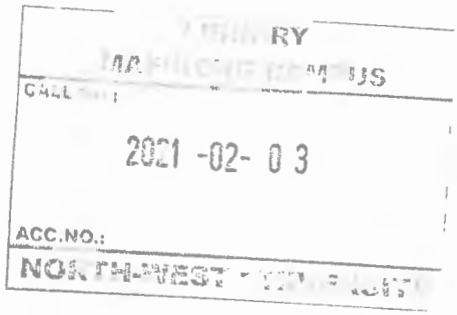
STRESS AND MENTAL HEALTH OF AFRICAN REFUGEES IN SOUTH AFRICA: MODERATING ROLES OF COPING, SOCIAL SUPPORT AND RESILIENCE



UFUOMA PATIENCE EJOKE

24435589

Dissertation (article format) submitted in fulfilment of the requirements for the degree of Master of Social Science in Research Psychology of the North-West University

(Mafikeng Campus)

Supervisor: Professor E.S. Idemudia

DEDICATION

This study is dedicated to my understanding husband and my wonderful children

Anthony, Enumah Ejoke

And

Chukwuka, Onyebuchi and Onyekachi Ejoke

DECLARATION

I Ufuoma Patience Ejoke declares that this dissertation titled: Stress and Mental Health Of African Refugees In South Africa: Moderating Roles Of Coping, Social Support And Resilience, submitted for the degree of Master of Social Science in Psychology at the North-West University, Mafikeng Campus is my own Work and has not been previously submitted by me to another University/Faculty and all resources that have been used or quoted have been duly acknowledged.

Researcher: Ufuoma Patience Ejoke

Signature:..... Date:27/03/15

Spervisor: **Professor E.S. Idemudia**

Signature:..... Date:.....

ACKNOWLEDGEMENT

Awesome GOD how great thou art, this study would never have reached accomplishment, if not for your purpose in my life. You made it possible for my admission to the North-West University, Mafikeng campus, in the first place, every plan fell into place because you are God.

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SUMMARY

The study sought to investigate the mental health of African refugees in South Africa and to understand how well refugees cope with their circumstances. In addition, it aimed at exploring the moderating roles of coping, social support and resilience of African refugees.

Three hypotheses were tested viz (i) Comparing the relationship between refugees' perceived stress and mental health (ii) assess coping strategy, social support and resilience with perceived stress and mental health and (iii) comparing the mental health of female refugees with male refugees.

The study followed a quantitative approach using a questionnaire. A Validated questionnaire was used to measure mental health, perceived stress, coping, social support and resilience.

Three hundred and forty (340) participants, 203 male (59.7%) and 137 female (40.3%), participants were randomly selected through age and sex stratification from the register list at the African Diaspora forum, in Yeoville, a suburb of Johannesburg, in the province of Gauteng, South Africa. The age of participants was 18years and above. The first hypothesis was tested with Pearson's product moment correlation, the second hypothesis was tested with a moderated hierarchical multiple regression on the data, and the third hypothesis was analysed with a t-test.

Results for hypothesis one showed a significant negative relationship between perceived stress and mental health, ($r = -599$, $p < .001$). As refugees are perceiving higher levels of stress, their mental health was decreasing. However, the second hypothesis suggested that coping, social support, and resilience would moderate the relationship between perceived stress and mental health. The Results for hypothesis two revealed that perceived stress, ($\beta = -.544$); coping, ($\beta = .143$); social support ($\beta = -.158$) and resilience ($\beta = -.294$), independently and significantly accounted for variation in mental health of the refugees. A test of moderation hypothesis in the model indicated that the variables (coping and perceived stress) explained 20.45% of the total variance in mental health. These two variables jointly influence and predict mental health in the model ($\beta = 20.45$, $p < .001$). The interactions of perceived stress and social support and that of perceived stress and resilience were excluded from the regression equation. Finally results for the third hypothesis showed that female refugees reported poorer mental health than male refugees.

In conclusion, the study contributed to the body of knowledge by showing that in the presence of stress, challenges to mental health can be reduced due to moderating variables of

coping, social support and resilience. It was also found that coping and perceived stress reduce the risk of mental health issues among refugees. Females were also found to exhibit poor mental health issues than male refugees.

Periodical workshops and a motivational plan based on cognitive intervention must be organised and offered to refugees. Mental health care should be given priority in the South African health care system. Other recommendations were made in line with the findings of the study.

PREFACE

Article format

For the purpose of this dissertation, as part of the requirements for a professional master's degree, the article format as described by General Regulation A.7.5.1.b of the North–West University was chosen.

Selected Journal

The target journal for submission of the current manuscript is the Journal of Social Sciences (JSS). For the purpose of examination, tables will be included in the text.

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The letter of consent from the co-authors, in which they grant permission that the manuscript "Stress and mental health of African refugees in South Africa: moderating roles of coping, social support and resilience" may be submitted for purpose of examination thesis, is attached.

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I, the undersigned, hereby give consent that Ejoke Ufuoma Patience may submit the manuscript entitled "STRESS AND MENTAL HEALTH OF AFRICAN REFUGEES IN SOUTH AFRICA: MODERATING ROLES OF COPING, SOCIAL SUPPORT AND RESILIENCE" for the purpose of a thesis in fulfilment of the requirements for the Master of Research degree in Psychology.

.....

Prof E.S. Idemudia

Supervisor

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STRESS AND MENTAL HEALTH OF AFRICAN REFUGEES IN SOUTH AFRICA: MODERATING ROLES OF COPING, SOCIAL SUPPORT AND RESILIENCE

STRESS AND MENTAL HEALTH OF AFRICAN REFUGEES IN SOUTH AFRICA: MODERATING ROLES OF COPING, SOCIAL SUPPORT AND RESILIENCE

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ABSTRACT

Background:

African refugees flee their homelands due to various factors including violence, and particularly if their lives are in jeopardy, While in South Africa, they are vulnerable to many challenges that might affect their mental health.

As human mobility continues to engulf South Africa, efforts to fully understand the complexity of migrants' mental health needs are undermined. Additionally, comprehensive coping strategies of refugees' adaptability are inconclusive.

Objectives:

(i) to empirically examine the relationship between stress and mental health among the refugees,

(ii) to assess how coping, social support and resilience influence mental health,

(iii) to explore the sex differential in mental health.

Method:

Data was collected from three hundred and forty (340) participants randomly selected through age and sex stratification from the register list at the African Diaspora forum, in Yeoville. The age of participants were 18 - 57years, male=203, female=137.

Results:

Results for hypothesis one indicated a significant negative relationship between perceived stress and mental health. While the results for hypothesis two showed that coping, social support and resilience independently predict mental health and also coping and perceived stress jointly and significantly account for variation in mental health of the refugees. Finally, the third hypothesis showed that female refugees reported poorer mental health than male refugees.

Recommendation:

It is recommended that mental health providers should conceptualise the specific issues affecting refugees and develop periodic workshops and a motivational plan based on cognitive intervention for refugees. Mental health care should be given priority in the South African health care system.

Keywords: Stress/Mental Health/ African Refugees//Coping/Social Support/Resilience

TABLE OF CONTENTS

INTRODUCTION AND PROBLEM STATEMENT

It is well known that refugees are faced with mental health issues. Migration is an event characterized with stress and uncertainty, the decision to move to another country is informed by hope for better living and to achieve aims that were impossible in the homelands (Helena, 2011). However, migrant studies have dealt with pre-migration stressors ignoring the consequences of the mental health of refugees upon resettlement. Post-migration stressors have been found to account for the same or higher variance in mental health symptoms relative to pre-migration war exposure and are consistently stronger predictors of mental health than pre-migration stressors (Ellis, MacDonald, & Lincoln, 2008; Montgomery, 2008).

Immigration is a social phenomenon common to many regions of the world, and the world is experiencing its most serious refugee crisis, largely due to the total number of people worldwide forcibly displaced because of war, violence, or political unrest, which has now reached 45.2m people, the highest level in almost 20 years (United Nation High Commission for Refugees [UNHCR], 2012). 'Global Trends' reports data for 2012 indicating that 7.6m people became displaced afresh: 1.1m as refugees and 6.5m as internally displaced persons (IDPs). This means that, there is one new refugee every 4.1 seconds, according to the UNHCR (2012).

In Africa, the refugee situation is becoming alarming with the number of refugees increasing to about 13 million, and this is second only to Asia (UNHCR, 2012). This increase in immigration is due to stressors such as civil unrest, wars, and political instability (Ehntholt & Yule, 2006; Zinyama, 2011).

South Africa is a major destination country for asylum-seekers as well as migrants looking for better economic and social opportunities. Latham and Cohen (2011) and Maharaj and Rajkumar (2007) give diverse reasons why refugees from the most troubled African countries (e.g., the Democratic Republic of Congo, Burundi, Rwanda, Zimbabwe, Angola, Mozambique, Ethiopia and Somalia) have chosen to come to South Africa. First, because of its geographical accessibility, (figure 1 below, shows the geographical location of most troubled countries). Second, South Africa is seen as a land of economic opportunity, or a haven from war-torn or troubled homelands. Third, the motivation for relocation is seen as a means to escape violence and poverty. Fourth, South Africa is seen as a beacon to stability and economic growth on the African continent, (Reitze, 1997; as cited in Idemudia, Williams & Wyatt, 2013). Finally, relocation to South Africa is prompted of the assurance that the South

African Constitution pledges to provide for 'all who live in the country, regardless of citizenship, nationality or country of birth' (Landau, Ramjathan-Keogh, & Singh, 2005).

The South African refugee situation is massive (UNHCR, 2010, 2009 report from global trends refugees). In 2009, the country received more than 222,000 new asylum applications, according to UNHCR (2010), United Nation (UN) and Refugee Agency (2010) this placed South Africa ahead of the United States, Sweden, France and Germany, in terms of the preferred asylum destination in the world (UNHCR, 2010).

By the end of 2013, some 233,100 asylum seekers mainly from Bangladesh, the Democratic Republic of the Congo (DRC), Ethiopia, Somalia and Zimbabwe were registered in South Africa (UNHCR, 2013). The country continues to be the recipient of the highest annual number of asylum applications worldwide (UNHCR, 2014). According to the reports from UNHCR country operations profile - South Africa.

Table 1, showing asylum seekers and refugees in South Africa.

Planning figures

UNHCR 2014 planning figures for South Africa

		Dec 2013		Dec 2014		Dec 2015	
TYPE OF POPULATION	ORIGIN	Total in country	of whom assisted by UNHCR	Total in country	of whom assisted by UNHCR	Total in country	of whom assisted by UNHCR
Refugees	Various	67,500	13,500	75,600	15,120	83,600	16,720
Asylum-seekers	Various	233,100	46,620	274,400	54,880	283,700	56,740
Total		300,600	60,120	350,000	70,000	367,300	73,460

From the table above, it is evident that the refugee population in South Africa keeps increasing. The increasing number and diversity of immigrants to South Africa for two decades has given rise to concerns and questions about refugee mental health (Larsen, 2004). In 2012, 5.7% of the South African population was foreign born, comprising legal and illegal immigrants (Statistics South Africa, 2012), illegal immigrants generally move from neighbouring countries for similar reasons as stated earlier, but they are termed as illegal

because they lack documents that allow them to operate freely in the host country (Sibanda, 2008).

Although South Africa operates a liberal asylum legislation that protects and provides refugees with all basic rights, (UNHCR, 2014), South Africa's national legislation incorporates the basic principles of refugee protection, for example freedom of movement, the right to work, and access to basic social services. However, some public institutions do not recognize refugees' permits, preventing them from benefitting fully from these rights. These rights are not accessible to refugees partly because most public institutions do not recognize these rights and also South Africa, as a middle-income country, has its own challenges with poverty, unemployment and economic inequality which puts refugees and asylum seekers in competition with citizens of the host country (Sharp, 2008). Refugees are confronted with difficulties in accessing these advantages (CDE, 2011; Landau, *et al.* 2005; Rulashe, 2010).

Inability, however, to access these rights can elicit tension and could result in mental health issues. Refugees are usually exposed to various stressors in the host country such as economic crisis, hostility from the host, environmental stressors like weather, inappropriate housing, unemployment, and the language barrier (Ryan, Leavey, Golden, Blizard, & King, 2006).

Contrasting views have come forth as to why refugees might be vulnerable to mental health issues, Australian researchers, such as Schweitzer, Melville, Steel, and Lacherez (2006) have suggested that immigrants are susceptible to significant mental health challenges due to the stressors encountered upon arrival in the new country. They reported that level of post-migration difficulties predicted anxiety and somatization. These findings were consistent with research in Sweden (Indencrona, Ekblad, Hauff, & 2008) who suggested that post-migration affect psychological mental health of recently settled Middle eastern refugees, they explained in terms of percentage that post migration or resettlement difficulties contributed 24% to the variance in mental health which is higher than the 22% which is contributed during previous trauma.

These mental health issues may include feelings of helplessness, grief, anxiety, depression, somatisation, shame, anger, shattered assumptions, sensitivity to injustice, and survivor guilt (Victorian Foundation for Survivors of Torture (VFST), 1998). Extreme isolation, humiliation, and immense losses, some of which are existential, including loss of

loved ones, the homeland, culture, identity, hope, trust and meaning in life (Burnett & Thompson, 2005).

A study conducted in Johannesburg, South Africa, gave a different view as to why refugees might face the above challenges. Amongst others, the study revealed that, because many refugees are educated, multilingual and much urbanised, finding themselves in the host country changes a lot of things about themselves, an educated refugee that had a good job in their own country finds himself jobless and might even be subjected to working as a cleaner just to make ends meet, this drastic change of life in the host country might elicit psychological symptoms (Landau *et al.,* 2005). While the host population views refugees as disease carriers, smugglers, crime perpetuators, competitors for basic services, the refugees' mind-set is that South Africa is a land of economic opportunity (CDE, 2011; Kihato, 2007).

In light of these challenges, it has become imperative to research refugee mental health not just to reduce the risk of psychiatric morbidity but also to enhance psychological and social well-being. Several Norwegian cross–sectional studies have revealed that psychopathology and distress scores are higher among refugees than the general population (Syed, Dalgard, Dalen, Claussen, Hussain, Selmer & *et al.*,2006; Thapa, Dalgard, Claussen, Sandvik & Hauff, 2007).

Similarly, a study showed higher mental distress scores among migrant as compared to the Norwegian population (Vaage, *et al.*, 2010). However, Idemudia, Williams and Wyatt (2013) have shown that post-migration stress of refugees contributes to poor mental health of Zimbabwean refugees in South Africa, with women having more post-traumatic stress disorder. Significantly though, most of the migrants' literature disregards the heterogeneity that exists within immigration groups (Zhang & Ta, 2009). This gap in literature shall be empirically addressed in this study.

There seems to be limited research addressing the mental health of African refugees, and the few studies (Schweitzer, Greenslade, & Kagee, 2007; Khawaja, White, Schweitzer, & Greenslade, 2008) that attempted to address this specific population failed to consider the moderating role of coping, social support and resilience which must be assessed when evaluating the mental health of immigrant populations. This could suggest insight on how to reduce psychiatric morbidity among the refugee population, thereby increasing adjustment, resulting in huge contributions by refugees to the new culture and economy (Bhugra & Gupta, 2011). Neglect of mental health needs of refugees could have negative impact on the economy

which could result to severe consequences to the country's welfare and health insurance system.

Furthermore, a deeper understanding of coping strategies, the role played by social support and resilience of refugees will rehabilitate and assimilate refugees into the society, and very importantly, an understanding of which of the coping strategies are of benefit and which are dysfunctional can be incorporated in the form of intervention strategies (Mesfin, Jayanti, Ivan, Komproe & De Jong 2007).

It is therefore important to introduce into the body of literature the moderating role of coping, social support and resilience as they are well outlined in this study. Refugees tend to employ various coping strategies (Khawaja, *et al.*, 2008), and use of social support networks during stressful situations. Schweitzer, *et al.* (2007) reveal the importance of religious beliefs as a coping strategy. Cognitive strategies and also the use of social support are variables which according to them are critical aspects that assist refugees to cope during stressful situations. Similarly, a number of studies (Ahern *et al.*, 2004; Jasinkaja-lahti, Liebkind, Jaakkola & Reuter, 2006; Schweitzer, Melville, Steel, & Lacharez, 2006), have noted that social support is associated with increased psychological well-being in refugees. In the same vein, the qualitative results of Khawaja, *et al.* (2008) indicated the importance of resilience. Personal qualities were identified as a strong point which assists in a stressful situation.

Researchers, (Idemudia *et al.*, 2013; Walsh, Shulman, & Maurer, 2008) however, have focused more on mental health during both the pre- and post-migration period, this has left a gap in the literature regarding positive adaptation in refugees. This leads to asking how these refugees adapt to their new situation. Individuals may respond to stressors (Guribye, Sandal, & Oppeda, 2011), but the knowledge of the effect of adaptive mechanisms in order to reduce the challenges of mental health occurring among refugees has resulted in research on moderating roles of coping, social support and resilience.

While these studies (Schweitzer, *et al.*, 2007) have been useful in identifying the coping strategies associated with refugees, they are limited in that they focus only on the coping strategies employed immediately after migration and as such, they ignore the impact of coping mechanisms and adaptation employed during the time of resettlement; there is no one study that has integrated the three variables (coping, social support and resilience) in a single study.

The research questions therefore are; is there any association between stress and mental health of these refugees? Can coping, social support and resilience influence stress as each relates to mental health? What are the socio-demographic predictors of stress and mental health of the refugees?

Idemudia, Williams, and Wyatt (2013) found an association between stress and mental health, they noted that refugees are at risk for emotional and physical trauma during the migration process. Agreeing with works of other scholars such as Fenta, Yman, and Noh (2004) who noted high rates of severe psychological stress resulting in serious psychiatric symptoms. Similarly, Cicchetti and Rogosch (2002) observed that challenges and stressors encountered during resettlement may directly or indirectly contribute to the development of mental illness. Studies have also shown that resettlement stressors (sometimes called post-migration stressors) are important contributors to mental distress in refugee populations (Silove, Steel, Bauman, Chey, & Mcfairlane, 2007; Porter & Haslam, 2005). While these studies have consistently indicated a relationship between stress and mental health, there is a gap in the literature as to the coping mechanism employed by refugees.

However, much less work has been done to identify factors that moderate the relationship between stress, mental health and coping, social support and resilience among refugees and especially on identifying the specific resources that enable them to protect themselves from the negative experiences of migration (Liebkind & Jasinskaja-Lahti, 2000). Most of this research focuses on psychological health following immigration (Walsh, Shulman, & Maurer, 2008) post-migration experiences which has been found to contribute to poor mental health outcomes subsequent to immigration is undermined.

STRESS AND MENTAL HEALTH:

Definition of Stress:

Stress is defined as resettlement stressors which involve the social, political, economic and cultural framework of the new society, which the individual would have to relate to, and roles related to gender, employment, health care issues, and a language barrier are some challenges or stressors (Bhugra & Gupta, 2011) encountered by the individual in the host country.

The resettlement environment may possess many stressors, which the individual would have to face and cope with. Researchers such as Jordans, Tol, Komproe, and De Jong (2009) have found negative correlates between mental health state and stress. Just as outlined above, exposure to stressful situations is found to elicit mental health problems such as depression and anxiety (see also Betancourt, Borisova, Soudiere, & Williamson, 2010).

INTEGRATION OF STRESS AND MENTAL HEALTH:

The term 'mental health' is used to cover a host of psychological distresses and psychopathologies that are evidenced among refugee population (Kline, 2003).

Migration (Stress) and mental health can be regarded as two aspects which are related positively or negatively in a number of ways (Newbold, 2005). There is no doubt that moving from one country to another can cause emotional difficulties (Rasmussen, Rosenfeld, Reeves, & Keller, 2007). While emphasis on the explanations on mental health issues among migrant population tend to be anchored on migration-morbidity hypothesis (Vaage, Thomsen, Silove, Wentzel-Larsen, Van Ta & Hauff, 2010), there remains a gap in the literature that addresses the challenges of eradicating or reducing the occurrence of mental health problems among migrant populations. This study intends to close this gap. Rack (1982) identified the factors that influence migration, the push or pull factors; refugees in this study could be considered as those "pushed" out of their homelands as a result of political factors and intrude into another country involuntarily; this "push" of refugees, may be the genesis or starting point of mental health issues.

Refugees are predisposed to exhibit mental distress when compared to the general population (Thapa, *et al.,* 2007). Sundquist, Johansson, DeMarinis and Johansson (2005) and Wahlsten and Ahmad (2001) posited that refugees who had experienced violence as indicated

in this study, are at risk of depression and post-traumatic stress, however, the refugees' vulnerability to developing mental health issues increases with the accumulated resettlement stress burden.

In migrant studies scholars such as Sack, Him, and Dickason, (1999); and Khamis, (2005) in Palestine have noted that Posttraumatic stress disorder (PTSD) and depression are particularly prevalent in refugee populations and rates of PTSD have ranged from 11.5% to 65 % in samples of refugee children and adolescents from Cambodia.

FACTORS THAT INCREASE THE RISK OF MENTAL HEALTH IN THE RESETTLEMENT ENVIRONMENT

UNEMPLOYMENT:

various factors that can increase the risk of mental health issues amongst migrants, among which was unemployment was revealed by Mulki, Raija-Leena, Samuli, Marja, and Saija, (2014); Kroll, Yusuf, and Fujiwara, (2011) in their research on Somalia refugees. Similarly, the deleterious effect of stress in the post-migration period was suggested by Schweitzer, Melville, Steel, and Lacherez (2006) who found that post migration difficulties for example, unemployment was associated with symptoms of depression and anxiety among resettled Sudanese refugees.

INAPPROPRIATE HOUSING:

Porter and Haslam (2005) identified a number of post-migration conditions, amongst which was poor accommodation. They also proposed that, while pre-migration experiences have a significant impact on mental health, post-migration stressors such as not having the right accommodation add appreciably to post-traumatic stress symptoms (Porter & Haslam, 2005).

ECONOMIC HARDSHIP:

Financial stress was proposed by Porter and Haslam (2005) as factors related to poor mental health outcomes. African refugees have been faced with economic challenges in South Africa which might contribute to greater prevalence of mental health problems. These challenges include: resettlement difficulties, family disintegration, economic hardship, language barrier and inappropriate housing. According to Simich, Hamilton, and Baya (2006), in Canada, economic hardship was the greatest risk factor associated with refugees.

Various studies around the globe have also revealed the same vulnerability to mental health issues as a result of resettlement stressors among refugees when compared to other immigrants. Such studies includes: USA (Steel, 2001), Europe (Steel, 2001), Australia (DIMIA, 2003; Schweitzer, *et al*, 2006); and Africa (Idemudia, 2007; Posel, 2003; Ward, Bochner, Furnham, 2003) Heptinstall, Sethna, and Taylor (2004) reported further that severe financial hardship was related to higher depression scores among refugee youth. This link between financial stress and poorer mental health in refugees has been found in other studies as well (Steel, Silove, Bird, McGorry, & Mohan, 1999; Sundquist, Bayard-Burfield, Johansson, & Johansson, 2000).

SOCIAL DISCRIMINATION, FAMILY DISINTEGRATION:

Various challenges have been found to be the reason for mental health problems among refugees; the studies conducted by researchers such as Ai, Peterson and Ubelhor (2002); Bhui *et al.* (2003); Jamil, Hakim- Larson, Farrag, Kafaji, Duqum and Jamil (2002); Keyes (2000); Steel, Silove, Phan, and Bauman (2002) proposed that social discrimination, family disintegration and resettlement stress have been assumed to be the main cause of vulnerabilities and increased mental health hazards. In the same vein Schweitzer, Melville, Steel, and Lacherez (2006) proposed that family separation resulted to increased risk of mental health among refugees.

There exists strong evidence that, stressors faced by refugees such as socio-economic challenges and inability to have control over, or provide solutions to these challenges can impinge on mental health (Lorant *et al.,* 2003; Turner & Avison, 2003). While migrants generally experience post-traumatic stressors during the resettlement period (Hovey, 2000), these stressors have been found to have a detrimental effect particularly on newly arrived migrants (see King *et al.,* 2005; Veling *et al.,* 2006).

The literature has pointed to elevated rates of emotional distress, symptoms of post-traumatic stress, anxiety and depression (Steel, Silove, Phan, & Bauman, 2002). Other mental health problems such as psychosomatic disorders, grief-related disorders and crises of existential meaning have also been reported but to a lesser extent (Silove, 1999).

This strong focus on mental health and stress, therefore, leaves some questions unanswered such as: what then can lead to positive adaptation for refugees? Are there any strategies able to alleviate the risk of psychiatric morbidity amongst refugees?

Coping, stress and mental health:

One point stands out clearly in the literature on coping, that it is not any individual stressor that automatically leads to maladjustment, but the accumulation of demands before and after the change, the availability of coping resources, and the perceptions of abilities to cope with the stressors of the event which influence adaptability (Frame & Shehan, 1994). Literature of coping among refugees tends to be anchored in pre-migration coping strategies. Coping strategies during resettlement or post-migration are rarely studied.

Coping includes cognitive or behavioural efforts to manage situations appraised as taxing or exceeding a person's resources (Lazarus & Folkman, 1984). Thus, coping is a regulatory process that can reduce the negative feelings resulting from stressful events

Khawaja, White, Schweitzer, and Greenslade (2008) identified some coping strategies such as the use of religion, social networks, and cognitive process of reframing the situation and finally, another cognitive process in nature is articulating wishes and aspirations for tomorrow.

Similarly, a limited number of studies (Brune *et al.,* 2002; Gorman, Brough, & Ramirez, 2003) have highlighted various cognitive processes and belief systems which help refugees cope with their difficulties. Vázquez, Cervellón, *et al.,* (2005) revealed practical cognitive means used by refugees to reduce stress, through means of interpretations and perceptions of oneself and one's situation; these include refugees' attitudes toward their internal resources, such as taking a positive approach, identifying strengths, reinforcing the determination to cope, and self-perception as a survivor rather than a victim (Gorman *et al.,* 2003). Furthermore, preparedness for difficulties, talking about the stressful situation, or giving these new meaning, have also helped refugees to adapt in their new situation (Basoglu *et al.,* 1997; Goodman, 2004). Making use of positive cognition strategies, by focusing on hope and aspirations for the future has been shown to help in overcoming psychological problems (Goodman, 2004).

The functions of hope and aspiration as coping strategies, is consistent with the cognitive theory of depression (Beck, Rush, Shaw, & Emery, 1979); this theory postulates that hopelessness exacerbates depression and other psychopathologies, whereas a hopeful emphasis on the future encourages emotional well-being and provides individuals with a reason for living.

Culturally, Africans are known to be very religious people, and when faced with challenges or stress, particularly as a refugee in a foreign land, without families or loved ones, they tend to be more prayerful, which automatically helps them to cope in stressful situations. In a study conducted on refugees from Ethiopia and Somalia, religious beliefs and practices were found to be the major coping strategy employed by them, Halcon *et al.* (2004) established that between 50% and 75% of these refugees made used of prayers to reduce their pains and sorrows.

Religious beliefs and practices provide a number of coping strategies commonly used by refugees from Africa. Colic-Peisker and Tilbury (2003) found a connection between religious beliefs and coping style and concluded that individuals are able to endure adversity and have a better future through religious beliefs. Thus, religious beliefs are likely to assist individuals in adapting to life's difficulties. Specifically, Brune *et al.* (2002) found that refugees who reported holding a firm belief system reported fewer symptoms of PTSD, and better mastery of language.

Whatever coping strategies an individual desires to use is at times a function of the situation, perceived powerlessness affect the choice of coping responses (Noh, Beiser, Kaspar, Hou, & Rummens, 1999). For instance, in a comparison study in response to employment discrimination, foreigners reported a more recourse to passive coping than the locals; this prompted the scholars to suggest that such response is because, the foreigners are convinced that the situation is beyond their control (Williams, Lavizzo-Mourey, & Warren, 1994). This led other researchers Colic-Peisker and Tilbury (2003) to categorize coping strategies used by refugees into "active and passive styles", although Punamäki-Gitai (1990) argues that the nature of the stress is what determines the coping style; while refugees exposed to extreme violence may adopt active styles such as involvement in political or religious activities, others exposed to discrimination may engage in passive coping styles such as avoidance, or making use of the cognitive strategy of reframing the situation (Basoglu *et al.*, 1997).

Crean (2004) predicted lower levels of psychological symptoms among refugees who adopted the active coping style. While studies focus on coping strategies, the impact of these mechanisms on refugees' adaptation is unknown, keeping in mind the importance of coping mechanisms in order to promote refugees' mental health.

SOCIAL SUPPORT, STRESS AND MENTAL HEALTH:

Social support has been found to be a valuable factor in strengthening the individual's coping mechanisms and contributing to the transition into the new culture (Pollock, 1989). In general, the effect of social support on an individual's mental health cannot be over emphasized (Komproe, Rijken, Ros, Winnubst, & Hart, 1997) specifically on an immigrants' adjustment (Hovey & Magana, 2000). The effect of social support is well appreciated when the stress level is high, but on the other hand, it is less beneficial to mental health in the absence of stress (Komproe *et al.,* 1997) Because of various stressors in the life of immigrants, social support may have a significant effect on refugees' adjustment.

Additionally, it may enhance the mental health of refugees, especially when they perceive post-resettlement stressors. Another significance of social support is that exposure to attack of discrimination may have a heightened effect when support networks are unavailable or limited (Jasinskaja-Lahti & Liebkind, 2001; Noh & Kaspar, 2003).

Access to support networks such as friends might be difficult for refugees, especially if the host country is not receptive to immigrants. For instance, a study conducted in Israel by Al-Haj (2002), found that 71% of the Soviet Jewish immigrants had no Israeli-born friends, therefore the immigrants only have support from their families and their ethnic community to protect their psychological mental health (Finch & Vega, 2003; Garcia, Ramirez, & Jariego, 2002; Noh & Kaspar, 2003).

Although, immigrants who have constant communication with support networks in their homeland may have a good source of support needed to enhance mental health for proper adjustment in the new society (Schultz, 2001) the importance of a support system formed by the majority representatives of the host society have been found to be of greater benefit to refugees' mental health. Garcia *et al.* (2002) found that the presence of people from the host country in the support network assisted refugees to adjust better to the host society. Additionally Birman, Trickett, and Vinokurov (2002) suggested that refugees' contacts with the society might be of great benefit to them psychologically. However, there is a dearth of research in the relationship between host support networks and the mental health of refugees (see Birman *et al.,* 2002; Jasinskaja-Lahti & Liebkind, 2001).

There is no doubt that sources of social support may differ cross-culturally (Kelaher, Potts, Manderson, 2001), but the important aspect is the availability of this support. Some researchers such as Hinton, Tiet, Tran, and Chesney (1997) have found that a large number

of social support networks is needed in order to reduce mental health issues among refugees. Unfortunately, the importance of social support, and the effect it has on different groups of immigrants and refugees have been under-stressed in research (Leduc & Proulx, 2004), and services that could also strengthen refugee support networks and support requirements, have not been solicited (McDonald & Kennedy, 2004).

According to Wills and Fegan (2001) there are different effects of social support on migrants, they were categorized into quantity versus quality of social support. The argument here is that the category of social support would result to a refugee is able to cope. Alayne, Sangeetha, Dominique (2002) and Zunzunegui *et al.* (2004) reported a correlation between strong social support networks and mental health.

While social support can influence immigrants' and refugees' feelings of belonging or isolation (Kelaher, Potts, Manderson, 2001), in the same vein, mental health issues such as anxiety, depression, apathy, feelings of marginality and alienation, and heightened psychosomatic symptoms among refugees have been found to be reduced with the presence of social networks (Jasinskaja-Lahti, Liebkind, & Vesala, 2002). There is evidence that social support, from families, communities or other sources, acts as a protective factor against the impact of violence and persecution experienced by many refugees (McMichael & Manderson, 2004). In particular, social support networks must be studied further in order to be an improving factor in the study of refugees who experience extreme resettlement stressors (Williams, 1993).

The rate of psychological adjustment among refugees has been extensively studied with contradictory findings. Some researchers (e.g Porter & Haslam, 2005) reported higher rates of psychological distress, depression, and anxiety among refugees as compared to the general population, researchers such as Kroll, Yusuf, & Fujiwara, (2011) and Mulki *et al.* (2014) have generally agreed that refugees face multiple stressors, which can have deleterious effects on their mental health. A few scholars such as Beiser (1999) and Menjivar (2000) have reported that social support from family and community members of similar ethnicity is one of the most powerful contingencies that can diminish the negative influence of stressors on refugees' psychological mental health.

The importance of social support in determining mental health outcomes; however, remains significantly unexplained (Kawachi & Berkman, 2001).

RESILIENCE, STRESS AND MENTAL HEALTH:

Research on resilience has increased over the years (Haskett, Nears, Ward, & McPherson, 2006), particularly because resilience theory is based on comprehending healthy development despite risks, and focuses on strengths instead of weaknesses (Fergus & Zimmerman, 2005). The social and behavioural health definition of resilience has undergone much criticism because of the ambiguities in the term, its definition and even the heterogeneity of what categorize someone as being resilient, in terms of the type and weight of the risk experienced (Earvolino-Ramirez, 2007; Vanderbilt & Shaw, 2008). For instance some researchers view resilience as an individual trait (Ong, Bergeman, Bisconti, & Wallace, 2006) or as an adaptive temperament (Wachs, 2006). Still other others (Fredrickson, Tugade, Waugh, & Larkin, 2003) say that what constitutes an aspect of trait resilience is a personal resource which makes coping effective and acts as a buffer against various types of adversities.

Resilience could further be referred to as successful or unpredicted adaptations to stress, risk, and other negative life experiences (Chan 2006). Resilience is associated with 'positive adaptation' (Luthar *et al.*, 2000), the ability to 'bounce back' (Sossou & Craig 2008).

Fredrickson *et al.* (2003) established out that positive emotion is an active component within trait resilience which specifically helps in the reduction of depression and enhances thriving. A qualitative study (Schweitzer *et al.*, 2007) of resilience and coping among Sudanese refugees found individual qualities such as positive or negative coping response to adverse events and comparison to others had effects on improved recovery after traumatic experiences.

In addition, a study (Klasen *et al.*, 2010) examining the resilient trait among refugees in Uganda found that, despite severe trauma experiences, 27.6% of refugees showed an absence of PTSD, depression, and clinically significant behavioral and emotional problems.

The factors that define resilience may include dispositional attributes of the individual, caregiver factors, cognitive schemas about trauma, and perceived social support. This last factor, social support, has been identified as a crucial protective factor for posttraumatic outcomes (Bonanno & Mancini, 2008; Ozer, Best, Lipsey, & Weiss, 2003) and for positive youth mental health outcomes (Araya, Chotai, Komproe, & de Jong, 2007; Luthar *et al.*, 2000).

Researchers Almedom, *et al.* (2005) have argued that resilience has links with mental health, with an emphasis on describing positive associations that promote coping and adaptive abilities in the face of adversity among individuals and communities. These authors used

methodological approaches such as harm-reduction, protection and promotion in conducting resilience related mental health research. (Davydov, Stewart, Ritchie, & Chaudieu, 2010). .

The environment can elicit resilient traits from an individual; when stressors become overwhelming, an individual may react psychologically to the stressors, Charles and Almeida, (2007) found that environmental stressors have a great influence on exerting resilience (protective effect) on individuals regardless of their gender.

Spitzer (2007) argued that women tend to be more resilient by the use of their particular community networks. There is a growing interest among researchers in the comparative male-female vulnerability to several stressful life circumstances and their coping capabilities. Gender differences have been established amongst refugees who have the ability to bounce back in the midst of adversity. While Sossou and Craig (2008) give an explanation to why women tend to be more resilient, the concept 'family' was emphasized as a factor that gave women a 'purpose'. One very interesting aspect of how women express high resilience is concealed within cultural values; it was reported that silence was used by women as a coping strategy and this helps them to be distracted from the past and focus on rebuilding their lives in the resettlement environment, as disclosure of taboo experiences such as rape were not acceptable in their culture (Tankink & Richters, 2007). While Goodman, (2004) found that male refugee youth maintained resilience by using cultural coping mechanisms such as suppression, distraction, and they also exhibited high levels of resilience when they found comfort in the collective experience of loss, constructing meaning from suffering, and focusing on the hopefulness of resettlement.

Other researchers (Cameron, Ungar, & Liebenberg, 2007; Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008) suggested some specific determinants of resilience which include; genetic, psychological, social and environmental causes meaning that these factors could be responsible for being resilient. Various studies (Hofer, 2006; Schneiderman, Ironson, & Siegel, 2005) that have explained resilience through adaptive systems, have further indicated that resilience and reduced vulnerability can be used inter-changeably with the ability to cope and adjust to adversity (Kim-Cohen, 2007).

Although resilience has been found to enhance mental health, it is also seen as a tool to identify and prevent mental disorder, and furthermore, it is likely to be important in determining outcomes among traumatized populations such as refugees. Lastly it could be used to develop effective interventions among refugees.

The effects of individual resilience have not been fully investigated (Almedom, *et al.,* 2005; Bonano, 2004). It has been argued that individuals from Africa demonstrate 'a strong, determined spirit and resilience that has helped them to survive during stressful situations. (Australian Human Rights Commission 2009). This African resilient trait has not been investigated. It is important, therefore, to consider the extent to which resilience is a useful concept in the context of African refugees' resettlement experience, because there is evidence showing a stronger relationship between stress and resilience factors in the post migratory environment with psychological morbidity than exposure to traumatic events (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004).

Resilience could also be determined by age. Youths have been found to have higher resilience (Goodman, 2004). Youth is not only a time of increased developmental risks but also a period of development of health-promoting skills (Call *et al.,* 2002) when youths unconsciously engage in pro-social behaviours, including positive coping; this may contribute to resilience. Research has linked active pro-social strategies that include coping behaviours to positive social interactions and support (Hobfoll *et al.,* 2009).

Migration has been found to disrupt the normal life style of individuals, and also results in a sudden change, which an individual must come to terms with, but some, however, struggle to attain balance, and this balance can be seen in two dimensions with themselves and with the community. On the one hand, study such as Khawaja White, Schweitzer, and Greenslade (2008) have even suggested that the majority of refugees adapt quite well under conditions of severe adversity and do not suffer long-term negative effects, refugees demonstrate remarkable strengths of resilience as they cope with situations of extreme suffering.

On the other hand, balance is obtained by community involvement in the resettlement process Doran (2005) and Schweitzer, Greenslade and Kagee (2007) highlighted how the refugee communities and service delivery help in building togetherness and enhance social capital that is integral to resilience. As Field and Anderson (2008) put it: 'Refugees must adapt to whatever environment they find themselves in, and the evidence shows they are stronger when they do this together'.

The findings from most of the above studies suggest that African refugees share much in common with other migrant and refugee groups, particularly in terms of stress. However, which specific resilience factors are most relevant and in which contexts are yet to be explored. Yet African refugees might be different from other migrant groups in the following areas; the nature of migration experience, the amount of deprivation endured, the preferred coping

strategies; unfortunately information about the strengths and resources of African refugees in the context of their resettlement experience is unknown.

GENDER, STRESS AND MENTAL HEALTH:

The connections between gender, stress and mental health are complex ones, while various gender theories have tried to explain differences between the sexes' behaviour, studies to date have reported conflicting results. Most studies on gender differences (Hapke, Schumann, Rumpf, & John, 2006; Piccinelli & Wilkinson, 2000) have shown that women are at a higher risk than men, yet others (Idemudia, *et al.*, 2013; Tolin, & Foa, 2006) have revealed that gender differences are linked to different exposure to traumatic events and to different response to traumatic events. These authors showed a higher life time prevalence in men than women, with women being more vulnerable to assaultive violence and men reported poor mental health due to socio-economic factors, such as subsistence, accommodation, feeding issues. Yasan, Saka, Ozkan and Ertem (2009) reported a higher exposure to traumatic events (53%) for men than women (44%), and a different risk of post-traumatic stress disorder (PTSD) among men and women with similar traumatic events.

Explanation as to the gender differences was further buttressed by Oliff *et al.* (2007) who stated that women's higher risk may be due to several factors. Some of these are are type of trauma being experienced, age at the time of trauma exposure, strong perception of threat and loss of control, higher level of peri-traumatic dissociation, insufficient social support resources and greater use of alcohol in managing gender-specific acute psychological reactions to trauma. (Oliff, 2007).

Bountziouka *et al.* (2009); and Kyoung and Linnea (2014) attributed the higher risk of mental ill health in women. Specifically older women, to a language barrier, and having experienced loss of a spouse, being lonely and financially constrained with no social support in the host country. In addition, gender has been found to impact mental health consequences. In a study conducted in Australia on Sudanese refugees, Schweitzer, Melville, Steel and Lancherez (2006) found that female gender predicted greater PTSD, depression and anxiety symptoms as compared to male gender.

While researchers such as Lee, Moon, and Knight (2004); Min, Moon, and Lubben, (2005) and Mui and Kang, (2006) did not find gender differences in a study conducted on a sample of Asian immigrants, these scholars posited that stressful life events, also loneliness

and socioeconomic stresses were positively related to depressive symptoms irrespective of their gender .

Age was also a contributing factor as to reasons for gender differences in mental health, according to Bountziouka *et al.* (2009); older refugee women were more likely to have depress

ive symptoms than older refugee men, in the same vein, Ron (2004) found that older immigrant women experienced higher levels of depression, and or hopelessness compared to older men.

Explanations reviewed within a male-controlled social system in most Western countries affirmed that the mental health status of men is better due to the privileges given to men over women as regards to power and property; this has oppressed women into a subordinate mental health status. Women become generally, more vulnerable to health issues than men, even though the self-assessed health of women has improved due to antidiscrimination laws (Schnittker, 2007).

Cummings and Jackson (2008) stated health differences between both sexes, and found that women are more likely to have better self-assessed health than men.

Findings on gender differences in migrant studies remain mixed and inconclusive. Migrant studies using data from Africa is infrequent, resulting in a gap in the literature. A study of mental health amongst African refugees in South Africa would narrow this gap and contribute to a better understanding of the gender differences among refugees.

THEORETICAL BACKGROUND

The study was conceptualized within the following theories. Stimulus and response theory by Selye (1956) and Holmes and Rahe (1967); this theory postulates that stress is a physiological phenomenon. The study also used Cohen and Wills (1985) stress buffer theory, which states that social support buffers or protects an individual from the negative consequences of stressful events. Also various resilience theories were used to explain resilience such as Flach (1988, 1997); this theory define the resilience process and Richardson, Neiger, Jensen, and Kumpfer (1990) further complemented the explanation by focusing on the interaction between challenges posed by the stressful event and the protective factors of resilience. The final theory on resilience was the meta-theory of resilience proposed by Richardson (2002), where resilience was described in three waves.

The sociocultural theory by Eagly and Wood (1999; 2012) was used to explain gender differences in mental health. Nonetheless, all the above theories could not totally conceptualize the relationship between all the variables in the study; two models were however compared to depict the relationship between all the variables in the study, these models are the stress theory (Cassel, 1976) and learned helplessness by Abramson, Seligman and Teasdale (1978). The theories are explained in detail below.

STIMULUS AND RESPONSE THEORY

The study used the stimulus and response theory of Selye (1956); Holmes and Rahe, (1967); and Masuda and Holmes, (1967) which postulates that stress is a physiological phenomenon. Selye viewed stress as a response to noxious stimuli or environmental stressors and defined it as the *"nonspecific response of the body to noxious stimuli"* (Selye, 1956 pp 12). Seyle's theory focused on describing and explaining a physiological response pattern known as the general adaptation syndrome (GAS) that concentrated on retaining or attaining *homeostasis,* which refers to the stability of physiological systems that maintain life (e.g., body temperature, heart rate, glucose levels). The following are the basic premises of this theory: (a) The stress response (GAS) is a defensive response that does not depend upon the nature of the stressor; (b) the GAS, as a defence reaction, progresses in three well-defined stages (alarm, resistance, and exhaustion); and (c) if the GAS is severe enough and/or prolonged, disease states could result in death or the so-called diseases of adaptation.

This model further views stress as means of responding to stressors caused by the environment, stressors and treats life changes or life events as the stressor to which a person responds. The changes within an individual's new environment pose some physiological variations within him, which now lead to some responses. The stimulus-based theory of stress came into existence when some psychologists became interested in applying the concept of stress to psychological experiences (Holmes & Rahe 1967; Masuda & Holmes 1967).

The central proposition of this model is that too many life changes in a relatively short period of time increase one's vulnerability to illness; the mental functioning of an individual is predicted as a result of environmental stressors.

The stimulus-based model was built on assumptions that are inherently problematic in explaining human phenomena. The primary theoretical proposition was based on the premise that (a) life changes are normative and that each life change results in the same readjustment demands for all persons, (b) change is stressful regardless of the desirability of the event to the person, and (c) there is a common threshold of readjustment or adaptation demands beyond which illness will result. In order words, the theory is saying that, changes and readjustment due to life variations are the same for all individuals; also change elicits stress irrespective of the attractiveness of the event and there is a peak an individual can get to, which can make illness to occur.

This theory is applicable to this study as environmental stressors impede on the mental functioning of an individual. Also, migration brings about life changes in the life of an individual, the social and environmental situation exposes migrants or refugees to mental health issues.

BUFFER THEORY

The study also uses Cohen and Wills (1985) buffer theory, where the focus is on support provided by families, friends and significant others. This model illustrates psychological and social factors that influence mental health. In this model support is related to well-being only, because it posits that support "buffers" (protects) persons from the potentially pathogenic influence of stressful events.

An individual's mental health is influenced by an important factor, which is the role of interpersonal relationships in buffering such an individual against the pathogenic effects of stressful events. The possible protective effect of social support will determine the effect on one's mental health, leading to improved coping mechnism (Rees, *et al.*, 2010).

This model further assists in understanding the role played by communities or significant others, and how they determine mental health. It can be posited that a lack of positive social relationships leads to negative psychological states such as anxiety or depression. In turn, these psychological states may ultimately influence physical health either through a direct effect on physiological processes that influence susceptibility to disease or through behavioural patterns that increase risk for disease and mortality (Cohen & Wills 1985).

THEORIES OF RESILIENCE

Furthermore, the study made use of more than one theory of resilience because the construct 'resilience' is an interdisciplinary subject within psychology; in spite of its growing popularity there is no universally accepted resilience theory (Luthar, Cicchetti, & Becker, 2000).

Flach (1988, 1997) suggested a model defining a resilience process. In this model, "bifurcation points" which characterize the traumatic times or life challenges disrupts the homeostatic state of individuals. This interruption leads to destabilization in cognitive, behavioural or affective constructs, called chaos. Flach mentioned that bifurcation points do not necessarily need to be life-challenging traumatic events, they can be daily life stressors. Those bifurcation points may provide grounds for being vulnerable, or more effective functioning may be reached due to extreme stress, called reintegration. Reintegration is "the process of reforming a worldview" (Richardson, Neiger, Jensen, & Kumpfer, 1990). The process starting from disruption and ending with reintegration is recurring. According to Flach (1997) "resilient personality" is the source of reintegration.

Another model of resilience used to further explain resilience is the one proposed by Richardson *et al.* (1990) which is similar to Flach's model mentioned above. This model essentially focuses on the interaction between negative life events and protective factors, named "biopsychospiritual protective factors." Biopsychospiritual homeostasis is "a point in time when one has adapted physically, mentally, and spiritually to a set of circumstances whether good or bad" (Richardson, 2002). Just like the Flach model, the continuous disruptive events such as life threats violate the homeostasis. Biopsychospiritual protective factors are exemplified as purpose in life, self-esteem, social skills and other factors. In the resilience process, individuals go through two main stages. At the first stage, individuals may become fearful, or confused; but then the adaptation process emerges either consciously or

subconsciously, with the individual deciding on what steps to take and this represents the beginning of reintegration. Four types of reintegration are described in the model: resilient reintegration (reaching a more effective functioning than before the stressor), homeostatic reintegration (going back to the same level of functioning), maladaptive reintegration (going back to an inferior level of functioning) and dysfunctional reintegration (using completely dysfunctional coping mechanisms).

Finally, a meta-theory of resilience and resiliency proposed by Richardson (2002) described resilience and resiliency in three waves. In the first wave, resilience is seen as having trait-based qualities or assets serving for adaptability. Then the resiliency process, which incorporates coping with adversity in a manner that results in enrichment of the resilient qualities identified in the first wave, comes with the second wave. In the third wave, named *innate resilience*, individuals recognize and acknowledge their inner force toward self-actualization and reintegration after adversity. Richardson (2002) also claims that "It is clear that society, as well as the academic revolution of the spirit or soul, supports the postulate that there is a healing, driving and motivating force within every soul"

The first wave of resiliency answers the question about which characteristics mark people who will thrive in the face of risk factors or adversity as opposed to those who succumb to the adversity. Most of the resiliency literature is a quest to describe those internal and external resilient qualities that help people to cope with or "bounce back" in the wake of high-risk situations or after setbacks. Benson (1997) assesses resilience qualities from a phenomenological view by focusing on the paradigm shift of risk factors that lead to psychosocial problems to the identification of strengths of an individual. The character, trait, or situational premise of resiliency is that people possess selective strengths or assets to help them survive adversity. Whether resilient qualities are learned or are part of one's genetic nature is a common debate among helping professionals, but clarified in resilience theory. These resilient characteristics have been referred to as protective factors or developmental assets.

The second wave of resiliency was a pursuit to discover the process of attaining the identified resilient qualities. Resiliency then became defined as the process of coping with adversity, change, or opportunity in a manner that results in the identification, fortification, and enrichment of resilient qualities or protective factors. Coping process is emphasized, a coping process that results in growth, knowledge, self-understanding, and increased strength of resilient qualities.

While the third wave of resiliency resulted in the concept of resilience, it became clear that in the process of reintegrating from distresses in life, some form of motivational energy was required. Resilience theory will be described in this study as the motivational force within everyone that drives them to pursue self-actualization, and humanity and to be in congruence with a psychic source of strength.

This wave of resilience answers the question as to what and where the energy source or motivation to reintegrate resilience is. A statement of fact of the resilience model is that there is a force within everyone that drives them to seek self-actualization, altruism, wisdom, and harmony with a spiritual source of strength. Werner and Smith (1992) argued that resilience is an innate "self-righting mechanism" and Lifton (1994) acknowledged resilience as the human capacity to transform and change, no matter their vulnerabilities. The primary common paradigm is that humans as well as other living things, have energy or resilience

This theory of resilience is applicable to the study because, characteristics, traits and other protective factors as explained in the theory give insight as to how refugees differ in their ability to cope. Although the premise of the theory is that everyone has the ability to be resilient, but some individual lacks this ability.

SOCIO-CULTURAL THEORY

Sociocultural theory, also called social role theory or social structural theory, proposed by Eagly and Wood (1999) and Wood and Eagly (2012) has been used to explained gender differences in mental health. Wood and Eagly (2002) found that gender differences are traced to human evolutionary history, the society dictates roles played by men and women, and this division of labour is affected by biology and environments, men find themselves doing some things and women do other roles.

Specifically, the theory argues that it is the role that an individual sex plays that makes them vulnerable to mental illness; for instance, women are susceptible to higher risk not because they are women but because of the roles they occupy. This could be seen in the key role placed on married women as compared to the role placed on married men, or even those that are not married. Nevertheless, sociocultural theory has received different results. Radloff (1978) posited that marital status, employment status, and sex interact in their relationship with mental health, however, he said that these social roles are not sufficient to predict sex differences in mental health. Fox (1980) reported results that showed that women are more likely to be mentally ill than men regardless of marital status. This results indicate the fact that the theory lacks internal validity.

The theory acknowledges biological differences between men and women, such as differences in size and strength and women's capacity to bear and nurse children reducing women to having a low self - esteem, lack of environmental mastery, resulting in mental illness. And believe that people are unable to change their helpless situation makes them depress (Seligman, 1978).

Finally, two models were compared, to depict the relationship between stress and mental health with the moderating roles of coping, social support and resilience. It was argued that these two conceptualisations partially overlap and that both were essential, these stress theory by Cassel (1976), and Learned Helplessness by Seligman and Teasdale (1978).

THE STRESS THEORY

The stress theory argues that strong social ties were protective against the potential pathogenic effects of stressful events. Cassel (1976) thought that stressors that placed persons at risk for disease were often characterized by confusing or absent feedback from the social environment. In contrast, the impact of the stressors was mitigated among individuals whose networks provided them with assistance to protect against risk. The argument was that those protected were those that had maintained communications with others, were cared for and valued. Cassel thought this protection occurred because these perceptions facilitated coping and adaptation.

The importance of support networks cannot be overemphasized where stress theory is concerned (Wethington & Kessler, 1986). How then do individuals get support? Although, research (Norris, *et al.,* 2002) have revealed that support network is of great importance to buffer against mental health issues, support helps to mediate between stressful event and mental health by reducing or preventing a stress appraisal. Specifically the perception that others can and will provide resources may redefine the harm potential of a situation and enhance one's perceived ability to cope with imposed demands, thereby preventing a situation from being appraised as highly stressful (Thoits, 1986). Also, support beliefs may reduce the affective reaction to a stressful event, dampen physiological response to the event, or prevent or alter maladaptive behavioural responses. The availability of a supportive network also helps to maintain good mental health (Kaniasty & Norris, 2008).

Finally, support may mediate by reducing the stress reaction or by directly influencing physiological processes. Support may alleviate the impact of stress by providing a solution to

the problem, or by offering a distraction from the problem. It may also tranquilize the neuroendocrine system so that people are less stress active (Cohen & Will, 1985). There are various typologies of support, ranging from informational to emotional; Cohen & Wills, (1985) maintained that the latter provides protection in the face of a wide range of stressful events thus reducing the effect on mental health.

LEARNED HELPLESSNESS

Abramson, Seligman and Teasdale (1978) believe that people are more likely to suffer from mental health issues when they have learned that the situation is beyond their control. According to these authors the cause of mental health issues is learned helplessness. One way in which this happens, they hypothesize, is learning that outcomes are uncontrollable results in three deficits: motivational, cognitive or emotional, depending on how the individual perceive and interprets the situation. If the individual thinks his current stressful situation is hopeless, emotionally he/she accept his helpless state and as such he is not motivated to do anything about it (Seligman & Teasdale (1978).

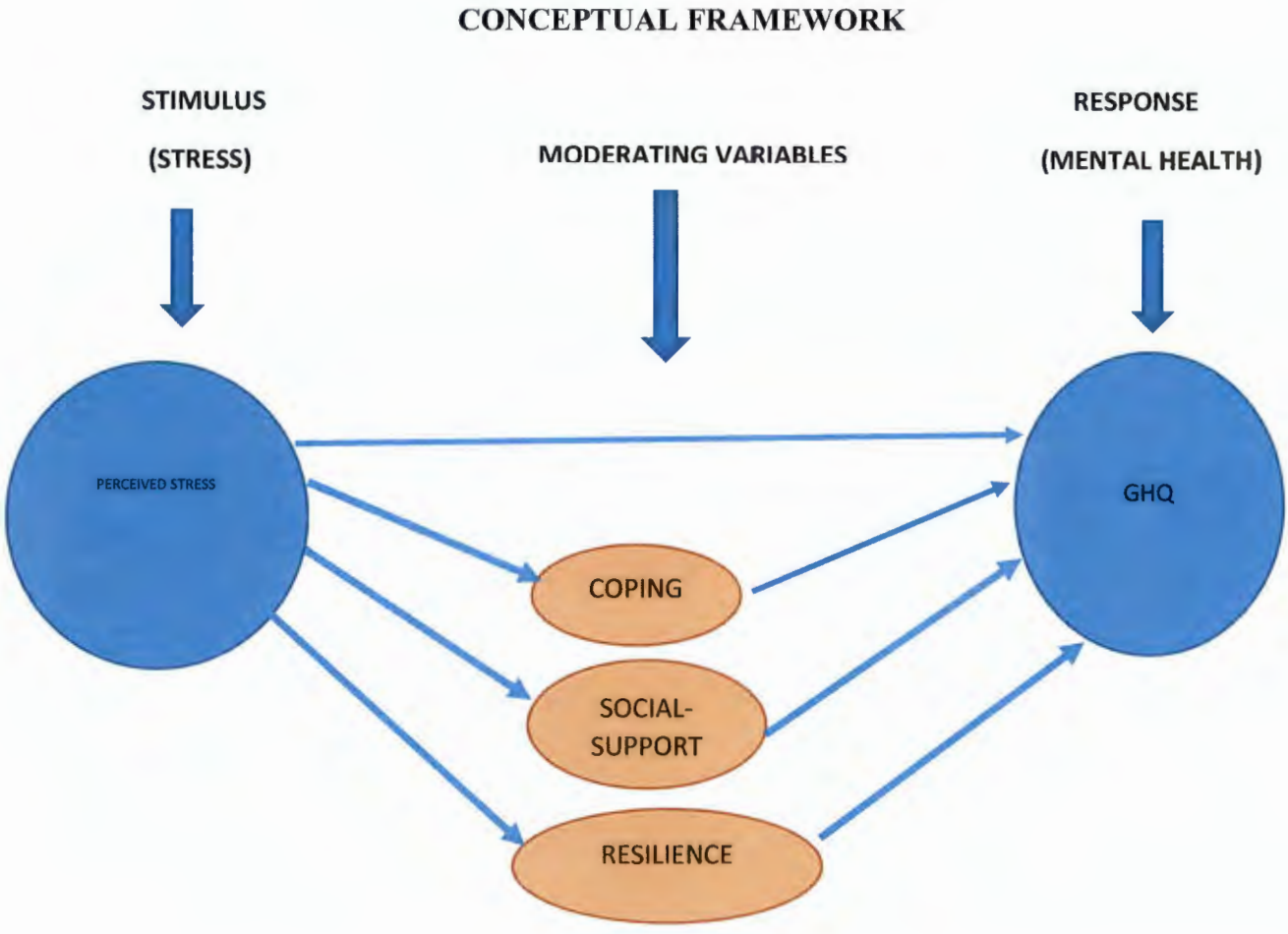
Similarly, in the previous year, Bandura (1977) explained how people become less resilient during stressful situation. According to him, people can give up trying because they lack a sense of efficacy in achieving the required behaviour, or they may be assured of their capabilities but give up trying because they expect their behaviour to have no effect on an unresponsive environment. This applies to the resettlement environment, refugees may be overwhelmed with stressors in their immediate environment and conclude that they are not able to change the situation.

Conceptually, as pointed out in figure 1 below, stress as the independent variable is regarded as a stimulus according to the study, and is measured with a perceived stress scale. The stressors are factors in the resettlement environment that can elicit tension in the life of the refugees, stressors like unemployment, financial constraints, poor housing, discrimination, language barriers, and the process of relocation itself, all these stressor have the ability to trigger a response which is the mental health, which also is measured with the GHQ scale, which when triggered, can lead to psychological symptoms such as depression, anxiety and somatic complains, if not checked can be a case of psychiatric morbidity.

However, from the figure, it is hypothesized that stress has an influence on mental health, also, stress in the presence of coping will have an influence on mental health, furthermore, stress and social support will influence mental health and lastly from the figure stress and resilience will influence mental health.

The presence of the moderating variables of coping, social support and resilience could reduce the effect of these stressors on mental health. In other words, mental health maybe influenced and affected by stress, coping, social support and resilience. In line with most analysts of social stress (e.g. Kyoung & Linnea, 2014) they showed that resettlement is potentially stressful. Such conditions as relocation to a new home, unemployment, hostility from host country, financial constraints and language barriers, all of these might give rise to poor mental health, stressors mentioned above, a perception that environmental demands exceed the abilities of the individual, essentially resulting in a risk of psychological and social adjustment problems as affirmed by Idemudia *et al.* (2013), although the effect is expected to be reduced in the presence of the moderating variables.

Figure 1: Showing the conceptual framework of the relationship between stress and mental health and the moderating roles of coping, social support and resilience



In summary, based on the aforementioned literature and theories, it was hypothesized that there will be a significant relationship between perceived stress and mental health of refugees, but the prediction will be moderated by coping, social support and resilience so that the tendency to experience mental risk will be reduced in the presence of high coping, social support and resilience. Finally it was hypothesized that gender differences would exist among refugees in terms of mental health.

Aim of the study

The study aimed to examine the association between mental health and stress in African refugees in South Africa, also to assess the moderating roles of Resiliency, Social Support and Coping styles of African Refugees.

Objectives of the study

The specific objectives of the study are identified as follows, to:

- Examine the association between stress and mental health among the refugees.
- Assess how coping, social support and resilience influence mental health.
- Explore the sex differential in mental health.

Significance of the study

The study may have both practical and theoretical significance. Conclusions drawn from this migrant study will benefit the government in terms of policy making and formulation of strategies to alleviate the mental health needs of refugees. Psychologists will be able to recognize mental health needs of this underserved population and at the same time develop skills to provide psychological services to refugees. Mental health providers would know the right approaches and services they need to render to refugees. The study further will assist society to have deeper understanding of the impact of stress on refugee mental health and identity.

Theoretically, it will add more knowledge to existing theories related to this study. Refugees' differences and individuality will also be presented, specifically from a psychological perspective. Finally it will project various coping strategies employed by African refugees in South Africa.

Hypotheses

- There will be a significant relationship between perceived stress and mental health of refugees.
- Coping strategies, social support and resilience will moderate the relationship between perceived stress and mental health of refugees.
- Female refugees will report poorer mental health than male refugees

METHODOLOGY

Study Design

This study is a cross-sectional design using a quantitative research approach. The Independent variable is stress and the dependant variable is mental health. The moderating variables are social support, coping, and resilience.

Sample

The participants are adult male and female African Refugees who must have lived in Yeoville for at least one year. Yeoville is a suburb of Johannesburg, in the province of Gauteng, South Africa. The detailed description of the characteristics of the participants are in the Table 2 below.

Stratified random sampling was used, the reason been that, it is the best known probability sampling technique suitable for heterogeneous populations such as the refugee population and the inclusion of the required percentage of the demographic variables can be ensured (variables like gender and age), (Mitchell & Jolley, 2001). From the register list at African Diaspora forum where the participants of the study were drawn, the sample size was stratified by age and sex to ensure representativeness of these important demographic variables, thereafter they were purposefully selected. The African Diaspora Forum is an NGO, a federation of African migrants associations in South Africa, .whose **mission** is to build an integrated society. The African Diaspora Forum is a non-profit organization representing African migrant communities living in South Africa. It is a refugee help center, where most concerns of legal refugees residing in South Africa are attended to. So far 21 African countries are represented in the Forum: Angola, Burkina Faso, Burundi, Cameroon, Congo-Brazzaville, Democratic Republic of Congo, Eritrea, Ethiopia, Ivory Coast, Malawi, Morocco,

Mozambique, Nigeria, Rwanda, Senegal, Somalia, South Africa, Sudan, Uganda, Zambia, and Zimbabwe. Their web site is http://adf.org.za

All Participants were 18-57years, (mean age =32.06, Range=39). The number of refugees who completed the five (5) questionnaires was 203 males and 137 females, giving a total of 340 participants.

Instruments and psychometric properties

The primary instruments used to collect data are all standardized scales. They are; General Health Questionnaire -28 (GHQ) developed by Goldberg (1978); Perceived Stress Scale (PSS), developed by Cohen and Williamson (1988); Brief Cope (BC), by Carver, (1997); Multidimensional Scale of Perceived Social Support (MPSS), by Zimet, Dahlem, Zimet, and Farley, (1988) and Connor-Davidson Resilience scale (CD RISC) developed by Connor and Davidson (2003). The description of these instrument follows next.

General Health Questionnaire:

This scale consists of 28 items and it is used to assess mental health. In particular, it is a screening tool to detect those likely to have or be at risk of developing psychiatric disorders. It is used to measure common mental health domains of depression, anxiety, somatic symptoms and social withdrawal (Goldberg, 1978). Since the introduction of this questionnaire, it has been translated into 38 different languages, testament to the validity and reliability of the questionnaire. The reliability coefficients have ranged from 0.78 to 0.95 in various studies, but for this study the reliability coefficient was 0.89. It is presented in four different versions, depending on the numbers of items; they are: GHQ 12, 28, 30 60. Each item is accompanied with four responses typically being 'not at all', 'no more than usual' 'rather more than usual' and 'much than usual'.

There are two recommended methods for scoring the GHQ. The first scoring method ranges from 0-3 respectively. The other scoring method uses a binary scoring method (with the two least symptomatic answers scoring 0 and the two most symptomatic answers scoring 1- i.e. 0-0-1-1).The total possible score on GHQ-28 ranges from 0-84, and allows for means and distributions to be calculated, both for the global total as well as for the four sub-scales (somatic symptoms, anxiety/insomnia, social dysfunction and severe depression) (Goldberg, Gater, Sartorius, Ustun, Piccinelli, Gureje & Rutter, 1997). The mean score stands as a bench mark for interpreting the scores on the scale for each individual, any individual that scores between 0-42 is regarded as having good mental health while the ones that score from 43-84 are considered as having poor mental health.

Perceived Stress Scale (PSS):

The Perceived Stress Scale (PSS) is a 14-item self-report instrument designed to measure "the degree to which situations in one's life are appraised as stressful" (Cohen & Williamson 1988). The scale exhibited an adequate level of internal consistency for the population under study (Cronbach's alpha coefficient = 0.48). There are 3 versions of the scale: the PSS14, the PSS10, and the PSS4 (Cohen and Williamson, 1988). The numbers that follow the acronym indicate the number of scale items, and the PSS14 is the most widely used version. The original English version of the PSS14 has been adapted into many languages by Cohen & Williamson (1988). The items on the scale are structured into groups of both positive items and negative items. Items 4, 5, 6, 7, 9, 10, and 13 are the positively stated items while the rest are negatively stated items. Participants are asked to respond to each question on a 5-point Likert scale ranging from 0 (never) to 4 (very often), indicating how often they have felt or thought a certain way within the past few months. The scores are obtained by reversing the scores on the seven positive items, e.g., 0=4, 1=3, 2=2, etc., and then summing across all 14

items. Notably, a mean score is derived from the composite scores on the scale, this serves as the bench mark for interpreting individuals with stress. High PSS scores have been correlated with higher biomarkers of stress.

Brief cope:

The Brief Cope, (Carver, 1997), this scale is adapted for use for measuring refugee stressful situation and is an abbreviated inventory of coping responses with a large number of distinct scales. The scale consists of 28 Items. Response format is for participants to bring to mind the most serious stressor they had experienced during the prior year and indicate how they had responded to it. Response choices ranged from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot). Alpha reliabilities for this study was 0.81, indicating good reliability. To interpret the scores for an individual on this scale, a mean score is calculated as a bench mark and all individual scores falling within the negative side of the graph are considered as having low coping styles while those individual with scores falling towards the positive on the graph are regarded as having high coping styles.

Multidimensional scale of perceived social support (MPSS):

The initial MSPSS was constructed with 24 items addressing relationships with family, friends and a significant other in the following areas: social popularity (e.g., I received invitations to be with others, or people look up to me) and items directly related to perceived social support (e.g., I get the help and support I need from my friends). Each item was rated on a 4-point likert-type scale ranging from strongly disagree (1) to strongly agree (4).

The results of several pilot studies led to the changes described later and to the revised and current version of the MSPSS. The present MSPSS which is used in this study includes 12 items. It provides assessment of three sources of support: family (FA), friends (FR), and significant other (SO). Zimet *et al.* (1988) have emphasized the unique features of this scale First, it is short (12 items in total) and is ideal for (a) research that requires assessment of multiple variables and (b) populations which, for one reason or another, cannot tolerate a long questionnaire. Secondly, a point related to (b) above, MSPSS items are easy to understand (requiring just fourth grade reading level) and are therefore suitable for young populations or populations with a limited literacy level. Third, despite being a brief instrument, MSPSS

measures support from three sources, and in particular, the SO subscale is unique among measures in the field. Who the "significant other(s)" is left to the respondent to define. Also the items directly addressing social support are divided into factor groups relating to the source of the support, i.e. Family, Friends, or significant others, each of these group consists of four items, In an attempt t to increase response variability and minimize a ceiling effect, a 7- point rating scale ranging from very strongly disagree (1) to very strongly agree (7) was implemented.

For the population under study, the cronbach's coefficient alpha, a measure of internal reliability, was obtained for the scale as a whole and the reliability of the total scale was 0.94. This value indicates good internal consistency for the whole scale and for the three subscales.

Connor-Davidson Resilience scale (CD RISC)

The Connor-Davidson Resilience scale (CD RISC), was developed by Connor and Davidson (2003) and consists of 10 items directly measuring resilience. It includes items such as; able to adapt to change, can deal with whatever comes, tries to see humorous sides of problems, coping with stress can strengthen me, with the response pattern of a 4 point rating scale, ranging from strongly disagree (1) to strongly agree (4). The scale Psychometric property is alpha value of 0.94, indicating good reliability.

Table 2, presents the frequencies and percentages of the social demographic variables of the participants in this study.

Table 2: Sample characteristics of refugees (N 340)

Demographic variables **No of refugees** %

Variables	Frequency	Percentage (%)
Gender		
Male	203	59.7
Female	137	40.3
Total	**340**	**100**
Marital status		
Single	160	47.1
Married	96	28.2
Divorced	32	9.4
Separated	24	7.1
Cohabiting	28	8.2
Total	**340**	**100**
Country of origin		
Angola	74	21.8
Democratic Republic of Congo	66	19.4
Ethiopia	6	1.8
Somalia	60	17.7
Zimbabwe	134	39.4
Total	**340**	**100**
Level of education		
No- education	34	10.0
Elementary	64	18.8
High school	152	44.7
University	90	26.5
Total	**340**	**100**
Religion		
Christian	200	58.9
Islam	36	10.6
Buddhist	20	6
Non-sect	84	24.7
Total	**340**	**100**

Procedures

Ethical approval for the study was obtained from the North-West University, Mafikeng Campus, as well as the institution where data was collected. After consent was obtained from the African Diaspora Forum and participants, dates for data collection were communicated to all concerned. On these dates, refugees who were selected from the register list were invited to participate in this study. The collection of data was conducted during an event called "African Week". The exercise took five days; on each day, the time was from 10h00-13h00.

Administration of the questionnaires took place under the supervision of the researcher together with one qualified research assistant alongside staff of African Diaspora who were appointed by the chairperson of African Diaspora to assist.

Both the research assistant and the staff of African Diaspora Forum were not new with administration of questionnaires, however, the researcher instructed them on how to go about distributing the instruments, both only helped in distribution and collection of questionnaires, instructions was read by the researcher.

The purpose of the questionnaire was clearly stated and instructions given by the researcher. Participants were informed about the content of the questionnaires and that participation was voluntary. No compensation was given for their involvement, and participants were permitted as much time as needed to complete the questionnaires. No identifying information was collected, and participants were assured of confidentiality.

After reading of the instructions by the researcher, the researcher requested volunteers to translate, for the purpose of better understanding of the questionnaires for those who could not read or understand English and since the questionnaires are close ended, participants completed the questionnaires confidentially, the translator only read and translated for them, it was easy for participants to tick after the translation. Volunteer translators from each African country represented, interpreted using the various African languages represented in the sample. Refugees completed the questionnaires anonymously. Afterwards, they were thanked for their time and sincere participation.

During those five (5) days of data collection, two clinical psychologists, were also present; the reason been that, some refugees could get emotional and hysterical as they answered questions from the questionnaires. However, apart from eight (8) refugees who exhibited some emotions during the exercise and were immediately taken care of by the

psychologists, no harm to the participants was experienced by the researcher. The clinical psychologists were paid for their services by the researcher, and their speedy intervention was much appreciated.

RESULTS AND TABLES

The study was anchored on three hypotheses. The first hypothesis stated that there will be a significant relationship between perceived stress and mental health of refugees. The second hypothesis stated that coping strategy, social support and resilience will moderate the relationship between perceived stress and mental health of refugees. And the last hypothesis stated that female refugees will report poorer mental health than male refugees.

The first hypothesis was tested using the Pearson r product moment correlation, in order to determine the relationship between both variables. Hypothesis 2 was analysed using a hierarchical multiple regression and a correlational analysis to determine whether the independent variables- perceived stress, coping, social support and resilience will significantly predict the dependent variable, mental health. Hypothesis 3 was tested using an independent t-test showing results between female and male refugees on mental health.

The first hypothesis which stated that there will be a significant relationship between perceived stress and mental health of refugees was tested using the Pearson r product moment correlation. The result is presented in Table 3, below. The result showed a significant negative relationship between social support and mental health, ($r = -.510$, $p < .001$). This indicates that refugees with good social support, are reporting better mental health. Also the result indicated a significant negative relationship between resilience and mental health ($r = -.564$, $p < .001$). This indicates that as refugees are exhibiting high resilience, their mental health is decreasing. There was a negative correlation between mental health ($M = 60.52$ $SD = 14.44$) and perceived stress ($M = 41.22$ $SD = 6.111$), r ($r = -599$, $p < .001$). This result means that perceived stress was related to better mental health.. Furthermore, a significant negative relationship was revealed between coping and mental health, ($r = -.204$, $p < .001$). Which indicates that as refugees score high on coping style, their mental health is better. The result showed a significant negative relationship between age and mental health ($r = -.347$, $p < .001$). This indicates that the older the refugees, the better their mental health. Gender reported a non-significant effect ($r = .098$, $> .072$). Indicating that gender does not influence mental health.

Table 3. Correlational analysis showing relationship between independent (stress) variables and dependent variable (mental health)

Variables	1	2	3	4	5	6	7
MH	-						
SS	- .510**						
Resilience	-.564**	-	-				
PSS	-.599**	-.707**	.629**	-			
Coping	-.204**	.576**	.596**	-.299**	-		
Age	-.347**	.473**	.262**	.315**	.060	-	
Gender	.098	.178**	-.038	-.201**	.034	-	-
Range	56.00	.058	28.00	26.00	64.00	.242**	-
Minimum	31.00	33.00	12.00	31.00	34.00	39	-
Maximum	87.00	12.00	40.00	57.00	98.00	18	-
Mean	60.52	45.00	26.75	41.22	66.72	57	-
SD	14.44	30.21	7.733	6.111	12.84	32.06	-
Skewness	-.472	9.08	-.269	-.223	-.117	10.29	-
Kortosis	-.007	-.343	-.839	-.962	-.249	-.384	-
		-.971					

*** Correlation is significant at 0.01 levels.*

MH = Mental Health, SS =Social Support, PSS = Perceived stress scale, SD = Standard deviation

The second hypothesis stated that coping strategy, social support and resilience will moderate the relationship between perceived stress and mental health of refugees. First, an initial correlation of all variables was carried out as shown as shown in Table 2, and the purpose of this was to assess which variables were significant for constructing result steps of hierarchical multiple regressions.

Furthermore, the methods employed in these analyses was that coping, social support, and resilience were expected to moderate between perceived stress and mental health. All these variables were inputted according to the rules of multiple regression with other variables

hierarchically entered by step a wise procedure. The results brought about six models as depicted in Table 4.

Hypothesis two, which stated that Coping, social support, and resilience will significantly moderate the relationship between perceived stress and mental health was tested using a stepwise moderated hierarchical multiple regression. The results are presented in Table 4.

Table 4. Moderated Hierarchical multiple regression for variables predicting mental health (N=340)

Variables	R	R^2	ΔR^2	F	P	ΔF	β	T	P
Step 1									
Age	.347	.121	.121	46.404	.001	46.404**	-.347	.681	<.001
Step 2									
PSS	.622	.387	.267	106.480	.001	146.570**	-.544	-12.11	<.001
Step 3									
Resilience	.663	.439	.052	87.668	.001	31.054**	-.299	-5.573	<.001
Step 4									
Coping	.672	.452	.013	69.072	.001	7.890*	.143	2.809	<.005
Step 5									
SS	.681	.464	.012	57.723	.001	7.209*	-.158	-2.685	<.008
Step 6									
Interaction term									
PSS XCoping	.721	.519	.056	60.000	.001	38.758**	- .20.45	-6.226	<.001

Excluded variables: Perceived stress X Social Support, Perceived stress X Resilience

** p< .01, ** p< .001*

Key: PSS =perceived stress scale, SS=social support,

R = multiple correlation coefficients, R^2 = the square of multiple correlation coefficients, ΔR^2 = change of the square of multiple correlation coefficients, F= F-ratio, P = probability, ΔF = change of F-ratio, β = standardized regression coefficients, t =t test.

In Step 1, the results indicate that when age was entered into the regression equation, the model significantly accounted for R^2 =.121, F (1, 338) = 46.404, p< .001 of the variation

in mental health of refugees. The $\beta = -.347$, $t = -6.812$, $p<.001$, meaning that age contributed about 35% to the variation in mental health.

In Step 2, when perceived stress was introduced to the regression equation, the results indicated that the model significantly accounted for $R^2 = .622$, $F(2, 337) = 106.480$, $p< .001$ of the variation in mental health of refugees. Also R^2 changed from .121 in step 1 to .387 in step 2. This indicates about .267 increase in R^2, and the increase was significant. The $\beta = -.544$, $t = -12.107$, $p<.001$, means that perceived stress contributed about 54% to the variation in mental health.

In Step 3, when resilience was introduced to the regression equation, the results indicated that the model significantly accounted for $R^2 = .663$, $F(2, 336) = 87.668$, $p< .001$ of the variation in mental health of refugees. Also R^2 changed from .387 in step 2 to .439 in step 3. This indicates about .052 increase in R^2, and the increase was significant. The $\beta = -.294$, $t = -5.57$, $p<.001$, means that resilience contributed about 29% to the variation in mental health.

In Step 4, when coping was introduced to the regression equation, the results indicated that the model significantly accounted for $R^2 = .672$, $F(4, 335) = 69.072$, $p< .001$ of the variation in mental health of refugees. Also R^2 changed from .439 in step 3 to .452 in step 4. This indicates about .013 increase in R^2, and the increase was significant. The $\beta = .143$, $t = 2809$, $p<.005$, means that coping contributed about 14% to the variation in mental health.

In Step 5, when social support was introduced to the regression equation, the results indicated that the model significantly accounted for $R^2 = .681$, $F(5, 334) = 57.723$, $p< .001$ of the variation in mental health of refugees. Also R^2 changed from .452 in step 4 to .464 in step 5. This indicates about .012 increase in R^2, and the increase was significant. The $\beta = -.158$, $t = -2.685$, $p<.008$, means that social support contributed about 16% to the variation in mental health.

Step 6 is a test of moderation hypothesis. At step 5, when the interaction term between perceived and coping was entered into the regression equation, the results indicated that the model significantly accounted for $R^2 = .721$, $F(6, 333) = 60.000$, $p< .001$ of the variation in mental health of refugees. Also R^2 changed from .464 in step 5 to .519 in step 6. This indicates about .056 increase in R^2, and the increase was significant. The $\beta = 20.45$, $t = 6.226$, $p< .001$, means that the interaction of perceived stress and coping contributed about 20.45% to the variation in mental health. This means that coping significantly moderated the relationship between perceived stress and mental health of the refugees.

However, the interactions of perceived stress and social support and that of perceived stress and resilience were excluded from the regression equation.

Hypothesis three which stated that female refugees will report poorer mental health than male refugees was tested using an independent t-test showing results between female and male refugees on mental health. The results are presented in Table 5.

TABLE 5: T-Test showing the Sex Differential in Mental Health among refugees.

Variables	Gender	N	Mean	S/D	Std Error	T	df	P
MH	Male	203	59.36	15.02	1.054	-1.806	338	.019
	Female	137	62.23	13.40	1.145			

MH = Mental Health, SS =Social Support, PSS = Perceived stress scale, ns= not significant.

N= total numbers of participants, S/D= standard deviation, Std Error = standard error, t = t-test, df = degree of frequency, P = probability. MH = mental health.

The results as shown above show the difference between males and females on mental health .There was significant difference in the scores on the GHQ for females (M = 62.23 SD = 13.40) and for males (M = 59.36 SD = 15. 02); t (338) = -1.806, p = .019. This indicates that female refugees report poor mental health than male refugees and the difference is significant at $p < .019$. Therefore hypothesis 3 is accepted.

DISCUSSION

In summary, the results of this study contribute to existing research in the field of immigrant and refugee mental health, in the sense that, to the knowledge of this author, this study is the first to introduce the moderating roles of coping, social support and resilience in moderating between stress and mental health of African refugees in one single study.

The study was anchored on three hypotheses. The first compared the relationship between perceived stress and mental health of African refugees, the second compared how coping, social support, and resilience will moderate the relationship between perceived stress and mental health and lastly the third hypothesis determined sex differential in mental health.

Through different literatures and theories, this study has indicated that perceived stress and mental health are connected, however this study further buttresses the importance of moderating roles of coping, social support and resilience.

The negative relationship brought about by perceived stress and mental health could be as a result of the moderating roles of coping, social support and resilience and lastly, gender differences was also determined. The results of this study indicated that interventions intended to reduce the psychological impact of post-migration, otherwise known as re-settlement stressors must be designed to promote coping responses that are dependable not only within one's cultural orientation but also one's immediate stressful circumstances. Nonetheless, many refugees differ in the way they handle stress, in the way they are resilient and also in the use of different coping strategies. It is important that routine psychological evaluations, aimed at re-building a more resilient self, be put in place so as to enhance good mental health among refugees.

The result of testing the first hypothesis showed that perceived stress was related to better mental health. The result is at variance with that of Betancourt, Borisova, Soudiere, and Williamson (2010) who revealed that exposure to stressful situations is positively connected to poor mental health problems, such as depression, or anxiety The reason for this variance could be attributed to the fact that when refugees are empowered with sufficient social support, they are able to cope better, and, despite the presence of stress they could maintain good mental health. These findings also was contrary to previous epidemiological studies by Steel, Silove, Phan, and Bauman (2002), these researchers affirmed gradual diminished mental health among Vietnamese Refugees in Australia.

The findings in this study, suggest that, moderating variables such as coping, social support and resilience could make refugees report lower risk of psychiatric morbidity, perhaps reflecting the importance of these variables. Some researchers Silveira and Allebeck, (2001); Weisman, Feldman, Gruman, Rosenberg, Chamorro, and Belozersky, (2005) propose that migration itself does not constitute a risk factor for mental health, rather absence of social support, culturally suitable health services and build-up of socio-economic stressors causes poor mental health. The result of the first hypothesis support the stated hypothesis.

Findings of the second hypothesis showed that perceived stress, coping, social support and resilience independently and significantly affect mental health, and a test of moderation indicated the joint interaction of perceived stress and coping on mental health. The result of the joint significant interaction of perceived stress and coping in this study is a contribution to the body of literature on migrant studies.

Refugees reported good mental health in the presence of either a good coping style, or social support, good resilience. This findings are in line with that of Colic-Peisker and Tilbury (2003) who found that individuals are able to endure adversity and have a better future through using religious beliefs as a coping strategy. Thus, religious beliefs are likely to assist individuals in adapting to life's difficulties. Also Halcon *et al.* (2004) established that between 50% and 75% of African refugees made used of prayers to reduce their pains and sorrows. This findings are supported by the results revealed in the demographics of this study (see Table 2) where 58.9% of refugees are Christians, this could give explanation to the reported good mental health of refugees in this study.

The independent findings of coping and mental health corroborate with the results of researchers such as, Vázquez, Cervellón, Pérez-Sales, Vidales, and Gaborit (2005) who found that refugees cope cognitively through means of interpretations and perceptions of themselves and their situation, and the independent findings on social support agrees with Kelaher, Potts and Manderson (2001) who found that refugee's feelings of belonging or isolation might be influenced by Social Support and finally that of resilience concur with researchers like Zahradnik, *et al.* (2010) they scrutinized resilience as a protective factors for mental health. But the combined interaction of coping and perceived stress yielded better mental health of refugees. This only means that when refugees are faced with perceived stress but in the presence of good coping strategy like using religion as shown from results from the demographic of refugees in this study (see Table 2) mental health issues could be reduced.

The Results of hypothesis 3 revealed that female refugees reported poorer mental health than male refugees. The stated hypothesis was supported. This result contradicts that of

Idemudia, *et al.* (2013); Tolin (2006); Breslau (2002) who sh owed a higher life time prevalence in men than in women. And it is in line with the study of Schweitzer, Melville, Steel, and Lacherez, (2006) they found that female gender predicted greater PTSD, depression and anxiety symptoms.

There are probably several reasons for this gender difference. One could be that men and women are affected differently by post-migration stressors. Blight, Ekblad, Persson, and Ekberg (2006) found different causes affecting the mental health of immigrants in Sweden, while job occupancy was significant to the mental health of men, but for the women employment and living in an urban region appeared to be associated with poor mental health. Another reason could be attributed to the manner in which different gender express mental health issues, it was found that men expresses their mental distress through substance abuse and aggression while women expression their mental distress through depression and anxiety (Thapa *et al.,* 2007). Furthermore, resettling may have gender-specific meanings and requires practical demands and this elicit different mental health from both men and women (Punama¨ ki, Komproe, Qouta, Elmasri, & de Jong, 2005), while men are more focused in society, women are more concentrated within the home, and the absence of a comfortable home as in the case of refugees could be attributed to why women in this study reported poorer mental health than men.

The result of hypothesis three can further be explained in line with sex-role theory which argues the role played by gender. Females in this study who reported poorer mental health can be connected to the role which they are now forced to occupy; most female refugees are without their spouse who might have been killed during the violence or war in their homelands, and are now burdened with extra responsibilities to care for the family. Also, these females might be reporting poor mental health because they lack social support that would have been provided by loved ones.

Theoretically, the findings in this study support the stress theory by Cassel (1976), where the theory argues that, strong social ties protected from the potential pathogenic effects of stressful events as in Cohen and Wills' (1985) buffer theory, where the focus is on support provided by families, friends and significant others. Social role theory or social structural theory (Eagly & Wood, 1999; Wood & Eagly, 2012), where, differences in the mental health of gender is attributed to the role played in the society. The study made use of more than one

theory of resilience because there is no universally accepted resilience theory (Luthar et al., 2000).

Finally, the learned helplessness theory of Seligman and Teasdale (1978), where the argument is that people are more likely to suffer from mental health issues when they have learned that the situation is beyond their control.

LIMITATION OF STUDY:

One limitation of the study was a language problem; some of the refugees did not speak English and a translator had to on read and translate to them. Their low level of education was another barrier to the study. The third was the length of the instruments used. It was rather a long one, they were five in numbers with quite a number of items. This resulted to more time consumed by the participants in completing the questionnaires.

RECOMMENDATIONS:

The following recommendations were made using the study:

- Policies and programs aimed at promoting positive adaptation, should be considered as fundamental, and logistics towards strategic implementation should be put in place. Practically, it would provide a more relaxed and conducive environment and will enhance good mental health of refugees not only in South Africa but also worldwide.
- It is also recommended that mental health care should be given priority in the South African health care system. The government should ensure that ministry of health receives adequate health budgets, funding, and human resources, there should be provision of the right medical deliveries and treatments as this would aid in reducing psychological morbidity amongst the refugee population.
- Policy makers should implement mental health policies that promote and favour periodical workshops and motivational plans based on cognitive interventions and should adopt services that are in line with issues that can bring about mental health during resettlement. These would help refugees to cope better and the motivational workshop would aid in developing a more resilient self and refugees would be ready to bounce back in the midst of a difficult situation.

- It is further recommended that adequate social networks be made available for successful integration of refugees into the host country. Additionally, it is expected that the dignity and rights of refugees are appreciated by health officials and also quality services within the mental health care are been provided, as this would enhance refugee adaptation in host country.
- Psychosocial support among refugees in South Africa can be effectively integrated into existing social work programmes, by providing mental health officials and social workers with appropriate knowledge, such as being familiar with the dynamics of migration and also the policies guiding immigrants for assisting refugees. When training is provided, they are able to offer more comprehensive assistance and refugees' needs are better met.
- It is hoped that further studies will complement this study by looking into other variables that predict mental health for more comprehensive findings. Such studies should adopt mixed methods to gain a better understanding of the developmental trajectories of mental health in refugee populations.

CONCLUSION

The following conclusions were drawn in this study:

- Perceived stress was related to better mental health and a negative relationship existed between the two variables.
- Social support predict mental health. The presence of social support predict good mental health.
- A significant relationship existed between resilience and mental health.
- A significant negative relationship was revealed between coping and mental health.
- The moderated hierarchical multiple regression for variables predicting mental health brought about six models, the first five models which were age, perceived stress, resilience, coping and social support all contributed to the variation in mental health. While the sixth model was a test of moderation, and the result revealed that the interaction of perceived stress and coping contributed about 204.5% to the variation in mental health.
- Gender differences existed among the refugees, there was a significant difference between female refugees and male refugees on mental health. Female refugees reported poorer mental health than male refugees.

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Declarations

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DERMOGRAPHIC QUESTIONNAIRE

Dear Participants,

The purpose of this questionnaire is to gather at a focusing on the stress and mental health of African refugees in South Africa. Your responses would be used for this purpose only. **Your name and identification number is not required.**

Please be assured that your responses would be treated confidentially.

SECTION A

DEMOGRAPHIC DATA

Gender **Male** ( ) **Female** ( )

Marital status

Single	Married	Divorced	Separated	Cohabiting

Age.....(In years)

Country of origin.....

Level of education.....

Religion.....

Thanking you for your sincere response and time and your input is highly appreciated.

SECTION B

PART B (i)

GHQ SCALE

Please answer all the following questions simply by underlining the answer, which you think, applies to you. Remember that we are looking out for your present and recent complaints only not those that you had in the past. It is important you answer ALL the questions.

HAVE YOU RECENTLY:

Been feeling perfectly well and in good health?	Better than usual	Same as Usual	Worse than usual	Much than usual
Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much than usual
Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much than usual
Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much than usual
Been getting any pains in the head?	Not at all	No more than usual	Rather more than usual	Much than usual
Been getting a feeling of up-tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much usual
Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much than usual
Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much than usual
Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much than usual
Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much than usual
Been getting edgy and bad tempered?	Not at all	No more than usual	Rather more than usual	Much than usual
Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much than usual
Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much than usual
Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much usual
Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much than usual
Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much than usual
Felt on the whole you are doing things well?	Better than usual	About the same	Less well than usual	Much
Been satisfied with the way you've carried out tasks?	More satisfied	About the same as usual	Less satisfied than usual	Much
Felt that you were playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much

Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much
Been able to enjoy normal day to day activities?	More so than usual	Same as usual	Less so than usual	Much than usual
Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much than usual
Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much than usual
Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much than usual
Thought of the possibility that you might make away with yourself?	Not at all	No more than usual	Rather more than usual	Much than usual
Found at times that you could not do anything because you were nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much than usual
Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much than usual
Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely

PART B (ii)

Multidimensional Scale of Perceived Social Support (MSPSS)

Instruction: Indicate your feelings on each statement and circle the most appropriate.

Very strongly disagree	Strongly disagree	Mildly disagree	Neutral	Mildly agree	Strongly agree	Very strongly agree
1	2	3	4	5	6	7

There is a special person who is around when I am in need	1		2	3		4	5		6	7
There is a special person with whom I can share my joys and sorrows	1		2	3		4	5		6	7
My family really tries to help me	1		2	3		4	5		6	7
I get the emotional help and support I need from my family	1		2	3		4	5		6	7
I have a special person who is real source of comfort to me	1		2	3		4	5		6	7
My friends really try to help me	1		2	3		4	5		6	7
I can count on my friends when things go wrong	1		2	3		4	5		6	7
I can talk about my problem with my family	1		2	3		4	5		6	7
I have friends with whom I can share my joys and sorrows	1		2	3		4	5		6	7

There is a special person in my life who cares about my feelings	1		2	3		4	5		6	7
My family is willing to help me make decisions	1		2	3		4	5		6	7
I can talk about my problems with my friends	1		2	3		4	5		6	7

Part B (iii)

RESILIENCE SCALE

Instruction: Please indicate your response by circling the most appropriate number on the scale.

Strongly disagreed	Disagreed	Strongly agreed	Agreed
1	2	3	4

Able to adapt to change	1	2	3	4
Can deal with whatever comes	1	2	3	4
Tries to set humorous side of problem	1	2	3	4
Coping with stress can strengthen me	1	2	3	4
Tend to bounce back after illness	1	2	3	4
Can achieve goals despite obstacles	1	2	3	4
Can stay focused under pressure	1	2	3	4
Not easily discouraged by pressure	1	2	3	4
Thinks of self as strong person	1	2	3	4
Can handle unpleasant feelings	1	2	3	4

PART (iv)

PERCEIVED STRESS SCALE (PSS)

The questions in this part ask you about thoughts during THE LAST FEW MONTHS. In each case, you will be asked to indicate your response by ticking HOW OFTEN you felt or thought a certain way. Although some of the questions are similar, there are differences between them, and you should treat each one as a separate question.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
In the last month, how often have you been upset because of something that happened unexpectedly?					
In the last month, how often have you felt that you were unable to control the important things in your life?					
In the last month how often have you felt nervous and stressed?					
In the last month how often have you dealt successfully with day to day problems and annoyances?					
In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?					
In the last month, how often have you felt confident about your ability to handle your personal problems?					
In the last month, how often have you felt that things were going your way?					
In the last month, how often have you found that you could not cope with all the things that you had to do?					
In the last month, how often have you been able to control irritations in your life?					
In the last month, how often have you felt that you were on top of things?					
In the last month, how often have you been angered because of things that happened that were outside of your control?					
In the last month how often have you found yourself thinking about things you have to accomplish?					

In the last month, how often have been able to control the way you spend your time?					
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?					

PART (v)

BRIEF COPING SCALE.

These items deal with ways you've been coping with the stress in your life. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true **FOR YOU** as you can. Please indicate your options by ticking.

1	2	3	4
= I haven't been doing this at all	= I've been doing this a little bit	=I've been doing this a medium amount	= I've been doing this a lot

I've been turning to work or other activities to take my mind off things.	1	2	3	4
I've been concentrating my efforts on doing something about the situation I'm in.	1	2	3	4
I've been saying to myself "this isn't real."	1	2	3	4
I've been using alcohol or other drugs to make myself feel better.	1	2	3	4
Been getting emotional support from others.	1	2	3	4
I've been giving up trying to deal with it.	1	2	3	4
I've been taking action to try to make the situation better.	1	2	3	4
I've been refusing to believe that it has happened.	1	2	3	4
I've been saying things to let my unpleasant feelings escape.	1	2	3	4
I've been getting help and advice from other people.	1	2	3	4
I've been using alcohol or other drugs to help me get through it.	1	2	3	4
I've been trying to see it in a different light, to make it seem more positive.	1	2	3	4
I've been criticizing myself.	1	2	3	4
I've been trying to come up with a strategy about what to do.	1	2	3	4
I've been getting comfort and understanding from someone.	1	2	3	4
I've been giving up the attempt to cope.	1	2	3	4

I've been looking for something good in what is happening.	1	2	3	4
I've been making jokes about it.	1	2	3	4
I've been doing something to think about it less, such as going to movies, Watching TV, reading, daydreaming, sleeping, or shopping.	1	2	3	4
I've been accepting the reality of the fact that it has happened.	1	2	3	4
I've been expressing my negative feelings.	1	2	3	4
I've been trying to find comfort in my religion or spiritual beliefs.	1	2	3	4
I've been trying to get advice or help from other people about what to do.	1	2	3	4
I've been learning to live with it.	1	2	3	4
I've been thinking hard about what steps to take.	1	2	3	4
I've been blaming myself for things that happened.	1	2	3	4
I've been praying or meditating.	1	2	3	4
I've been making fun of the situation.	1	2	3	4

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CERTIFICATE OF LANGUAGE EDITING

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