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Coping mechanisms associated with depression among refugees at Palorinya refugee settlement: A cross-sectional study.

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Abstract

Background
Depression is a significant public health concern among refugee populations due to trauma, displacement, poor living conditions, and limited access to mental health services. Globally, the prevalence of depression among refugees ranges from 20% to 45%. Refugees employ various coping mechanisms to manage psychological distress, including adaptive strategies and maladaptive strategies. Despite the large refugee population in Palorinya Refugee Settlement in Northern Uganda, limited research exists on coping mechanisms associated with depression in this setting. This study examined coping mechanisms associated with depression among refugees aged 18–50 years in Palorinya settlement.

Methodology
A cross-sectional quantitative study was conducted among 470 refugees selected through stratified random sampling across different zones. Data was collected using a structured interviewer-administered questionnaire incorporating the Patient Health Questionnaire (PHQ-9) to assess depression and the Brief COPE Inventory to measure coping mechanisms. Data were analyzed using SPSS version 26. Descriptive statistics summarized coping mechanisms, while chi-square tests examined associations between coping mechanisms and depression at an α-level of 5%.

Results
Significantly associated coping mechanisms included: self-blame ($p < 0.001$), humor ($p < 0.001$), religion ($p = 0.006$), positive reframing ($p = 0.031$), substance use ($p < 0.001$), emotional support ($p < 0.001$), venting ($p < 0.001$), active coping ($p = 0.005$), denial ($p < 0.001$), and self-distraction ($p < 0.001$). Individuals experiencing depression were more likely to engage in maladaptive coping mechanisms like self-blame, denial, substance use, and venting; while non-depressed respondents employed adaptive strategies such as active coping, positive reframing, religious coping, and emotional support.

Conclusion
Adaptive coping strategies appear protective against depression, while maladaptive coping mechanisms increase vulnerability to depressive symptoms among refugees.

Recommendations
Strengthening Mental Health and Psychosocial Support (MHPSS) services that promote adaptive coping strategies is recommended.

Keywords: *Depression, Coping mechanisms, Refugees, Mental health, Palorinya Refugee Settlement, Uganda*
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Background

Studies show that the prevalence of depression among refugees can range from 20% to 45%, depending on the geographical area, population, and conditions of displacement (Charlson *et al.*, 2019).

Globally, refugees use a variety of coping mechanisms to manage the psychological distress associated with displacement and depression. They engage in both adaptive and maladaptive coping mechanisms depending on the resources available to them, culture, and individual resilience. These mechanisms vary significantly, influenced by cultural, social, and environmental factors, often shaped by the level of access to mental health services and support systems (Steel *et al.*, 2014a).

In a study comparing German refugees and residents, Schlechter *et al*., (2021) found that refugees reported higher levels of psychological distress, more exposure to potentially traumatic events, less social support, less resilience, and more perceived support from their faith than German residents.

In Asia, particularly in refugee camps hosting Rohingya refugees, traditional and religious coping strategies dominate (Al-Shatanawi et al., 2023; Riley et al., 2017). Going to school, praying and reading the Holy Quran, listening to music, as well as talking to friends and engaging with them were reported as the main coping mechanisms among Syrian refugees in Jordan (Al-Shatanawi et al., 2023). A study by Riley et al. (2017) in Bangladesh found that, 75% of refugees relied on religious faith, such as prayer and participation in religious rituals, to cope with the hardships of displacement.

According to studies in Africa, refugees often employ a mixture of personal, social, and community-based coping mechanisms (Chiumento *et al.*, 2020). Community cohesion in camps often provides emotional relief, while religious leaders play a significant role in providing psychological and spiritual guidance. However, the rise of negative coping mechanisms such as aggression and substance use among young male refugees, driven by frustration and a lack of prospects has also been noted (Chiumento *et al.*, 2020).

In the East African region, where many refugee camps house populations from South Sudan, Somalia, and the Democratic Republic of the Congo, social and religious coping mechanisms are prevalent (Seruwagi *et al.*, 2022; Chiumento *et al.*, 2020). A study carried out among Congolese refugees living in two settings in Uganda and Rwanda found that refugees utilized social support from family members and friends as a primary coping strategy (Chiumento *et al.*, 2020). Religious faith, including daily prayer and attendance at religious gatherings, was also a significant coping mechanism for many refugees (Seruwagi *et al.*, 2022). However, those who lacked social or religious connections often resorted to isolation or risky behaviors such as substance abuse, which further exacerbated their mental health issues. These studies further suggested that, Mental Health and Psychosocial Support Services (MHPSS) should focus on strategies which strengthen the existing social networks among refugees to address psychological distress. For instance, community-based group psychosocial support interventions that seek to harness the collective strengths and resources of refugee communities (Chiumento *et al.*, 2020; Seruwagi *et al.*, 2022).

In Uganda, coping mechanisms among refugees vary widely depending on access to resources and social networks. A notable proportion of refugees (around 15%) engaged in maladaptive coping strategies such as use of illicit drugs, alcohol consumption particularly among male refugees who experienced significant loss or trauma (Aziku, 2023). A study carried out among refugees in Bidi Bidi found that at least 4,000 adults in Zone 5 of Bidi Bidi refugee settlement needed mental health and psychosocial support service (MHPSS) that address depression and post-traumatic stress. However, the participants were unaware of the availability of the services hence never utilized them (Elshafie and Golden, 2020). Furthermore, services for migrants are affected by restricted accessibility, cultural barriers (stigma associated with mental health) and linguistic barriers which often prevents refugees from seeking professional help (Rousseau and Frounfelker, 2019).

Factors such as poor living conditions, limited mental health services, and ongoing trauma from displacement were linked to these rates. Coping mechanisms, including reliance on community networks, religious practices, and resilience-building activities, have played a role in addressing mental health challenges among refugees in Uganda, though significant gaps remain in providing adequate mental health support.

Palorinya refugee settlement, located in Northern Uganda, hosts a large number of refugees, predominantly from South Sudan. Studies specific to Palorinya remain limited, however, existing data indicates that the prevalence of suicidal ideations resulting from depression is high, influenced by similar factors such as past trauma, poor living conditions, and the lack of structured mental health support (Bwesige and Snider, 2021). Understanding the coping

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mechanisms associated with depression among refugees in Palorinya settlement is crucial for developing effective interventions and support systems. The study therefore aimed at determining the coping mechanisms associated with depression among refugees at Palorinya refugee settlement.

Methodology

Study design

This study used a cross-sectional research design and employed quantitative means. The cross-sectional approach was chosen as it allowed for the collection of data at a single point in time to estimate the prevalence of depression and its associated factors. Additionally, a descriptive design helped in understanding the coping mechanisms and refugee camp institutional factors that influence depression among refugees aged 18-50 years.

Study area / setting

This study was carried out in the year 2025, data was collected from May 2nd to June 1st, 2025 at Palorinya refugee settlement located in Moyo district, Northern Uganda.
Palorinya Refugee Settlement, lies approximately at coordinates 3.3647° N, 31.6711° E and is boredered by Obongi District to the south, Yumbe District to the west, Moyo District to the north and east (the settlement is part of Moyo District, so it also shares its overall northern border). Covering 37.58 square kilometers, Palorinya sits near the Era Central Forest Reserve and Otze Forest Sanctuary, both rich in biodiversity and important for local environmental conservation efforts.
Established in December 2016, Palorinya is home to approximately 174,000 refugees, primarily from South Sudan, and is managed by the Office of the Prime Minister (OPM) in collaboration with UNHCR and other humanitarian organizations (UNHCR, 2022). It was initially created to alleviate overcrowding in other camps like Bidibidi. The settlement consists of various zones and is equipped with basic services, such as health facilities and schools. The settlement has an organized zoning system to manage its population and services effectively. The zones are used to streamline resource allocation, maintain public order, and accommodate essential services like education, healthcare, and water supply. They also facilitate community organization and enhance support systems tailored to the diverse demographic needs of the refugees. However, there are still significant gaps in mental health services, making it an ideal area to explore depression and related factors among refugees.

Inclusion criteria

The following was the criteria for inclusion into the study:

- Refugees aged 18-50 years residing in Palorinya settlement.
- Refugees who were willing and able to provide informed consent.

Exclusion criteria

Refugees with severe cognitive impairment or other mental health conditions that prevented effective participation in the study were excluded from the study.

Sampling

A stratified random sampling method was employed. First, zones within the settlement were stratified, and then households within these zones/strata were randomly selected. From each selected household, one eligible refugee was interviewed. This method ensured representativeness across different areas of the settlement and maximized the study's validity.

Sample size

The number of refugees/participants needed for this study was determined using the following formula by (Daniel, 1999):

$n = \frac{Z^2 * p(1-p)}{d^2}$

Where: n = Sample size; Z = Z value at 95% Confidence Level (1.96); p = Prevalence of depression among refugees estimated at 50% since the current prevalence of depression at Palorinya settlement is not documented; d = Desired level of absolute precision; which was set at 5%.
Therefore, sample size: $n = 1.96^2 * 0.5(1-0.5)/0.05^2$

n = 0.9604/0.0025

n = 384 participants

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Accounting for 25% drop out rate: $n = 384 + (25/100*384)$

$n = 480$ participants

Study variables

Dependent variables

Prevalence of depression was measured using the PHQ-9.

Independent variable

Coping mechanisms were measured using the Brief COPE inventory.

Data sources

Primary data was used in this study and was obtained from the refugees in Palorinya settlement. Findings were compared with existing secondary data in the discussion.

The primary data collection tool was a structured interviewer-administered questionnaire. The questionnaire was adapted from the Patient Health Questionnaire (PHQ-9), which is widely used for screening for depression (Kroenke et al., 2001). The PHQ-9 consists of nine items that correspond to the diagnostic criteria for major depressive disorder according to the DSM-IV. Each item was scored based on the frequency of symptoms experienced over the past two weeks, using a 4-point Likert scale: 0 = Not at all (0 days); 1 = Several days (1-2 days); 2 = More than half the days (3-6 days); 3 = Nearly every day (7-14 days). The scores for each of the nine items were summed to produce a total score ranging from 0 to 27.

Higher scores indicated greater severity of depressive symptoms, i.e., 0-4: Minimal or no depression; 5-9: Mild depression;10-14: Moderate depression; 15-19: Moderately severe depression; 20-27: Severe depression. A score of 5 or higher was used as a cutoff to indicate the presence of clinically significant depressive symptoms, warranting further evaluation or intervention.

Coping mechanisms were assessed using the Brief COPE Inventory (Carver, 1997), which categorizes various strategies that refugees may employ to deal with depressive symptoms. The Brief COPE consists of 28 items, measuring 14 different coping mechanisms. Participants rated each item based on their frequency of use over the past month, using a 4-point scale: 0 = I haven't been doing this at all; 1 = I've been doing this a little bit; 2 = I've been doing this a medium amount; 3 = I've been doing this a lot. The inventory included two items for each of the 14 coping strategies (domains). For each subscale, scores were calculated by summing the responses for the two relevant items. This resulted in a score for each coping strategy ranging from 0 to 6, with higher scores indicating greater use of that particular coping mechanism. The Brief COPE allowed the identification of coping strategies that were most frequently employed by individuals and helped inform therapeutic approaches or interventions based on identified coping patterns. Understanding coping mechanisms was essential for developing interventions that promote adaptive strategies and improve overall mental well-being. The questionnaire was translated into the local language for better comprehension.

Bias

Use of Established and Validated Scales: Both the PHQ-9 and Brief COPE Inventory have shown high levels of validity in prior studies among refugee populations, ensuring that these tools are suitable for measuring depression and coping mechanisms accurately. The PHQ-9 and Brief COPE Inventory have undergone rigorous testing for construct validity in other studies, confirming that these tools effectively capture the intended dimensions of depression and coping, respectively. Construct validity in this context ensured that items were appropriately related to theoretical constructs of depression and coping mechanisms.

Translation and cultural adaptation

Since this study involved refugees, the questionnaire was translated into the relevant languages used within Palorinya settlement, ensuring clarity and cultural relevance. Back-translation was performed to check for consistency between the original and translated versions, ensuring that the meaning of questions remained intact across languages.

Pilot testing

Before the full data collection, a pilot test was conducted with a small subset of the study population to identify any ambiguities or misunderstandings in the questionnaire. Feedback from the pilot test helped to refine the questions, ensuring that participants interpreted them consistently.

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Training of data collectors: Data collectors underwent thorough training on the questionnaire and interview procedures to standardize data collection across participants. The training of data collectors included instruction on maintaining neutrality to reduce interviewer bias. Additionally, responses were kept anonymous, encouraging participants to provide honest answers, which enhanced response validity.

Ethical considerations

Ethical approval for this study was obtained from the CIU Research Ethics Committee NUMBER CLARKE-2024-1545 on 03rd March, 2025. After that, clearance was sought from the Uganda Refugee Accredited Ethics Review Board. Administrative clearance was also sought from the administrators at Palorinya settlement before commencing the study.

Participants were provided with informed consent, ensuring voluntary participation. Confidentiality was maintained, and data was anonymized.

Data analysis

Quantitative data were analyzed using the Statistical Package for Social Sciences (SPSS) version 26. Frequencies and percentages were presented as tables. Coping mechanism means were also obtained and presented as a bar graph.

Univariate and Bivariate analyses were used to identify coping mechanisms significantly associated with depression, with a significance level set at $p<0.05$.

Findings

Participants were recruited using stratified random sampling across the five zones of Palorinya Refugee Settlement. Out of the entire population of refugees in the settlement at the time (148,000), the total adult refugee population (18–50 years) was 88,800 refugees, distributed as follows: Zone 1 (17,760), Zone 2 (18,020), Zone 3 (17,448), Zone 4 (17,740), Zone 5 (17,832). Stratification ensured proportional representation from each zone. Based on this distribution, approximately 108 participants were selected from Zone 1, 110 from Zone 2, 107 from Zone 3, 108 from Zone 4, and 110 from Zone 5, randomly totaling 543 individuals approached and interviewed.

During recruitment, approximately 5 of the respondents selected were deemed ineligible due to severe cognitive health conditions. Another 38 were absent or declined participation. These individuals were replaced with other eligible participants from the same zones to maintain proportional sampling.

Following data collection, data cleaning identified 73 questionnaires with incomplete or inconsistent responses, which were excluded from analysis.

Ultimately, 470 participants were included in the final analysis. The final sample remained proportionally distributed across all five zones, providing a representative assessment of coping mechanisms and depression among adult refugees in the settlement.

Descriptive data

According to results in Table 1, out of the total 470 refugees who participated in the study, most respondents (24.8%) were aged 30–34 years, while the smallest age group was 20–24 years (8.8%). This age distribution shows that most of the respondents were young to middle-aged adults, which is typical of the economically active refugee population. Females constituted the majority (60.2%) of the respondents. Regarding nationality, almost all participants (99.4%) were South Sudanese, while only 0.6% were Congolese. With respect to marital status, the majority were married (57.4%), while 26.4% were single. Educational attainment varied considerably among respondents. A majority (about 39.1%) had attained secondary education, and only a small proportion had reached tertiary (4.3%) or university level (2.3%) education. These findings demonstrate that most refugees have low to moderate education levels, which may influence employment opportunities and coping strategies. In terms of employment status, more than half of the respondents (58.3%) were unemployed, while only 1.7% were formally employed.

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Table 1: Sociodemographic characteristics of the study population (n = 470)

Variables	Categories	Frequency	Percentage (%)
Age	≤19	49	10.3
	20-24	42	8.8
	25-29	71	14.9
	30-34	118	24.8
	35-39	97	20.4
	40-44	49	10.3
	≥45	50	10.5
Gender	Female	283	60.2
	Male	187	39.8
Nationality	Congolese	3	.6
	South Sudanese	467	99.4
Marital Status	Divorced/Separated	52	11.1
	Married	270	57.4
	Single	124	26.4
	Widow/Widower	24	5.1
Education level	No formal education	133	28.3
	Primary	122	26.0
	Secondary	184	39.1
	Tertiary Institutions	20	4.3
	University	11	2.3
Employment status	Formally employed	8	1.7
	Self employed	84	17.9
	Student	104	22.1
	Unemployed	274	58.3

Source: Primary Data, 2025.

The coping mechanisms. Univariate analysis of the individual coping mechanism questions is shown in Table 2. The Brief Cope Inventory has 28 questions, two questions corresponding to each of the 14 domains. The scores represent the Likert scale as elaborated in the methodology.

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Table 2a: Univariate analysis of coping mechanisms associated with depression among refugees at Palorinya

COPE INVENTORY VARIABLE (Question)	Scores (0-3)	Frequency (n=470)	Percentage (%)
How have you been coping? [I've been turning to work or other activities to take my mind off things.]	0	34	7.2
	1	360	76.6
	2	76	16.2
How have you been coping? [I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.]	0	114	24.3
	1	267	56.8
	2	88	18.7
	3	1	0.2
Self-distraction (Total of the two variables above)	0	23	4.9
	1	81	17.2
	2	243	51.7
	3	101	21.5
	4	22	4.7
Self distraction (Mean score)	**1.019**		
How have you been coping? [I've been concentrating my efforts on doing something about the situation I'm in.]	0	40	8.5
	1	368	78.3
	2	60	12.8
	3	2	0.4
How have you been coping? [I've been taking action to try to make the situation better.]	0	22	4.7
	1	324	68.9
	2	116	24.7
	3	8	1.7
Active coping (Total of two variables above)	0	10	2.1
	1	28	6
Active coping (Total of two variables above)	2	293	62.3
	3	100	21.3
	4	36	7.7
	5	2	0.4
	6	1	0.2
Active coping (Mean score)	**1.143**		
How have you been coping? [I've been saying to myself, "this isn't real".]	0	287	61.1
	1	98	20.9
	2	84	17.9
	3	1	0.2

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Table 2b: Univariate analysis of coping mechanisms associated with depression among refugees at Palorinya(Continuation)

COPE INVENTORY VARIABLE (Question)	Scores (0-3)	Frequency (n=470)	Percentage (%)
How have you been coping? [I've been refusing to believe that it has happened.]	0	278	59.1
	1	152	32.3
	2	40	8.5
Denial (Total of two variables above)	0	194	41.3
	1	136	28.9
	2	79	16.8
	3	37	7.9
	4	24	5.1
Denial (Mean score)	**0.533**		
How have you been coping? [I've been using alcohol or other drugs to make myself feel better]	0	233	49.6
	1	191	40.6
	2	46	9.8
How have you been coping? [I've been using alcohol or other drugs to help me get through it.]	0	234	49.8
	1	170	36.2
	2	64	13.6
	3	2	0.4
Substance abuse (Total of two variables above)	0	189	40.2
	1	68	14.5
	2	142	30.2
	3	51	10.9
	4	18	3.8
	5	2	0.4
Substance abuse (Mean score)	**0.624**		
How have you been coping? [I've been getting emotional support from others.]	0	193	41.1
	1	221	47
	2	56	11.9
How have you been coping? [I've been getting comfort and understanding from someone.]	0	28	6
	1	349	74.3
	2	93	19.8
Use of emotional support (Total of two variables above)	0	13	2.8
	1	174	37
	2	178	37.9
	3	82	17.4
	4	23	4.9
Use of emotional support (Mean score)	**0.923**		
COPE INVENTORY VARIABLE (Question)	**Scores (0-3)**	**Frequency (n=470)**	**Percentage (%)**

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How have you been coping? [I've been giving up trying to deal with it.]	0	191	40.6
	1	195	41.5
	2	80	17
	3	4	0.9
How have you been coping? [I've been giving up the attempt to cope.]	0	209	44.5
	1	198	42.1
	2	63	13.4

Table 2c: Univariate analysis of coping mechanisms associated with depression among refugees at Palorinya(Continuation)

COPE INVENTORY VARIABLE (Question)	Scores (0-3)	Frequency (n=470)	Percentage (%)
Behaviour disengagement (Total of two variables above)	0	127	27
	1	120	25.5
	2	116	24.7
	3	89	18.9
	4	18	3.8
Behaviour disengagement (Mean score)	**0.735**		
How have you been coping? [I've been saying things to let my unpleasant feelings escape.]	0	51	10.9
	1	342	72.8
	2	77	16.4
How have you been coping? [I've been expressing my negative feelings.]	0	83	17.7
	1	320	68.1
	2	67	14.3
Venting (Total of two variables above)	0	19	4
	1	78	16.6
	2	270	57.4
	3	80	17
	4	23	4.9
Venting (Mean Score)	**1.011**		
How have you been coping? [I've been getting help and advice from other people.]	0	32	6.8
	1	367	78.1
	2	70	14.9
	3	1	0.2
How have you been coping? [I've been trying to get advice or help from other people about what to do.]	0	15	3.2
	1	361	76.8
	2	88	18.7
	3	6	1.3
Use of instrumental support (Total of two variables above)	0	7	1.5
	1	26	5.5
	2	307	65.3

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	3	97	20.6
	4	31	6.6
	5	2	0.4

Table 2d: Univariate analysis of coping mechanisms associated with depression among refugees at Palorinya(Continuation)

COPE INVENTORY VARIABLE (Question)	Scores (0-3)	Frequency (n=470)	Percentage (%)
Use of instrumental support (Mean Score)	**1.133**		
How have you been coping? [I've been trying to see it in a different light, to make it seem more positive.]	0	35	7.4
	1	364	77.4
	2	71	15.1
How have you been coping? [I've been looking for something good in what is happening.]	0	55	11.7
	1	308	65.5
	2	99	21.1
	3	8	1.7
Positive reframing (Total of two variables above)	0	9	1.9
	1	51	10.9
	2	277	58.9
	3	101	21.5
	4	32	6.8
Positive reframing (Mean score)	**1.102**		
How have you been coping? [I've been criticizing myself.]	0	205	43.6
	1	209	44.5
	2	56	11.9
How have you been coping? [I've been blaming myself for things that happened]	0	212	45.1
	1	204	43.4
	2	54	11.5
Self-blame (Total of two variables above)	0	155	33
	1	87	18.5
	2	157	33.4
	3	52	11.1
	4	19	4

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Self-blame (Mean Score)	**0.673**		
How have you been coping? [I've been trying to come up with a strategy about what to do.]	0	33	7
	1	318	67.7
	2	113	24
	3	6	1.3
How have you been coping? [I've been thinking hard about what steps to take.]	0	94	20
	1	264	56.2
	2	109	23.2
	3	3	0.6

Table 2e: Univariate analysis of coping mechanisms associated with depression among refugees at Palorinya(Continuation)

COPE INVENTORY VARIABLE (Question)	Scores (0-3)	Frequency (n=470)	Percentage (%)
Planning (Average of two variables above)	0	10	2.1
	1	85	18.1
	2	219	46.6
	3	99	21.1
	4	53	11.3
	5	3	0.6
	6	1	0.2
Planning (Mean Score)	**1.12**		
How have you been coping? [I've been making jokes about it.]	0	268	57
	1	146	31.1
	2	56	11.9
How have you been coping? [I've been making fun of the situation.]	0	289	61.5
	1	144	30.6
	2	37	7.9
Humour (Total of two variables above)	0	206	43.8
	1	124	26.4
	2	85	18.1
	3	38	8.1
	4	17	3.6
Humour (Mean score)	**0.506**		

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How have you been coping? [I've been accepting the reality of the fact that it has happened.]	0	52	11.1
	1	342	72.8
	2	73	15.5
	3	3	0.6
How have you been coping? [I've been learning to live with it.]	0	35	7.4
	1	336	71.5
	2	93	19.8
	3	6	1.3
Acceptance (Total of two variables above)	0	7	1.5
	1	55	11.7
	2	293	62.3
	3	70	14.9
	4	40	8.5
	5	4	0.9
	6	1	0.2
Acceptance (Mean score)	**1.103**		

Table 2f: Univariate analysis of coping mechanisms associated with depression among refugees at Palorinya(Continuation)

COPE INVENTORY VARIABLE (Question)	Scores (0-3)	Frequency (n=470)	Percentage (%)
How have you been coping? [I've been trying to find comfort in my religion or spiritual beliefs.]	0	27	5.7
	1	354	75.3
	2	84	17.9
	3	5	1.1
How have you been coping? [I've been praying or meditating]	0	53	11.3
	1	324	68.9
	2	85	18.1
	3	8	1.7
Religion (Total of two variables above)	0	17	3.6
	1	32	6.8
	2	290	61.7
	3	93	19.8
	4	29	6.2
	5	6	1.3
	6	3	0.6
Religion (Mean Score)	**1.122**		

Source: Primary Data, 2025

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For easier management and understanding of the data, total scores of the 14 coping mechanism domains were used instead of the 28 individual questions as presented in Table 3, and means in Figure 1.

Table 3a: Univariate analysis of 14 domains coping mechanisms associated with depression among refugees at Palorinya

COPE INVENTORY VARIABLE (Domain)	Scores (0-6)	Frequency (n=470)	Percentage (%)
Self distraction	0	23	4.9
	1	81	17.2
	2	243	51.7
	3	101	21.5
	4	22	4.7
Active coping	0	10	2.1
	1	28	6
	2	293	62.3
	3	100	21.3
	4	36	7.7
	5	2	0.4
	6	1	0.2
Denial	0	194	41.3
	1	136	28.9
	2	79	16.8
	3	37	7.9
	4	24	5.1
Substance abuse	0	189	40.2
	1	68	14.5
	2	142	30.2
	3	51	10.9
	4	18	3.8
	5	2	0.4
Use of emotional support	0	13	2.8
	1	174	37
	2	178	37.9
	3	82	17.4
	4	23	4.9
Behaviour disengagement	0	127	27
	1	120	25.5
	2	116	24.7
	3	89	18.9
	4	18	3.8
Venting	0	19	4
	1	78	16.6

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	2	270	57.4
	3	80	17
	4	23	4.9
Use of instrumental support	0	7	1.5
	1	26	5.5
	2	307	65.3
	3	97	20.6
	4	31	6.6
	5	2	0.4

Table 3b: Univariate analysis of 14 domains coping mechanisms associated with depression among refugees at Palorinya (Continuation)

COPE INVENTORY VARIABLE (Domain)	Scores (0-6)	Frequency (n=470)	Percentage (%)
Positive reframing	0	9	1.9
	1	51	10.9
	2	277	58.9
	3	101	21.5
	4	32	6.8
Self-blame	0	155	33
	1	87	18.5
	2	157	33.4
	3	52	11.1
	4	19	4
Planning	0	10	2.1
	1	85	18.1
	2	219	46.6
	3	99	21.1
	4	53	11.3
	5	3	0.6
	6	1	0.2
Humour	0	206	43.8
	1	124	26.4
	2	85	18.1
	3	38	8.1
	4	17	3.6
Acceptance	0	7	1.5
	1	55	11.7
	2	293	62.3
	3	70	14.9
	4	40	8.5
	5	4	0.9
	6	1	0.2
Religion	0	17	3.6
	1	32	6.8

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	2	290	61.7
	3	93	19.8
	4	29	6.2
	5	6	1.3
	6	3	0.6

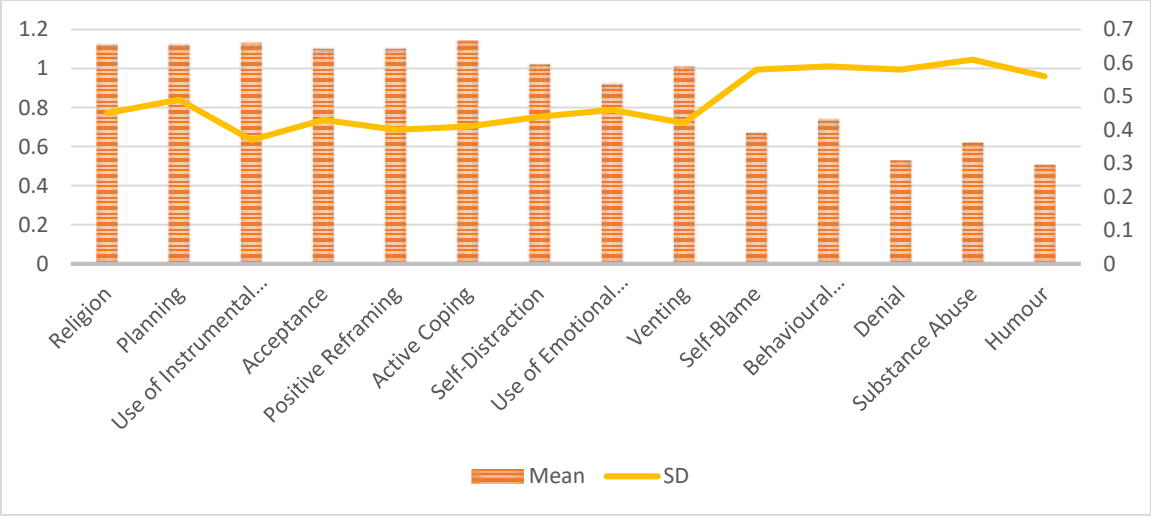
Source: Primary Data, 2025

The analysis of coping mechanisms using the Brief COPE inventory showed that respondents mainly employed adaptive coping strategies in managing stress. The most commonly used coping mechanisms were active coping (M = 1.14 ± 0.41), use of instrumental support (M = 1.13 ± 0.37), religion (M = 1.12 ± 0.45), planning (M = 1.12 ± 0.49), and acceptance (M = 1.10 ± 0.43). These findings highlight a preference for constructive and problem-solving approaches, reflecting individuals' proactive efforts to deal with stressors rather than avoiding them. The prominence of religious coping indicates that spirituality and faith serve as vital sources of strength, resilience, and meaning-making within this population.

In addition, emotion-focused coping strategies such as self-distraction (M = 1.02), venting (M = 1.01), and use of emotional support (M = 0.92) were moderately used. This suggests that respondents occasionally relied on emotional expression, temporary diversion, or social support to manage distress. Although these strategies are less problem-focused, they still contribute positively to emotional regulation and psychological well-being.

Conversely, maladaptive coping mechanisms—including self-blame (M = 0.67), behavioural disengagement (M = 0.74), denial (M = 0.53), and substance use (M = 0.62)—were the least utilized. These low mean scores indicate that participants were less likely to resort to avoidance, withdrawal, or harmful behaviors when faced with stress. This pattern reflects a healthy coping profile, dominated by adaptive and faith-based strategies rather than maladaptive responses.

Figure 1: Coping mechanisms of refugees at Palorinya settlement



Source: Primary Data, 2025

A bivariate analysis was conducted to examine the association between different coping mechanisms and the presence of depression among respondents – see Table 4.

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Table 4a: Bivariate analysis of coping mechanisms associated with depression among refugees at Palorinya

Variable	Score	DEPRESSION		χ^2	P-value
		No (n= 280)	Yes (n= 190)		
Self-blame	0	116 (41.4%)	39 (20.5%)	28.925	**0.000***
	1	41 (14.6%)	46 (24.2%)		
	2	91 (32.5%)	66 (34.7%)		
	3	26 (9.3%)	26 (13.7%)		
	4	6 (2.1%)	13 (6.8%)		
Planning	0	7 (2.5%)	3 (1.6%)	5.946	**0**.429
	1	44 (15.7%)	41 (21.6%)		
	2	135 (48.2%)	84 (44.2%)		
	3	60 (21.4%)	39 (20.5%)		
	4	30 (10.7%)	23 (12.1%)		
	5	3 (1.1%)	0 (0.0%)		
	6	1 (0.4%)	0 (0.0%)		
Humour	0	152 (54.3%)	54 (28.4%)	33.427	**0.000***
	1	65 (23.2%)	59 (31.1%)		
	2	41 (14.6%)	44 (23.2%)		
	3	16 (5.7%)	22 (11.6%)		
	4	6 (2.1%)	11 (5.8%)		
Acceptance	0	6 (2.1%)	1 (0.5%)	6.377	0.382
	1	30 (10.7%)	25 (13.2%)		
	2	171 (61.1%)	122 (64.2%)		
	3	43 (15.4%)	27 (14.2%)		
	4	25 (8.9%)	15 (7.9%)		
	5	4 (1.4%)	0 (0.0%)		
	6	1 (0.4%)	0 (0.0%)		
Religion	0	9 (3.2%)	8 (4.2%)	18.201	**0.006***
	1	28 (10.0%)	4 (2.1%)		
	2	164 (58.6%)	126 (66.3%)		
	3	54 (19.3%)	39 (20.5%)		
	4	16 (5.7%)	13 (6.8%)		
	5	6 (2.1%)	0 (0.0%)		
	6	3 (1.1%)	0 (0.0%)		
Use of Instrumental Support	0	3 (1.1%)	4 (2.1%)	7.042	0.218
	1	20 (7.1%)	6 (3.2%)		
	2	182 (65.0%)	125 (65.8%)		
	3	58 (20.7%)	39 (20.5%)		
	4	15 (5.4%)	16 (8.4%)		
	5	2 (0.7%)	0 (0.0%)		
Positive reframing	0	9 (3.2%)	0 (0.0%)	10.663	**0.031***
	1	27 (9.6%)	24 (12.6%)		
	2	156 (55.7%)	121 (63.7%)		

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	3	67 (23.9%)	34 (17.9%)		
	4	21 (7.5%)	11 (5.8%)		
Substance abuse	0	157 (56.1%)	32 (16.8%)	133.238	**0.000***
	1	57 (20.4%)	11 (5.8%)		
	2	44 (15.7%)	98 (51.6%)		
	3	14 (5.0%)	37 (19.5%)		
	4	7 (2.5%)	11 (5.8%)		
	5	1 (0.4%)	1 (0.5%)		

Table 4b: Bivariate analysis of coping mechanisms associated with depression among refugees at Palorinya (Continuation)

Variable	Score	DEPRESSION	χ^2	P-value	Variable
		No (n= 280)	Yes (n= 190)		
Use of emotional support	0	11 (3.9%)	2 (1.1%)	27.330	**0.000***
	1	121 (43.2%)	53 (27.9%)		
	2	104 (37.1%)	74 (38.9%)		
	3	38 (13.6%)	44 (23.2%)		
	4	6 (2.1%)	17 (8.9%)		
Behaviour disengagement	0	83 (29.6%)	44 (26.2%)	6.416	0.170
	1	75 (26.8%)	45 (23.7%)		
	2	65 (23.2%)	51 (26.8%)		
	3	50 (17.9%)	39 (20.5%)		
	4	7 (2.5%)	11 (5.8%)		
Venting	0	13 (4.6%)	6 (3.2%)	22.936	**0.000***
	1	63 (22.5%)	15 (7.9%)		
	2	152 (54.3%)	118 (62.1%)		
	3	44 (15.7%)	36 (18.9%)		
	4	8 (2.9%)	15 (7.9%)		
Active coping	0	7 (2.5%)	3 (1.6%)	18.397	**0.005***
	1	25 (8.9%)	3 (1.6%)		
	2	168 (60.0%)	125 (65.8%)		
	3	62 (22.1%)	38 (20.0%)		
	4	15 (5.4%)	21 (11.1%)		
	5	2 (0.7%)	0 (0.0%)		
	6	1 (0.4%)	0 (0.0%)		
Denial	0	99 (35.4%)	95 (50.0%)	23.949	**0.000***
	1	88 (31.4%)	48 (25.3%)		
	2	62 (22.1%)	17 (8.9%)		
	3	22 (7.9%)	15 (7.9%)		
	4	9 (3.2%)	15 (7.9%)		
Self distraction	0	21 (7.5%)	2 (1.1%)	33.968	**0.000***
	1	60 (21.4%)	21 (11.1%)		
	2	135 (48.2%)	108 (56.8%)		
	3	60 (21.4%)	41 (21.6%)		
	4	4 (1.4%)	18 (9.5%)		

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***Statistically significant p-value at α- level of 5%.**
Source: Primary Data, 2025

The results in Table 4 revealed statistically significant associations between depression and several coping mechanisms, including: Self-blame, $\chi^2(4, n = 470) = 28.93$, $p < 0.001$; Humor, $\chi^2(4, n = 470) = 33.43$, $p < 0.001$; Religion, $\chi^2(6, n = 470) = 18.20$, $p = 0.006$; Positive reframing, $\chi^2(4, n = 470) = 10.66$, $p = 0.031$; Substance use, $\chi^2(5, n = 470) = 133.24$, $p < 0.001$; Use of emotional support, $\chi^2(4, n = 470) = 27.33$, $p < 0.001$; Venting, $\chi^2(4, n = 470) = 22.94$, $p < 0.001$; Active coping, $\chi^2(6, n = 470) = 18.40$, $p = 0.005$; Denial, $\chi^2(4, n = 470) = 23.95$, $p < 0.001$; and Self-distraction, $\chi^2(4, n = 470) = 33.97$, $p < 0.001$.

These findings suggest that individuals experiencing depression were more likely to engage in maladaptive coping strategies, including self-blame, denial, substance use, venting, and self-distraction. In contrast, non-depressed respondents tended to use adaptive strategies such as active coping, positive reframing, religious coping, and emotional support.

However, no significant associations were observed for planning, $\chi^2(6, n = 470) = 5.95$, $p = 0.429$; acceptance, $\chi^2(6, n = 470) = 6.38$, $p = 0.382$; use of instrumental support, $\chi^2(5, n = 470) = 7.04$, $p = 0.218$; and behavioural disengagement, $\chi^2(4, n = 470) = 6.42$, $p = 0.170$.

Overall, coping mechanisms such as self-blame, substance use, denial, and venting were significantly linked to higher levels of depression, while active coping, emotional support, and positive reframing appeared to be protective against depressive symptoms.

Discussion

The analysis of coping mechanisms using the Brief COPE inventory revealed that most respondents utilized adaptive coping strategies, including active coping, use of instrumental support, religion, planning, and acceptance. These strategies suggest proactive efforts to confront stressors constructively rather than avoid them. In contrast, maladaptive coping mechanisms such as self-blame, behavioral disengagement, denial, and substance use were least utilized. This indicates that most refugees demonstrated a healthy and resilient coping profile, possibly influenced by cultural, religious, and communal support systems.

These results align with global findings that refugees rely on both problem-focused and emotion-focused strategies to manage displacement-related distress (Schlechter et al., 2021). In particular, religious and social coping mechanisms are highly prevalent across refugee populations, reflecting the centrality of spirituality and community cohesion in promoting resilience (Al-Shatanawi et al., 2023; Riley et al., 2017).

A significant association was found between active coping and depression ($\chi^2(6, n = 470) = 18.40$, $p = 0.005$). Non-depressed individuals more frequently used active coping compared to their depressed counterparts, suggesting that taking deliberate actions to manage stress contributes to better psychological outcomes. This finding supports Chiumento et al. (2020), who observed that refugees engaging in purposeful activities such as problem-solving, livelihood initiatives, and goal-setting experienced reduced depressive symptoms. It also aligns with Seruwagi et al. (2022), who highlighted the importance of proactive coping in sustaining hope and resilience among displaced persons in East Africa.

Positive reframing was also significantly associated with depression ($\chi^2(4, n = 470) = 10.66$, $p = 0.031$), indicating that individuals who reinterpret stressful events in a more optimistic way are less likely to experience depression. Positive reframing fosters emotional adjustment and reduces hopelessness, especially in prolonged crises. This is consistent with Schlechter et al. (2021), who noted that resilient refugees often exhibit cognitive flexibility and a hopeful outlook despite adverse circumstances.

Similarly, religious coping showed a significant relationship with depression ($\chi^2(6, n = 470) = 18.20$, $p = 0.006$). Respondents who reported strong reliance on religion exhibited fewer depressive symptoms. This finding reflects the vital role of spirituality in providing meaning, comfort, and community belonging. Studies among Rohingya and Syrian refugees revealed that daily prayer, reading holy scriptures, and engaging in communal worship were dominant coping mechanisms that promoted psychological stability (Riley et al., 2017; Al-Shatanawi et al., 2023). In East Africa, Seruwagi et al. (2022) and Chiumento et al. (2020) similarly observed that faith-based coping was central to emotional resilience, with religious leaders often serving as informal counselors and sources of hope. Thus, religion

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not only functions as an individual coping mechanism but also as a culturally embedded resource for psychosocial healing.

Furthermore, use of emotional support was significantly associated with depression ($\chi^2(4, n = 470) = 27.33$, $p < 0.001$). Refugees who sought emotional support from friends, family, or community members were less likely to report depressive symptoms. Social support enhances a sense of belonging and reduces isolation—two critical buffers against depression. This finding is consistent with Chiumento et al. (2020), who noted that social cohesion within refugee communities in Uganda and Rwanda provided emotional relief and stability. Similarly, Rousseau and Frounfelker (2019) emphasized that communal relationships and social trust can mitigate the psychological impact of displacement when professional mental health services are scarce.

Moderate use of self-distraction ($\chi^2(4, n = 470) = 33.97$, $p < 0.001$) and venting ($\chi^2(4, n = 470) = 22.94$, $p < 0.001$) indicates that some respondents employed temporary emotional regulation strategies to manage distress.

While these strategies provide short-term relief, excessive reliance may delay problem resolution. Venting—expressing frustration—was more common among depressed respondents, suggesting that unstructured emotional expression may exacerbate negative mood when not supported by constructive dialogue or counseling. Similar patterns were reported by Al-Shatanawi et al. (2023), where refugees who vented emotions without supportive feedback exhibited higher distress levels. Nonetheless, limited use of such mechanisms in the present study may indicate growing emotional regulation skills within the refugee population, possibly aided by peer and community counseling initiatives.

The study identified strong associations between depression and maladaptive coping mechanisms, particularly self-blame ($\chi^2(4, n = 470) = 28.93$, $p < 0.001$), substance use ($\chi^2(5, n = 470) = 133.24$, $p < 0.001$), and denial ($\chi^2(4, n = 470) = 23.95$, $p < 0.001$). Respondents with depressive symptoms were significantly more likely to engage in these harmful coping behaviors. Self-blame was prevalent among depressed individuals, reflecting internalized guilt and hopelessness. This is consistent with findings from Schlechter et al. (2021) and Riley et al. (2017), who reported that persistent self-blame was a strong predictor of depressive cognitions among refugees facing chronic adversity.

Substance use emerged as one of the most potent predictors of depression. Refugees who reported using alcohol or drugs were substantially more likely to exhibit depressive symptoms, echoing Aziku (2023), who found that approximately 15% of male refugees in Uganda resorted to alcohol or drugs as a maladaptive response to trauma and loss. Substance use often provides temporary relief but aggravates long-term emotional instability, contributing to a vicious cycle of dependency and despair.

Denial, though less frequently used, was also significantly related to depression, supporting Chiumento et al. (2020), who noted that refugees who refused to acknowledge distress or avoided discussing traumatic experiences often presented with delayed emotional breakdowns. Persistent denial prevents effective adaptation and increases vulnerability to chronic depression.

No significant associations were found between depression and planning ($\chi^2(6, n = 470) = 5.95$, $p = 0.429$), acceptance ($\chi^2(6, n = 470) = 6.38$, $p = 0.382$), use of instrumental support ($\chi^2(5, n = 470) = 7.04$, $p = 0.218$), and behavioral disengagement ($\chi^2(4, n = 470) = 6.42$, $p = 0.170$). While these strategies were moderately used, they may not directly influence depression levels in this population. It is possible that refugees' planning and acceptance reflect adaptation to chronic hardship rather than active emotional recovery, as suggested by Seruwagi et al. (2022). Similarly, instrumental support may have a limited impact due to resource scarcity or inconsistent institutional assistance, as reported by Elshafie and Golden (2020).

Generalizability

Although the results provide valuable insights into depression and coping mechanisms among refugees in this setting, the findings may not be fully generalizable to refugees living in other settlements, urban refugee populations, or refugee populations in different countries with different health systems and support structures. Refugee populations often differ in terms of nationality, cultural background, migration history, access to services, and exposure to trauma, etc, which may influence mental health outcomes and coping mechanisms.

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Conclusion

Coping mechanisms significantly associated with depression included active coping, positive reframing, religious coping, emotional support, self-distraction, venting, self-blame, substance use, and denial. Refugees who used adaptive coping mechanisms reported lower depression levels, while those who used maladaptive strategies had higher depression levels.

Limitations

This study faced limitations, including self-reporting bias, as participants underreported depressive symptoms due to stigma. Additionally, language barriers could have affected the accuracy of responses, despite the use of translators. Efforts were made to mitigate these challenges by building rapport with participants and ensuring the use of trained interpreters.

Recommendation

Health facility managers and Mental Health and Psychosocial Support (MHPSS) coordinators are advised to enhance MHPSS delivery by expanding counselling services, group therapy, and community-based psychosocial interventions that foster resilience and adaptive coping.

Academic institutions and research organizations are encouraged to undertake longitudinal studies that examine the long-term effects of both adaptive and maladaptive coping mechanisms on mental health outcomes among refugees.

Academic researchers and research institutions are also urged to prioritize studies on cultural and faith-based coping mechanisms among refugee populations to support the development of contextually appropriate mental health interventions.

Acknowledgement

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List of Abbreviations/Acronyms

COPE: Coping Orientation to Problems Experienced
KAP: Knowledge, Attitudes/Beliefs, and Practices
PHQ-9: Patient Health Questionnaire -9
NCST: National Council for Science and Technology
SDA: Seventh-day Adventist
UNHCR: United Nations High Commissioner for Refugees
WHO World Health Organisation

Conflict of interest

The authors have no conflicts of interest in this study.

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This study was self-sponsored; no funding from outside sources was provided.

Author biography

Jasper Adoto is a humanitarian Volunteer with 6 years of experience in Project Healthcare Management of Populations in Precarious situations, especially with International Humanitarian Organizations responding to emergencies, natural and man-made disasters in challenging environments, including projects with complex security contexts.

At the moment, he holds a Bachelor's degree in Public Health, a Post Graduate Diploma in Project Management, and is en route to a Master's in Social & Political Science as well as Public Health.

These competencies position him to better manage the challenges of complex humanitarian crises experienced globally.

Maurice Tukei Osire is a Clinical Psychologist with a passion for mental health and wellbeing. He has been in practice for the last 10 years and derives a sense of accomplishment from helping mentally distressed people.

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Maurice holds a Bachelor's of Community Psychology, a Master of Science in Clinical Psychology, and is currently pursuing a PhD. program with a focus on students' mental health.
With the above training and practice, Maurice hopes to be able to contribute to Mental Health research to improve awareness and well-being in the community.

Author contribution

Jasper Adoto conceived the study idea and, together with Maurice Osire Tukei, developed the research design and methodology. Jasper Adoto conducted data collection and analysis as well as drafted the original manuscript. The authors both contributed to the interpretation of the results. Maurice Osire Tukei provided general oversight, guidance, and approved the final manuscript.

Data availability

Data from this study can be obtained on request from the Author.

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