7, who was very worried because of her grandchild left behind, found help through praying to Allah and said: "Allah is the only one who can help me to be strong". On the other hand, participant # 12 had chosen to avoid exposure to negative situations such as world news and people from his community who he identified as being the main cause of his "turmoil and agitation".

Religion and faith were described as being powerful sources of comfort when facing emotional difficulties. Religious belief was described by participants as the main motivator to function within the host society by encouraging active problem solving and acceptance of the situation. This was clearly described by participant # 5 who had experienced a long period of unemployment because of his age and non-recognition of his previous qualifications. His acceptance of the situation helped him to cope with this uncertainty and he named religion as being his main support:

*"Because of our strong belief in our God, I thought that everything will be okay .../... We have a saying God tells us to move first and then he will give help". This means that if you do not move or if you just sit, nobody will help you. This is the idea. I think it has some relation with Christianity because it is said that if you knock the door, the door will be opened. If you ask you will be given. The same idea is with us in the Holy Koran, Always be smart and look for the things, don't stay and wait that God gives you everything."*

After a period of three to twelve months, participants explained that they started to develop a problem solving strategy in addition to reducing emotional discomfort. It seemed that family reunification refugees and single mothers (widows or women separated geographically from their husbands) were able at an earlier stage to make personal efforts and find rapid solutions to ensure their household's economic sufficiency. Data suggested that such a necessity led to problem solving behaviour by an active mobilisation of personal and/or external resources (i.e. learning English, how to drive, finding unskilled work) to cover daily living costs.

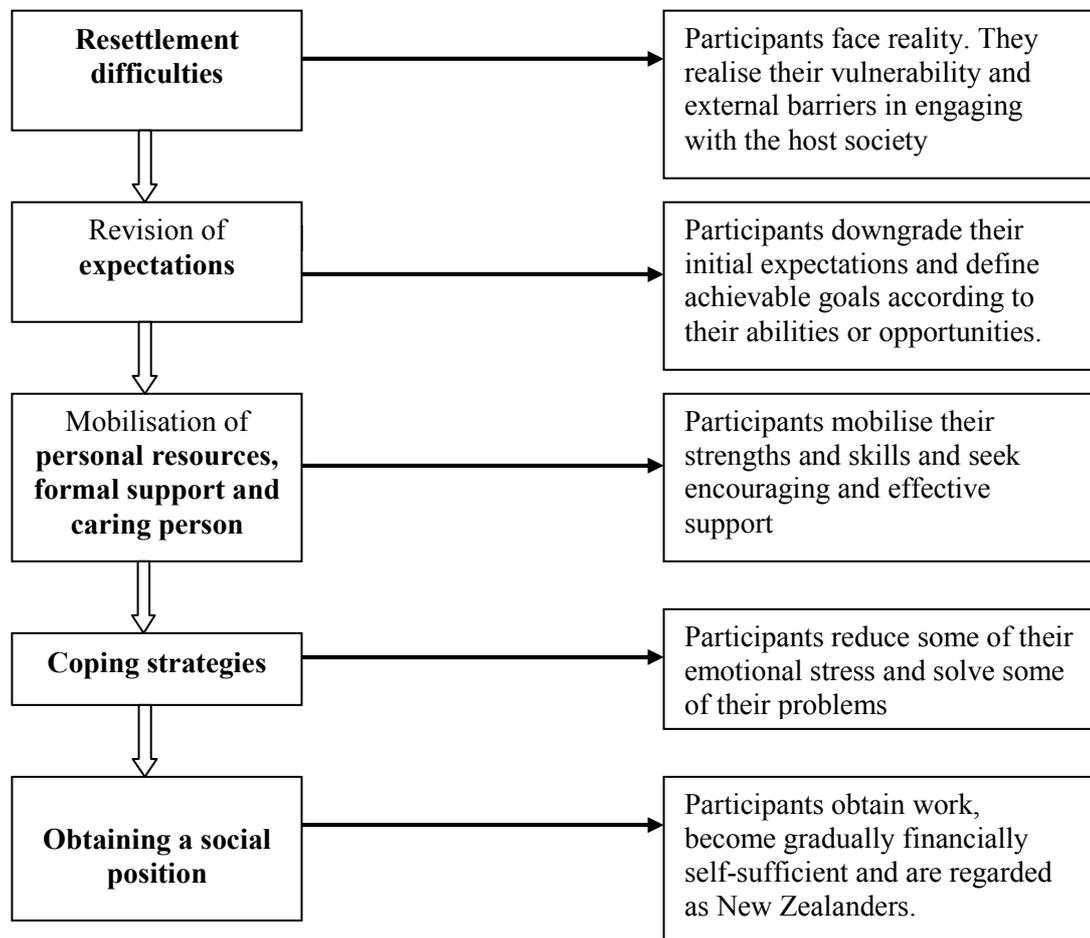
After thirteen interviews, similarities and differences within patterns of solving problems were noticed. Of eight participants who were working part or full time, four had an excellent command of English and previous professional experience whereas this was not true of the other four. When seeking to establish if there were any behavioural differences between both groups, data indicated that those who did not face language problems had managed to obtain work because of their personal *flexibility* by being prepared to accept an activity usually below that for which they had been trained. For example, participants # 1 and # 5 who were

teachers in their homelands became a taxi driver and a part time bilingual teacher respectively. Participants # 2 and #12 became a shopkeeper and a team coordinator. They explained their flexibility by emphasising their need to maintain a positive self-image and to overcome constrained circumstances so as to regain control over their lives. By contrast, data suggested that those with lower levels of flexibility faced greater difficulties. For example, participants # 6 and # 8 expressed their past sacrifices in obtaining university degrees. They considered themselves to be sufficiently qualified and competent in their chosen fields and indicated being reluctant in searching for other options. Similarly, participant # 9 was still looking for an occupation "by choice and not by chance" according to her previous high social status in her country of origin. Those with a limited command of English and no professional skills reported frequently their strong determination and personal capacities to secure a good life. They accepted unskilled work such as cleaners, factory workers, where verbal communication was basic, thereby enabling them to confront and solve their unemployment problem. These practical options were described as being important to start their adaptational process into New Zealand.

Data suggested that the choice of one coping strategy over another appeared to be directed by participants' specific socio-economic and/or emotional needs and was reassessed accordingly. It appeared to be influenced by the length of residence in New Zealand, gender and participants' perceived burden and control over daily challenges. Whereas "reducing emotional stress behaviour" was used to deal with situations which participants could not influence (e.g. family separation and crisis, losses, immigration bureaucracy and legal barriers) "solving problems behaviour" was used to manage practical issues (English proficiency, transport, unemployment) because participants considered that they had the capacity to do so.

At that stage of the analysis it became apparent that specific aim # 1 relating to adult refugees' resettlement experiences, coping processes and resources so as to overcome resettlement adversity had been addressed. The seeking of categories' relationships to explain the occurrence and development of adult refugees' coping processes enabled the identification of

a gradual coping process made up of seven interrelated categories described by the participants. This progression was noted in the research diary as illustrated in figure 4<sup>53</sup>.



**Figure 4: Gradual coping process adult refugees describe so as to obtain a social position**

It was not possible to establish a realistic time frame for the processes outlined in figure 4 because of disparities occurring between individuals. Indeed, at the earliest stage of their relocation participants frequently described that they confronted *resettlement difficulties* which made them realise that they might have had unrealistic *expectations* vis-à-vis the host society. Many indicated that this initial appraisal forced them to downgrade their prospects and to re-define achievable goals based on their *personal resources* and available external support (*formal support* and *caring person*).

<sup>53</sup>As indicated in the literature review on grounded theory, the construction of diagrams can help to comprehend the final theoretical explanation by showing how categories relate to each other and the core category by visualizing their relationships through a graphic version

Data suggested that *coping strategies* were developed according to participants' personal and external resources and their level of control of events. Solving the problem or reducing emotional stress were two strategies used interchangeably according to participants' difficulties combined with their intention to *obtain a social position* within New Zealand's society.

- *Level of life satisfaction , personal achievements, lack of control and obtaining a social position*

Those four categories identified in phase 1 of the analysis were related to the ongoing process outlined previously which was readjusted constantly according to personal outcomes identified as *personal achievements* and/or *lack of control* which resulted in varying *levels of life satisfaction*.

In phases 1 and 2 of the analysis, all participants acknowledged having been able to achieve protection and freedom followed by different levels of familial, social and professional accomplishments. Despite resettlement adversities, they expressed strongly their sense of belonging to New Zealand which they associated with the obtaining of New Zealand Citizenship coupled with their children's future and their inability to return to their countries of origin.

In phase 3 of the analysis, it appeared that despite naming New Zealand as their "new home", participants' life satisfaction varied considerably. Whereas parents indicated frequently being satisfied and happy for their children to be able to embrace the host culture, yet many felt dissatisfied with their own personal situation because of not having been able to regain control over their lives. This variation seemed to be associated with the length of residence and their ability to attain some of their priorities. Indeed, to be reunited with their family was described by many as their main concern followed closely by being financially independent through having work. Being successful in achieving both was deemed to have a crucial role in maintaining morale, giving meaning to their flight and consequent adjustment to New Zealand. As an illustration, participant # 8 who arrived eight years ago, faced chronic unemployment problems despite his New Zealand degrees and had become very frustrated. He felt discriminated against because his competence was not recognised and he regarded himself as an "outsider" as indicated in the following excerpt:

"For me, I cannot work. Nobody gives me chance to work. I have Kiwi degree, they do not give me the job because they say that I need experience but how can I get experience if they do not give me the job? I try every time to be positive and happy, because of my children.../...However for me this is like being ON and OFF all the time. I have to be happy in front of my children, but unhappy for me because time is passing, I am becoming old and I achieve nothing."

After analysing his transcript, the following memo was noted in the research diary:

*"This participant expressed very clearly that despite New Zealand being his home, he felt he was not being considered as a New Zealander because of his unsuccessful attempts to obtain work. It appeared to affect severely his self-esteem and morale. Is it because he does not have a social recognition/function that he feels that he does not control his life?"*

At the follow-up interview he supported this possible explanation by stating:

"If I go back to my country I will be put in jail and certainly be killed. I am here now, I have obtained my New Zealand Citizenship and now I want to be treated as a Kiwi and have a status in the society by having a job. This is important for reconstructing me and finding my place. Yes, without this, I cannot control anything".

This statement highlighted that in all cases participants' life satisfaction went beyond the sphere of obtaining protection, sense of belonging to their new country and children's success. Indeed, data suggested that it was associated strongly with their ability to obtain an occupational and social status which participant # 8 described as being treated and regarded as a New Zealander. Moreover, this appeared to be critical in this particular case relative to his moving forward and overcoming past traumatic experiences.

As further interviews continued, similar statements were collected. Participant # 11 said that one of her difficulties, despite her New Zealand Citizenship, was being regarded constantly as a "refugee". She viewed this classification as separating refugees from the rest of society by emphasising their different ethnic backgrounds. She stated: "They say we are New Zealander but they do not treat us as New Zealander". When asked how this affected her life, she said that she had been put in jail in her homeland and obliged to live in camps because of her ethnic origin and, therefore, could not control her life. She felt the same alienation and distress in Christchurch because of what she regarded as the refugee "stigma" and being unemployed.

By contrast, participant # 12 who had been able to find satisfactory employment acknowledged that work had helped him to accept his situation and gradually regain

confidence because he was able to prove that he could contribute positively to his employer. He considered that, because of his hard work, he was respected by his colleagues and felt part of the team. Being able to be self-sufficient financially also gave him the possibility of making further plans such as writing a book on his culture and progressing in his profession. When asked why it was so important for people to have employment, he said that for any human being this was a crucial element in obtaining a social role within the country. According to him, work was the "key" by which former refugees could behave as "Kiwis" and thereby facilitate their integration. Similarly, participants who were working with New Zealanders reported that they were "somebody among them" and were satisfied with their lives despite missing their culture and original landmarks.

At that stage of the analysis, data indicated that having the same opportunities and obligations as New Zealanders was critical to interacting socially with other people, thereby reducing marginalisation and preventing psychological distress. A difference regarding a reported "good life" was noted during the interviews and further talks between those who had succeeded in obtaining work in comparison with those who had not. Chronic unemployment and its negative impact on self-image were identified by many participants as one of the main causes of their poor mental well-being despite their efforts to engage with the mainstream society.

- *Parenthood and obtaining a social position*

Another relationship between categories was the significance of obtaining a social position so as to assume parental tasks. Most participants were extremely proud and happy for their children, yet they shared deep expressions of commitment and concern about their parental role. They talked about their responsibilities to support their children until they could become independent and insisted on the importance of showing and teaching them good behaviour and values.

As the analysis was progressing, it became noticeable that unemployed parents, especially men, were more stressed when trying to achieve this parental function. Many male participants stated that not having secure employment forced them to stay at home. They associated this unintentional situation with their difficulties to influence or stimulate their

children in terms of being a role model because of their inability to demonstrate that working leads to success as indicated by the following excerpts:

Participant # 6: "Good things are done here for the children but nothing for the parents. You know the parents are dependant of the children and because of that they lose their authority and children are not respecting them and said "Now you have to learn English". You see, if there is no parents' responsibility, children start to drink, to smoke.../...Look here in Christchurch there are more than 1,000 refugees, only very few adults work. Why is it like that? You see parents cannot talk with their children, about life, about their work, about colleagues. Children go back home and find their parents completely isolated from the social world, what image will they have about their mum, their dad?"

Participant # 8: "Parents need to be strong also and for that they need job to show to their children the right way. How can parents influence their children to work hard at school if they cannot show them? Look, parents they stay at home all day long. When they say to their children "do your homework!" the children do not listen, they go to town and they smoke or drink. Parents cannot show the rules and this creates family conflict. It is very sad!"

On the other hand, participant # 10 found casual work within a few months after his arrival and when asked why it was so important for him to work, he replied:

"What you do with your hand, what you get is sweeter. It gives you good morale. You are responsible. If you have benefits you are not alive, you are out of the system. You cannot grow up and become somebody in the society and support your family. Each time, I am working, I feel that I am responsible of my family and I like supporting them. But whenever I get this unemployment benefit, I feel not responsible and I cannot show to my children that I care for them and that I am proud to work for them."

Furthermore, and as indicated previously through some statements, all participants considered employment to be a major factor whereby parents could understand New Zealand's culture and thereby comprehend their children's demands when adjusting to a new way of life.

Similar interviews created the awareness that obtaining social position also impacted upon adult refugees' childrearing responsibilities. Some participants described their unbalanced relationships with their children. Indeed, rapid language acquisition through access to education provides the young with communication and social skills which some parents do not yet have. This leads to a role reversal where children often act as mediator between their family and the new society resulting in dependency on children, parental disempowerment and sometimes loss of authority. Single mothers appeared to be the most affected and described pressures from their children, for example to buy expensive fashion items. Participant # 3 faced conflict with her teenage children because of her poor command of English, low salary and the

absence of a male/father role model at home. Nevertheless, all parents showed a high level of engagement towards their children and after eighteen interviews the following was noted in the research diary:

*"Because of the children's rapid adjustment to a new environment, obtaining a social position, especially through work, enables parents to understand their children's evolving behaviour and consequent demands. This is critical in ensuring that the parent/child family bond is both maintained and strengthened at a time when inter-generational cultural misunderstanding could cause family disruption."*

All parents indicated having some concern about bringing up children in an unfamiliar culture because of the risks of alcohol, smoking, using substances or mixing with unreliable friends. They mentioned placing significant importance on transmitting their cultural values such as respecting religious rules, cultural behaviour and speaking their native language to protect their children from perceived "insane" attitudes and preserve knowledge of cultural roots. Young adults thought that it was important to keep those roots, especially their mother tongue and traditional festivities. Although parental control and their cultural narrow-mindedness were sometimes perceived as "too much", yet young participants acknowledged that they respected their parents because they understood that they were trying to do their best.

### **5.3.2 Core category or "Basic Social Process"<sup>54</sup>**

As indicated in the literature review, grounded theory does not aim at identifying which independent or "explanatory" variable increases the probability of a higher value on the dependent or "outcome" variable. The methodological tenets of constant comparison and theoretical sampling permitted the identification of relationships between categories so as to initiate a better understanding and theoretically integrated explanation of adult refugees' coping processes.

Accessing the labour force and having satisfactory work, being economically self-sufficient to achieve good living conditions, contributing to the mainstream society and being regarded as a New Zealander were central and recurring themes described by the participants. Such accomplishments permitted them to regain and obtain a social position within the mainstream society which emerged as the basic social process to overcome resettlement barriers.

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<sup>54</sup> A basic social process refers to what, essentially, people do in dealing with their main problem (Punch, 2005).

Indeed, the obtaining of a social position was the core category mentioned most frequently and being interconnected with many of the other categories and which accounted for most of the variations of participants' coping processes. When asked why obtaining a social and occupational status was such an important issue, the majority replied that it was critical in coping and adjusting both economically and socially. Participant # 14 during the follow-up summarised this by saying that being part of and being recognised by the main stream society enabled her to "stand up on her feet" because she and her family did not have any alternative. Participant # 15 considered that having a social position was very important for parents in order to give them credibility, trust and respect in front of their children. Based on this understanding, the following memo was written:

*"Gaining a social status, position or role (position is the word participants use the most and appears to be more appropriate as status refers to class level) seems to be the core category. It is a common pattern emerging from many participants. Many said it is crucial to give meaning to their flight and to reconstruct themselves to "start a new life" and they do not have an alternative. Others said it explains and directs their coping strategies so as to deal with resettlement difficulties. To this end, personal resources and external support are used to reach that goal. It is also a key element to support parents when facing resettlement challenges so as to keep a link with their children, reinforce their parental role and ensure a future for their children. Those who have been able to realise social achievements (employment, New Zealander network, economic self sufficiency) declared themselves to be very satisfied with their lives. This turning point seems to conclude their exile and thereby brings them a sense of peace/serenity."*

With this in mind, further participants were sampled to refine and confirm the emerging theoretical explanation so as to establish the trustworthiness of the findings. I explained to them that all refugees have to look for a new social position and "identity", to learn a new language and become familiar with often alien cultures and social values.

Participants indicated that the combined effort of coping with this social process places upon them a considerable pressure which may affect their mental well-being. They frequently stressed that their gradual adaptation to an unfamiliar environment depended strongly on the perception and supportive attitudes of the host society as well as upon their own constant efforts to demonstrate their capacities to "cross the bridge" (participant # 1). They considered that their regular achievements to become self-sufficient and interact with their new social environment were essential to their life-satisfaction and thereby to a satisfactory mental well-being. Those unable to reach that point were doubting themselves constantly and questioning

if they should relocate to another place such as Auckland or Australia which they thought might improve their socio-economic needs.

Participant # 20 who, after five years, had been able to achieve an acceptable command of English language, find satisfactory work as a driver, see her children successful in their studies and be then reunified with her husband after many years of forced separation, during which time she had not known what had happened to him, stated:

"This is a good life now and I am happy. I had to study and work very hard to be where I am today. People also helped me a lot here. How can I say that: first God gave me life and second New Zealand gave me my second life because if I did not come here I do not know if I would be still alive? This is my country now and I will die here."

This statement, suggested also that the obtaining of a social position signified the end of the flight trajectory and gave meaning to refugees to their forced exile because of their inability to return to their homeland. In the transcript's analysis, the following memo was noted:

*"This participant has confirmed that she had to make considerable effort to regain control over her life. Her main goal despite resettlement adversities remained the achievement of social recognition by learning English, working, ensuring her family's success, developing a social network, having good housing. Her accomplishments comforted her and she stated clearly that she did not have any intention to move again and will finish her life in New Zealand. This is consistent with the theoretical ongoing process that the motivator of adult refugees' coping process is the obtaining of a social position to overcome major new life-changes and thereby adjust to their new environment. Nevertheless, I consider it important to verify if this motivation is shared by adult refugees who are still at the earlier stage of their resettlement. "*

The purpose behind the last five interviews conducted in Nelson with newly arrived Burmese refugees (between twelve and eighteen months), and in line with grounded theory procedures, was to check for confirmation. All participants agreed with the findings and as an example participant # 24 said:

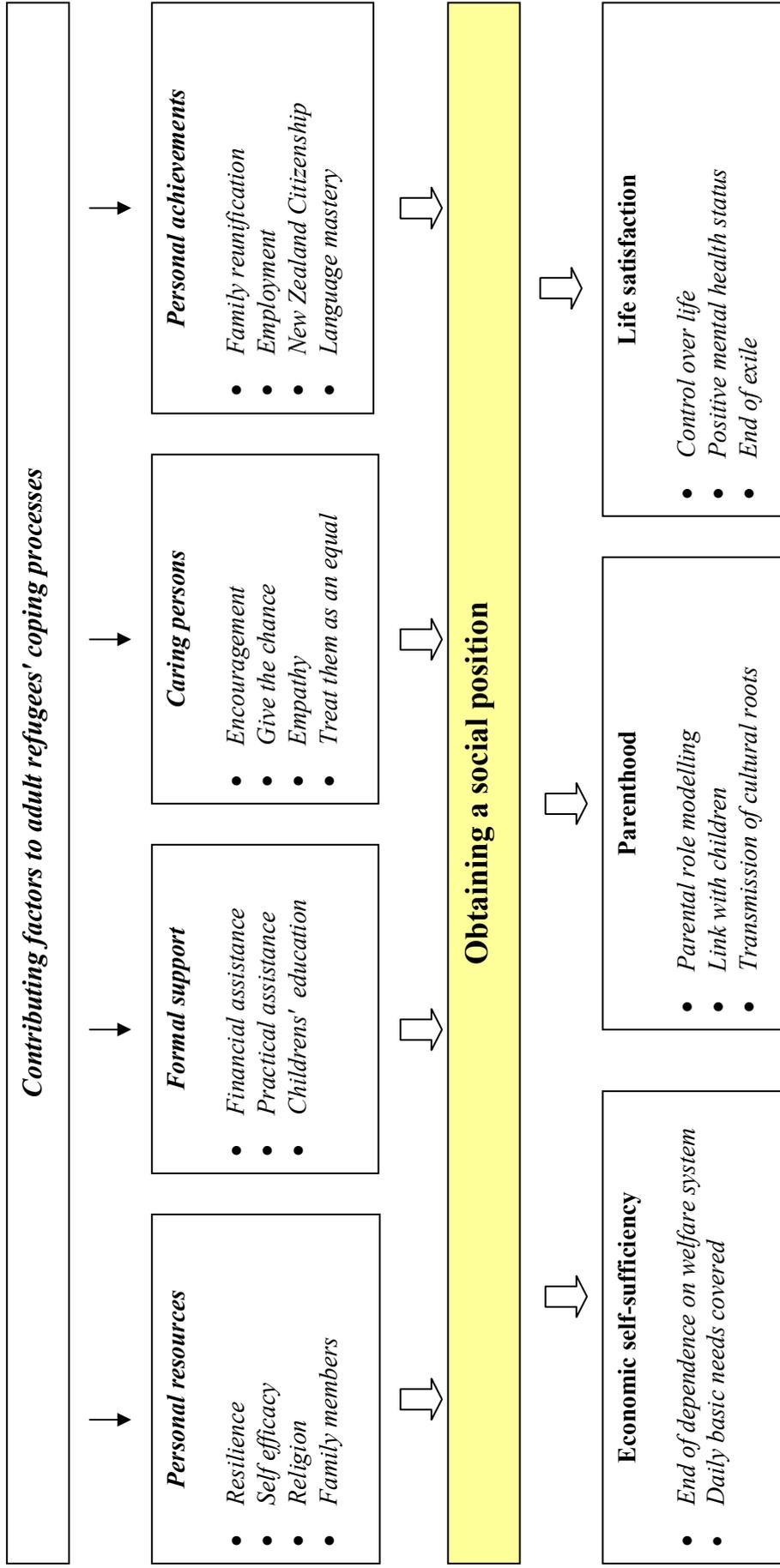
"Language is difficult and finding a job. But I am learning English now and this will allow me find a job. **When I will have my citizenship this will help me a lot. My difficulties will be over. I will be like the other people.** I have no other choice. I cannot go back to my country. My home is here now".

#### **5.4 Central finding**

The basic social process of the *obtaining of a social position as the main goal which motivates adult refugees in developing their coping processes to overcome resettlement difficulties and to adjust to life in New Zealand* represents the central finding of this study. The overall aspiration of adult refugees throughout the course of resettlement described by the participants of this study was to obtain a better life which they explained mainly as obtaining safety, work and "earning a lot of money", having a "good house", ensuring that their children have a good education and supporting family members overseas. In the earlier stages of resettlement, most of them sought economic survival and adaptation which they strived to achieve by finding (usually) unskilled and low-paid work and/or relying on formal and informal financial and practical assistance. Personal and external resources were mobilised and coping behaviour developed in order to reach that initial goal.

When that step was reached, after a period of a few months or sometimes up to one or two years, participants highlighted that their focus was to reach "a good position, a good status within the society". This was associated with having an opportunity to contribute to their "new home" especially by being able to access and obtain satisfactory work and be regarded as a New Zealander. Most of them, regardless of their nationality and gender, explained that this was of significant importance in the regaining and maintaining of a satisfactory mental well-being. Moreover, men stressed that it contributed to the rebuilding of their self-esteem and confidence since they are considered in African and Oriental cultures as the "breadwinners". Participants frequently stressed that being able to interact with other members of the host society was deemed to be critical in helping individuals to recover from some of their past traumatic experiences because it gave them back hope and the ability to think positively in the making of future plans. In that sense, findings suggest that the obtaining of a social position could be explained as the end of the trajectory that finalises and gives meaning to refugees' forced flight and exile because of their inability to return to their homeland for persecution reasons and with no alternative other than to stay in New Zealand. Such progression and outcomes introduced above are presented graphically in figure 5.

**Figure 5: Obtaining a social position which motivates adult refugees' coping processes**



## 5.5 Rigour/Trustworthiness

The basic question addressed by the notion of trustworthiness, according to Lincoln and Guba (1985, p. 290) is: "How can an inquirer persuade his or her audiences that the research findings of an inquiry are worth paying attention to?" The following will describe the various techniques used to answer that question.

First of all, different processes have enabled and stimulated theoretical sensitivity so as to gain insights into the data. Literature review permitted the gathering of information on current resettlement policies and regulations, problems and challenges encountered by former refugees and services providers in both New Zealand and worldwide. It has also helped to determine and generate the questions which needed to be asked of the participants as the findings were developing. My own personal experiences as a foreigner in New Zealand together with my professional work were an advantage in developing theoretical sensitivity. I have faced, and thereby could identify with some of the participants' concerns when arriving in New Zealand such as cultural differences and a different language. Secondly, because of nearly two decades of field work in war zones in most of the participants' countries of origin, I could understand some of their personal backgrounds. My professional training ensured that at all times preconceptions were put aside so as to avoid bias when conducting the study and its analysis. I have acquired, during all these years, the ability to remain sensitive in difficult situations<sup>55</sup> whilst at the same time being able to stand back and avoid approaching the facts from "one angle only".

Several other "measures" also were taken to ensure trustworthiness. Constant data collection and analysis permitted a greater familiarity with the topic under investigation fostering thereby a gradual understanding of participants' meanings. Memos, post interviews notes, diagrams and the research diary helped to investigate all possible variations in the data throughout the entire analytical process. Negative cases were considered so as to contrast findings and refine the developing theory. Emerging findings were compared constantly and discussed with participants, the Canterbury Refugees Council and my supervisors so as to remain "open" to new and/or other ideas, thus preventing bias and distortion. Specific guidance in the use of grounded theory was received from one of my supervisor who

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<sup>55</sup> Amongst the International Committee of the Red Cross "working" principles are those of neutrality and impartiality which means being able to listen and support without taking preference.

supported the understanding and application of the methodology and explained, for example, how categories' properties and dimensions were established (as described in previous section 5.2.5). Research progress reports were presented regularly and were the basis of supervision meetings. This assisted in providing other perspectives from which to view what was emerging from the data. Discussions helped in identifying and refining categories, improving methodological recruitment, detecting categories' links or inconsistencies which required further data investigation so as to refine constantly the emerging findings and gradually establish the theory. The following techniques were applied so as to meet the four main criteria of trustworthiness: *credibility*, *transferability*, *dependability* and *confirmability* (described in Chapter II, Part C, literature review on grounded theory, heading 5) aimed at evaluating the quality of this research which may be summarised as follows in table 3:

**Table 3: Trustworthiness: criteria and applied techniques**

| <b>Criteria</b>        | <b>Applied techniques</b>  |
|------------------------|--|
| <b>Credibility</b>     | <ul style="list-style-type: none"> <li>• Audio tapes were listened to repeatedly</li> <li>• Meticulous reading of transcripts</li> <li>• Supervision meetings to share findings and refine the methodological process and analysis</li> <li>• Member check :verifying information and sharing findings with participants during follow-up interviews and at the end of the analysis</li> <li>• Checking data and procedures</li> </ul> |
| <b>Transferability</b> | <ul style="list-style-type: none"> <li>• Maximising data variation through theoretical sampling, examining negatives cases</li> <li>• Theoretical sensitivity: sharing and contrasting findings with supervisors and existing literature</li> <li>• Constant data comparison</li> <li>• Data saturation</li> <li>• Detailed procedures of the methodology (thick procedure)</li> </ul>   |
| <b>Dependability</b>   | <ul style="list-style-type: none"> <li>• Audit trail: research diary, memos, notes, drawing, diagramming categories' relationships</li> <li>• Detailed description of the research procedures, analytical phases and data presentation</li> <li>• Supervision/guidance meetings</li> <li>• Checking data and procedures</li> </ul>   |
| <b>Confirmability</b>  | <ul style="list-style-type: none"> <li>• Checking of final results and overall research course from the initial data collection until analysis closure (audit trail)</li> <li>• Presenting /discussing/revising findings with peers</li> </ul>   |

## Chapter IV- Discussion

### 1. Introduction

A significant proportion of international research about adult refugees has investigated clinical perspectives and emphasised the impact of pre-migration and post-migration experiences as key factors affecting their mental health status. A clear understanding of refugees' mental health status and psychiatric morbidity, however, is difficult to obtain due to major prevalence variations and discrepancies between studies because they have targeted help-seeking groups or have used instruments with limited or untested validity and reliability (Fazel et al., 2005; Graig et al, 2006; Hollifield et al., 2002). More recently, research investigating the cultural and social aspects of refugees experiencing resettlement in a third country, has demonstrated the influence of such factors on individuals' behaviour and subsequently on their mental well-being. Such knowledge in New Zealand, however, remains insufficiently documented and recent studies have underlined the limitation and constraints of health providers' abilities to meet refugees' mental health needs (Briggs & Macleod, 2006; Guerin et al., 2004). Furthermore and despite the acknowledgment of refugees' endurance abilities to overcome traumatic events during their pre-migration flight and in first asylum countries (Hollifield, 2005; UNHCR, 2002), relatively less is known about their capacities to show positive adaptation to life's tasks in the course of resettlement and how this impacts on preventing mental health problems.

The current study, therefore, was undertaken to obtain a contextual and comprehensive knowledge of adult refugees' coping processes to overcome resettlement difficulties and to adjust to life in New Zealand including subsequent impact on their mental well-being. This was achieved by using grounded theory methodology where qualitative data were collected from participants' interviews and analysed using an inductive approach to identify key concepts and their relationships relevant to the research questions and its specific aims. The expected outcome was the development of a middle-range theory which could describe and explain such a phenomenon for which there is, as yet, no strong theoretical framework.

The value of a middle range theory is that it is specific to a particular group or field of interest and applicable in practice. Indeed, "middle-range theory is close enough to observed data to be incorporated in propositions that permit empirical testing" (Merton, 2002, p.386). It

emerges at the intersection of research and practice because the theory provides a framework for understanding and taking actions about a phenomenon under investigation. Moreover, it has a heuristic value for other researchers because it helps to develop further hypotheses and/or stimulate further investigations.

In this study, firstly, the participants confirmed the practical, socio-economic, cultural and emotional difficulties reported in the existing literature as being major barriers in adjusting to New Zealand. Secondly, they frequently explained that the mobilisation of their personal resources, the availability of formal support as well as that of caring members of the community, plus their gradual achievements, were critical factors contributing to the development of their coping strategies in responding to the various sources of stress. Findings suggest that these contributing factors were interrelated and were influenced strongly by participants' determination to regain control over their lives enabling them, therefore, to deal with their life transition and move forward.

The basic social process<sup>56</sup> that adult refugees described in this study indicates that the obtaining of a social position is the main goal which motivates them in developing their coping processes to overcome resettlement difficulties and to adjust to life in New Zealand. Participants emphasised that the obtaining of a social position contributed to their life satisfaction, including a satisfactory mental well-being, because it gave meaning to their forced flight, helped them to "reconstruct themselves" and concluded their exile through being able to interact with their new social environment. Those who were not able to achieve such a goal mentioned doubting themselves and questioned whether they should relocate to another place, such as Auckland or Australia, which they thought might improve their socio-economic circumstances.

This theoretical explanation provides a framework to understand the resettlement pressures faced by former refugees as well as their coping skills and strategies and contributing factors to overcome personal challenges for which little information is available. Such understanding could contribute to improve capacity with which to address adult refugees' psychosocial needs and better prepare them for a positive future thereby preventing and/or reducing their mental distress. Related findings will be expanded within the context of the available literature.

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<sup>56</sup> Reminder : a basic social process refers to what, essentially, people do in dealing with their main problem (Punch, 2005).

Moreover, the contribution and implications of this study to existing resettlement policy and mental health practices will be outlined together with possible implications for further research.

## **2. Strengthening contributing coping factors to overcome resettlement difficulties**

Although there is a growing body of knowledge on refugees' coping strategies and skills in general, there is no widely accepted and over-arching theory of how they cope with the challenges of resettlement. Nevertheless, participants in this study identified four major factors contributing to their coping processes which included (i) their personal resources, (ii) formal support, (iii) caring/encouraging New Zealanders and, (iv) gradual achievements. Such findings will be reviewed in the following sections by pointing to those key factors which help or have helped participants' in overcoming resettlement adversity and to adjust to life in New Zealand.

### **2.1 Personal resources**

Determination, hope, planning for the future, acceptance of the situation, knowledge, use of their past experiences, flexibility and personal skills were recurrent personal attitudes reported by the participants to cope with resettlement adversity. These characteristics could be associated with the concept of *resilience*<sup>57</sup>, however, it is worth noting that only two participants comprehended fully the terminology of this concept. Participants' beliefs in their ability to overcome resettlement adversity because "they had known worth" and had been able to survive, also were recurrent themes emphasised especially by men, as well as by single mothers (widows or missing husbands). This personal judgement could be associated with the concept of *perceived self-efficacy*<sup>58</sup>, however, as with resilience, this concept was not known by most of the participants.

The interrelation and utilisation of these positive characteristics were described by adult refugees as being manifest in taking effective actions to achieve a "better life", their initial goal. To secure this achievement, participants sought work by "knocking at every door", asking friends, relatives and religious associations for help and viable introductions.

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<sup>57</sup> The concept of resilience has been explained previously in Chapter II, part B, section 1.3.

<sup>58</sup> The concept of self-efficacy has been explained previously in Chapter II, part B, section 1.4.

Attendance at English language classes was described as another method with which to develop communication skills and thereby employment opportunities.

In the present study, findings suggest that original socio-cultural contexts and pre-resettlement experiences might have fostered in participants certain protective factors such as hope, determination, and suppression of traumatic memories contributing to their "resilience" and thereby to effective coping during the course of resettlement. This is consistent with research conducted by Goodman (2004) who investigated how unaccompanied young Sudanese resettled in the U.S.A. coped with trauma and daily hardship. Hoping and planning for an independent future were major motivating forces in their making intensive efforts at school so as to regain the power to effect a change in their lives and become self-reliant.

Religion and/or faith were reported also as powerful sources of comfort and hope enabling participants to give meaning to their current situation, encouraging them to be proactive in finding solutions to their problems and to be motivated to function within their new environment. Most of the participants indicated that this spiritual source helped them to promote their acceptance of personal difficult life experiences and religious practice was the foremost reported coping behaviour in response to stressful situations. This is consistent with studies conducted amongst former South East Asian refugees resettled in Canada by Dorais (2007) and amongst Iraqis in the U.S.A. by Shoeb et al. (2007) which found that religion was an important source of hope, meaning and acceptance throughout the refugees' migration process. Religious affiliation permitted people to be actively involved with others and to demonstrate their capacities of control and organisation to meet their spiritual needs. It also helped to preserve and reinforce individuals' identity.

The fourth major personal resource commonly reported by participants in assisting with their coping was their family which played a key role in terms of emotional support. Women reported that children helped them considerably by giving them hope and motivation. Children's success at school was an important source of satisfaction and pride reported by all parents. Findings suggest that those who had been able to resettle with their nuclear family demonstrated better coping capacities in comparison to those who had not. Immigration bureaucracy and procedural slowness delaying family reunification were identified as genuine causes of constant anguish for many participants. The complexity and costs, financial as well as in human terms of stress (i.e. time consuming, perceived suspicious attitudes from the

immigration services) to achieve family reunification was described by many participants as one of the main reasons of “being constantly sad and angry” and having “their mind full” because of the worries that their family members could be killed and/or were living in chronic poverty. As a consequence, many expressed that they could not concentrate on other matters and faced great difficulties in coping with adaptation challenges.

This is consistent with the reported buffer role played by a supportive family to cope with adversity and resettlement underlined as a major protective factor in resilience reviews and international and national health policies (Aigabi & Wilson, 2005; Harrop et al., 2006; Ministry of Health, 1997; WHO, 2001). The New Zealand Immigration Service and Department of Labour (Refugee Voices, 2004) reported that facilitating refugee family reunion impacted resettlement outcomes positively by reducing the emotional and financial strain caused by anxiety over family members left behind. In Australia, Schweitzer et al. (2007) when investigating the coping resources of thirteen Sudanese former refugees resettled in Brisbane, highlighted the fundamental role of the family in enabling individuals who have experienced traumatic events to give meaning to these events.

Despite refugees often being noted as exemplars of resilience and survival there is a paucity of information describing their personal attitudes and beliefs to overcome their migration journey and to be able to defeat resettlement adversity. The information presented above should contribute to ameliorating this knowledge gap. Although personal resources and readiness for change served participants in developing their coping strategies and skills, yet this dynamic was further enhanced by being eligible for formal support (referring to social services and resettlement services providers) and the availability and positive attitudes of caring New Zealanders.

## **2.2 Formal support**

Participants in this study reported that financial assistance, housing support and children’s enrolment in the education system on arrival enabled them to cope with initial adaptation stress. However, many regarded the initial re-establishment grant (also called in some reviews resettlement grant) of NZ\$1,200<sup>59</sup> as insufficient and those who were benefit recipients

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<sup>59</sup> The re-establishment grant applies to families of up to 4 persons and thereafter an additional NZ\$100 per child. The grant has not been index-linked since 1993 (personal communication, RMS office, Christchurch, April 2008).

reported difficulties in meeting their family's needs because of the continual increase in the cost of living. Support with which to access the labour market and immigration issues was perceived by many as ineffective. The information system was found by participants to be complicated and unfriendly because much of the information is provided by a telephone answering machine, leaflets or website. This lack of personal interface was described as being an important source of stress and many participants indicated that the impossibility of dialogue influenced their decisions not to seek further help and thereby not to access the information. Importantly, the focus by resettlement service providers on refugees' weaknesses instead of recognising their past survival experiences and personal competence were perceived as additional causes affecting negatively the participants' self-esteem and confidence.

Such a deficit approach and lack of recognition was perceived by most of the participants as hampering potential opportunities to build up new contacts and experiences which might boost their motivation to move forwards. As a consequence, some participants reported making minimal use of their personal coping resources even though, unintentionally and as a result, they became more prone to remaining passive rather than active because of the lack of encouraging support. This is consistent with a recent study conducted in Perth, Australia by Colic-Peisker and Tilbury (2003) when exploring the process of resettlement of refugees coming from former Yugoslavia and Africa. It appeared that the Australian resettlement services tended to "medicalise" the refugee experience thereby resulting in refugees' passivity in re-establishing a normal life and solving their daily problems. This approach delayed an optimal adjustment because social interventions to develop or strengthen such skills were not provided adequately.

A major finding of this study suggests that the support provided by resettlement services in New Zealand generates ambivalent feelings amongst adult refugees. Many participants deplored the lack of an encouraging, adequate and caring approach by stakeholders in meeting their social inclusion needs after the initial 6-12 months period of resettlement. This is consistent with research conducted by Simich et al. (2004) in Canada who found that Chinese immigrants and Somali refugees did not seek immediate help from government services because of insufficient or inadequate information about social services, and discourtesy in the attitude of civil servants. Both groups perceived the support in orientating people for work as

ineffective and unhelpful to cope with settlement challenges and that institutional impediments jeopardised newcomers' adaptation and well-being.

The findings of the present study contribute to understanding refugees' frustrations and bitterness vis-à-vis the host society which might be additional causes of their emotional distress. These findings also provide information on the refugee "clientele's perception" of the quality and sometimes inefficacy of the resettlement services' provision and subsequent effects on refugees' morale and coping strategies for which little information is available in New Zealand.

### **2.3 Caring person**

Whereas data suggested that the perceived efficacy of formal support has triggered contrasting views, a large majority of participants have emphasised that RMS sponsor volunteers (for quota refugees) or "anonymous" New Zealanders played a fundamental role in their coping processes. Participants indicated that the presence and availability of these caring persons were decisive to overcome their difficulties because they encouraged them, showed empathy, treated them as equals, helped them financially and practically and gave them the chance to demonstrate and use their skills. They also acknowledged that such caring persons provided them with the opportunities to extend their New Zealander social network for social activities and developing contacts. The same positive appreciation was given to ESOL<sup>60</sup> tutors who visit former refugees in their homes a few hours each week to give practice in social English. Such nurturing support was described by adult refugees as an important contributing factor to boost and mobilise their inner resources to overcome resettlement difficulties. Many explained that such a support comforted them in their self-belief that they could gradually adjust and thereby cope with their new environment.

This is consistent with self-efficacy theory (though the same value and meaning for self-efficacy cannot be assumed across widely different cultures) and highlights social persuasion (referring to verbal persuasion, which aims at convincing and strengthening people's beliefs that they are capable of performing a task and succeeding) as one of the sources of creating self-efficacy (Bandura, 1994; Parajes, 2002). It is also consistent with resilience theory which

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<sup>60</sup> ESOL: English for Speakers of Other Languages. At the time of the research, there was a shortfall of 170 volunteers caused, for example, by time constraints with work and non-reimbursement of transport costs.

identifies a supportive environment or supportive relationships outside the family as protective factors serving to improve coping or decrease the negative influence of being at risk.

A major finding of this study is that the social support provided by volunteers and other caring New Zealanders was perceived as more effective than the support provided by formal workers because of their positive approach. This is consistent with the previous findings underlining participants' perceived inadequacy of resettlement services providers. This contributes to knowledge about the role and benefit of sponsor volunteers during the course of resettlement which is seen to be very important but which has been little researched (Gray & Elliott, 2001; UNHCR, 2002).

#### **2.4 Personal achievements**

Accessing work and being reunified with their family members were reported by all the participants as being the goals to achieve as well as being major coping resources to resettle in New Zealand. Many participants indicated that both were linked intrinsically: not working adversely impacted on meeting family needs and not being reunified with the family affected participants' morale negating their active coping strategy and resources.. Participants in this study viewed satisfactory work (described as correctly paid and interesting) as being critical to cope with daily financial needs and to regain a social status and overcoming culture shock. Employed participants described that having a meaningful employment enabled them to observe, mix with and learn from New Zealanders and to demonstrate their capacities in the face of stereotyping and discrimination. Similarly, all explained that family reunification was a major achievement and a powerful force in coping with resettlement adversity. Participants stressed that it enhanced problem-solving coping because it upheld an individual's sense of responsibility, including pride, to show their capacity to care for their loved ones as indicated by some statements included in the previous Chapter III. Because personal achievements are also part of the obtaining of a social position, related findings within the context of the literature will be explained under heading 3 (below) and related sections.

The findings of the present study contribute to understanding what is helping adult refugees by pointing to what they described as being contributing key factors in their coping processes in overcoming resettlement difficulties. The findings also underline participants' perception of

institutional limitations which appeared to jeopardise people's coping processes and further adaptation to New Zealand. This adds to a growing knowledge of refugees' coping strategies and skills in general and provides information to influence improvement in the current resettlement services provision and future research.

### **3. Obtaining a social position to restore and maintain refugees' mental well-being**

Participants in this study viewed obtaining a social position as the main goal which motivated them in developing their coping skills and strategies so as to overcome resettlement adversity. This terminology has been chosen because they considered that "social position" reflected their optimum meaning which encompassed: (i) having satisfactory work, (ii) being economically self-sufficient to achieve meaningful living conditions, (iii) contributing and participating to the mainstream society and, (iv) being regarded as a New Zealander.

Such understanding can be referred to broadly as a socio-economic position which Salmond and Crampton (2002) when working on the index of deprivation in New Zealand described as a "descriptive term for a person's position in society, which may be expressed on an ordinal scale using criteria such as income, educational level obtained, occupation, value of dwelling place, deprivation of area of residence, etc." (p.36). Nevertheless, it is worth noting that this understanding is not as straightforward as it might first seem because of cultural variations and distinctions when describing social position.

The relationship between socio-economic status and health is one of the most well documented aspects of public health and socio-economic status and is recognised as a major predictor of health (Ministry of Health, 2002). Further, Wilkinson (2006) when reviewing the impact of socio-economic determinants on health within "developed" societies, stated that "health amongst the most affluent countries is a reflection of social position and relative income, rather than of exposure to differences in living standards alone" (p.342).

Over the past decade, a consistent body of literature has described, or acknowledged, the major role of socio-economic health determinants such as level of income, employment, education, living standards, health care setting, social inclusion and participation in protecting and promoting good health amongst a population (Howden-Chapman, 2005; Ministry of Health, 2000; Wilkinson & Marmot, 1998, as cited in WHO, 2003). Unfortunately, the lack of robust data to explore the relationship between the socio-economic status of resettled refugees

and their health status is an ongoing worldwide problem. Data are either not collected or refugees are categorised by the catch-all term “other” instead of being recorded by their respective nationality and/or ethnicity or residence status (Spoonley et al., 2005). The following discussion will highlight some of the findings related to participants’ socio-economic resettlement outcomes and the related impact on their overall well-being, especially mental status, in relation to the existing literature.

### **3.1 Employment**

Farmer and Hafeez (1989) when investigating the resettlement experience of 114 South East Asian refugees resettled in New Zealand found that "the most important thing to a newly arrived refugee in the host country is to find a job and become financially independent" (p.166). Not being able to achieve that goal leads to adverse mental outcomes documented worldwide (Chile, 2002; Colic-Peisker & Walker, 2003; McSpadden, 1987). Studies conducted by these authors amongst different groups of refugees resettled in New Zealand, Australia or the U.S.A. found that chronic unemployment or job insecurity increased people's feelings of being both hopeless and useless, as well as their sense of stigma and discrimination. This also affected their ability to plan towards improving their situation and their idea of a better future. It also impeded their gradual adaptation in a new environment because of being unable to participate in socio-economic life.

In the present study, participants reported constantly the substantial role played by employment in restoring and maintaining a satisfactory mental health status in their life transition because it helped them to become economically self-sufficient. Experiencing involuntary unemployment was perceived by all participants as the foremost social risk-factor raising the probability of adverse mental outcomes. Findings suggest that participants who had been able to access the labour market (representing 50% of the sample amongst which only 23% were fully employed) reported much better health than participants who had not. Because of the small size of the sample, it was not possible to confirm such a hypothesis. Nevertheless, it appears to be consistent with the above cited study as well as with the New Zealand Ministry of Health reports (1997, 2000) which identified unemployment as a major mental health hazard leading to stigma and increased psychological risk.

Interestingly, in this research and as indicated by some of the participants' statements used in the Chapter III, *men* who faced chronic unemployment or who had only casual work seemed to be more affected morale-wise than women. This, however, must be treated with caution, because of the small sample size and men's personal history and past traumatic events which were not investigated and might have influenced such an interpretation. However, it is worthwhile indicating that such findings might be consistent with a recent research conducted by Blight et al. (2006) on the relationship between mental health, employment and gender amongst more than 400 Bosnian refugees resettled in Sweden. The authors found higher levels of poor mental health amongst unemployed men in contrast to women.

Apart from its financial benefits, employment provides other advantages such as time structure, supporting the development of secure identity and self-esteem, sense of accomplishment and participation within the mainstream society (Bartley et al., 2006; Tousignant, 1992). In this study, participants underlined not only the potential adverse consequences of unemployment on their own mental health status but also the increased risks of adverse mental and behavioural outcomes on the whole family. Beyond the loss of men's self esteem and inability to confirm their breadwinner role, many male participants explained that being unemployed affected their spouses' morale because of financial constraints as well as stigma from their groups of origin. Some indicated that it also led to intergenerational conflicts with their children because of the lack of parental role modelling. In that respect, many participants stressed that employment was critical for parents to maintain strong and positive family links and understand some of their children's requests and challenges in a new organisational and cultural context thereby preventing their children experiencing emotional and behavioural problems. This is consistent with longitudinal studies conducted in Europe which reported the adverse effects on parents' temperament and subsequent child raising resulting in family poverty as well as within ill health of the rest of the family (Graham, 1984, as cited in Wadsworth & Butterworth, 2006).

The present study contributes to the existing literature on the perceived negative impact of chronic unemployment and job insecurity on refugees' mental health. It highlights also the benefit of employment, as a critical determinant for the whole family's mental well-being, for which little knowledge is available. Moreover, data collected in this study suggest that unemployment has a greater impact on men's well-being because it impedes their social participation and interaction with others. This appears to be in contrast with the common

assumption that refugee women are more prone to develop mental distress because of social isolation.

### **3.2 Being economically self-sufficient**

Over the past decades, longitudinal epidemiological studies conducted in Europe and U.S.A. (Keleher, 2004; Marmot, 2005) have established that people of lower socio-economic status are more prone to early morbidity and mortality than others because of the unequal distribution of, and access to, material resources and social services leading, to significant inequalities in health. These inequalities appear to follow a "social gradient" defined in public health as an individual's or a group's position in society and his/their ability to access available resources. Indeed it is recognised that individuals who are situated in an elevated position in the social hierarchy tend to experience better health than those who are socially disadvantaged (Wilkinson & Marmot, 1998, as cited in WHO, 2003).

In New Zealand, the Ministry of Health in its report "Reducing inequalities in health" (2000) stated that inequalities in health exist between gender, ethnic groups, people living in different geographic areas and socio-economic groups. Studies conducted amongst Māori and Pacific people indicated that both groups have poorer health because of socio-economic deprivation in comparison with European New Zealand groups. On the other hand, Howden-Chapman (2005) reported an ongoing longitudinal study of Māori households which found that having a secure cultural identity was a protective factor against poor health.

In this study, and as a consequence of work-insecurity and/or part-time work with a minimum wage, many participants indicated that they were living in a state of economic poverty which they described as a lack of money to meet their daily needs. Although this study did not investigate the economic level of the respondents in detail, descriptive quantitative data indicated that the average weekly income for a family of 5 members rarely exceeded NZ\$400-500 net after tax to cover their basic necessities leading to constant worries because of financial pressures. Issues such as poor housing, prohibitive rents, and the inability to afford school costs, pay telephone, heating or electricity bills were described by all as being additional risk factors contributing to their mental distress. Eighty percent of the participants were dependant on the welfare system, thus indicating that the majority belonged to the low economic strata and was, therefore, socially disadvantaged. Additionally, the amount of

financial support was often viewed as insufficient because of the increase in daily living costs. This appears to be consistent with Nazroo (1998, as cited in Shaw, 2006) who asserted that in the U.K. much of the variation in health among migrants, including refugees, could be explained by standards of living as well as the experience of harassment and discrimination which were strongly related to individuals' social position.

In this study, participants stressed that financial constraints were one of the main causes of losing control over their lives thereby affecting their coping strategies and consequently their emotional well-being. Findings suggest that those who had to struggle to cover their daily needs described greater emotion-focused coping such as fatalism, waiting for something to happen or accepting the situation which appeared to increase their distress. Problem-focused coping was an option difficult to achieve. For example, several participants indicated that borrowing money from their peers who were also struggling was not possible, neither was accessing work because of the lack of recognised professional skills and/or lack of English. This is consistent with research conducted by Caplan and Shooler (2007) in the U.S.A. who have examined the relationships between socio-economic status, control beliefs and two coping styles (problem-focused vs. emotion-focused) in the context of financial stress amongst an original sample of 4,100 men. The authors reviewed a longitudinal study for which data were collected over the past thirty years. The use of emotion-focused and problem-focused coping was influenced by individual socio-economic status with those having a less favourable position in the society demonstrating more emotion-focused financial coping. Findings suggested that individuals of low socio-economic status may have engaged less in efficacious coping mechanisms because they believed that they could achieve relatively little to effect a change.

In this study, findings suggest that the dependence upon social service assistance also had a negative impact on participants' morale resulting in increased amounts of distress which they described as being anxious, insecure, feeling like an alien or an outsider and different. Being a benefit recipient after a period of more than a year or two, was often perceived as being a factor exacerbating participants' feelings of worthlessness and hopelessness because of both limited financial resources and non-participation in meaningful activities. This highlights the non-financial benefit of work for psychological health as described previously and is consistent with studies reported by Bartley et al. (2006) which were conducted in England, Sweden, Italy and Finland. It was found that when being made redundant, workers presented

both physical and psychological illness because of being socially isolated despite some of them (Italy) continuing to receive the whole of their normal wage.

One of the important findings in this research is that participants faced the dilemma of having to be dependant upon the welfare system, which they perceived as humiliating and stressful but without which they could not survive. The conflicting feeling in this involuntary situation of constantly being a benefit recipient and not having the power to signify their dissatisfaction (i.e. cold and wet government subsidised housing with poor insulation) appeared to exacerbate participants' sense of alienation and frustration which is rarely reported in the available literature. This contributes to an understanding of some of the causes of distress faced by refugees which are often hidden, or not expressed because of the feeling of "shame" and stigma relating to the necessity of being assisted and which compounds their inability to confirm their capabilities and skills in becoming self-reliant.

Additionally, the findings provide information on the reality that many former refugees resettled over the past decades are likely to have faced socio-economic deprivation which is not well described in current literature.

### **3.3 Contributing/participating to the mainstream society**

Spoonley et al. (2005), when investigating a potential indicator framework with which to measure settlement outcomes for both newcomers and hosts in New Zealand, described social participation as "involvement in economic and social (cultural, religious, leisure) activities, in the work place, family and community settings, in groups and organisations and in political and civic life such as voting or standing for election on a school board of trustees" (p.103). Unfortunately, robust data on refugees' participation within their host society are limited because, as indicated earlier, they are often recorded as "other". Information available in Christchurch is limited to work participation indicating that refugee groups resettled over the past decade have experienced the highest rate of unemployment varying from 15 % to 30% in comparison to the overall rate of unemployment of 4.5% (Christchurch City Council, 2007).

In this study, when asked what contribution to the host society meant to them, participants highlighted their need to be part of the labour market, being involved in the decision process and social activities and to "give back to New Zealand" meaning being able to demonstrate

their gratitude to the country which has given them a second chance. Nevertheless, they indicated that religious practices and events represented their most frequent social activities regardless of their religious affiliation and despite current legal obstacles to bringing in religious leaders relative to specific religious tenets. They acknowledged, however, their satisfaction at having a place where they could pray without feeling "threatened". The Muslim Association and Christian churches were mentioned frequently as intermediaries in facilitating contact between people, or in helping them when needed. On the other hand, many reported that they did not have any contact with New Zealanders, except from sponsor families or agents working in resettlement agencies, therefore limiting their abilities and means to engage with the mainstream society.

### ***Language barriers***

Language is assumed to be at the core of the relation between the "self" and the rest of the society (Elliott, 2001). Participants in this study reported their difficulties in mastering the English language which impacted negatively not only upon their access to employment but also upon their participation in social life beyond the scope of their family and close friends.

In this study, seventy-three percent of the participants had been, or were enrolled in English language support. Whereas most of them stressed not having faced difficulties to attend English classes, they had contrasting views regarding the quality and effective outcome of such support. On the one hand, participants stressed their appreciation regarding the availability of former refugees as bilingual teachers because of their ability to help students as well as having the skill to liaise with the educational system. On the other hand, many viewed the provision of classes as being both inadequate and inefficient because of the complexity of teaching methods according to their level of understanding. Findings suggest that some participants' educational deprivation in their homeland had affected detrimentally their knowledge and mastery of the structure of their own language. Indeed, several participants indicated that this resulted in acute difficulties in attempting to comprehend the components to parse either in their own or in a new language and in some cases caused voluntary withdrawal from the classes. They emphasised that their inability to acquire sufficient skills to communicate with New Zealanders and other groups led to frustration and exacerbated their perceived discrimination when approaching the labour market and their incapacity to gain control over the situation. Additionally, some felt discriminated against because of their

accent which attracted unpleasant remarks, mockery or perceived lack of effort on the part of New Zealanders in being prepared to try to understand what they were saying.

This is consistent with a recent study conducted by Butcher et al. (2006) in New Zealand while investigating the nature and incidence of discrimination experienced and/or perceived by both immigrants and refugees and the implications for the host society. English language shortcomings and accent were a recurrent source of discrimination which newcomers faced when applying for work resulting frequently in their rejection. Similarly, Bach and Seguin (1986) have studied the complexities of Southeast Asian refugees' participation in the U.S. labour market in relation to the host-language ability and work requirements. It appeared that the contribution of English proficiency was not a generalised, indispensable resource for work but was often used as an excuse not to employ "non-native" English speakers. To this end, the authors stated that English language proficiency was often "a highly differential resource, with its benefits conditional upon the availability and organisation of local social network and the conditions of the local market" (p.402). A practical illustration of this statement occurred in respect of 54% of the participants in this study who were working full or part-time and who had an extremely poor to limited command of English.

In that respect, Bourdieu, a recognised French sociologist (as cited in Cone, 2007) who during his life's sociology work and research on the mechanisms of how social classes interact with each other, emphasised that language is not merely a method of communication, but is also a mechanism of power. It designates the relational position in a social space by determining who has the right to talk, to listen or interrupt a conversation. Cone (2007) when exploring resilience characteristics of Russian immigrants living in the U.S.A. found that the relationship between language learners and those who could already speak effectively was often marked by an imbalance of power exaggerated within a school system or community over immigrants and their families.

This study provides an insight into some of the learning/training problems faced by low-educated former refugees for which little is documented. Whereas, literature often advances individuals' deficits to explain their difficulties to speak the host country's language, the quality of the language service providers and the trust of the learners in such services have received little research attention in New Zealand. Moreover, the fact that language acquisition

and mastery could be used and misused as a powerful force, even though unintentionally, to justify the poor participation of newcomers within their host society should be investigated.

### *Involvement of refugees in the decision making process*

In this study, 80% of the participants were dependent on the welfare system making it unlikely that they will be able to become actively involved in social activities. Few participants, for example, used their civil rights in terms of voting because such rights were not respected and/or not available in their country of origin and/or because of the lack of information on how and why to exercise those rights in New Zealand. Additionally, the linguistic barrier experienced by many of them was described as hindering their consultation in the decision process.

In this study, the limited number of established former refugees living in Christchurch who are employees within the current resettlement services provision system, who could be used as a catalyst in supporting and guiding newcomers by sharing their own experiences and knowledge, was of serious concern to the participants. Although some had acknowledged that social workers and agencies' staff tried to do their best to support them, yet they emphasised that many such workers and staff were lacking in cultural expertise necessary for understanding them. Despite a few established former refugees having been employed as interpreters or social workers, it was perceived that insufficient individuals' capacities were utilised. This is consistent with a review conducted by Valtonen (2002) amongst social work practitioners in Finland involved in resettlement support. She emphasised the absence of recognition and utilisation of previously acquired strengths and skills of competent established refugees in any advisory capacity and orientation to assist newcomers. In that respect, the author highlighted the need to reverse this trend and stated: "the reserve of such expertise in the ethnic groups should be brought into the public sphere, through the opening up of reception and integration services to include more community members in roles of responsibilities and also authority" (p.118). Similarly, Korac (2003) reported that refugees' social inclusion in Italy and Holland was made difficult because of resettlement policies and structural limitations of the services' provision.

A major finding in this study is that despite the multiplicity of forums and/or consultation groups concerning refugee resettlement issues in New Zealand, the asset of having refugees

involved in supporting their fellow countrymen beyond the sphere of voluntary work and/or informal support appears to be too often ignored. Many participants perceived an existing conflict of interest amongst resettlement providers related to personal agendas and/or funding activities. Indeed, many reported that some agencies' staff were maintaining discord between refugee groups and/or individuals in order to justify their role. Data collected in this study indicated that such perceived attitudes, even if unintentionally, diluted the effectiveness expected from stakeholders' support, by maintaining refugees "at the bottom of the scale". Interestingly, many participants indicated that voluntary work was not an effective tool to engage in and/or contribute to the mainstream society because such a concept does not exist in their home country and does not confer a recognised position upon them.

Such findings suggest the necessity to employ established refugees in positions of authority who can understand their peers, find appropriate responses to their problems and also act as role models in demonstrating a successful integration. Additionally, this study has highlighted the perceived poor quality and effectiveness of the resettlement services' provision in New Zealand, as experienced by the refugee "clientele", which has received little attention and is imperfectly documented.

### ***Involvement in community setting***

A consistent body of literature has described the important role played by communities of origin in maintaining a strong ethnic identity, buffering the stress linked to the resettlement process and facilitating the integration and participation of the refugees in mainstream society (Ministry of Health, 1997; Kelly, 1986; Nguyen, 1989; Tran, 1987). On the other hand, some studies are more reserved when analysing the functions of the community in supporting their peers to comply with resettlement requirements. For example, Beiser and Hou (2006) have examined the relationship between the ethnic identity attachment and common sources of stress (i.e. unemployment, lack of fluency in English) of more than 600 Southeast Asian refugees resettled in Canada. The affiliation with ethnic social organisations mitigated the damaging effects of not being able to acquire the dominant language. On the other hand, it was found that a strong ethnic identification made people more prone to depressive problems when encountering unemployment or discrimination because it increased the likelihood of interpreting such experiences as being ethnically based.

A major finding of the current study was that most of the participants, regardless of their gender and nationality, perceived their community of origin to be very weak and/or dysfunctional<sup>61</sup>. They linked such phenomena to historically disruptive events between sub-groups and/or current armed conflict in their homeland resulting in mutual suspicion due to wartime and "historical" prejudices. Additionally, participants reported resentful pressure from fellow countrymen when comparing resettlement outcomes in terms of employment, material acquisitions or level of income. Some indicated having experienced jealousy from their peers because of being successful in bringing their relatives to New Zealand, or speaking competent English, or obtaining satisfactory work and housing. Some participating single mothers (widows, divorcees or those separated geographically from their husbands) have been made aware of gossip against them because of their becoming capable of raising their children and coping with life's vicissitudes without a male partner. Others described being rejected by their own cultural group because of trying to make friends with New Zealanders or members of other national sub-groups. This resulted in many neither seeking nor expecting support from their peers because of mistrust and to avoid further personal turmoil. Additionally, participants frequently mentioned that every family had to deal with the same stressful adjustments, as well as not going to community reunions because "people were fighting and took their problems there". Community network, therefore, was described as often being reduced to friends and relatives who were helping to support each other. Only a few participants mentioned having received support from their group which was consistent with the New Zealand Immigration Service and Department of Labour, Refugees' Voice Report (2004).

Another recurrent issue highlighted by participants in this study was the funding of specific refugee community bodies which many viewed as fuelling division between their members. This was consistent with the minutes of the Report of the Refugees Issues Forum in Wellington (2005, as cited in Ward, 2006) stressing the lack of strategic direction to build up strong communities including the deficient "silo" funding approach. Some considered that refugee community leaders were manipulated by resettlement service providers to cater for political or staff agendas instead of helping individuals pragmatically. This apparent malaise was illustrated by the fact that ten of the participants (40%) were not recognising their current

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<sup>61</sup> It is worth reporting that such reactions are not exclusive to former refugees, indeed, many New Zealanders reported similar attitudes from within other ethnic groups.

“community” representative usually because of perceived non-existence of leadership qualities portrayed as being too young, dishonesty, belonging to different clan, ethnicity or tribal backgrounds). This was consistent with a study conducted by Kelly (2003) amongst Bosnian refugees resettled in Britain. The author reported divisions and rivalries amongst people because of the nature of the 1990's ethnic conflict. For example, links with non-Muslims which may have been very close before the war, were unlikely to be re-established. Additionally, there existed mistrust between Muslims themselves, due to wartime experiences, added to which there was little evidence of a unified and strong Bosnian community. Although existing Bosnian associations were able to conform to British policy expectations in order to gain the financial advantages of a formal and recognised body, they did not reflect the needs of all the members of the group. What existed in Britain were not Bosnian communities with a feeling of obligation to others but rather, kinship groups, friends and networks supporting each other.

This knowledge complements current understanding of the challenges of building cohesive “refugee” communities in New Zealand and about which little has been documented. Interestingly, the term “community” (for which there is no agreed definition in sociological literature) was unfamiliar to many participants who associated the concept as being with close friends and relatives. Findings suggest that such a concept was rarely associated with participants' entire group of origin because of their different organisational and cultural backgrounds. This highlights the difficulties of community representatives in gathering people into the circle of community associations of the type in existence in New Zealand and for which understanding is limited.

### **3.4 Being regarded as a New Zealander versus perpetuating a refugee identity**

Many participants in this study stressed the importance of having the same opportunities and obligations as New Zealanders and interacting socially with other people, thereby reducing marginalisation and the prevention of psychological distress. Being able to access satisfactory and appropriate employment, as repeatedly described herein, was the most “equal treatment” participants were expecting. Indeed, they frequently indicated that their life satisfaction was not only linked to obtaining protection and children's success but also to being regarded as a New Zealander by being recognised as useful and not being “dependent on others”. Data suggested that the social context in which adult refugees can develop a sense of belonging has

important effects on individuals' coping processes that are used to overcome resettlement adversity.

A important finding in this research suggests that despite having, or being in the process of obtaining New Zealand Citizenship, participants were concerned at the repeated practice of being referred to as "refugees". This appellation was perceived by many that they are "poor victims" and unable to decide for themselves or, "exploiters of the system" or, an "alien" group. Participants frequently indicated that such stereotyping was often fuelled by the media whose release of positive information on refugees was too often counterbalanced by describing isolated cases of misbehaviour with a strong emphasis on ethnicity instead of reporting likely psychosocial issues. Moreover, many reported having been asked, many times, when they plan to leave New Zealand and go back to their own country or having been accused of abusing the welfare system or taking work from New Zealanders. Such remarks might have been unintentional, but were perceived as being additional sources of stress impeding people trying to express their identity or be accepted by the wider community.

This is consistent with a study conducted amongst Bosnian refugees in Australia by Colic-Peisker and Walker (2003) who described Bosnians' difficulties to engage within the mainstream society because of being classified as "refugee". The obtaining of Australian Citizenship had "its positive psychological effects on people but did not fill the void of the refugee identity" (p.343). Being classified as "refugee" destroyed individuals' sense of being part of the dominant group and confined them within the common belief that refugees are socially disadvantaged, culturally distant from the rest of the society and a demanding and dependent social category. In the U.K. Tomlinson and Egan (2002) conducted a study of organisations providing employment-related services to refugees, the nature of their services and the organising practices involved. They confronted the official discourse of "empowering" of service providers in supporting people to access work (i.e. work searching techniques), to learn English or obtain training and the "empowerment" impact on twelve refugees when accessing the labour market. It appeared that despite being equipped with "employable" resources, such support did not necessarily result in securing employment. The main reason for such failure was linked to the "seeming irrationality and implacability of employers' continuing suspicion of refugees" (p.1041). This highlighted that the provision of resources for refugees to become successful was not sufficient on their own to change the connotation of the "refugee" identity which perpetuated their differences and outsider-status.

The present study provides supplementary evidence to understand the negative impact on people's mental well-being because of the unintentional prejudice created by labelling them as "refugee" because the term is full of opprobrium. It is also consistent with a recent review conducted in New Zealand by Nash et al. (2006) on social work practices with immigrants, refugees and asylum seekers. The authors stressed the importance of having skilled social workers with a sufficient cultural knowledge and a broader way of thinking by addressing the centrality of work or citizenship when supporting refugees. Indeed, data collected in this study suggest that such sensitivity is often lacking in the current establishment and has resulted in ineffective support to assist newcomers with their civic and social integration.

### ***Discrimination***

In this study, 50% of the participants were unemployed, 27% had part time work (often casual and ranging between 4 and 15 hours/week), 38% were unable to communicate in English despite having been enrolled in English classes and 80% were benefit recipients. Data suggest **that** such a fragile socio-economic situation led to personal anxiety, sadness and worries, however, very few participants reported having been a victim of overt discrimination.

Three of the participants who were, or had been working as taxi drivers, reported racist insults, inappropriate behaviour (drinking, smoking) or, frequently, not having been paid by customers. When asked how they coped with such conduct, diplomacy was their first answer by trying to explain their differences and why they were living in New Zealand, or by reporting to the police or forbearance. Participants described defensive attitudes by New Zealanders ranking from rude answers when enquiring for information or explanation, to mockery or ignorance. When asked how they reacted in such cases, many reported remaining quiet because they could not reply properly and/or did not want to have problems vented in public. Muslim women encountered resistance when trying to convince potential employers of their need to wear head scarves, not only for religious and cultural reasons but also because they felt more comfortable and safe by covering their hair. People from the Middle East and Afghanistan reported that since the terrorist attack of 11th September 2001 in the United States, they have faced greater difficulties in terms of immigration hindrances and an increased level of unpleasant remarks. Discrimination, however, was perceived by many participants as very restrained, covert and hard to grasp. This was consistent with Butcher et al. (2006) who noted that both immigrants and refugees living in New Zealand reported "that

the discrimination they experienced or perceived was subtle: rarely were they called names or verbally or physically abused” (p.49). This also was pointed out by Orovwuje<sup>62</sup> (1989) when describing his own experience as a “visible” migrant in New Zealand during the first National Health Conference in New Zealand. The author said the “attitude of the average New Zealander towards migrants and refugees is at best non-committal and at worst hostile and suspicious” (p.134). The author emphasised that it was expected that migrants and refugees conform rapidly to New Zealand culture and lifestyles, but such attitudes of suspicion and avoidance made this difficult to achieve.

Data collected in this study provide some elements of adult refugees’ coping attitudes when facing racism and discrimination for which little information is available. Findings suggest that both emotion and problem-focused coping are used subject to the perceived level of controlling the situation. Furthermore, participants’ statements provide supplementary information of the silent, covert discrimination former refugees might face without reporting it because of individuals’ sensitivity to a social desirability factor and fears that complaining could affect them or their family when applying for residence, citizenship or seeking support.

#### **4. Implications of the study**

##### **4.1 Resettlement services provision**

Participants in this study described a number of coping factors which play a positive role in their coping processes that are used to overcome resettlement difficulties and ultimately on their obtaining of a social position. Such an achievement was described by many as ending their dependence upon the welfare system by permitting them to regain control over their lives after, for some of them, decades of uncertainty.

In contrast with commonly held assumptions reporting that refugees have high or unrealistic “expectations” whilst resettling, participants in this study were keen to describe their future hopes in terms of rational expectations namely earning sufficient income, being satisfied with their housing and employment and enjoying a physical and emotional security so as to be able to socialise with others. These aspirations do not differ materially from the New Zealand Settlement Strategy which was launched by the government in 2004 and revised in 2007 and

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62 The author is from Nigeria

which aims to support all newcomers including refugees and their families in achieving the following goals:

- being accepted and respected by the host communities,
- obtaining employment appropriate to their qualifications and skills,
- being supported to communicate confidently in English,
- accessing appropriate information and responsive services,
- forming supportive social networks and establishing a sustainable community identity,
- feeling safe within the wider community in which they live, and
- accepting and respecting the New Zealand way of life and contributing to civic, community and social activities.

In the light of the previous findings, data collected in this study suggest that most of those goals were far from being reached by the majority of the participants. Despite all participants being indebted to New Zealand for having protected their lives and given them the chance to enjoy a freedom which had been denied to them in their own homelands, yet they had contrasting views concerning their social inclusion. Whereas most of the participants in this study indicated that they had expected to encounter barriers because of their differences and weaknesses, what they had not anticipated was that it would take many years to overcome some of those barriers. For example, the average period to find work was between 2 to 3 years and to be reunited with their family members between 3 to 5 years with the result that many descended into discouragement, doubt and anxiety one or two years after arrival.

Furthermore, the findings indicated that the motivation to obtain a social position determining adult refugees' coping processes appeared to be hindered for many participants by the host society's attitudes and an insufficient utilisation of established refugees in positions of authority. Additionally, the quality and effectiveness of resettlement services' provision was poorly perceived by the "refugee clientele" who frequently explained that it maintained them in a state of dependence rather than on becoming economically and socially self-sufficient. The participants' questioning of their inability to participate fully in mainstream society should reinforce the importance of distinguishing between their perceived and their received support. It should be remembered that if the support which is given is not perceived as responding to adult refugees' needs, then it is likely to be ineffective regardless of good

intentions. Such perceptions need to be acknowledged in order to provide a more committed environment for those refugees who have been directed for resettlement to New Zealand so as to break the pernicious cycle of personal exclusion.

Results of the present study indicated that participants, regardless of their gender, were motivated to secure a "good life" very soon after their arrival in New Zealand. They described that flexibility, determination and personal belief in their abilities to succeed, religious practices were important resources to mobilise in order to reach that goal especially at the early stage of resettlement. Many participants indicated that the readiness to use such capacities required encouragement and orientation such as pragmatic support to access work, active support from immigration services, driving lessons, or minimal financial support to start a business. Findings suggested, however, that personal drive and energy tended to decline after a period of two years subject to individuals' accumulated failures in achieving self-reliance. Therefore, interventions focusing on people's motivation, determination and other inner resources and the organising of support around those strengths by supporting individuals' aspirations and establishing goals, even modest ones, might be more appropriate if applied soon after arrival.

Importantly, supporting adults to attain a rewarding position in their new environment has a direct effect on their children as it could prevent familial and intergenerational conflicts often linked to parental disconnection and disempowerment with the dominant group. Indeed, data collected in this study suggest that if this opportunity to provide people with effective support to secure a better life is not achieved, it can rebound and result in provoking former refugees into becoming part of a socio-economically disadvantaged group (which is not the aim of resettlement) with the accumulated frustration of being unable to regain control in an extended network of relationships.

This knowledge should provoke an awareness of institutional hindrances to optimal service provision about which there is limited information. It should also facilitate the identification of actions to influence potential changes and improvements to the betterment of former refugees, their whole family and the host society which will be described in the section 5 "Strategic issues".

## 4.2 Mental health care provision

Although resettlement difficulties and challenges have adverse effects on former refugees' mental health (New Zealand Ministry of Health, 1997), health interventions tend to associate their mental health problems with pre-migration traumatic events rather than focusing on the core, post-migration, and adaptational issues. In that respect and despite the international recognition that refugees are at risk of developing mental health disorders, the World Health Organisation (2007) recalled the need to avoid the assumption that entire refugee populations are prone to mental disorders and in need of psychiatric care. Consistent with this statement, results of the present study suggested that adult refugees associated most of their mental health difficulties with their inability to find work, to be reunified with their family members and for some of them, poor living standards. This resulted in many reporting having "their mind full", thereby reducing their ability to cope with their life's transition.

Ninety-two percent (92%) of the participants viewed mental health support as inadequate when facing distress because of the following reasons which they described as follows:

- it did not solve their day-to-day problems,
- health professionals were not above God and could not help,
- they doubted the quality of follow-up because of the non-directive role of the health professionals which contrasted with their desires for direction and immediate "remedies" for their present concerns,
- too much focus was on their past experiences which they did not wish to revisit,
- they did not want to share their feelings with others despite the availability of interpreters and regardless of the training of that person, and
- they perceived the relationship between them and some of the health professionals as an unequal relationship, thus accentuating their position of vulnerability and inability to take care of themselves.

As a consequence, participants' main resources in dealing with emotional concern were primarily religious beliefs and practices, followed by sharing feelings with family and close friends, reading, writing and exercising.

This was consistent with Briggs (as cited in Todd, 2008) who underlined that “refugees referred for psychiatric assessment need a different kind of help” and that “putting Western concepts on to non-Western people who have another way of understanding the world and expressing distress does not work”<sup>63</sup>.

Health professionals caring for refugees should be made aware of such perceptions which could negate the expected improvements from mental health interventions. Similarly to various studies cited in this research, participants stressed that direct actions for ameliorating their social circumstances and subsequent mental well-being were more effective than psychological or counselling support.

The theoretical and practical implications of the present study indicate the importance of strengthening a collaborative and coordinated approach between the stakeholders, including the health system, in contributing to the maintenance or restoration of individuals' personal harmony which cannot be resolved by the health sector on its own. Findings suggest that in regard to the complexity of issues and needs of former refugees a holistic approach, by being supportive and encouraging and focusing on their personality characteristics and abilities, is critical in influencing the development of effective coping processes thereby minimising resettlement related distress.

Participants indicated that their choice of emotion-focused or problem-focused coping strategies and behaviour was directed by their specific socio-economic and emotional needs and was re-assessed accordingly. They explained that they used reducing emotional-stress behaviour to deal with situations which they could not influence, and solving-problems behaviour to manage practical issues because they considered that they had the capacity to do so. With this knowledge, mental health interventions might be more effective if they reflect the refugees' need to obtain a social position and are focused on refugees' priorities and coping factors which would contribute to the prevention and/or reduction of adverse mental outcomes associated with failures to achieve that goal.

Such considerations have a direct implication for the effectiveness of current mental health approaches and resettlement policies and raise important questions. Is it preferable to develop

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63 Section A.11, "The Press", 18.02.2008.

and improve the existing mental health care provision to support those with mental health problems or to establish the resettlement conditions which are necessary to achieve a satisfactory life, thereby contributing to a better mental health status? If refugees' socio-economic priorities which lie beyond the immediate control of the health sector are not addressed, they will be likely to lead to health inequalities which are proven to raise the probability of adverse mental outcomes. Targeting refugees' priorities could prevent costly health interventions, the efficacy and efficiency of which are likely to be minimal because they do not have the trust of the "refugee clientele" and do not resolve major sources of resettlement distress.

WHO (2001) in its yearly health report devoted to mental health, underlined that many mental disorders require psychosocial solutions and stated that "links need to be established between mental health services and various community agencies at the local level so that appropriate housing, income support, disability benefits, employment, and other social service supports are mobilised on behalf of patients and in order that prevention and rehabilitation strategies can be more effectively implemented" (p.92). This approach to health shifts the focus from health, as an object of interest or measurement, to making health determinants the object of analysis and the basis for intervention and responses in ensuring a whole population's well-being (Keleher & Murphy, 2004).

A theoretical understanding of refugees' coping processes such as that provided by the present study could be of interest and use to mental health programmes so as to stimulate these contributing factors identified by the participants as critical to adaptation and foster self-help thereby reducing feelings of worthlessness. It could help the mental health care provision to strengthen an intersectoral approach with which to promote active coping behaviour leading to positive resettlement outcomes and subsequent mental well-being because it is beyond the capacities of the health sector on its own. Furthermore, supporting refugees to develop active coping skills and behaviour, therefore, should be considered as a decision making process that involves the refugee clientele at the early stage of resettlement.

## 5. Strengths and limitations of the study

### 5.1 Strengths

This study was one of the first attempts to collate data relating to adult refugees' coping processes in New Zealand. It has involved males and females from diverse nationalities, quota and family reunification refugees sponsored by former quota refugees from different organisational backgrounds and from varying educational and socio-economic levels. Such diversity, in line with the grounded theory methodology, aimed to maximise variations, similarities and differences in participants' experiences and perspectives so as to reach a conceptual understanding of their coping processes through a progressive and systematic process.

An informal preliminary meeting prior to each interview permitted explanation of the research aims and expected outcomes and required potential participation. All such meetings resulted in positive responses. The enthusiasm of participants in being part of the study has to be emphasised and all spent time in answering the questions thoughtfully and ensuring that their views were well understood. They did not hesitate to refine the evolving theory and complement the findings during the follow-up interviews and the majority<sup>64</sup> validated the central finding.

In contrast to deficit approaches which focus on individuals' weaknesses and problems, this research highlights former refugees' abilities, efforts, strengths, interests and values. It placed emphasis on investigating those contributing factors which participants described as enabling them to develop their coping processes and ultimately on their obtaining of a social position which participants identified as being to overcome resettlement adversities. Such positive orientation provides insights into “what works” which could contribute to current knowledge to enhance the well-being and adjustment of former refugees to New Zealand.

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<sup>64</sup> Two participants could not be reached for the follow-up interview and therefore did not confirm the emerging theory because they were overseas.

## 5.2 Limitations

The lack of comprehensive and robust data about former refugees' resettlement outcomes and mental health status was a problem<sup>65</sup>. This gap in service provision has made difficult the illustration of current concerns as well as establishing what happens to former refugees following the initial stage of resettlement. Additionally, one of the key resettlement services providers did not appear to be interested in supporting the study. On one occasion, the researcher was told that "refugees have been over-researched in New Zealand", however after seeking verification, the Ministry of Health and other stakeholders involved in refugees' support did not confirm this statement. Unfortunately, this restricted the input of some services providers whose extensive knowledge could have been important and relevant to the study.

The sample size of 26 participants was sufficient to elaborate a theoretical explanation about the adult refugees' coping processes by following and respecting the rigorous tenets of the grounded theory qualitative methodology including data saturation. On the other hand, this limited sample size was not sufficiently representative to be able to conduct some quantitative analysis in relation to participants' health status and especially on their mental health.

Considering the mental health implications of the findings, some proposals for further research will be developed in the following section. Moreover and despite the researcher's knowledge of the refugees' backgrounds and the participants' apparent confidence during the interviews, it cannot be guaranteed that they answered the questions comprehensively either because they are not used to being asked for their opinions or feared further sanctions by expressing their thoughts.

## 6. Potential application of findings and future research

In this research, the findings established a middle-range theory whereby the obtaining of a social position was the main goal which motivated participants in developing their coping processes. The prospect of becoming financially self-reliant, regaining control over their lives

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<sup>65</sup> This lack in service provision was also mentioned during the first National Refugee Health Conference in Auckland (2007) which stressed that the lack of surveys and knowledge of former refugee groups affect the efficiency of the current assistance provision..

in a social network beyond their family and groups of origin, as well as having the means of acting as effective parental role models, thereby securing their family links, has been described by most of the participants to be the driving force in stimulating their coping abilities and positive behavioural patterns. They frequently indicated that this is critical in preventing or reducing adverse mental health outcomes in an unfamiliar environment.

Such an explanation provides a framework for understanding adult refugees' coping processes and potential actions, in an area where little prior investigation has been undertaken. This understanding could be applied to the practice of those seeking to support refugee resettlement. It could also be used as a guide to stimulate further investigations so as to comprehend the complex issues related to these processes, or develop further hypotheses which could be tested in further research. For example, would resettlement interventions, including mental health, be more effective by assessing individual contributing coping factors which people do or do not possess in order to address their emotional needs?

During the analytical process participants expressed that their personal resources, the availability of formal support and a caring person and their personal achievements were important factors in developing their coping processes. These contributing factors presented in Figure 3 of this study may have almost self-evident face validity, as a "common sense" depiction of inter-related coping resources. However, it is in fact a radical departure from the dominant paradigm which tends to conceptualise former refugees' adjustment process in non-coping terms as presence or absence of psychopathology.

This knowledge, together with the theoretical framework developed in the study, could be used as the basis for a simple self-assessment tool or for the development of structured questionnaires drawing on these contributing coping factors. Such an assessment could highlight those personal strengths which need to be activated together with those personal deficits which require support in order to help adult refugees to obtain a social position which was identified as being the main goal to achieve for the restoring and/or maintaining of their mental well-being. Additionally, such an assessment could also be employed to examine other contributing coping factors linked to cultural or educational backgrounds or personal experiences which have not been explored in this study.

Another area of further research is the need to develop a comprehensive set of data assessing the health status of former refugees; such data which are not currently available. It could be

valuable to ask newcomers as their residence progresses to self-assess their physical and mental health status and repeat the assessment at different stages by using for example the Short-Form SF-12 ® Health Survey<sup>66</sup>. This questionnaire<sup>67</sup> has been used already amongst former refugees resettled in a third country (Hoffman et al., 2005; Momartin et al., 2006; Steel et al., 2002) and was shown to be appropriate in terms of applicability and understanding of various cultures. Results are expressed in two physical and mental scores indicating limitations in individual role-functioning as a result of physical and mental health. This could be of use to relate both scores to demographic and socio-economic variables such as gender and work or other variables (e.g. social network, family reunification) so as to establish potential influence and association on individuals' health status. Indeed this was not tested in this study because of the small sample size (n=26).

Such a longitudinal study using a quantitative approach could provide information confirming the level of physical and mental disability in an increasingly multicultural group which is not represented statistically in New Zealand census data. Moreover, the combination of qualitative and quantitative methodologies could complement the understanding of adult refugees' coping processes which cannot be accommodated fully within a single approach, thereby guiding professionals in the taking of decisions when supporting former refugees.

Although the primary focus of this study was to provide a framework for understanding adult refugees' coping processes, there are some areas detailed below which require to be investigated in greater depth so as to comprehend the complex issues related to these processes.

Significant data concerning former refugees are lacking or are difficult to access. Follow-up data indicating, for example, the number of former refugees who have been able to access the labour market, the average length of their unemployment, their perceived quality of life, their level of social interaction or their income levels are not available. Findings in this research suggest that many participants are likely to fall into the low socio-economic strata. A

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66 Developed by Ware, Kosinski and Keller in the United States (1996). The updated and last version is SF-12v2™, 2007.

67 It is a shorter alternative to the form SF-36® Health Survey questionnaire which is in use in New Zealand. For example, the Ministry of Health in its report "Reducing Inequalities in Health" (2002, p.13) has used that scale while exploring gender differences in reported health self-assessment.

quantified measure of deprivation (New Zealand Deprivation Index) is likely to be of practical value in confirming or moderating such an assumption. Such gaps in empirical evidence make it difficult to demonstrate reported critical issues so as to quantify the extent of the problems and available options to resolve them.

In the light of participants' perceived major role played by volunteers such as sponsor families for Quota refugees, ESOL (English Speakers of Other Languages) tutors and "anonymous caring New Zealanders" to facilitate their gradual adaptation process, the perceptions and roles of such key players have not been investigated. It is likely to be of considerable relevance to explore their experiences and knowledge. This information is not currently available and could be of interest when structuring assistance policies and programmes.

Another issue which became apparent during the study was the average New Zealander's lack of basic knowledge and comprehension of refugees and their backgrounds. When examining issues related to the discrimination faced by immigrants and refugees living in New Zealand, Butcher et al. (2006) reported that the "growing cultural diversity has proved to be an outcome not always welcomed by New Zealanders" (p.48), however, relatively little is known about such perception and resistance. Because policies aim to promote social interaction, it may be important to investigate general public attitudes towards former refugees. Defensive or protective attitudes might be related to a lack of awareness of refugees' backgrounds, their pre-arrival traumas and other factors which transcend intentional discrimination or racism. Such investigation could highlight the requirements of a more comprehensive promulgation of information at both government and mass-media levels. Indeed, New Zealand's international humanitarian commitment to admit refugees within its borders and to consider them in the same light as any other New Zealander, despite being foreign-born, appeared to be largely unknown. Understanding the reasons for such misconceptions is likely to be of help in developing communications informing and reminding the public that they have a critical and personal role to play in assisting the New Zealand Government with its humanitarian commitments and international obligations.

## **7. Strategic issues**

Consistent with the foregoing, adult refugees' coping processes to overcome resettlement difficulties are related strongly to their access to socio-economic resources and their ability to

participate in societal activities which they are unlikely to be able to control directly. Regaining control over their lives requires comprehensive support from the resettlement services to replace the lost protective factors offered in their original societal environment (religious, cultural, extended family). Findings suggest that more structured and tailored individualised support needs to be developed rather than expecting community or non-government organisations to respond to individuals' needs which are not being met by the statutory authorities. This appears critical so as to maintain or restore individuals' mental well-being. Based on the refugees' own accounts of their experiences since resettling in New Zealand, the following steps should be considered to enhance their ability to cope and contribute to their host society.

1. Strengthen individual, practical and direct assistance in supporting former refugees, especially men, to assist them to access the labour market in the early stage of resettlement.
2. Undertake a review of the one-off Re-establishment Grant of NZ\$1,200 with the purchasing power to be linked to the Consumers Price Index (CPI). The grant has not been index-linked to the cost of living since 1993; its reduced purchasing power in 2008 has a value of NZ\$743 (Source: Reserve Bank of New Zealand).
3. Implement a positive affirmative action programme whereby established and qualified former refugees should be given preference in filling employable positions in the agencies providing resettlement services.
4. Considerable emphasis is given currently to reinforcing a sense of community by focusing on the formation of associations whilst little attention is given to the solving of current infighting and disagreements within the various refugee groups. Influential persons, such as religious leaders, elders and esteemed women should be more frequently consulted and involved in promulgating discussion, understanding and focusing on "what brings refugees together" in New Zealand and on "what they expect to achieve".
5. Strengthen coordinated and pragmatic actions between resettlement service providers and develop an action plan relating to the implementation of the New Zealand resettlement strategy which is not yet available in Christchurch. Such a working document, plus its

indicators of results, could be of value in following policies' implementation and developing a data base on former refugees which does not currently exist.

These steps could be achieved given the small number of refugees resettled annually in New Zealand (750 persons with an estimated 20% in Christchurch). Other issues which require attention relate to reported poor living conditions, English language classes, the lack of a convivial and shared meeting place to meet and the organisation of mother tongue teaching classes for children. Because of the complexity of factors surrounding the strengthening of individuals' coping processes, such wider issues have not been investigated being beyond the focus of the study.

## **8. Conclusion**

The expected outcome of this research was to develop a theoretical explanation (middle-range theory) of adult refugees' coping processes to overcome major adjustments whilst resettling. The basic social process of obtaining a social position in the host society was described by the participants as their main goal which motivated the development of these coping processes to defeat resettlement adversity thereby adjusting positively to life in New Zealand.

Data collected in this study suggest that participants' ability to cope and activate effective coping strategies was underpinned by the inter-relationship of their personal resources and achievements which appeared to be influenced by external support from resettlement services providers and caring New Zealanders. Participants expressed that the effective utilisation of their personal abilities and skills in finding solutions to overcome resettlement challenges was largely influenced/associated by the availability of a pragmatic and encouraging support which they sought from relatives, empathetic New Zealanders, informal associations and, when eligible, resettlement services providers.

Findings suggest that support which recognises former refugees' competences rather than their deficits and facilitates their inclusion within the host society appears to be critical to overcome their radical life changes after having been forced to leave their country. Many participants described that an encouraging support helps them to interrupt their long experience of being rejected by enabling them to regain control over their lives in a social network with attendant support structures which goes beyond their family and community of origin. Furthermore, they explained that it gives them the means of acting as effective parental

role models and to be able to interact with the host population. Should this support not be available, the purpose of resettlement which is to provide a resettled refugee and his/her family with access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals, turns instead into dependence on the welfare system or relatives which is difficult to break. This frustrating and continuing experience of unintentional alienation aggravates and accentuates their sense of worthlessness which impacts negatively on their mental health status and family cohesion.

This dynamic process, in which personality and environmental factors interacted in a reciprocal and transactional relationship, was the condition *sine qua non* to negotiate and manage resettlement challenges. Participants frequently emphasised that if this interaction was not activated they faced greater difficulties in coming to terms with their new environment and in their adjustment to life in New Zealand, thus leading potentially to adverse mental health outcomes.

Despite considerable efforts to improve resettlement outcomes in New Zealand (Department of Labour, 2007) supportive action tends to focus on refugees' weaknesses and activities are organised around those limitations instead of taking note of individuals' capacities, interests and efforts which could be of considerable value to both themselves and the country. Participants in this study viewed such a deficit approach, despite good intentions, as preventing them from regaining control over their lives which they associated with their current adverse mental health outcomes and described as "sadness, anger, anguish, depression or uncertainty". As a consequence, participants considered that their motivation to obtain a social position often was hindered by an assistance based on social dependence rather than on supporting their strengths and socio-economic priorities which are critical to coping. Conversely, data collected in this study indicated that participants had a sense of their own identity and efficacy, that they were able to decide for themselves, able to define some goals (albeit modest ones) and to believe in their future so as to gradually become a part of New Zealand and "give back" to the country which accepted them. They frequently mentioned that they were ready to do, if permitted, so as to attain a level of societal participation and interaction.

This study has highlighted the potential to reduce adverse mental health outcomes by juxtaposing individuals' coping processes in reaching their own resettlement goals. Such goals

are similar to those targeted by the resettlement providers, however, the proliferation of policies (which appear not to be known by many refugees) often masks the accountability and responsibility for their implementation. In that respect, findings suggest that multisectoral interventions to assist former refugees in their process of adaptation, which participants of this study strongly related to their obtaining a social position, need to be strengthened. Indeed, going beyond the attainment of self-reliance, such an accomplishment appears to be an important factor to reduce adverse mental health outcomes, because it also signifies the refugees' finalisation of their exile.

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## **Appendices**

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| <b>Appendix A: Ethics Committee, letter of approval</b> |
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**Upper South B Regional Ethics Committee**

Ministry of Health  
4<sup>th</sup> Floor, 250 Oxford Terrace  
PO Box 3877  
Christchurch  
Phone (03) 372 3018  
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14 May 2007

Ms Marie-Therese Pahud  
C/- Paul Cotton  
5 Piper Lane  
Beckenham

Dear Ms Pahud

**Ethics Ref: URB/07/04/012**

**The coping mechanism/ abilities of refugees living in New Zealand to overcome past and present adverse circumstances: A study amongst Somall and Afghan communities resettled in Christchurch**  
**Investigator: Ms Marie-Therese Pahud**

The above study has been given ethical approval by the Upper South B Regional Ethics Committee.

**Approved Documents**

Information sheet Appendix 4 – version 2, dated 30.04.07  
Consent Form Appendix 5 – version 2, dated 30.04.07

**Accreditation**

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

**Progress Reports**

The study is approved until 30 October, 2008. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in May 2008. The report form is available on <http://www.newhealth.govt.nz/ethicscommittees>. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

**Amendments**

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

**Please quote the above ethics committee reference number in all correspondence.**

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

Di Rutledge  
Upper South B Regional Ethics Committee Administrator

**Appendix B: Questionnaire: demographic and socio-economic characteristics**

Participant's number:

Date of interview:

**1. Demographic information**

- Age:                      Sex:                      Nationality:                      Date or age of arrival in NZ:
- Are you

- Quota refugee
- Asylum seeker (Convention Refugee)
- Family reunification refugee

- How many people live with you?                      Composition of the Family:
- Why have you been forced to leave your country?

- War
- Personal persecution (political, religious, ethnic)
- Other

- When did you leave your country?
- Where did you go?
- Family overseas:

|  | Yes | No |
|--|-----|----|
| Do you have family left in your country of origin? |     |    |
| Do you have regular contact with them?             |     |    |
| Do you support them financially?                   |     |    |

- What is your main worry about your overseas family?

**2. Housing**

- Are you happy with your standard of housing?                      Yes                      No

**3. Employment**

- Are you working in Christchurch?                      Yes                      No
- For how long?
- What are you doing?
- What was your original profession?
- Are you satisfied with your job?                      Yes                      No

**4. Income**

- Do you receive government benefit?                      Yes                      No
- Do you have enough money to cover your monthly needs? Yes                      No

## 5. Health

- Do you have access to health services?                      Yes                      No
  
- Do you have a Community Services Card?                      Yes                      No
  
- Are you satisfied with the support of health services when you are sad/worried? Yes                      No
  
- What is the main reason for your satisfaction or dissatisfaction?
  
- What helps you when you are sad, worried?
  - Traditional medicine and/or healer
  - Self-medication
  - Church-Mosque/Prayers
  - Community group counselling
  - Family and/or friend counselling
  - Other

## 6. English language

- Did you have a good command of the English language before arriving in NZ? Yes                      No
  
- Do/did you receive English language support?                      Yes                      No
- If yes, where do/did you learn?
  - Formal classes (Peeto or other?)
  - Informal classes,
  - Friend/ relatives
  - other
  - Are you satisfied or dissatisfied with the English classes?

## 7. Community-Friends

|  | YES | NO |
|--|-----|----|
| Is there a leader representing your community?                     |     |    |
| Do you meet regularly with other people from your country?         |     |    |
| Do you meet with other people from New Zealand or other countries? |     |    |
| Are you part of a group/association-social activity?               |     |    |

## 8. Summary

- Are you satisfied with your life in New Zealand?                      Yes                      No

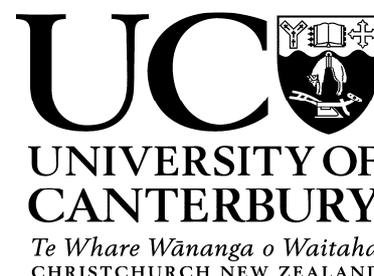
## Appendix C: Participants' information sheet

University of Canterbury Private Bag 4800, Christchurch 8020, New Zealand. [www.canterbury.ac.nz](http://www.canterbury.ac.nz)

### Health Sciences Centre

Tel: +64 3 364 2987, Fax: + 64 3 364 2490

Email: [healthsciences@canterbury.ac.nz](mailto:healthsciences@canterbury.ac.nz)



### Research Participant's Information Sheet "Coping Abilities and Strengths of Refugees Living In Christchurch"

Please take you time to read this information sheet carefully.

You are invited to take part in a research study looking at the skills and strengths of refugees living in Christchurch. This study is conducted under the supervision of the Health Sciences Centre of the University of Canterbury/Christchurch, and has the support of the Refugee Council of Christchurch.

A week after you receive this information sheet the researcher, Miss Maite Pahud will contact you and will ask whether you would like to participate or not, or if you would like to meet her for more explanation of the study. If you decide to participate, we will be very grateful for your willingness to contribute to better understanding of refugee's strengths and skills. If you decide not to participate, there will be no disadvantage to you and we thank you for considering our request.

#### 1. What is the aim of the study?

The aim of the study is to understand the personal strengths and skills of refugees to overcome both their past difficulties and problems as newcomers to New Zealand.

You will be asked your opinion on what helps refugees to build their new lives. Your valued information will help us to see how these strengths and skills could be better recognised in New Zealand to help others, especially those coping with their new life in New Zealand.

#### 2. How many participants will be involved?

20-30 participants (male and female) from different countries and who are relatively satisfied with their lives in New Zealand.

#### 3. What is your participation?

- Your participation is voluntary and you are free to withdraw from the study at anytime without having to give a reason. There will be no disadvantage to you.
- You can ask for an interpreter of your choice if necessary.
- **Your name and personal details are strictly confidential and will not be mentioned in the final report.**
- If you decide to participate, you will be asked to sign a consent form when you are interviewed to confirm your willingness to be involved. You will be given a copy of the consent form.
- The first talk will take one and half-hours (details of the interview are explained in point 7).

- A second talk, a few months later will be scheduled with you to verify the results of the study before writing the conclusions. This should take 30 minutes maximum.

#### **4. What kind of compensation will you receive?**

- If you decide to participate, a food or petrol voucher of \$30 (you have to mention one would you prefer) will be offered to you at the end of the first talk in appreciation of your time and input.
- If you need an interpreter, that person will also receive a food or petrol voucher at the end of the first talk.

#### **5. Where will the talks be conducted?**

You can decide where the talks will be conducted for example:

- At the University of Canterbury
- At your home
- At another place of your choice

#### **6. When and how will the talks be conducted?**

The study will involve one individual meeting between May and September 2007, and one further meeting a few months later to share with you the analysis of the results.

With your approval, the talk might be recorded to allow the analysis of your answers. If you do not want to be recorded, the researcher will need to write some notes.

#### **7. What questions will you be asked?**

##### **7.1 During the first meeting;** you will be asked

- Your personal views on what has helped you to overcome past and present difficulties. This should take around 45-60 minutes
- Unidentifiable (no name) information about your general health and details on housing, employment, English fluency, refugee status, size of family, community networks and time in this country. This should take 20 to 30 minutes maximum to answer

##### **7.2 During the second meeting;** a few months later, you will be asked

- Your opinion on the analysis of results of the information you gave during the first interview. This should take 30 minutes maximum.

#### **8. What will happen to the information?**

Every participant will be identified with a study number (no name will be used). All the information will be kept at the Health Sciences Centre/University of Canterbury. Only the researcher and two supervisors will have access to it to enable your answers to be analysed.

**9. What are the risks and the benefits of the study?**

There is no risk to you as a participant, other than possible sadness about sharing difficult experiences. If there are some questions you do not want to answer, you are free not to answer. The benefit of the study is that your opinion on what has helped you to cope successfully in this country could be useful to better address other refugees' needs when building their lives in New Zealand.

**10. What will happen to the results of the study?**

It is expected that the final writing of the research will be done in July 2008. You will receive a copy of the summary of the final report if you wish. The Refugee Council of Christchurch will receive a full copy of the final report.

**11. Who pays for the research?**

The study is financed by the University of Canterbury

**12. Who has reviewed the study?**

This study has received ethical approval from the Upper South B Regional Ethics Committee/Canterbury region

**13. Where can you receive more information?**

You can request more detailed information from the principal researcher – Miss Maite Pahud- 03-364-2987 extension 8362 at the University or at any time at 03-337-6258. E.mail: [mtpahud@gmail.com](mailto:mtpahud@gmail.com)

Supervisors of the study: Prof Andrew Hornblow, 03-364-7628, Dr Ray Kirk, Director of the Health Science Centre, 03-364-3108, Health Science Centre, University of Canterbury, Private Bag 4800, Christchurch

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent Health and Disability Advocate, as follows:

South Island 0800 377 766 Free Fax (NZ wide) 0800 2787 7678 (0800 2 SUPPORT)

Email (NZ wide) [advocacy@hdc.org.nz](mailto:advocacy@hdc.org.nz)

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| <b>Thank you for considering taking part in this study and for taking time to read this paper</b> |
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| <b>Appendix D: Participants' consent form</b> |
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Email: [healthsciences@canterbury.ac.nz](mailto:healthsciences@canterbury.ac.nz)



**Consent Form for the study**

**“Coping mechanisms/abilities of refugees resettled in Christchurch”**

**Request for Interpreter**

|                                |     |    |
|--------------------------------|-----|----|
| I wish to have an interpreter. | Yes | No |
|--------------------------------|-----|----|

Please tick to confirm

- I have read and understand the information sheet for the above research study.
- I have had the opportunity to ask questions about the research study, and to discuss it with family and friends and have had time to consider whether to take part.
- I understand the purpose of the research study, and how I will be involved.
- I understand that taking part in the study is voluntary (my choice) and I understand that I may withdraw from it, at any time and for any reason
- I understand that **my participation in this study is confidential** and that **my name and personal details will not be included in the report**
- I know who to contact should I have any questions whatsoever about the study or my participation in the study.
- I understand that I will be contacted a second time after the interview to participate in the analysis results of the study
- I wish to receive a summary of the study's results

I \_\_\_\_\_ (please print full name) consent to take part  
in the above research study.

Signed [Subject] \_\_\_\_\_ Date \_\_\_\_\_

Person taking consent/Researcher \_\_\_\_\_ Date \_\_\_\_\_

This study is being conducted by Miss Maite Pahud, PhD student through the University of Canterbury/ Christchurch. You can contact Maite at the University: 364 2987, extension: 8362, or at home 337-6258 if you have any question or wish to discuss your participation.

E-mail address: mtpahud@gmail.com

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**Supervision:** This project is being undertaken under University of Canterbury Health Sciences Centre supervision.

Supervisors:

- Prof Andrew Hornblow, Health Sciences Centre. (Ph. 364 7628)
  - Dr Ray Kirk, Director of the Health Sciences Centre.(Ph.364 3108)
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| <b>Appendix E: Grounded theory: establishment of categories</b> |
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Phase 1 of the analysis: Open Coding

**List of coded categories**

1. **Initial expectations**
2. **Personal achievements**
3. **Lack of control**
4. **Level of life satisfaction**
5. **Resettlement difficulties**
6. **Formal support**
7. **Caring person**
8. **Fragile community**
9. **Personal resources**
10. **Parenthood**
11. **Coping strategies**
12. **Obtaining a social position**

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The following outlines how participants' statements were broken down so as to highlight relevant issues related to refugees' coping processes in the course of resettlement to overcome major adjustments in a new environment. It has enabled the assignment of codes to each developing category. This involved reading, line-by-line, the participants' transcripts by interview number and narrative sections.

|   |
|---|
| <b><u>1. Initial expectations: participants described what they expected when they arrived in New Zealand</u></b> |
|---|

# 1: "I expected to have the same work I was working at home. I had high expectations to have a nice job."

# 2: "I wanted to understand the Western life and where did I fit in it. I wanted to find a job as a radio telecommunication technician but realized that what I have learned was 30-40 years behind the New Zealand technology."

# 3: "I hoped to have a very high class way of life and to have a lot of money."

# 5: "I wanted to get a job as the same as I have in my country because I was a senior lecturer at the university."

# 8: "When I arrived, I expected to find freedom, peace, safety, democracy. I was expecting also to find a job and give a good education to my children. That point was very important for me, I wanted them to reach a good educational level."

# 12: "I was thinking going back to University to study Anthropology or History to come up with a PhD."

# 17: "I expected a big country, big houses; that everybody was going to tell me I love you, that we were going to have a lot of stuff, becoming very rich.../...I thought it would be easy to adjust to the culture."

# 24: "I did not expect anything because I was very worried about the past. My husband and one of my children were not with me. After few weeks in Mangere, I wanted to find safety and good health for my family and for me."

|   |
|---|
| <p><b>2. <u>Personal achievements</u>: Participants described what they have been able to achieve since their arrival</b></p> |
|---|

# 2: "Today I have achieved something in my life I have my own business and succeeded to do something good for my children.../... My skills are really recognized. I started business from zero and now I am in a very good position."

# 4: "I have been able to bring my husband and also my parents. Now I speak English, I can understand and everybody understands me."

# 5: "Today and yesterday is completely different. Two of my children finished high school. Now they know what to do, in their career, in the future. One of my sons is working. My younger son has Kiwi friends and he does not have problems, he is very happy. He has more Kiwis' friends than Afghans! Sometimes, his friends help him or happily come to my house. My wife also, has contacts with the neighbours."

# 9: "One good thing that I could achieve was to take in my in-laws. It took me 7½ years.../... It was a lot of stress but I succeeded."

#13: "I bought a house in Christchurch. You know I have been working hard since I arrived. My English is better but still not good enough but I have learnt in my work. I also know many people now and I know the country. You know what I have mainly learned and achieved it is to live with different people, culture, religion. This is a lot."

# 15: "I have two more children now. I had problems during one of my delivery. If this had happened in Africa, I would have died. Here, immediately they knew the problem and they treated me. I also have a car; I have learned how to drive. I am like a Kiwi. I am living in a nice flat. It is a lot for me because I even did not expect that. You know, I am alive and this is the big thing."

# 17: "I think I have contributed to show the differences and make other people to accept the differences .../... I am accepted. I am part of the place now."

# 19: "During the first five years, I have worked in 9 different places because I was not qualified .Now I am working in the same place for 5 years as a cook. I am very happy with what I have."

# 20: "I am not afraid anymore of people because here people look after themselves. They leave you in peace. If I was in my country I could not have my children with me, my daughters will have to be married. I am safe and my children have plans. I can speak a little English and communicate and I feel very happy with that. I can also drive and have a part-time job as a driver. This keeps me busy. My husband is also with us now, this is a good life."

|  |
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| <b>3. Lack of control: participants described in which way they failed to regain control over their lives.</b> |
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# 1: “I thought having the same job that I had a home: teaching but this never happened. On the other hand, they told me to go back to the university. At the age of 47, I cannot go back to the university. Everything for a long time was out of my hands”.

# 3: “After 7 years, I cannot speak English. I went to classes but lessons are not good. I could not follow but also teachers here could not teach me properly. They give you papers that nobody understands. I did not like it at all, I think the problem is me because my education was completely different in my country and my knowledge is low.”

# 6: “I know there is a problem because I cannot find a job but I have to solve it. When I was alone it was my matter, but here within the family everybody asks. I know they do not want to hurt me but each time I have to explain to everyone, I feel more pressure and evidence that I am losing something here.”

# 8: “I cannot work. Nobody gives me chance to work. I have Kiwi degree, they do not give me the job because they say that I need experience but how can I get experience if they do not give me the job?”

# 9: “Because I did not succeed to have a good work, this has affected my married life badly. For long, I thought that it was because of me. I felt so guilty. I do not doubt anymore and do not blame myself but I blame myself for long time and therefore I had a big depression. Today I know this is the system, not us.”

# 11: “For us as parents, life is difficult. We do not have proper job and benefits are not enough to live properly. Today after 6 years, I did not achieve what I wanted, because of the lack of money and unemployment. I can feed my family that’s all. .../... You know, I have been in jail for years, then in camp. For 8 years I did not have control of my life, this is the same here, I cannot control. But now this is because I do not have enough money to live.”

# 17: “By keeping our culture so strict, our parents also make us different, they kept us isolated because they are afraid that we start to drink, to take drugs, to go out with boys. Our parents also stereotype the Kiwi society.../... But due to the lack of communication between us we cannot discuss. They have to adapt to the Kiwi culture. We are multicultural now.”

# 22: “It is also difficult economically. The benefits are not enough when you have a big family. If you work, they start to cut the benefits without considering that we are earning the minimum and we cannot live correctly. At the same time being under benefits is not good because you are not like the other people.”

|   |
|---|
| <p><b>4. Level of life satisfaction: participants described how they feel with their life in New Zealand and why they feel this way</b></p> |
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# 2: "I feel peaceful for my children because they succeed at school and frustrated sometimes for myself because in a business, you do everything by yourself and you have always to be there. Nevertheless, I feel happy from where I make income, living and I am quite happy about it."

# 4: "Today, I can do everything by myself. I feel free and independent because everybody understands me."

# 5: "I did not achieve what I wanted unfortunately. However, I work as a bilingual teacher and I feel happy because I am teaching and I like it."

# 8: "Because I cannot get a job, this makes me very upset. This is like being ON and OFF all the time. I have to be happy in front of my children, but unhappy for me because time is passing, I am becoming old and I achieved nothing."

# 9 "When I came I did not have any mental health issues but, after 8 years I have so many because I could not achieve many things that I hoped. I feel frustrated, very sad and angry."

# 11: "They say we are New Zealander but they do not treat us as New Zealander. Nevertheless and despite all the problems here, I am able to recognize that my life is better here than being in prison."

# 13: "Because I am working with a lot of New Zealanders, I am somebody among them. I am happy here and will continue to be happy because I belong to New Zealand."

# 15: "I cannot say that there is nothing for me here. I am fine.../... *This participant has succeeded in bringing in her family, this happened 6 weeks after the first research interview and said during the follow-up meeting:* "You know, everybody is here now... I had to wait more than 4 years. Today I am free, I can fly, I am so happy!"

# 17: "I have many friends. At school, everybody knows me. I put myself out there. I get involved in sport, I dance, I play drama, I am accepted, I am part of the place now."

# 19: "I have been upgraded in my job, I feel very happy. You know I feel at home here and I want to finish my life here."

# 20: "I have a good life and I am happy.../... How can I say that: first God gave me life and second New Zealand gave me my second life because if I did not come here I do not know if I would be still alive? This is my country now and I will die here."

# 21: "I can speak English and communicate and I feel very happy with that. I can also drive. I feel safe also and this is so important. I feel that I become more and more independent."

# 26: "For the moment I am trying very hard to learn English and I can communicate, it is not perfect but I start to become independent."

# 25: “It is difficult because we cannot work here... /... If you do not work, you do not belong to the society.”

**5. Resettlement difficulties: Participants described their difficulties to adjust to New Zealand and how this affected and/or affects their morale.**

# 4: “The language was a problem. I was very worried also about my family, where they are what are they doing. My husband was not there and we did not know where he was for 2 years. That was very difficult. I wondered all the times: where are my parents, do they know if we are here? My mind was full of thinking of everything and of everybody all the time. I could not learn anything because my mind was full.”

# 6: “Kiwis do not have a lot of qualifications but they got the jobs even though they are not good. They did not learn and sometimes, I realize they know less than me and if they do not give me the chance to work why to be here?”

# 7: “The main problem is my grandchild left in Ethiopia. It is difficult for everybody. He is with one uncle but we do not know. Here, I have big problems to send my elder children who are more than 18 years old to school because the New Zealand regulation specifies that no help is provided during the 2 first years after arrival for people above 18 years, especially for the ones who are not quota refugees. They and I do not see the future still today. You see if my children are not happy I am not happy also.”

# 8: “Each time, I send my application for job, I show them the qualification. But some of them they do not even contact me after the interview. They prefer to take others. They never say directly why you do not fit to the position. I think this is racism and discrimination. Because here when you are from overseas, they do not accept you to work here. They do not give you the chance, so they cannot see what we can do. You know in our country, in Africa in Middle East, they are many problems, if you do not follow the rules or instruction or if you disagree with them they can kill you with weapons. But here, they do not kill you with guns because this is a freedom country but they can kill you with words. They can really make you feel upset and stressed.”

# 9: “Refugees are associated with wrong ideas. Kiwis think that refugees are poor people, not educated, no skills, deprived, that they cannot talk, that they need seven-day week assistance. Refugees are stereotyped and the host society cannot go beyond that point. There is a lot of discrimination, but not an obvious way. Christchurch is very much snob, people do not have interest in the others. They have their own boundary. We are discriminated for job opportunities, they do not bother to explain you why you do not fit to a job.”

# 10: “I did not have the knowledge of the country and the culture. I do not speak English, it is difficult to find someone to help you because people are always busy.../... I always feel something and as long as I feel something, it is hard to be happy.”

#11: “Housing was very difficult, we were four people for only one bedroom. We had to wait four years and a half to get this house.”

# 12: “Christchurch is the most traditional English city. It has a long way to go in accepting the others. It is a very conservative and insular city. They do not have travel very far, sometime to Australia. Their global outlook is very limited. If you do not speak their own

accent and do not behave like them, it is hard to be received and you are rejected. This is a monoculture and traditional society. They are very defensive and happy with their own things. They do not have sympathy for people. It is difficult to make friends.”

# 13: “I did not understand when people wanted to see me. It was very difficult to socialize with Kiwi people because I did not understand them. It was also difficult to understand how I should behave because my religion is different. It is not a question of colour, but I did not know if people were accepting me despite my differences.”

#15: “My biggest problem is that I cannot bring my family in New Zealand. The immigration services are so strict, they want now DNA samples of my relatives. They do not understand that war is going on in my country. Women are raped, sometime you cannot prove like this, that this is your family, you cannot prove everything all the time. Asking such things in my culture is considered as a crime because it means you do not trust your family members. For me the life here is OK but I am struggling like everybody who wants to bring in their beloved.”

# 20: “I have to ask for help all the time. I was responsible for my five children without my husband. I had to understand the system, how to go to school, how to behave. I could not control anything.”

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| <p><b>6. Formal support : participants described their perception of available formal support whilst resettling.</b></p> |
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# 2: “The current information system does not work at all, and sometimes creates more confusion than informing people.../... In my case the agencies did not help me at all. My opinion is that they have to create problems amongst the refugee communities to get funded by the government.”

# 5: “We had problem to know where to send our children for school, but RMS, especially a lady helped us to enrol the children at school.”

# 7: “Here nobody asked me what I can do. I think that they will not ask me because I do not know the language. I go to English classes, but this is not enough. I have homework but I cannot do it because nobody can help me. Often we do not understand the teachers, they ask us to find a word in a dictionary but it does not exist in Somali language.”

# 8: “The agencies do not help us. As individuals they help but not as organisations. We miss coordination and miss voice representation. The forums are more for the agencies or NGOs’. They do not employ refugees to help others to create connection and develop network. They have some refugees acting as interpreters but that is all but they do not involve refugees when decisions have to be taken.”

#10: “When we arrived, they give us unemployment benefit and they to say to us you are welcome. But how this can help us to be part of the society? We do not have guidelines at all. It is really like if they say “hello to us and bye-bye” at the same time. Agencies should advise us better, by telling us what could we do at our age, where to go to find a job. .../... I do not want to receive unemployment benefits, it is very good for a short time to allow people to find job, but not for long.”

# 11: “When we have problems we go to the offices which are supporting refugees. But people working in the government services reply that we should be happy with what we have and that this is not their problem! So why do they bring us here? They make us feel dependant and that is not what I want. When we arrive we receive \$1200 resettlement grant, but we cannot do what we want with it, we do not have the freedom of choice. This year the government gave us more money for each child per week, but on the other hand, they have increased our rent. What are they doing? This is like giving us something with one hand and takes all of it back with the other hand.”

# 14: “The government is good for us. I am grateful with the government here.”

# 16: “You have people working in the agencies who are confusing people. Some of them they do not want us to learn English. They are afraid that if we understand English we will understand our rights and rules and that we will not need them.”

# 18: “I think the agencies are not too bad and they help people. They have been good for my family.”

# 19: “A lady at RMS has helped a lot. She gave me a lot of attention, she explained to me how to pay bills.”

# 23: " Today, I can speak English because I am going to school for one year now. The teachers are nice and they help me, when they see that I cannot understand they help me. I have gained confidence because I can communicate"

# 25: “RMS in Nelson helps me a lot and my tutors. The government gives us benefits which are good but they do not help us to find a job. Benefits and salary are the same amount, so if you work at the minimum salary you earn the same as if you are under benefits. This is not good for people.”

### *Health services*

# 2: “Doctors and agencies need to understand the cultural way of people. Too many headaches, too many thinking are related to something. Before prescribing a medicine, the doctor should advise more. When he know what’s caused the headache he has to find the next way to attack the problem.”

# 3: “If I have a physical pain I go to the health centre, but not when I am sad or upset because of my poor English and it is very expensive. I do not want an interpreter, my worries are mine and I do not want somebody I do not know to be aware about my personal problems. And you know, the GP he is a normal "human being". Like me he knows something because he has learned, but he cannot understand what my worries are. It is beyond his capacities. He cannot help me as God can help me.”

#4: “Few months ago, I was worried because I cannot bring my sister in. The doctor gave me tablets. This helped me with my children during the day because I was always angry when they asked something. Sometimes I took tablets sometimes not.../...What could have helped me was the immigration but not the doctor. The tablets the doctor gives you it is good sometimes but not good for all the times. Maybe it helps for the brain, it stops thinking but it is not good for everything but the problem is still there. It is better to solve the problem.”

# 5: "I do not go to the health centre when I am upset, I just go when I am sick. Personal turmoil does not belong to the doctor. I think that if you talk about your emotions, feelings and especially if you related them to the past, they cannot understand such things. It is not physical and they cannot do anything. Religion is the first help."

# 8: "God gives me the motivation. People go often to see the doctor, they receive pills, but they do not feel well, because stress is only stopped if you stop the cause. People here are stressed because their families are far away, because they do not talk with the children etc. This is often minimized here. But the religious leaders could help by listening to the people."

# 9: "The system does not work, the professionals do not talk to us. They are up and we are down. There is no connection between them and us."

# 14: "You know I have lost my brother and since I have a lot of mental problems. I need tablets to sleep for 2 years and a half. I try to leave the tablet for twenty days it was so difficult, I could not sleep I had pain in my jaws and body. The GP changed my tablets and he sent me to physiotherapy.../... Everybody has been nice to me. I think tablets are not good, but I am worse without them, the doctor said to me that I still need tablets."

# 15: "I have taken anti depressors for a long time. This did not help. I had many side effects and this has affected my health. The main problem is that I am worried for my family left behind. You know if you know that you need your family to feel better and that you cannot have it, what can you do? I miss them a lot, but drugs will not help for that."

# 16: "I went to see a GP few months ago because I had severe stomach pains. The doctor has asked me if I had worries and I explained to him my housing problems, family problems. This has helped me. Our family doctor is good and he listens to us. He explained to me that my worries were causing my stomach pains and it was good because he confirmed to me what I was suspecting."

# 17: "If you are angry, you have to take time and think. Doctors cannot help with everything. Drugs do not help. If you are mentally disturbed medicines can prevent you to kill yourself but do not solve the problem."

# 20: "The doctor gave me a lot of drugs to make me sleep. I was very worried because I did not know what was happening to my husband. He sent me to see a psychologist who made me talk and talk. I felt better. But now, I do not want to talk about the past."

# 22: "I do not see the doctor because he is not above God. I go to the church because God can do everything."

**7. Caring person: participants described the support which they received from individuals during their resettlement.**

# 2: “My Kiwi friend has a farm. That man helped me a lot, he explained to me how I needed to cope, how to find a job. Because I could not speak very good English at that time, he came to my place. When I had some financial difficulties, he gave me money. He also helps other people from my country.”

# 3: “I was driving for my friend who has business and I was watching what he was doing. One day I asked him if I could do the same. He said” why not?” He was very positive. He mentioned that I had to ask first to a Kiwi lady who was in charge to give the permission to hire some space on the market place. I asked her and she said yes. So I rented some square metres, my friend provided me with some craft to sell. He helps me to learn, he gives me advices.”

# 4: “Mrs.R and Mr.D came to see me everyday because I was alone at home. And then we were talking, and we went to the shop. I was not afraid anymore, I was not alone any more. I was very happy with my Kiwi friends because they have been like a family to me.”

# 6: “I need positive people around me, who gave me confidence. People who reassure me that this is not my fault if I do not get a job. Here this is because of bureaucracy, the problem is not me.”

# 8: “I have been lucky to have a very helpful Kiwi woman. She looks at the problem and she tries to find the solution and treat us as a New Zealander. She gave me a lot, she helps others by listening, encouraging me, us. She gave us good morale. If she was not there many people will have more problems than they have now.”

# 10: “I have some Somali friends who encourage me. Some teachers are good and they also encourage me, they take us to some working places in town and explain to us how it works. My wife’s sister helped us a lot, but you know she has 7 children and I have six ... We could do a football team! (Laugh).”

# 13: “I think that what has helped me is the Muslim Association who putted me in contact with the meat industry, on my own I could not have succeeded.”

# 12: “A sponsor lady who had travelled a lot has recognized my capacities. .../... Whenever I did not feel well, her house was open. The help of this woman to reconstruct my optimism has been enormous. After one year she left, I still did not have a job but I was able to stand on my own feet. It is important to have someone who “upgrades you”. My actual boss has helped me a lot. He gave me the chance and he could see the results! After few months, he offered me to work full time with responsibilities and challenges.”

# 15: “My sponsor, she really helped me, helped us a lot. She helped me from her heart, she cared so much and she was suffering for me. She was with me all the time. She changed my life, she loved us and she was always very kind for us. She did a lot to find solutions with us. It has been the most important support. She is still helping us a lot after all these years.”

### **8. Fragile community: participants explained how they perceive their community of origin.**

# 2: “As you know, we have a problem back home and what’s going on at home is going on here. Therefore, my community did not help me at all, except few personal friends. There is a kind of skeleton but it does not work anyway”

# 6: “Because you know the people around us they talk “bull...”, they know you have problems but they do not help you. In the Eastern culture this is like that, I do not like them because I do not feel part of my community.”

# 7: “Problems between people are like back home. I do not like that, I want one Somalia. Here, you can see that people are divided and I am not interested in that.”

# 9: “I tell them that women are not in New Zealand to fight with men, but that they can talk and said what they have to say. At the beginning the men they were very stubborn, but after eight years they start to be more open. They changed a lot because they see their children going at school, becoming teenagers. And they have seen their daughters also, but you know it takes time: leopards do not change their spot and our men also! (Laugh).../...”

# 10: “Since I am here, there is no structure in my community. We do not have a place where to meet. There is a lack of understanding among the people to help each others. You know in Somalia, we do not have this kind of social workers etc... You see if one Somali here starts to be a social worker, or have a high position, he misunderstand his role. He thinks that he can be command everybody and be president or a “warlord” and do not consult anybody. In Somalia, clan is important not community. It is difficult for us to understand what they mean by community. In my country we are different groups and we cannot be only one big group.”

#15: “I do not have real relationship with my community. Problems continue here, it was the same in the camps. People are jealous if you succeed, if you have more than they do. They judge you badly when you can manage because they do not understand, they do not know”

# 16: “My community could not help me a lot because they are poor. All the refugee community is poor. My community, like the others communities, is not strong because as in the other communities, some do not want to share with the others. The community is split.”

# 19: “I do not have any problem with anybody. I just avoid going to meetings for five years because I lost my time. People are always arguing and I do not understand what they want. Community makes me feel bad because they talk about politics. This makes it very hard to gather people and make them happy. People bring here their problems on the table.”

### **9. Personal resources: Participants described their strengths and skills to face and overcome resettlement difficulties**

# 1: “My own experience and knowledge has helped me, because I was very social and I tried to know everyone, I was talking to everybody and asked everything when I did not know. That is why I have crossed the bridge. I was not afraid to ask for help. I am very confident about myself, if you are not confident, you cannot achieve anything. I respect myself first and then I respect the others: that makes it easy to contact the others.”

#3: "I was determined, I really wanted to have a better life for my children. I needed to be strong because I understood that I had to live here and I have asked God to help me because a human being cannot do anything unless God guides you. "

# 4: My brother was very bossy and told me I have to learn English on my own. And I thought okay I will do it. I was asking my sponsor family all the time. When I did not understand I was showing them a book with pictures and ask how do you say spoon, how do you say this and that?"

# 8: "You know to succeed, you have to struggle! I try, try and try. I will not give up! One day will come I will succeed, I have hope."

# 9: "I am definitively committed with refugees groups. I am very much honest and patient with people. When I make my mind I go for things."

# 11: "I am grateful of God, he is my best strength. He gives me the patience. You know I have learned to survive. I never thought when I was in jail that I will see my husband again, that I will come here. Everything was imposed on me. "

# 12: "I decided to have achievable, realistically possible goals in New Zealand. I follow my ideas and I am committed to do it. I trust myself. I have regained my self confidence at a normal level, not too low, not high either"

#13: "You know at home I was working, I knew that I was capable to do something. I was confident with myself I knew the importance how to keep the time, respect people with whom you work. This is important to respect here otherwise you do not get job. "

#15: "I have learned how to be strong and how to survive and manage with life. I have experienced the worst and I have learnt how to hope. My children also helped me a lot, they keep me happy. Praying also, the Bible helps me. I am also thinking a lot of my childhood, because I came from a very happy family. My good memories help me a lot."

# 17:" I think this is my personality. .../... I have developed my communication skills. You have to be determined, you have to work hard otherwise you will not be recognized. I am concentrating on what is ahead and on the good things. I write things down. I think about what I will do in the future.../...I also often think of one of my teacher, who says to us not being a ship. I believe in that. I try to keep my faith, my own belief and stand up for myself."

# 19: "I dreamt a lot and said to myself that I have to go ahead. Sometimes I did not succeed and sometimes I did and this motivated me. You know I am somebody very simple and have easy objectives according to who I am and what I am able to do. I look at my conditions and choose easy things to achieve."

# 21: "I think because of my work before and my difficulties in my country I have learnt how to be strong."

# 22: "I have to be strong because I cannot go back to my country. I have to make efforts all the time and God helps me a lot to do well"

# 26: "I always try to find solution because I have plans. I want to work as a welder. I am like many other former refugees, I am doing a lot of efforts to reach my dreams. I can communicate and my life was very hard before. I will succeed."

**10. Parenthood: Participants explained the importance of ensuring their parental function.**

# 2: "I have a family and have the experience of being a responsible person. I needed to defeat the difficulties in front of my children and found a positive way.../...In Africa if the father is positive the family will follow.../... Today I am separated from my wife. It has been very difficult but we manage to stay good friends. In our culture we look at the benefits of our kids. Today our kids are more adapted to the Kiwi way of life and always we respect the country."

# 3: "I have my 3 children, sometimes we agree, sometimes not. .../... But they help me at home. They make me happy when they agree with me. But I am worried with them because they have sometimes problems at school and I cannot help them because of my poor educational level, and because they lack a male/father model."

# 8: "I need to be very close to my children if I do not want to lose them. Here this is very easy to lose your children because they do not like to go to school. I have to stimulate them all the time .../... Parents need to be strong and for that they need job to show to their children the right way. How can parents influence their children to work hard at school if they cannot show them? Look, parents they stay at home all day long, when they say to their children "Do your homework!" children do not listen, they go to town and they smoke or drink. Parents cannot show the rules and this result in family conflict".

#10: "What helps me to continue and try to be happy is the fact that we are in a secure society and I am with my family. So I keep on to make myself happy, I have to do it also for my children. Maybe my children will understand this way of life, of Western world (lots of laughs) but for me I am very far away from what I know."

# 14: "We are responsible of our children and we have to support them and talk to them. It is important to show them the example.../...I really talk and explain to them what is good all the times. I want them to understand and give the example. I go to school everyday to learn English. I do not want to be on benefits and I need to find a suitable job for myself. I always talk about the future with my children. I make plans with them."

# 16: "You know you have problem everywhere, in any society. Living is a struggling and we have to survive. The problems here affect me, but I try to struggle and I want to adjust here. I do not belong to another place because I do not have any other place to go. This is the future for my children."

# 20: "I also wanted to be a model for my children. You know I was alone and they needed to see me strong."

# 18: "I do not have any problems with my parents. We discuss a lot and all the time and ask what the problem is. We communicate a lot between each other."

# 22: "I am very worried for my children because here the rules are very free for the youth. I am so afraid that they start to smoke, drink and drive too fast. I am afraid that they follow bad examples. I always talk to them, always and show them the good way."

# 23: "I do not have problems with my parents. I accept their mind and respect what they want for me. They want me to be an accountant and I will do that. I do not have problems with them."

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| <p><b>11. Coping strategies: Participants explained the coping strategies which they have developed to master or minimize resettlement difficulties and emotional distress</b></p> |
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#1: "In my current job, many people ask me from where I come and some told me to go back to Africa! You know some of them even do not want to pay me. They say "F.... black go home!" Anyway, I laugh and ask them about their origin. Their grand-grand parents came from England, Scotland etc., they are like me, at the origin, they are not New Zealander but they become Kiwis. I try to explain them that, I always talk with diplomacy and calm with each of them."

# 2: "I was working in a slaughterhouse and I realized that I could not go on like this for the rest of my life. I needed to have something with my own culture and thought about African art/craft. I took risk and decided to go back to Africa where I bought some samples. I sold them here it was positive. I researched more on what people will buy and found the items which people liked."

# 3: "Allah helps me always and I feel better because he knows how to make my worries better."

# 6: "When I pray I promise to myself that this will not affect me. I also think to myself that I have to be strong, I need to forget the bad thing and go again. If somebody gives me logical reason to go ahead, I move."

# 12: "I have the power of self assessment: if I have a problem I blame myself first and so as to solve the problem if something is wrong with me.../... I was badly traumatized and never accepted defeat in my life, so I adjusted. I had also sleeping problems, memory problems. I forgot things such as appointments. This never happened in my life before. I had two choices, either to go to see the doctor or manage on my own. I choose jogging to restore my sleeping, to boost myself and to adjust to the weather. I should not listen to the world news and be selective with people of my community, because some of them are gossiping. This was causing me turmoil and agitation in my mind. I did not need that."

# 13: "I wanted to keep control of my situation. I pass an interview to work but I failed that first interview. However, the next season I tried again the test and I have been accepted. I am working with them for more than 10 years! Employers need good persons to work with. But also you need to knock the door and ask the employers or agencies if they want you. You have to be proactive and not to wait."

# 16: "I also make plans for the future. You know I believe that there is a solution for everything. I might go to Auckland to have a better life than in Christchurch."

# 18: "I am a quiet and careful person. I think this has helped me to keep my patience. This helps me also to think first before acting. Also when I want to do thing I do them. I wanted to drive and I have learned and today I have a car. I did not wait for that. Also I ask advices to people when I am not sure."

# 21: "When I arrived it was difficult for me and I was smoking (laugh). I stopped because this made me nervous and it was very expensive! I also avoid talking about the past. Past is gone and I want to progress."

**12. Obtaining a social position (stand on my feet): Participants described the importance of re-establishing their life in a new environment especially through social activities**

# 3: "I want my children to be well educated and go to the university. I want to work myself and have a successful business and I want to buy a house. I would like to visit my family in Africa to see if they are OK and see if my brother can come here."

# 4: "I want to work myself. When I have a job and my husband also we can buy a house, helping my children and their studies and all the family who is overseas."

# 6: "I want to get a good job. My third one is to really set up my own life, here or in another place and find a person with whom I can live with"

# 7: "I need to achieve the language, to find a better work and reach a good level in the society to be like the Kiwis".

# 8: "I want a job to reconstruct myself and be integrated."

# 11: "I want to have a better house and a job. I belong now to New Zealand, this is my home. I want to be treated as a Kiwi, because they say we are New Zealander but they do not treat us as New Zealander. We are different but we do not want to harm anybody. I hope having a good standard of life without worrying and doubting constantly if life might be better in Dunedin, in Auckland, in Australia."

# 12: "The government should provide them with work to give them the chance to behave as a Kiwi. This will facilitate their integration."

# 13 "Refugees need to work hard to be part of the society. The ones who succeed can be a model for the others refugees. The government should consider and support the family reunification".

# 14: "I want to speak better English and push myself to learn more. I want a job. Sometime I am joking with my husband to become a bus driver, because my English is enough to read the streets and the maps. I like wearing hats. ... I would like this very much. I could even put my scarf in the cap and no problem for my community and for the employer!"

# 17: "Adults should be involved in more social events to talk to each other to become more social and give them the feeling that they achieved something. .../... They have to mix the refugees with the Kiwis. This could help them to build their self-esteem by giving them rapidly access to work where they can meet people and talk."

# 18: "It will be good to have government agency at the City Council to help people who need to work. This is so important for economic sustainability and for the integration in the mainstream society and keep the link with their children."

# 21: "I have applied for New Zealand Citizenship. You know I belong to here because I live here and I will die here. This is my country now. I need to have an identity because my family, my children they will live here, they will stay. I want to find a job, I want also that my children succeed in their future and I would like to bring my sister here because life for her is too difficult because of the war in our country."

# 22: "I really want to have my New Zealand Citizenship and become a New Zealander because my difficulties will be over. All of us we need to be like the New Zealanders, work, have good standard of life. We cannot go back home, here this is our home now."

# 26: "I want to find a job as a welder and I want to have the New Zealand Citizenship. I will be as everybody living here."

**Appendix F: Grounded theory: detailed summary points**
**Phase 1: Detailed summary points related to each category**

The following points were obtained by reading and analysing each participant's transcript when developing each category. They were used as a guide to identify and describe categories' properties and dimensions during phase 2 of the analysis.

**1. Category "Initial expectations"**

- To have a better life: money , good house, good car,
- To get a job
- To get a job according to previous professional skills
- To be accepted
- To be with their family
- To understand the New Zealand culture
- To find peace, freedom and democracy
- To study
- To have good health
- To obtain a good education for children

**2. Category "Personal achievements"**
*2.1 Safety for all of them, immediate*

- Freedom of talking and moving
- Independence (gradual, especially for women)

*2.2 Employment for some of them varying from a few months up to 2 years in general*
*2.3 Personal and/or family integration*

- New Zealand Citizenship
- New children born in New Zealand
- Integration of the children through the school system
- Social network: New Zealand friends/caring persons after 2 to 5 years
- Being accepted
- Mastery of English for some of them (some spoke good English on arrival)

*2.4 Family reunification*
*2.5 Material acquisitions*

- Car
- Good housing
- Appliances
- House

### 3. Category “Lack of control”

#### 3.1 *Social disconnection*

- Chronic unemployment, casual unsatisfactory work
- No recognition of professional or personal competence
- No proper command of English (for some of them, both genders)

#### 3.2 *Dependence on others*

- Government support/welfare system (most of them)
- For communication/translation

#### 3.3 *Parents’ disempowerment vs. children’s empowerment especially for single women or those who are unemployed*

### 4. Category “Level of life satisfaction”

#### 4.1 *Satisfied/positive emotional outcomes*

- Happiness because of hope, future and plans for the children
- Relieved when family is reunified (no more pressure and worries)
- Sense of belonging to their new home (all)
- Pride of being recognised by others, either Kiwi or within their communities
- Satisfying work/self-esteem, respect
- Economically self-sufficient

#### 4.2 *Dissatisfied/negative emotional outcomes*

- Dependence on others
- Frustration (high and often linked with unemployment or unsatisfactory work)
- Not being considered or treated as a New Zealander (frequent)
- Sadness , anxious feeling
- Low self confidence, poor image among the family and “community”
- Eating disorder
- Anger, upset, frustration
- Low self esteem, low self confidence (i.e. I do not have a job because I am not good enough, I do not speak English because I am not well educated etc.)
- Constant uncertainty/worried about the job and future
- Doubt (why am I here, should I stay?)

## **5. Category “Resettlement difficulties”**

### *5.1 Practical difficulties*

- Language barriers (some, controllable)
- Legal blockages to bring in the family (lengthy process, highly stressful, uncontrollable)
- Poor access to information (too formal and complicated)

### *5.2 Emotional difficulties*

- Past memories/traumas for a few of them
- Anxiety especially high when unemployed and when waiting for completion of immigration procedures
- Acculturative stress for most of them on arrival

### *5.3 Socio-economic inequity*

- Economic difficulties, low incomes for most of them
- Poor housing ( few of them)
- Poor access to workforce labour/opportunities (for the majority, chronic)
- Chronic unemployment or casual work (for some of them, long)
- Perceived discrimination and racism
- Poor involvement in the decision making process

### *5.4 Socio-cultural difficulties*

- Culture shock ( during the first year for most of them)
- Negative stereotyping by the host society perceived by most of them
- Conservatism in Christchurch : narrow minded, resistant, defensive host society
- Role reversal: loss of parental authority, women become independent, children empowerment
- Social isolation (especially for those who are unemployed)
- Family pressure from overseas (financial pressure).

## **6. Category “Formal support”**

### *6.1 Resettlement providers*

- No proper access to information for accessing work, rights/obligations in New Zealand
- Lack of compassion/empathy from the civil servants (some of them)
- Not enough constructive encouragement.
- Focus on problems rather than on opportunities
- Lack of cultural sensitivity confusing people and creating problems amongst families
- Tendency to victimise refugees (some of them)
- No follow-up (most of the participants)
- English classes are not adapted to adult refugees’ needs (both genders)
- Staff have their own “agenda” and contribute to refugee communities divisions instead of helping individuals

- Agencies create problems to obtain funds
- No political will to let them become independent
- No coordination between resettlement providers
- RMS is helpful (for quota refugees especially on arrival)
- Sponsor family for quota refugee is highly appreciated : having a caring person is more helpful/effective than agencies (most of them)

### *6.2 Government support*

- The differential between rates of benefit and minimum wage after tax is insignificant and this does not encourage people to work (most of them)
- Insufficient resettlement grant on arrival for large families. No freedom of choice to buy what they want
- Government benefits on arrival are good but for a short time
- System is very good for children (all of them)
- Teachers are encouraging (perceived especially by young adults)
- Re-establishment grant not sufficient and not index linked since 1993

### *6.3 Health care provision*

- Trust the health system for physical disorders not for mental issues
- Lack of connection between mental health professionals and patients (majority, independent of gender, educational level and nationality)
- No compassion, health professionals are too formal, not friendly (some of them)
- Consultations are too expensive
- Results are not shared with patients (many participants)
- Poor satisfaction for the ones who have experienced the mental health system (regardless of gender, age, nationalities)
- Doctors, psychologists etc. do not have the competence to solve mental issues. Only Allah or God can help (most of them)
- Do not solve the problem because they focus on the cause (majority, regardless of gender, educational level and nationality)
- Do not want to share their feelings, it is personal matter.
- GPs give recommendations which participants already know: do not see the added value of this support (most of them)
- Kindness of some of the GPs when facing mental issues (only two out of twenty six)

## **7. Category "Caring person"**

- Recognition
- Give them the chance
- Treat them as an equal
- Practical support (financial, help to enrol children at school, transport etc.)
- Take the time to explain the culture, to inform, to show
- Interest, empathy, compassion, understanding (constant)
- Give them good morale
- Encourage them constantly
- Provide them with pragmatic solutions

## 8. Category “Fragile community”

- Division
- People overwhelmed by their own problems
- Support is limited to close friends and close family
- Lack of representative leadership (all the groups)
- Do not understand the New Zealand concept of community (many of them)
- Suspicion (frequent)
- “Power game”
- Community pressure: gossip, jealousy
- Adult rivalry
- Leaders used by government agencies (half of them)

## 9. Category “Personal resources”

### *9.1 resilience traits*

- Determination to achieve their expectations (strong, most of them)
- Acceptance of the situation, no other choice (all of them)
- Optimism
- Hopes, dreams, aspirations, plans
- Good memories
- Have known worse
- Responsibility
- Humour, perseverance, open minded, diplomatic, tolerant, flexible, careful

### *9.2 Religion and/or Faith in another "force"*

### *9.3 Self-efficacy*

- Belief that s/he can control the situation
- Motivated
- Take risks
- Personal knowledge, common sense
- Self respect, discipline

### *9.4 Personal skills*

- Helping other refugees
- Communication skills
- Social skills (to interact and function with others)
- Analytical skills

### *9.5 Family members*

- Children are important for women when facing practical difficulties and emotional distress (give them hope and reason to be strong)
- For accommodation, bureaucratic matters, financial assistance

- For sharing feeling , talking

## **10. Category “Parenthood”**

- Parental role model (all of them)
- Provide support to the children to ensure a good future for them (all, very important)
- Transmission of cultural roots
- Parental responsibilities and commitments

## **11. Category “Coping strategies”**

### *11.1 Emotion focused*

- Smoking, overeating (very few of them)
- Reading, writing
- Talk, sharing feelings with friends
- Being alone for a while (men mainly)
- Sharing feelings with family and close friends (most of them)
- Meeting positive persons and friends (all)
- Thinking about the future, making plans (most of them)
- Thinking about good memories (parents, childhood)
- Relaxation techniques , exercises, walking (some, both genders)
- Avoidance of stressful influences (fellow countrymen, world news, English classes)

### *11.2 Problem focused*

- Praying, spiritual resources (all, constant )
- Seeking guidance and support from caring person (all)
- Confronting difficulties and blockages (most of them)
- Taking risks (most of them, indeed they took their first risk when fleeing their homeland)
- Fixing achievable goals ( according to established boundaries after their analysis of the situation and available resources, especially high amongst “low” educated people)
- Making personal effort: hard working, proactive, commitment, creativity ( most of them, both genders, higher amongst family reunification refugees in comparison to quota)

## **12. Category “Obtaining a social position”**

- Obtain New Zealand citizenship (all of them)
- Become and be regarded as a New Zealander Have the same life as Kiwis (all of them)
- Having a job (most of them)
- Having a good position, role, status in the society (all of them)
- To work towards retirement
- To continue my work and be happy as I am
- To have a good and warm house
- To provide children with a good education and profession
- No to be dependant on the system but to contribute to the system (most of them)
- Unified community
- Travel and visit relatives.

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| <b>Appendix G: Grounded theory: categories' properties</b> |
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Examples from interview data describing the properties of the categories: "*Personal Resources*", "*Formal Support*" and "*Caring Person*" established during the phase 1 analysis.

**Part 1: Properties of the category "Personal Resources"**

Refers to individuals' characteristics and skills describing and explaining their personal resources which enable them to face and overcome adversity.

| <b>Personal Resources</b>   |   |
|---|---|
| <b>Participant number and personal statements</b>   | <b>Properties</b>   |
| <p># 10: "I have been able to find the job to the freezing place, <b>it is a hard work. I knew that.</b> However, I have been able to work for 6 months, every day I cut meat. <b>I do not like it but I have to do it</b> (laugh). This job is seasonal, but I will go back in October. In between, I am <b>also determined to learn English</b> and I go to school."</p> <p># 11: "You know <b>I have learned to survive.</b> I never thought when I was in jail that I will see my husband again, that I will come here. Everything was imposed on me. <b>I am able to recognize that my life is better here than being in prison.</b>"</p> <p># 15: "I have learned how to be strong and how to survive and manage with life. <b>I have experienced the worst and I have learnt how to hope.</b>"</p> <p># 26: "I am doing a lot of efforts to reach my dreams. <b>I can communicate and my life was very hard before. I will succeed.</b>"</p> | <p><b>Resilience characteristics</b></p> <p><i>Determination</i></p> <p><i>Acceptance</i></p> <p><i>Hope</i></p> <p><i>Experience</i></p> |
| <p># 5: "Because our <b>strong belief in our God,</b> I thought that everything will be okay. This idea is for all the Afghan family that everything will be solved by the will of God. We have a saying <b>God tells us to move first and then he will give help</b>".</p> <p># 7: "<b>I believe in Allah</b> and that any problem I have; only Allah can help me. He gave me all the strengths to be strong."</p>   | <p><b>Religion/faith</b></p>  |

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| <p># 13: <b>“At the same time I believe that everybody has ability to work. You know at home I was working, I knew that I was capable to do something. I knew the importance how to keep the time, respect people with whom you work.”</b></p> <p># 17: <b>“I realized that the teacher did not give me the same homework as the other pupils. I was so angry that I asked her why. I asked her to give me the same work as the others, I asked for a dictionary and I did everything on my own.../... I did not want to be treated different. I wanted and was determined to work hard. I did not want any sympathy. I needed to prove who I am.”</b></p>  | <p><b>Perceived self-efficacy</b></p>  |
| <p># 1: <b>“I was very social and that’s why I have crossed the bridge. .../...I respect myself first and then I respect the others. That makes it easy for me to contact the others.”</b></p> <p># 3: <b>“I think that my business skills are step by step recognized. People on the market know me and respect me.”</b></p> <p># 2: <b>“My professional skills are really recognized. I started business from zero and now I am in a very good position. I am quite happy about it.”</b></p> <p># 9: <b>“I started to involve myself within the refugee community. I am definitively committed, very much honest and patient with people.”</b></p> <p># 12: <b>“A position itself does not give you respect, but you have to work very hard. I am working very hard to be accepted and recognized as a team coordinator.”</b></p> | <p><b>Personal skills</b></p> <p><i>Communication</i></p> <p><i>Helping others</i></p> <p><i>Professional skills</i></p> |
| <p># 4: <b>“My children help me with everything, especially with computers, with language. I ask them when I do not know. When we watch movies or the cartoons I ask them “what’s happening here” and they explain to me.”</b></p> <p># 10: <b>“My wife’s sister has helped us a lot when we arrived for few months with money, accommodation, food.”</b></p>   | <p><b>Family members</b></p> <p><i>Financial support</i></p> <p><i>Communication support</i></p>                         |

## Part 2: Properties of the category “Formal Support”

Description and explanation of participants' perception of the support of social and resettlement services providers. *For confidential reason, participant's gender, refugee classification and nationality will not be specified*

| Formal Support  |   |
|---|---|
| Participant number and personal statements  | Properties  |
| <p># 1: “You go for example to RMS, they are very helpful, but no one is coming to your home and talks to you and to explain the Kiwi culture etc. This <b>is not a friendly environment.</b>”</p> <p># 11: “We said to them that <b>some families are really struggling.</b> But the people working in the government services <b>reply that we should be happy with what we have and that this is not their problem! So why do they bring us here?</b>”</p> <p># 6: “She is <b>learning English for 4 years and she cannot speak.</b> The teachers they give those complicated papers, verbs conjugations without any explanations. <b>People do not understand. The teachers are not professionals.</b>”</p> | <p><b>Inadequate</b></p> <p><i>Participants perceived that resettlement services have a poor caring and supportive approach</i></p> |
| <p># 2: “<b>The agencies did not help me at all.</b> My opinion is that <b>they have to create problems amongst the refugee communities</b> to get funded by the government. They are not helpful at all.”</p> <p># 8: “They (agencies and departments) <b>are afraid that refugees associations become strong</b> because <b>if this happen they will lose funds.</b> So, it is better for them to say that we have problems to get funds.”</p>  | <p><b>Inadequate</b></p> <p><i>Participants perceived conflict of interest amongst resettlement services stakeholders.</i></p>      |
| <p># 11: “This year the government gave us NZ\$10 more for each child/week, but on the other hand they have increased our rent by NZ\$40. <b>What are they doing? This is like giving us something with one hand and takes all of it back with the other hand.</b>”</p> <p># 10: “When we arrived, they give us <b>unemployment benefit and they say to us you are welcome. But how this can help us to be part of the society? We do not</b></p>   | <p><b>Inadequate</b></p> <p><i>Participants questioned the logic of financial assistance</i></p>                                    |

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| <p><b>have guidelines at all. It is really like if they say hello to us and bye-bye at the same time.”</b></p> <p># 25: “It is also difficult because we cannot work here, they <b>give us benefits which are good but they do not help us to find a job.</b> Also benefits and salary are the same amount, so <b>if you work at the minimum salary you earn the same as if you are under benefits. If you do not work you do not belong to the society.”</b></p>  |   |
| <p># 9: “They thought that <b>we were unable to take decision for ourselves.../... we want to be seen a positive part of the country and we want to have responsibilities. We are able to carry things on our shoulders too.”</b></p>  | <p><b>Inadequate</b></p> <p><i>Participants perceived that they are not sufficiently involved in the decision process</i></p>                                     |
|  |   |
| <p># 5: “We had problem to know where to send our children for school, <b>but RMS agency, especially a lady</b> helped us to enrol the children at school.”</p> <p># 15: “The <b>government has helped us</b> to have a house, to survive and to have enough to live, to pay the basic fees.../... The <b>system has been good for me.</b> I had problems during one of my delivery. If this had happened in Africa, I would have died. But <b>here, immediately they knew the problem and they treated me.</b> I am lucky.”</p> <p># 20: “Also the government helped us a lot. They pay for my <b>children school</b> and for me to learn English. People were good to us.”</p> | <p><b>Adequate</b></p> <p><i>Participants perceived formal support sufficient in terms of financial assistance, caring approach and children’s education.</i></p> |
| <p># 12: “<b>Our sponsor family has helped us.</b> Some of them have remained friends even though we do not need their help anymore.”</p> <p># 8: “The agencies do not help us. As <b>individuals they help</b> but not as organisations. There are good people. I have been lucky to have a <b>very helpful Kiwi woman.</b>”</p>  | <p><b>Adequate</b></p> <p><i>Participants are appreciative about the support given by RMS sponsor families.</i></p>   |
|  |   |
| <p># 4: “<b>The tablets the doctor gives you it is good sometimes.</b> People they should take it every day <b>but this is not good for all the times. Maybe it helps for the brain, it stops thinking but it is not good for everything but the problem is still there. It is better to solve the problem.”</b></p>   | <p><b>Inadequacy of mental health services</b></p>  |

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| <p># 7: “There is no point to see a doctor. I do not believe that a doctor or other services can help you when you are upset. <b>I stay at home, pray. Sometimes friends come and we chat. The doctor can do nothing, only GOD can help. The doctor he can treat you if you have pain, in your body but not in your mind.../...You know he will tell me to do what I know that I have to do: take rest and calm down.</b></p> <p># 13: “<b>I am the only one who can find the solution. The psychological support here is not efficient.</b> It might help for people who are really lost but usually everybody has something in him to find solution.”</p> | <p><i>Participants described and explained their perception of mental health services.</i></p> |
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### Part 3: Properties of the category “Caring Person”

Caring person refers to New Zealanders or close friends who have supported or are still supporting participants to deal with resettlement difficulties. Participants describe and explain how they perceive this support.

| Caring Person   |   |
|---|---|
| Participant number and personal statements  | Properties  |
| <p># 2: “My <b>Kiwi friend</b>, who has a farm, <b>helped me a lot</b>. I worked for him at that time and <b>we became, we still remain friend. He explained to me how I need to cope, how to find a job...</b>...He came to my place, when I had some financial difficulties. He lended me money to start my business. <b>He trusted me</b> and I could buy some products and I paid him back.”</p> <p># 12: “My new boss <b>gave me the chance and he could see the results. He was very impressed .../...</b>After few months, he <b>offered me to work full time with coordination responsibilities and challenges</b>. I accepted that job.”</p>   | <p style="text-align: center;"><b>Give the chance,<br/>recognition</b></p> <p style="text-align: center;"><i>Participants described the opportunities given by one person who recognised their abilities.</i></p> |
| <p># 4: "You know R and D <b>they came to see me everyday because they knew I was alone at home.../.../... I was not afraid anymore; I was not alone any more</b>. I was very happy with my Kiwi friends because <b>they have been like a family to me.</b>"</p> <p># 15: "My sponsor, she really helped me, helped us a lot. She helped me <b>from her heart, she cared so much and she was suffering for me</b>. She was with me <b>all the time. She changed my life, she loved us and she was always very kind for us. She did a lot to find solutions with us</b>. It has been the most important support. <b>She is still helping us</b> a lot after all these years."</p> <p># 12: "She took me every week nearly a year on the hills and we were walking, talking, we discussed many topics of interest.../.../... Whenever I did not feel well, <b>her house was open</b>. The help of this lady to reconstruct my optimism was <b>enormous</b>. After one year she left, I still did not have a job but <b>I was able to stand on my own feet.</b>"</p> | <p style="text-align: center;"><b>Empathy</b></p> <p style="text-align: center;"><i>Participants described the morale support given by New Zealander to face emotional and practical difficulties.</i></p>        |

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| <p># 8 “Our sponsor, she <b>looks at the problem and she tries to find the solution and treat us as a New Zealander.../... If she was not there many people will have more problems</b> than they have now.”</p> <p># 13: “I am working with a lot of people who are New Zealanders. From the beginning they treated me as if I was like them. I am somebody among them.”</p>  | <p><b>Treat them as equals</b></p> <p><i>Participants described the importance of being considered as equal</i></p>                       |
| <p># 3: “I was driving for my friend who has business and I was watching what he was doing. One day <b>I asked him if I could do the same. He said” why not?” He was very positive. .../... my friend provided me with some craft to sell. He helps me to learn, he gives me advices.</b>”</p>   | <p><b>Encouragement, positive.</b></p>  |
| <p># 4: “If R and D were not there I could not have learnt English, they came here everyday. I was asking them all the time when I did not understand .I <b>was showing them a book with pictures</b> and ask how do you say spoon, how do you say this and that?. They were talking to me all the time and we were talking and we were shopping <b>If they had not been there I could not have learnt English.</b>”</p> <p># 12: “One Kiwi friend <b>helped me and taught me how to drive</b> here. Usually you do not find this type of <b>vital help</b> amongst agencies. Mr. D. helped me to get my driving licence; <b>he was going out with me. He helped me to become independent.</b> Having a car here is important because <b>it helps you to have the practical control of your life.</b>”</p> | <p><b>Practical help</b></p> <p><i>Participants described pragmatic support provided by their sponsor family or anonymous friend.</i></p> |

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| <b>Appendix H: Grounded theory: Phase 2- Categories' properties</b> |
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| <b>Category</b>                       | <b>Properties</b>  |
|---------------------------------------|--|
| <b>1. Initial expectations</b>        | <ul style="list-style-type: none"> <li>• Economic self-sufficiency</li> <li>• Bring in family</li> <li>• Safety and freedom</li> <li>• Better future for the children</li> </ul>   |
| <b>2. Personal achievements</b>       | <ul style="list-style-type: none"> <li>• Safety/peace</li> <li>• Satisfactory employment</li> <li>• Sense of belonging</li> <li>• Family reunification</li> <li>• Material acquisitions</li> </ul>   |
| <b>3. Lack of control</b>             | <ul style="list-style-type: none"> <li>• Social disconnection</li> <li>• Dependence on others and welfare system</li> <li>• Parents' disempowerment</li> </ul>   |
| <b>4. Level of life satisfaction</b>  | <ul style="list-style-type: none"> <li>• End of exile</li> <li>• Control over life</li> <li>• Plans</li> <li>• Outsider</li> <li>• Emotional distress</li> <li>• Seek another place</li> </ul>   |
| <b>5. Resettlement difficulties</b>   | <ul style="list-style-type: none"> <li>• Practical difficulties</li> <li>• Emotional difficulties</li> <li>• Socio-economic inequity</li> <li>• Socio-cultural difficulties</li> </ul>   |
| <b>6. Formal support</b>              | <ul style="list-style-type: none"> <li>• Inadequate (poor caring and supportive approach, no follow-up)</li> <li>• Adequate (for quota on arrival, good support for children in terms of education)</li> <li>• Inadequacy of mental health services</li> </ul> |
| <b>7. Caring person</b>               | <ul style="list-style-type: none"> <li>• Encouraging and positive</li> <li>• Give the chance, recognition</li> <li>• Treat them as equals</li> <li>• Empathy, understanding, patience</li> <li>• Practical help</li> </ul>                                     |
| <b>8. Fragile community of origin</b> | <ul style="list-style-type: none"> <li>• Internal division and suspicion</li> <li>• Poor leadership</li> <li>• Community concept poorly understood</li> <li>• Community pressure</li> </ul>  |

|  |   |
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| <b>9. Personal resources</b>           | <ul style="list-style-type: none"><li>• Resilience characteristics</li><li>• Religion and/or faith</li><li>• Self-efficacy</li><li>• Personal skills</li><li>• Family members</li></ul>                                       |
| <b>10. Coping strategies</b>           | <ul style="list-style-type: none"><li>• Problem-focused coping</li><li>• Emotional-focused coping</li></ul>   |
| <b>11. Parenthood</b>                  | <ul style="list-style-type: none"><li>• Parental role model</li><li>• Keep/transmit cultural roots to children</li><li>• Support children</li></ul>   |
| <b>12. Obtaining a social position</b> | <ul style="list-style-type: none"><li>• Become and be regarded as a New Zealander</li><li>• Occupational and social status</li><li>• Good living conditions and self-sufficiency</li><li>• Contribute to the system</li></ul> |