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STRESS COPING SKILLS AND STRATEGIES AS ANTIDOTE TO MENTAL HEALTH FOR ADULT MALE MIGRANTS – OPEN SPACE FOR CBT INTERVENTIONS

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Abstract
Migrants often encounter numerous stressors that can significantly impact their mental health. Understanding the coping strategies employed by migrants and assessing their mental health status is crucial for developing effective support systems. The main aim of this study was to examine the most common coping skills and strategies of young adult migrants in order to generate ideas for creating a comprehensive CBT support program. The study explored the frequency of different coping strategies employed by migrants in correlation with their levels of depression, anxiety, and stress. This study utilized a quantitative approach and recruited a sample of 184 male migrants from 14 different countries facing stressful situations. The findings revealed that religion was the most commonly used coping strategy, followed by planning for the next steps and actively coping with the situation. Substance use was identified as the least utilized coping strategy. The mental health scores of male migrants reflected moderate levels of depression, anxiety, and mild manifestations of stress symptoms. These results underscore the importance of understanding and addressing the coping mechanisms and mental health needs of migrants to provide appropriate support and interventions.

Keywords: migrants, coping strategies, mental health, stress, religion, depression, anxiety, stress management.

Migrants frequently encounter various stressors that can markedly influence their mental well-being. It is imperative to comprehend the coping mechanisms adopted by migrants and evaluate their mental health status to formulate efficacious support systems. This research divulges essential insights into coping strategies and

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mental health among migrants in challenging circumstances, elucidating the predominantly employed coping mechanisms, as well as the levels of depression, anxiety, and stress.

In 2018, an estimated 25,000 refugees and migrants entered Bosnia and Herzegovina, primarily through the Serbian and Montenegro border, in contrast to 755 recorded arrivals in 2017 (UNHCR, 2019). From 2017 to 2024, approximately 150,000 refugees and migrants entered Bosnia and Herzegovina, with around 3,000 still residing in Temporary Reception Centers such as Lipa and Borici in Bihac, and Blazuj and Usivak in Sarajevo (IOM, 2024). The Una Sana route remains the most popular for refugees and migrants attempting to enter Croatia and the European Union. In these centers, supported by the European Union, the International Organization for Migration (IOM) addresses the basic needs of migrants, including food, hygiene products, water, sanitation, and facilities. According to IOM (2024) reports, the countries of origin vary from North Africa (Algeria, Tunisia, Morocco, and Libya) to the Middle East (Yemen, Iraq, Iran, and Palestine) and across South Asia (Afghanistan, Pakistan, India, and Bangladesh).

The reasons for leaving one's country of residence and home differ among migrants. Some individuals flee from war or persecution, while others seek new economic opportunities. The modes of travel and transportation also vary, ranging from perilous boat journeys on the open Mediterranean Sea to air travel to Turkey or Serbia, followed by crossing numerous borders to reach the center of Europe. Some migrants undertake extensive journeys on foot, covering over 5000 km from Asia or Africa to Europe, traversing countries, borders, and landscapes. Regardless of the method each migrant employs to reach Bosnia and Herzegovina at this stage in their lives, they may have experienced distinctly traumatic events during their journey and in their overall life experiences.

The UN Refugee Agency’s annual Global Trends study found that 68.5 million people had been internally displaced across the world at the end of 2017 (Edwards, 2018). As of May 2023, over 110 million individuals have experienced forced displacement globally due to persecution, conflict, violence, or human rights violations. These figures mark the highest levels of displacement ever recorded (UNHCR, 2024). Mental health among refugees and migrants still hasn’t received enough attention, yet it needs to be understood and explored better (Nickerson et al., 2011). Among refugees, there is usually a high prevalence of psychological difficulties and problems, especially anxiety disorders, depressive problems, PTSD, and suicide (Carney & Freedland, 2002; Heeren et al., 2012; Nickerson et al., 2010).

CBT Coping Skills and Strategies

Coping is defined as the 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person' (Lazarus and Folkman, 1984: p. 141). Additionally, coping can be considered a bridge and protective mediator

between stress and psychological well-being (Lazarus and Folkman, 1984). Stress occurs when environmental pressure surpasses an individual's coping capacity, serving as the first line of defence. Essentially, there exists a discrepancy between demands and individual coping strategies (Park & Folkman, 1997). In concluding thoughts on stress and coping strategies, one might invoke the wisdom of Epictetus: *People are often not disturbed by things, but by the views they take of them.*

Coping strategies can be assessed individually or analysed as adaptive and maladaptive methods. They can also be examined as problem-focused or emotion-oriented. Individuals with PTSD are more likely to employ an emotion-oriented coping style when faced with adversity (Voges & Romney, 2003). Cognitive-Behavioural Therapy (CBT) coping skills involve managing negative emotions in a healthy way, providing strategies for navigating difficult situations with reduced tension, anxiety, depression, and stress. These coping skills and strategies aim to assist individuals in managing uncomfortable emotions, such as anxiety and depression, promoting physical well-being and improved decision-making. CBT coping skills are particularly beneficial for individuals with specific mental health conditions, helping reduce symptoms in people with PTSD. CBT works by altering unhealthy behavioural patterns through changing the interpretations that lead to them. It teaches the skills and cognitive strategies needed to better cope with whatever challenges life presents.

Problem-based coping is considered a proactive and adaptive set of strategies. Focusing on the problem includes actively seeking and formulating alternative solutions, learning new skills, and adopting more efficient and helpful behaviour’s. On the other hand, emotion-based coping (such as avoiding the situation, distancing oneself from emotions, acceptance, seeking emotional support, selective attention, or using alcohol and drugs, sleeping too much) can be viewed as more maladaptive. Individuals might feel that they have no control over the situation, perceiving the problem as something outside of their reach and unchangeable (Folkman & Moskowitz, 2000).

The two most commonly researched and documented coping stress strategies are social support and religion. A strong sense of community can be an important protective factor against mental health problems and can enhance problem-solving abilities (Hjern & Jeppsson, 2005). Social support has been found to play a significant moderating role in the relationship between exposure to trauma and PTSD among Eritrean and Sudanese asylum seekers (Nakash et al., 2017). Refugees often find solace in religion and seek meaning when facing trauma (Goodman, 2004; Bolea, 2003). A study with Bosnian refugees who immigrated to Chicago concluded that religion is an essential mechanism used to cope with stress (Weine et al., 2002). Religion can foster a sense of meaning after trauma, which is crucial following traumatic events (Vanista-Kosuta & Kosuta, 1998).

This study aims to delve deeper into cognitive-behavioural potential protective factors that can assist migrants along their migration journey and likely safeguard their mental health. The focus will be more on salutogenesis rather than

pathology. If we examine an average migrant odyssey, we might find many triggers that could potentially lead to depression, anxiety, and even PTSD.

Research problem and goal

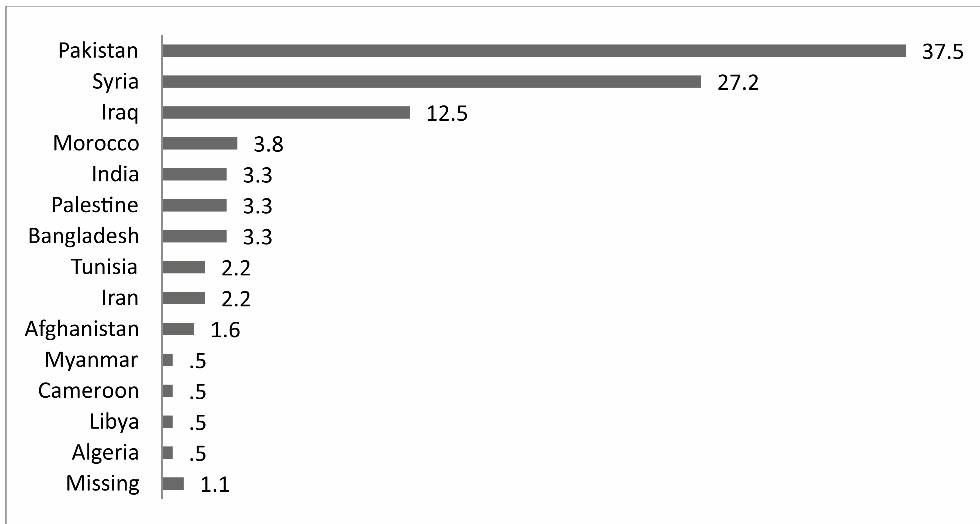
The aim of this research was to examine the most prevalent coping skills and strategies employed by young adult migrants to generate insights for the development of an effective Cognitive-Behavioral Therapy (CBT) support program. Potential findings would shed light on the mental health status of migrants affected by the crisis, as well as the psychological factors serving as protective mechanisms, aiding them in navigating emotional challenges. Abandoning one's place of origin, along with numerous stressors during the migration journey, can deteriorate the mental health of any individual. Understanding which protective factors play a significant role in preserving mental health can be of great importance in fostering programs that have the potential to enhance these skills and traits among adult male migrants. Since the migrant route shifted through B&H at the end of 2017, there have not been grand studies examining these phenomena among migrants in B&H. This study would like to provide answer to these questions:

1. *What are the most common coping strategies for migrants?*
2. *What is the level of depression, anxiety, and stress among migrants?*
3. *Do CBT coping skills and strategies serve as moderators between depression, anxiety and stress scales as predictors, and hopelessness as outcome?*

Method

Participants

The survey comprised 184 participants in the final data analysis, conducted within Temporary Reception Centres in Bosnia and Herzegovina. All participants met the criterion of being male, a prerequisite for this survey. The average age was 27 years, ranging from 18 to 52 years, with the majority being single males (*n=139; 75.5%*), one individual reported being divorced *(n=1; .5%*), and the remaining were married (*n=44; 23.9%*). The survey instruments were available in Arabic, Urdu, Farsi, and English, distributed on a voluntary basis, primarily during the registration process. According to the responses from the surveyed subjects, the majority of participants originated from Pakistan (*37%*), followed by Syria (*27%*), and Iraq (*12.5%*). As we can see in graph 1, a total of 14 countries were represented in this research.



Graph 1. Country of Origin

Instruments

Participants completed self-report measures, including a coping strategies inventory The Brief – COPE, DASS -21-The Depression, Anxiety and Stress Scale and BHS – Beck Hope(lessness) Scale.

The Brief-COPE (Carver, 1997). The instrument consists of 28 items that measure 14 factors of 2 items each, which correspond to a Likert scale ranged from 0 (never) and 3 (almost always). Cronbach's alphas for the Brief COPE sub-scales in this research range from .20 to .72. In this study total score of Cronbach alpha is *α=.87*. Factors: (I) Self-distraction (1 and 19; *α=.43*); (II) Active coping (2 and 7; *α=.20*); (III) Denial (3 and 8; *α=.24*); (IV) Substance use (4 and 11; *α=.72*); (V) Use of emotional support (5 and 15; *α=.55*); (VI) Use of instrumental support (10 and 23; *α=.52*); (VII) Behavioral disengagement (6 and 16; *α=.36*); (VIII) Venting (9 and 21; *α=.38*); (IX) Positive reframing (12 and 17; *α=.55*); (X) Planning, (14 and 25; *α=.48*); (XI) Humor (18 and 28; *α=.63*); (XII) Acceptance (20 and 24; *α=.27*); (XIII) Religion (22 and 27; *α=.48*); (XIV) Self-blame (13 and 26; *α=.24*). Sample of items: *"I've been learning to live with it"*. Subscales can be combined in three aggregate dimensions, Problem (2, 7, 10, 12, 14, 17, 23 and 25; *α=.76*), Emotion (5, 9, 13, 15, 18, 20, 21, 22, 24, 26, 27 and 28; *α=.71*) and Avoidant (1, 3, 4, 6, 8, 11, 16 and 19; *α=.71*) coping strategies. Original author recommend examining each scale separately and independently of complete scale. In this study focus will be on three coping aggregate dimensions.

BHS - Beck Hope(lessness) Scale (Beck et al., 1974) measures negative attitudes about the future. Responding to the 20 true or false items on the participants

can either endorse a pessimistic statement or deny an optimistic statement. Beck et al. (1974, p. 864) defined hopelessness *"as a system of cognitive schemas whose common denomination is negative expectations about the future"*. Sample of items: *"When things are going badly, I am helped by knowing they cannot stay that way forever"*. Cronbach's alphas in most research are above $\alpha > .80$ (Aloba et al., 2019; Bouvard et al., 1992; Steed, 2001). In this study total score of Cronbach alpha is $\alpha=.63$. Due to the dichotomy of the scale, lower score is expected. In this study focus will be on total scale.

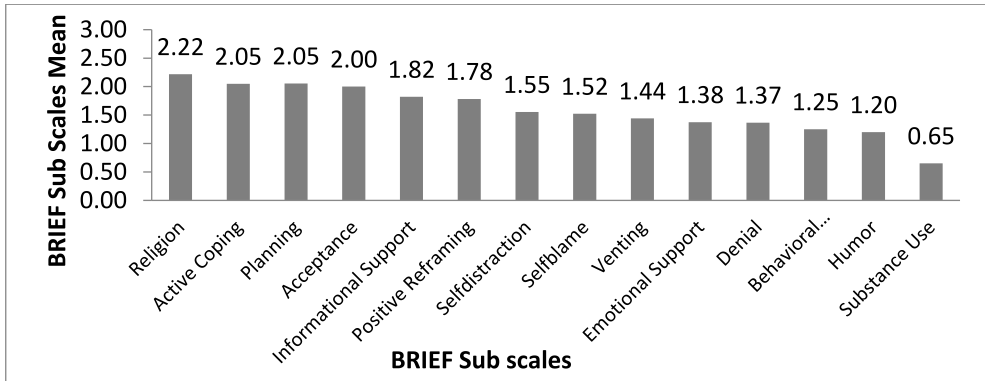
DASS-21 – The Depression, Anxiety and Stress Scale (Lovibond & Lovibond, 1995). DASS-21 is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress. The rating scale is as follows: 0 *(did not apply to me at all – NEVER), 1 (applied to me to some degree, or some of the time – SOMETIMES)*, 2 *(applied to me to a considerable degree, or a good part of time – OFTEN),* 3 *(applied to me very much, or most of the time - ALMOST ALWAYS).* Each of the three DASS-21 scales contains **7** items, divided into subscales with similar content. The depression scale (3,5,10,13,16,17 and 21; $\alpha=.62$) assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest / involvement, anhedonia and inertia *(e.g., "I couldn't seem to experience any positive feeling at all").* The anxiety scale (2,4,7,9,15,19 and 20; $\alpha=.80$) assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect *(e.g., "I was aware of dryness of my mouth").* The stress scale (1,6,8,11,12,14 and 18; $\alpha=.33$) is sensitive to levels of chronic nonspecific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable / over-reactive and impatient *(e.g., "I found it hard to wind down").* Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items. Cronbach's alphas in most research are above $\alpha > .70$ for all subscales (Lee et al., 2019). In this study total score of Cronbach alpha is $\alpha=.88$. In this study focus will be on three separated sub-scales (Anxiety, Depression and Stress).

Statistical analysis

The primary software employed for analysis was IBM SPSS 23. Reliability analysis of instruments underwent testing using Cronbach's alpha. Descriptive statistics were utilized to present the main statistics of the instruments. The Pearson correlation coefficient was employed to assess correlation. Finally, interaction (moderation) effects were tested through the IBM SPSS extension Andrew Hayes Process Macro for Moderation Analysis.

Results

As it can be seen from Graph 2., the results demonstrated that migrants utilized a range of coping strategies when faced with stress.



Graph 2. Coping strategy in stressful situation for migrants

In stressful situations, migrants use different coping strategies. In this research, the most frequently employed coping strategy is religion (*M=2.22*), followed by planning for the next steps (*M=2.05*) and actively coping with the situation (*M=2.05*). Substance use (*M=.65*) is the least utilized strategy in stressful situations for migrants.

Table 1. Scoring for Depression, Anxiety and Stress (DASS) scale

	DASS - Depression	DASS – Anxiety	DASS – Stress
N	184	184	184
M	**1.06 (Min=0-Max=3)**	**1.10 (Min=0-Max=3)**	**1.22 (Min=0-Max=3)**
ΣM	**7.43 (Min=0-Max=21)**	**7.8 (Min=0-Max=21)**	**7.55 (Min=0-Max=21)**
SD	.69	.67	.62
MIN	0	0	0
MAX	3	3	3

Note: N=Participants; M=Mean; ΣM=Sum of Means; SD=Standard Deviation; MIN=Minimum score range; MAX=Maximum score range

Table 1. indicates that the mental health scores of the migrants indicated moderate levels of psychological symptoms. Specifically, on the depression sub-scale, migrants achieved an average mean score of *M=7.43*, signifying a lower level of moderate depressive symptoms. The anxiety sub-scale unveiled moderate anxiety symptoms, with an average mean score of *M=7.8*. Furthermore, the stress sub-scale exhibited an average mean score of M=*7.55*, indicating a mild manifestation of stress symptoms.

Table 2. Correlation between Hopelessness (BHS), Depression, Anxiety, Stress (DASS) and frequency of different coping strategies (BRIEF)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1.BHS	1	.459**	.479**	.416**	.340**	-.310**	-.017	.252**	-.311**	-.156*	-.173*	-.304**	.139	.004	.125	-.262**	-.340**	.211**	-.059	.191**	.319**	.236**
2.DASS Total		1	.994**	.923**	.912**	.027	.274**	.372**	-.085	.060	.158*	-.075	.198**	.187*	.334**	.004	-.074	.314**	.155*	.299**	.333**	.252 **
3.DASS Depression			1	.898**	.886**	.010	.261**	.368**	-.100	.051	.145*	-.087	.201**	.179*	.329**	-.008	-.087	.297**	.150*	.293**	.339**	.245**
4.DASS Anxiety				1	.761**	-.010	.273**	.346**	-.107	.042	.132	-.119	.189*	.175*	.344**	.025	-.111	.338**	.121	.278**	.320**	.246**
5.DASS Stress					1	.126	.274**	.341**	.015	.105	.207**	.033	.160*	.195**	.275**	.030	.026	.291**	.179*	.285**	.259**	.235**
6.BRIEF Problem Coping						1	.642**	.463**	.779**	.725**	.723**	.771**	.351**	.459**	.257**	.560**	.506**	.261**	.453**	.427**	.147*	.302**
7.BRIEF Emotion Coping							1	.645**	.447**	.523**	.505**	.440**	.643**	.713**	.659**	.594**	.447**	.599**	.525**	.464**	.372**	.464 **
8.BRIEF Avoidant Coping								1	.246**	.374**	.487**	.257**	.501**	.528**	.471 **	.259**	.076	.487 **	.611**	.698 **	.758 **	.742 **
9.BRIEF Active Coping									1	.391**	.418**	.561**	.213 **	.364**	.079	.438**	.396**	.191 **	.334**	.245 **	-.050	.191 **
10.BRIEF Info. Support										1	.339**	.425**	.358 **	.378**	.235 **	.389**	.359**	.215 **	.303**	.359 **	.140	.267 **
11.BRIEF Positive Reframing											1	.361**	.212 **	.367**	.344 **	.316**	.361**	.259 **	.404**	.401 **	.275 **	.304 **

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
12.BRIEF Planning												1	.265**	.259**	.086	.548**	.403**	.107	.309**	.258**	.050	.127
13.BRIEF Emotional Support													1	.370**	.368**	.251**	.016	.285**	.378**	.311**	.380**	.340**
14.BRIEF Venting														1	.334**	.294**	.249**	.356**	.391**	.364**	.310**	.428**
15.BRIEF Humor															1	.225**	.083	.326**	.319**	.291**	.388**	.323**
16.BRIEF Acceptance																1	.327**	.169*	.354**	.226**	-.010	.183*
17.BRIEF Religion																	1	.036	.190**	.178*	-.111	-.018
18.BRIEF Selfblame																		1	.289**	.320**	.344**	.416**
19.BRIEF Selfdistraction																			1	.195**	.288**	.268**
20.BRIEF Denial																				1	.386**	.399**
21.BRIEF Substance Use																					1	.411**
22.BRIEF Behav.Disengagement																						1

Note: *N*=184; **. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).

Table 2. shows that hopelessness is in correlation with depression (*r=.479*), anxiety (*r=.416*), stress (*r=.340*), problem focused coping *(r=-.310)* and avoidant focused coping strategies (*r=.252*). No noticeable or significant correlation with emotion focused strategies. Depression has a positive small correlation (*r=.261*) with emotion-focused coping strategies and a moderate correlation (*r=.368*) with avoidant-focused coping strategies. There is no correlation with problem-focused coping strategies. Anxiety has a positive small correlation (*r=.273*) with emotion-focused coping strategies and a moderate correlation (*r=.346*) with avoidant-focused coping strategies. There is no correlation with problem-focused coping strategies. Stress has a positive small correlation (*r=.274*) with emotion-focused coping strategies and a moderate correlation (*r=.341*) with avoidant-focused coping strategies. There is no correlation with problem-focused coping strategies.

Table 3. Linear regression and interaction (moderation) effect for Hopelessness (BHS) as outcome, Depression, Anxiety, Stress (DASS) as predictor and frequency of aggregate dimensions of the BRIEF coping strategies as moderators

Measure	R	F	p	B^{MOD}	SE^{MOD}	t^{MOD}	p^{MOD}
BRIEF Problem Focused Coping (W1)	.567	28.411	.01**	.057	.043	1.322	.188
BRIEF Emotion Focused Coping (W2)	.483	18.282	.01**	.027	.05	.53	.596
BRIEF Avoidant Focused Coping (W3)	.470	17.045	.01**	-.036	.042	-.848	.398

Note. N=184; X=independent variable (DASS); Y= dependent variable (BHS); W=Moderator (BRIEF).
R= Coefficient of determination; F=F-statistics; p=significance; **$p < .01$.
B^{MOD}=beta interaction (moderation) coefficient; SD^{MOD}=standard deviation for (moderation) coefficient; t^{MOD}= t-test interaction of moderator and independent variable; p^{MOD}=Interaction significance.

In Table 3. we can see that problem focused coping aggregate dimensions of the BRIEF scale, with DASS as additional independent variable explain *56%* of the variance of the BHS. Emotion focused coping and DASS as additional independent variable explain *48%* and avoidant focused coping and DASS as additional independent variable explain *47%* of the variance of BHS. None of the three aggregate dimensions are significant moderator.

Discussion

This research underscores the diverse coping strategies employed by migrants facing stressful situations. Religion was identified as the most frequently used coping strategy, followed by planning for the next steps and actively coping with the situation. Substance use was reported as the least utilized coping strategy among migrants, indicating a preference for more adaptive coping mechanisms. The significant role of religion, coupled with planning and active coping, suggests the

resilience and proactivity of migrants in managing stress. The significant use of religion as a coping strategy by migrants emphasizes the importance of spirituality and faith in their coping process. Religion likely serves as a source of solace, hope, and meaning, offering comfort and support in times of stress. The findings also highlight the significance of planning and active coping strategies among migrants. Planning for the next steps indicates a proactive approach to managing stress, showcasing the resilience and determination of migrants to navigate challenging circumstances. Active coping suggests engaging actively with stressors, utilizing problem-solving skills, and seeking solutions rather than passively enduring them.

The moderate levels of depression, anxiety, and mild stress symptoms underscore the need for targeted mental health support and interventions. These scores highlight the importance of addressing the mental health concerns of migrants, as moderate levels of depression and anxiety can have significant impacts on their well-being and integration. Considering the conditions migrants are facing, the results seem relatively low. One reason for these relatively low scores can be traced to the cultures of the countries of origin, where discussions about emotions are not the primary focus. Additionally, individuals may withhold their emotions until the end of their journey when they can finally express themselves. While the migrant population exhibited moderate levels of psychological symptoms, the findings suggest that the overall mental health status falls within a manageable range. However, it is crucial to monitor and address these symptoms to prevent further deterioration and ensure the well-being of migrants.

Even though none of the three aggregate dimensions of coping strategy were deemed significant moderators, they concurrently function as substantial indicators of hopelessness. Subsequently, individual subscales of coping strategies were examined as moderators, and none of the 14 subscales proved to be significant moderators. Among the three aggregate dimensions, problem-focused coping strategies, along with DASS as a predictor, accounted for the highest percentage of explained variance.

Clinical implications

The results emphasize the importance of considering the cultural and religious backgrounds of migrants when designing mental health support interventions. Acknowledging the significance of religion as a coping strategy can inform the development of culturally sensitive interventions that incorporate and respect migrants' spiritual beliefs and practices. Addressing the coping strategies and mental health needs of migrants can pave the way for the development of appropriate support systems, fostering their well-being and successful integration into the host society. These interventions should focus on enhancing coping skills, promoting adaptive strategies beyond religion, and offering accessible and culturally appropriate mental health support services. There are multiple ways that can be used in order to assist people on the move.

Psychoeducation: Providing psychoeducation to adult male migrants about the nature and effects of stress can enhance their understanding and awareness of their own mental health. This knowledge empowers them to recognize stress triggers, symptoms, and the importance of seeking appropriate support.

Culturally Sensitive Assessment: Implementing culturally sensitive assessment tools and techniques enables mental health professionals to gain a deeper understanding of the specific stressors faced by adult male migrants. This assessment can inform the development of tailored coping strategies that take into account cultural, social, and contextual factors.

Cognitive Restructuring: Cognitive restructuring techniques help individuals identify and challenge negative thought patterns, replacing them with more realistic and positive thoughts. By reframing their perceptions, adult male migrants can reduce stress, manage anxiety, and develop a more adaptive mindset.

Mindfulness and Relaxation Techniques: Practicing mindfulness and relaxation techniques, such as deep breathing exercises, meditation, and progressive muscle relaxation, can help adult male migrants manage stress, improve emotional regulation, and enhance overall well-being. These techniques promote self-awareness, relaxation, and a sense of calm in the face of stressors.

Social Support and Community Engagement: Establishing social support networks and encouraging community engagement are vital for the mental health of adult male migrants. Facilitating connections with local communities, support groups, or fellow migrants can provide opportunities for emotional support, social integration, and shared experiences, reducing feelings of isolation and loneliness.

Coping Skills Training: Providing skills training workshops that focus on effective coping strategies equips adult male migrants with practical tools to manage stress. These workshops may cover topics such as problem-solving, assertiveness, communication skills, time management, and self-care. By developing these skills, migrants can enhance their resilience and adaptive coping mechanisms.

Trauma-Informed Care: Recognizing and addressing the potential trauma experienced by adult male migrants is crucial. Implementing trauma-informed care approaches can help mental health professionals provide a safe and supportive environment, ensuring that trauma-related symptoms are appropriately addressed through evidence-based therapies like trauma-focused CBT.

Limitations and directions for future research

Future studies should undoubtedly incorporate a larger and more diverse sample. Special attention ought to be directed towards families, as this study exclusively concentrated on single men. The study should be broadened by incorporating variables such as resilience and self-efficacy. A longitudinal study, encompassing testing at various stages of the migration journey, could also prove to be beneficial and yield significant results. The Brief-COPE instrument sub-scales have only two items, which contributed to lower internal consistency for most of the

sub-scales. The results for these sub-scales should be taken with high caution. Future research should use other scales for this measure.

Conclusion

Overall, this research underscores the complexity of stress coping strategies among migrants, highlighting the roles of religion, planning, and active coping. By recognizing and addressing the mental health needs of migrants, tailored interventions can be developed to support their well-being and facilitate their successful integration into the host society. Depression, anxiety, and stress scores were relatively low. One of the main reasons is likely not the absence of these factors but rather the influence of the cultural context. At times, individuals may suppress their emotions until the end of their journey when they can finally find relief. Most of the time, migrants seek solace in religion, plan for the next step, engage in active coping, and accept the situation. While none of the three aggregate dimensions of coping strategy emerged as significant moderators, all three dimensions are significant predictors of hopelessness at the same time. To paraphrase Frankl (1984), coping strategies are crucial because when we are no longer able to change a situation, we are challenged to change ourselves.

Authors' note

Declaration: Portions of these findings were presented as a poster at the EABCT's 2023 Annual Congress – CBT in a Changing World: Migration and Cultural Diversity, Antalya, Turkiye.

Conflict of interest: None.

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