ABSTRACT

Title of Dissertation: STRESS, MENTAL HEALTH, AND SELF-CARE AMONG REFUGEE TEACHERS IN MALAYSIA

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The mental health of post-conflict refugee teachers is understudied, yet critically important given the current refugee crisis which has displaced more than 70 million people (UNHCR, 2019). Teachers in hidden refugee schools¹ are often refugees themselves, have little teacher education, and are faced with overwhelming classroom demands and other unique stressors. This study utilizes a mixed method design to examine stress, mental health (i.e., depression, and anxiety), and self-care among teachers in hidden refugee schools in Kuala Lumpur, Malaysia. Quantitative data are archival, collected in Malaysia in 2013. Quantitative study participants included 97 primarily Burmese refugee teachers and 26 non-refugee teachers living in Malaysia. Quantitative measures included (a) Depression, Anxiety, and Stress Scales (DASS); (b) a self-care strategies questionnaire, and (c) a demographic questionnaire. Quantitative results suggest that refugee teachers have significantly higher

¹ In Malaysia, refugee children are prohibited from attending Malaysian public schools, thus the refugee community has established hidden schools. These schools are very under-resourced as they receive no assistance from the Malaysian government and depend on limited assistance from organizations like UNHCR. See detailed description on page 40.

rates of mental health and stress, but lower rates of self-care as compared to their non-refugee peer teachers. In addition, higher rates of self-care are associated with lower rates of mental health symptoms and stress rates; the association is moderated by age. Qualitative data were collected in June 2018 via individual interviews with eleven Burmese refugee teachers working in Malaysia. Qualitative results shed light on the unique definitions and experiences of stress, mental health, and self-care among refugee teachers in the context of macrolevel factors. Overall, this dissertation found that macrolevel factors unique to being a refugee impact refugees' rates, experiences, and definitions of microlevel mental health symptoms, stress, and self-care.

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MALAYSIA

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Dedication

This dissertation is dedicated to all those who have been displaced or otherwise impacted by conflict.

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Chapter 1: Introduction

Post-conflict refugee education is a challenge in the face of the current global refugee crisis which has forcibly displaced more than 70 million people, including nearly 26 million child refugees in need of post-conflict education (UNHCR, 2019). Currently, one person is displaced every two seconds, a rate that has rapidly increased over the past decade (UNHCR, 2019). Eighty-six percent of the world's refugees have not been resettled and live in a post-conflict setting (i.e., the non-Western country to which they fled) (UNHCR, 2016). A refugee is defined as a person who has been forced to leave his or her home country to escape war, persecution, or natural disaster, etc. (UNHCR, 2017). Post-conflict refugees include refugees who have fled their home country to another country, labeled a post-conflict country, for the purpose of seeking asylum; 86% of refugees live in post-conflict settings (UNHCR, 2015). Often, post-conflict countries are unwilling to host refugees, and these post-conflict countries do not view refugees as refugees, but, rather, view them as illegal immigrants. Resettlement is defined by The Office of the United Nations High Commissioner for Refugees (UNHCR) as a formal “transfer of refugees from an asylum country (referred to as a post-conflict country in this dissertation) to another State that has agreed to admit them and ultimately grant them permanent settlement” (UNHCR, 2019). Resettlement countries are typically Western countries. Unlike a refugee who is officially resettled directly from their country of origin, a post-conflict refugee endures a dangerous flight without support. During flight, they must remain hidden while trekking through regions where officials are typically actively attempting to capture them (Gosnell, 2017; O’Neal, Atapattu, Jegathesan, Clement, Ong, & Ganesan, 2018a). Many refugees face persecution and oppression in

post-conflict countries (Low, Kok, & Lee, 2014; Nathan, 2012). Post-conflict refugees' experiences are very different from resettled refugees who are typically resettled to Western countries and receive official refugee status in addition to increased financial support, job support, and support with citizenship paperwork (UNHCR, 2017). Specifically, post-conflict refugees have faced multiple unique stressors including socio-political conflict, traumatic and/or difficult flights from their home countries, and challenging living conditions and hostility from their new post-conflict country (Almqvist & Broberg, 1999; Fazel & Stein, 2002). Post-conflict teachers of refugee children, who are refugees themselves (hereafter referred to as refugee teachers), face additional stressors beyond those faced by refugee adults (as discussed in more detail later) (Low et al., 2014). However, the potential relations among stress, mental health, and self-care among post-conflict refugee teachers have received little attention and these constructs have not yet been examined together in one study. Note that this study will utilize Orem's (1995) operationalization of self-care as "action of persons who have developed capabilities to use appropriate, reliable and valid measures to regulate their own functioning and development in stable or changing environments" (p. 43).

There are several risk factors that may affect the mental health of teachers in refugee schools in post-conflict settings including: the behaviors and mental health of their refugee students, the larger discrimination and lack of support by the post-conflict country's government, and, in many cases, their own at-risk status as refugees (Gosnell, 2017; Low et al., 2014; O'Neal, et al., 2018a). Educating refugee children is especially difficult given that psychological demands on child refugees weigh heavy and affect refugee children's ability to learn, permitting they are fortunate enough to receive a post-

conflict education (Dryden-Petersen, 2016; McBrien, 2005). Fortunately, in Malaysia, school enrollment rates for refugee children have increased from 4% in 2006 to around 40% in 2014 (UNESCO & UNHCR, 2016) as more hidden refugee schools have been established within communities (see page 40 for a detailed description of hidden refugee schools in Malaysia). However, the 40% of post-conflict child refugees in Malaysia who do receive an education are often taught by teachers who are also stressed refugees with little education and overwhelming classroom demands (Dryden-Petersen, 2016).

The refugee teachers who participated in this study were mostly Burmese refugees living in Malaysia. As of April 2019, there are approximately 170,460 refugees and asylum-seekers registered with UNHCR in Malaysia. About 147,590 refugees living in Malaysia are persecuted ethnic groups from Myanmar (i.e., 90,200 Rohingyas, 24,720 Chins, 9,750 Myanmar Muslims, 4,000 Rakhines, Arakanese, and other ethnicities) (UNHCR, 2019). Currently, there are no legislative or administrative provisions in place for dealing with the situation of refugees and asylum-seekers in Malaysia (UNHCR, 2019). On the contrary, the Malaysian government has taken a strong stance against refugee adults and children, evidenced by their history of human rights abuses against refugees (Nathan, 2012) and the barring of refugee children from attending government schools (Malaysia Immigration Act, 1959/63; Nathan, 2012). On top of the stress of both marginalization and persecution back in Burma, refugees who have fled to Malaysia live in fear, and they experience extreme hardship, discrimination, and psychological turmoil (Low et al., 2014). The Malaysian Government is not a signatory to the 1951 UN convention nor its 1967 protocol. Malaysia is also not a party to the 1954 and 1961 U.N. Statelessness Convention. Thus, Malaysia is without a legal framework for protecting

refugees. Instead, refugees in Malaysia are viewed as illegal immigrants who are subject to fines, detention, deportation and whipping with a cane for illegal entry (Low, Kok, & Lee, 2014; Nathan, 2012). In addition, they are denied access to legal employment (all employment is “under the table” and working conditions are not regulated) and have inadequate access to healthcare due to its financial burden. Immigrant, refugee, and asylum-seeking children and adults continue to be arrested and detained in Malaysia’s immigration detention centers where they face difficulties accessing protection (CRC Malaysia, 2013). As of April 2019, there were 43,710 child refugees and asylum-seekers under the age of 18 were registered with UNHCR in Malaysia (UNHCR, 2019).

Given number of children in need of a post-conflict education and the laws prohibiting refugee children from attending Malaysian public schools, refugee communities have created hidden “informal learning centers” for refugee children. Although teaching is already considered a high-stress, high burn-out profession (Friedman-Krauss, Raver, Neuspiel & Kinsel, 2014), teachers and students at these hidden refugee schools can be very stressed while living in an urban environment in a country hostile to refugees (Low, Kok, & Lee, 2014). Teachers who are refugees, themselves, working in refugee schools face additional unique stressors including lack of formal training, low resources, little supervision, and limited curriculum support (Low et al., 2014). Refugee teachers in Kuala Lumpur face an additional stressor of teaching in an urban setting (Abel and Sewell, 2014). These issues are exacerbated as their students also have an increased risk for mental health and behavioral issues due to fleeing conflict, discrimination in Malaysia, and poverty (Gosnell, 2017; Hepinstall, et al., 2004; O’Neal, et al., 2018a).

The demands and stressors that come with teaching in a hidden refugee school may impact teacher mental health, yet there is little research on stress and mental health among refugee teachers. Since refugee teachers may be at an increased risk for developing mental health problems due to the unique stressors they experience, it is important to study stress, mental health, and self-care among a refugee teacher population. In addition, since engaging in self-care is related to positive mental health outcomes, self-care may moderate the relationship between stress and mental health, yet there is no research on self-care practice among refugee teachers. Since the constructs of mental health, stress, and self-care are Western concepts, it is important to establish qualitative, culture-specific definitions of these constructs to aid further quantitative work.

Current Study

This dissertation study addresses the identified gaps in the research as it seeks to understand, measure, and examine associations among mental health, stress, and self-care among post-conflict refugee teachers working in hidden refugee schools in Kuala Lumpur, Malaysia using a mixed method design. The current study measured rates of negative mental health symptoms, stress, and use of self-care strategies among refugee teachers (and a non-refugee teacher comparison group). In addition, it examined the association between self-care and mental health and whether the association between stress and mental health is moderated by self-care. Further, through participant interviews, microlevel factors (i.e., stress, mental health, and self-care) were explored in the context of macrolevel factors unique to the refugee experience. Such macrolevel factors (e.g., refugee status and associated risk factors) may impact the microlevel

experience of stress, mental health, and self-care in addition to the way the constructs are conceptualized among refugee teachers.

Questions and hypotheses.

1) *Question:* What are the rates of depression, anxiety, stress, and use of self-care strategies among Southeast Asian refugee teachers teaching in refugee schools in Malaysia? How do these rates compare to non-refugee teachers teaching in refugee schools in Malaysia?

i. *Hypothesis:* Southeast Asian refugee teachers living in Malaysia will have higher rates of negative mental health symptoms (i.e., depression and anxiety) in comparison their non-refugee peer teachers.

2) *Question:* Is less frequent use of self-care strategies associated with negative mental health symptoms (i.e., depression and anxiety) among Southeast Asian refugee teachers and non-refugee teachers teaching in refugee schools in Malaysia?

i. *Hypothesis:* Use of self-care strategies will be negatively associated with negative mental health symptoms among Southeast Asian refugee teachers living in Malaysia and their non-refugee peer teachers.

3) *Question:* Does self-care moderate the association between stress and negative mental health symptoms among Southeast Asian refugee teachers and non-refugee teachers teaching in refugee schools in Malaysia?

- i. *Hypothesis:* Self-care will moderate the positive association between stress and negative mental health symptoms among both Southeast Asian refugee teachers and non-refugee teachers teaching in refugee schools in Malaysia.

4) *Qualitative Question:* How do Southeast Asian refugee teachers living in Malaysia and working in hidden refugee schools experience stress, mental health, and self-care in the context of macrolevel factors related to the experience of being a refugee?

- i. Individual interviews explored how Southeast Asian refugee teachers living in Malaysia and working in hidden refugee schools experience stress, mental health, and self-care.
- ii. Individual interviews shed light on the various macrolevel factors Southeast Asian refugee teachers living in Malaysia and working in hidden refugee school raise as being related to their stress, mental health, and self-care in the context of their experience as refugees.

Chapter 2: Literature Review

The current study aims to examine stress, mental health (i.e., depression and anxiety), and self-care (in addition to establishing culture-specific definitions of these constructs), among teachers in hidden refugee schools in Kuala Lumpur, Malaysia. The literature review that follows will first discuss the study in the context of the Developmental Ecological model and then review research on teacher mental health and stress across various teacher populations. Next, it will review unique sources of stress which may impact mental health among refugee teacher populations. Since research on refugee teachers' mental health is limited, I will also review adult refugee mental health and stressors in a broader sense. Finally, since no research exists on self-care as it relates to mental health among refugee teachers, or even among refugee adults more broadly, I review self-care as it relates to mental health among adults, and more narrowly, among teachers.

Macrolevel Risk and Microlevel Mental Health: The Developmental Ecological Model

This study utilizes the Developmental Ecological Model which is Suarez-Orozco and Colleagues (2011) adaptation of Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner & Morris, 2006). Bronfenbrenner's model includes five levels interactions between the individual and their environment. The first level, the Microsystem, refers to the institutions and groups that most immediately and directly impact development (e.g., family, work, neighborhood, peers). The Mesosystem, the second level, refers to interactions between the microsystems (e.g., between peers and family). The Exosystem is the third level and it involves links between a social setting in

which the individual does not have an active role and the individual's immediate context (e.g., home experiences being influenced by work experiences). The fourth level, the Macrosystem describes the culture in which individuals live and can evolve over time (e.g., a developing country). The fifth and final level is the Chronosystem which is the pattern of environmental events and transitions over the life course (e.g., divorce) (Santrock, 2007).

The Developmental Ecological model (Suárez-Orozco, Yoshikawa, Teranishi, & Suárez-Orozco, 2011) is an adaptation of Bronfenbrenner's Ecological Systems Theory. In proposing the Developmental Ecological model Suarez-Orozco and colleagues (2011) examined how at each level of the ecological system, undocumented immigrant students were affected. It is essentially an adaptation of Bronfenbrenner's model specific to the experience of undocumented immigrants. According to Suarez-Orozco et al. (2011), the environments in which individuals exist include various levels of risk and protective factors that may enhance or detract from positive outcomes, especially among immigrants. A Developmental Ecological model considers human development to be a set of interactions between the individual and their immediate environment, which vary based on the individual, their culture, and time (Suarez-Orozco et al., 2011). The Developmental Ecological Model was developed specifically to capture the experience of immigrants, using Bronfenbrenner's original framework which posits that interactions between the individual and immediate environment (microsystem) take place within nested systems, which include the mesosystem (interrelation among microsystems like school, work, and family), the exosystem (neighborhood, community), the macrosystem (e.g., society, immigration policy, and culture), and the chronosystem (major life

transitions, historical/ environmental changes over time) (Bronfenbrenner & Morris, 2006; Suarez-Orozco et al., 2011) (see figure 1). The Developmental-Ecological framework considers a multitude of risk and resilience factors that interact with the individual's characteristics and may affect individual outcomes and responses (Suarez-Orozco et al., 2011).

There are several risk factors that may affect the mental health of teachers in refugee schools in post-conflict settings: the behaviors and mental health of their refugee students, the larger discrimination and lack of support by the government, and, in some cases, their own at-risk status as refugees (Gosnell 2017; O'Neal et al., 2018a). This study measures microlevel constructs (stress, mental health, and self-care) in the context of macrolevel factors unique to the refugee experience (e.g., persecution in country of origin, flight from country of origin, discrimination in post-conflict country). The quantitative data examine relations among microlevel factors in the context of macrolevel stressors (e.g., refugee status). I conceptualize refugee status as a macrolevel factor because refugees are impacted by macrolevel factors such as immigration policy and an individual's refugee status impacts how they are viewed within Malaysian society and Malaysian culture. Through qualitative data, this study explores how the experience of unique macrolevel factors shape refugee teachers' definitions of the microlevel constructs of stress, mental health, and self-care practice. It captures individual definitions of microlevel stress, mental health, and self-care through the lived experiences of those impacted by unique macro factors (e.g., Malaysia's culture of hostility toward refugees).

I have adapted Suarez-Orozco et al.'s (2011) model for undocumented students to my model of refugee teacher mental health. Macrosystem factors such as refugee status and public policies (e.g., refugee schools being hidden, lack of resources for refugee teachers, detention, caning), societal norms against refugees, and shared negative attitudes toward refugees (e.g., a "snitch culture" in which Malaysian citizens threaten to report refugees to deportation authorities) may affect the constructs this study will measure: microlevel stress, mental health, and self-care (and the way these constructs are defined) among refugee teachers (O'Neal, et al., 2018a). At the exosystem level, many variables may impact refugee teachers (e.g., Malaysian laws that cane refugees in detention, lack of legal employment). Exosystem factors may also make it difficult for refugee teachers to obtain resources necessary to support their student's learning and development (Suarez-Orozco et al., 2011). These risk factors at the macrosystem and exosystem levels (e.g., refugee status) may influence refugee microlevel mental health (Suarez-Orozco et al., 2011). Conceptualizing refugee status as a macrolevel factor is based on the assumption that refugees differ from non-refugees in risk factors for mental health. Additionally, the chronosystem is particularly complex for refugees who have recently faced major life transitions (e.g., transition from life in their country of origin to the country to which they fled) and have experienced life as a refugee during the current global refugee crisis.

Although I am only measuring microlevel factors (stress, mental health, and self-care) directly, I examine these constructs in the context of and in relation to higher level factors (e.g., refugee status). Specifically, higher level environmental conditions including maltreatment, poverty, and exposure to violence can place individuals at a

higher risk for the development of various forms of mental illness such as depression, anxiety and post-traumatic stress (Logue, Logue, Kaufmann & Belcher, 2014; Tan & Yadav, 2012). Macrolevel factors impact microlevel stress and mental health; thus, these microlevel factors must be studied in the context of the macrolevel factors which affect them. I assume that macrolevel factors may shape participant's definitions of the above microlevel constructs. The open-ended nature of the qualitative questions provide room for participants to answer at macro and microlevels. Through the qualitative interviews of eleven refugee teachers, it is likely that both macrolevel and microlevel factors will be discussed by participants and they will be interpreted in the context of this Developmental Ecological model. The participants in the current study are mostly Burmese refugee teachers who fled to urban Malaysia where they have experienced poverty, maltreatment, discrimination, and other negative environmental conditions (Low et al., 2014; O'Neal et al., 2018a). For example, urban poverty and mental health have a complex relationship with each other. Macrolevel factors such as living in an urban area can be a microlevel mental health risk, especially for low-income individuals. Refugee status may be another macrolevel factor which impacts microlevel mental health, stress, and self-care which is why I will examine these constructs among refugee teachers as compared to non-refugee teachers (who are also teaching in refugee schools in Malaysia). Using a Developmental Ecological framework (Suarez-Orozco et al., 2011), this study examines microlevel stress (risk factor) and self-care (protective factor) as predictors of microlevel mental health (outcome) among refugee teachers interpreted in the context of larger macrolevel factors (e.g., refugee status, Malaysian laws and policies, poverty,

maltreatment, discrimination) which may impact mental health, stress, and self-care (Figure 1).

Figure 1. Bronfenbrenner's Ecological System's Theory including current study variables.

Teacher Stress and Mental Health

In general, teaching is a high-stress profession and stress is associated with negative mental health symptoms. Thus, I will review stress and mental health among teachers in general and then review the unique stressors associated with refugee teacher stress and mental health. The stress of teaching may be amplified for teachers of refugee children who are refugees themselves and who face additional stressors unique to the experience of being a refugee. These additional stressors include: refugee student–teacher ratios, refugee student mental health and behavior, lack of resources, and sociopolitical

challenges (O’Neal et al., 2018a). Among adults, high stress levels are related to mental health symptoms including mental health and anxiety (Avison & Turner, 1988; Finlay-Jones & Brown, 1981; Monroe and Harkness, 2005). Since teaching is a high-stress profession, teachers may experience more stress, which then puts them at a greater risk for mental health problems like depression and anxiety (Ballou, 2012; Bauer et al., 2007; Kovess-Masfety, Rios-Seidel, Sevilla-Dedieu, 2007).

Being a refugee is an additional risk factor for mental health problems as adult refugees have more mental health challenges than non-refugees (Schewitzer, Brough, Vromans, & Asic-Kobe, 2011; Lindert, von Ehrenstein, Priebe, Mielck, & Brahler, 2009; Kroll, Yusef, & Fujiwara, 2011). Refugee teachers experience additional unique stressors, including poverty, maltreatment, discrimination, and other negative environmental conditions, (Low et al., 2014) on top of the stress of being a member of the teaching profession. Furthermore, because their refugee status creates an additional risk for mental health issues, their risk for developing mental health problems is likely higher than teachers in general. The section below will operationalize stress and negative mental health symptoms (i.e., depression and anxiety), provide support for the association of stress and mental health symptoms, and explore their association among teachers, in general, and among refugee teachers.

Operationalization of stress and mental health. According to the Encyclopedia of Behavioral Medicine, stress is typically defined as both a stimulus and a response. Stress as a stimulus is often called a stressor, and it is defined as an event that occurs and impacts an individual (e.g., losing a job, getting divorced) (Folkman, 2013). Stress as a response refers to the body’s reaction which is characterized by psychological arousal and

negative affect. According to Lazarus (1966), stress is a relationship between an individual and their environment, which is appraised by the person as significant (i.e., taxing, unable to cope using existing resources). Suldo, Shaunessy, and Hardesty, (2008) introduced the notion of perceived stress which refers to “interactions between an environmental precipitant (external stress); the physiological reactions of the body (distress); and a person’s cognitive, emotional, and behavioral response to this interaction” (p. 274). The current study will operationalize stress in this way, although one of the goals of this study is to determine how refugee teachers operationalize stress.

Given that stress is highly correlated with negative mental health outcomes including depression and anxiety (Jaser et al., 2005), the current research seeks to explore the association between stress and mental health among refugee teachers. According to the World Health Organization (2004), “mental health represents a state of well-being in which the individual realizes his/her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to the community” (1). According to the Encyclopedia of Behavioral Medicine (2016), poor mental health or mental illness refers to “particular ways of thinking, feeling, or behaving that are typically associated with distress or impairment” (1). The current research will use this operationalization of mental illness although one of the goals of this study is to determine how refugee teachers experience mental health. In the Diagnostic and Statistical Manual, 5th Edition (DSM-5, 2013) the American Psychiatric Association (APA) classification system separates mental illnesses into categories based on symptoms observed by a mental health professional or reported by the patient. The proposed study will focus on two forms of mental illness: depression and anxiety. Note that when this

study refers to the relation between mental health and stress or self-care, I am actually referring to negative mental health symptoms.

Operationalization of depression and anxiety. Depression is a serious mood disorder which results in symptoms like persistent low mood, lack of interest, weight loss, sleep disturbance, fatigue, feelings of worthlessness and guilt, trouble concentrating, and psychomotor agitation (DSM-5, 2013). These symptoms impact the way individuals feel, think, and carry out daily activities (e.g., sleeping, eating, or working) (National Institute of Mental Health [NIMH], 2018). Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder (DSM-5, 2013). Depression symptoms are often comorbid with symptoms of other mental illnesses including anxiety disorders (DSM-5, 2013).

Typically, anxiety is associated with feelings of fear, worry, discomfort, and dread (Antony & Barlow, 1996). Although anxiety is related to fear, they are two distinct constructs. For example, anxiety can be seen as a negative mood state involving anticipation of a future threat, while fear is “an emotional response to a real or perceived imminent threat” (DSM-5, 2013). According to the Encyclopedia of Behavioral Medicine “anxiety disorders are a group of disorders characterized by intense or excessive fear, nervousness, dread, or worry” (Millstein, 2013). Anxiety is a normal part of daily life which creates feelings of worry; however, normative anxiety subsides once the stressor is no longer present. In contrast, anxiety that is not normative (i.e.,

pathological anxiety experienced by those with anxiety disorders) is high intensity, excessive, lasts longer than six months (and possibly beyond developmentally appropriate periods), and interferes with an individual's daily functioning (DSM-5, 2013; Millstein, 2013). Although there are several distinct anxiety disorders, they all share common "features of excessive fear and anxiety and related behavioral disturbances" (DSM-5, 2013). Anxiety disorders include Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder (Social Phobia), Panic Disorder, Panic Attack Specifier, Agoraphobia, Generalized Anxiety Disorder, Substance/Medication-Induced Anxiety Disorder, Anxiety Disorder Due to Another Medical Condition, Other Specified Anxiety Disorder, and Unspecified Anxiety Disorder (DSM-5, 2013). The proposed study will focus on depression and anxiety as they are operationalized above while also examining how refugee teachers experience depression and anxiety.

Stress and mental health among adults. Stress is associated with negative mental health symptoms and psychiatric disorders among adults (Avison & Turner, 1998; Finlay-Jones & Brown, 1981; Langner & Michael, 1963; Monroe and Harkness, 1992). It is argued that psychopathology is best understood as the interaction between biology, personality, and stressful events (Zuckerman, 1999). Decades of research supports the understanding that stress is an important factor in the development of negative mental health symptoms (e.g., Hawkes, 1857; Hinkle, 1974; Rees, 1976; Rosen, 1959). Life stress in both childhood and adulthood, predicts mental health symptoms among adults (Langner & Michael, 1963). Depression and anxiety are considered stress-related disorders since stressful life events are related to both depression and anxiety symptoms among adults (Avison & Turner, 1998; Finlay-Jones & Brown, 1981; Monroe and

Harkness, 1992). In fact, several theories of depression have adopted stress-diatheses models (e.g., Abramson, Metalsky, & Alloy, 1989; Beck, Brown, Steer, Eidelson, & Riskind, 1987; McGuffin, Katz, & Bebbington, 1988; Robins & Block, 1989). The stress-diathesis model proposes mental health disorders are developed via an interaction between a predisposed vulnerability and stress caused by life events. The model explores how biological traits (diatheses) interact with the environment (stressors) to produce disorders such as depression and anxiety (Monroe & Simons, 1991). In addition, a form of stress especially relevant to the proposed study is social stress (e.g., stress as a result of identifying as a member of a minority group) is linked to negative mental health outcomes [Aneshensel, 1992; Meyer, 1995]).

Stress and mental health in the teaching profession. Research suggests that teaching is a high-stress profession, that teachers are at risk for developing mental health problems, and that teacher stress is associated with teacher mental health (Ballou, 2012; Bauer et al., 2007; Kovess-Masfety, Rios-Seidel, Sevilla-Dedieu, 2007; Kyriacou, 2000). With regard to teaching as a high-stress profession, more than 40% of teachers have experienced significant stress as a result of excessive workload and abusive parents and students (Austin, Shah and Muncer, 2005; Dunham & Varma, 1998; Farber, 1991; Kyriacou, 2000; Kyriacou & Sutcliffe, 1978; Travers & Cooper, 1996). The number of referrals of teachers to therapists for stress-related disorders such as anxiety and depression is increasing (Austin, Shah and Muncer, 2005). In a pivotal study on teacher stress Huberman (1993) found that most teachers experience a period of self-doubt, disenchantment, and reassessment. They resolve their concerns by either continuing their career as a teacher, or by leaving the profession altogether. Results suggest that the most

common reasons for deciding to leave teaching were fatigue, nervous tension, frustration, difficulties in adapting to pupils, personal fragility, and routine (Huberman, 1993). Thus, stress-related reasons may ultimately lead teachers to leave the teaching profession. Overall, research has established that teachers are highly stressed, especially teachers who work in urban settings, like the teachers in our sample. For example, Abel and Sewell (2014) examined symptoms of burnout and sources of stress among a sample of American rural (51) and urban (46) secondary school teachers from eleven school systems across Georgia and North Carolina. Researchers measured stress and burnout via self-report measures (The Sources of Stress Questionnaire [Borg & Riding, 1991], Maslach Burnout Inventory [MBI; Maslach & Jackson, 1981,1986]). Urban teachers experienced more stress due to poor working conditions and poor staff relations in comparison to their peers teaching in rural schools. Pupil misbehavior and time pressures were the greatest stressors for both groups. Overall, results suggest that teachers who work in schools in urban settings experience more stress and different predictors of burnout than teachers in rural settings. Thus, it is possible that an urban setting, may be another variable which impacts teacher stress among teachers working in refugee schools in Kuala Lumpur, Malaysia. However, this study was limited by a relatively small sample size and sole reliance on self-report measures.

As mentioned previously, student factors play a role in teacher stress, especially student behavior. Friedman-Krauss, Raver, Neuspiel, Kinsel (2013) examined the relationship between child behavior problems (measured via teacher-report) and pre-school teacher job stress. Participants included 69 pre-school teachers in 31 early childhood classrooms across four Head Start centers. Data were collected via web-based

self-report surveys and web-based direct assessment tasks. Results via multi-level modeling indicated that more child behavior problems (as perceived by teachers) were related to higher levels of teacher job stress (Friedman-Krauss, Raver, Neuspiel, Kinsel, 2013). Student behavior is particularly relevant for teachers of refugee children as refugee students are at an increased risk for mental health and behavioral issues due to fleeing conflict, discrimination, and poverty (Gosnell, 2017; Hepinstall, et al., 2004; O’Neal, et al., 2018a). Refugee students present unique behavioral challenges which will be discussed in more detail later, and these student behavioral challenges may affect the stress experienced by teachers of refugees.

Among adults, stress is associated with negative mental health symptoms and psychiatric disorders (Avison & Turner, 1998; Finlay-Jones & Brown, 1981; Langner & Michael, 1963; Monroe and Harkness, 1992). Since teaching is a high-stress profession, it makes sense that teachers experience high rates of mental health problems related to the unique stressors they face as members of the teaching profession (Ballou, 2012; Bauer et al., 2007; Kovess-Masfety, Rios-Seidel, Sevilla-Dedieu, 2007). For example, among a sample of 949 German teachers, 29.8% self-reported experiencing mental health problems via the General Health Questionnaire – 12 (GHQ-12) (Bauer et al., 2007). The authors also found that full-time teachers work more than 51 hours per week and 42% of the teacher sample had experienced verbal insults from students, suggesting that specific stressors unique to the teaching profession may impact mental health. Ballou (2012) compared rates of mental health among teacher versus non-teacher adults, finding that American public-school teachers (124 women, 116 men) were more likely to experience negative mental health as compared to other professionals employed by the government

(305 men, 74 women) using the self-report General Health Questionnaire (GHQ).

Specific factors such as reduced job satisfaction (among female teachers only) and a lack of leisure time were associated with psychiatric disorders. It is important to note that these studies relied solely on self-report measures that were not specific to mental health.

In a similar study among a sample of public school teachers in France (n=3586) aged 20-60, Kovess-Masfety, Rios-Seidel, and Sevilla-Dedieu (2007) sought to determine the prevalence of psychiatric disorders and identify work-related stressors related to mental health. Results suggest that prevalence of mental health issues may differ by teaching level, but there were significant differences in this finding between men and women. Male teachers who worked in special education, nursery, and intermediate level schools and women working in secondary schools were found to be at the greatest risk for mental health disorders (Kovess-Masfety, Rios-Seidel, Sevilla-Dedieu, 2007). Specific stressors of fear of physical abuse (especially in women) and fear of verbal attacks were related to mental health problems.

Overall, the literature on teacher mental health suggests that teachers are highly stressed and experience higher than average rates of mental health problems associated with stressors unique to teaching. However, the literature is somewhat limited by reliance on self-report measures rather than stronger measures of mental health (e.g., diagnostic clinical interview). Further, various protective and risk factors may moderate the relationship between teacher stress and negative mental health symptoms among teachers. For example, Bauer et al. (2007) evaluated occupational burnout, mental health, and coping style among 408 teachers in German grammar schools. The authors used the Measure of Coping Capacity Questionnaire (MECCA) to evaluate participant

styles of coping with occupational stress and found that 32.5% percent of the sample suffered from burnout and 17.7% from severe psychological strain. In terms of coping, 17.7% were classified as having a tense coping style, 32.5% were classified as having an exhausted/resigned coping style, 35.9% demonstrated an unambitious coping style (defined by the measure as “lack of involvement with work coupled with strong dissociation from problems dealing with the work situation, mental resilience with regard to pressure, [relative] contentment”), and only 13.8% showed a healthy-ambitious coping style (defined by the measure as “clear but not excessive involvement with work, combined with maintained capacity for distancing oneself from work-related problems, positive coping behaviour and resilience with regard to pressure and strains, positive attitude to life”). Specifically, rates of burnout were higher among women, divorced teachers, and teachers who worked part-time (Bauer et al., 2007). In addition, with the exception of high numbers of students per classroom, teachers rated destructive and aggressive student behavior as the greatest contributor to occupational burden. To analyze psychological symptoms, the authors used The Symptom Checklist-90-R SCL 90 R and found that 20% of the sample experienced a severe degree of psychological symptoms and that psychological symptoms were correlated with teacher burnout (Bauer et al., 2007). Thus, burnout due to occupational stress may be related to negative mental health symptoms among teachers. Certain risk factors (e.g., being a woman) and protective factors (although the moderation was not examined in the above study) (e.g., healthy coping style) may impact the relationship. This supports the current study’s framework which explores teacher mental health and self-care in the context of risk (e.g., refugee status) and protective factors (e.g., self-care).

Refugee Teacher Stress and Mental Health

There are various unique stressors experienced by refugee teachers on top of the stressors associated with teaching including: refugee student–teacher ratios, refugee student mental health and behavior, lack of resources, and sociopolitical challenges (O’Neal et al., 2018a). These additional stressors coupled with their refugee status, may put teachers of refugee children who are also refugees, at a greater risk for experiencing negative mental health symptoms as compared to teachers in general. Although several studies discuss evidence of additional stressors experienced by post-conflict refugee teachers (Arabaci, Basar, Akan, and Goksoy, 2014; Kirk, 2010; Kirk and Winthrop, 2007), one other small-scale qualitative study has actually reported high levels of post-conflict refugee teacher stress (Low et al., 2014). I argue that post-conflict refugee teachers are more stressed than non-refugee teachers given the presence of unique stressors experienced by refugee teachers. Refugee instruction in first-asylum countries comes with a unique set of challenges, like student–teacher ratios nearly twice the UNHCR guideline of 40:1 (Dryden-Petersen, 2016). Additionally, refugee education quality can be low in these first-asylum countries, with low percentages of teachers with professional training, teacher-centered approaches, and with teachers lecturing most of the time, leaving little room for refugee student active engagement (Dryden-Petersen, 2016). Finally, as mentioned, the refugee students have experienced a great deal of trauma which may present as a risk factor for their teachers. Experiencing trauma as a child can be associated with child behavior problems and classroom management challenges for teachers. Thus, teachers who work with traumatized students may

experience distress from their work (Alisic, Bus, Dulack, Pennings, & Splinter, 2012; Meldrum, King, and Spooner, 2002).

Several qualitative studies have interviewed refugee teachers in order to shed light on the structural (e.g., tents as classrooms), educational, and student-related stressors they face (Arabaci, Basar, Akan, and Goksoy, 2014; Kirk, 2010; Kirk and Winthrop, 2007). For example, Kirk and Winthrop (2007) interviewed teachers in Northern Ethiopia who were Eritrean refugees as an initial step prior to implementation of the International Rescue Committee's Healing Classrooms intervention. The authors learned that refugee children had no resources to support their learning and the teaching methodology was primarily teacher talk. In this refugee community, pre-school classes were left to the least experienced teachers as more qualified individuals taught high status grades and subjects (science and math). Most of the teachers in these refugee classrooms did not view teaching as part of their identity as they had never before considered themselves (or wanted) to be teachers; community leaders simply identified the most educated individuals and requested that they teach. Most teachers had not completed their own high school education and were not confident in their ability to be "real" teachers (Kirk & Winthrop, 2007).

In a related qualitative study among the same population of Eritrean refugee teachers and also part of the Healing Classroom's initiative, Kirk (2010) interviewed teachers after they had participated in the Healing Classroom's training, a culture-specific intervention developed based on pilot data collection. Post-training, teachers expressed feeling more confident and more like real teachers. They also experienced greater status in their community and financial empowerment since they were previously unpaid and

now received a small salary. These two studies suggest that refugee teachers face unique stressors that greatly impact them, but with targeted, culture-specific interventions, their well-being may be improved.

In another qualitative study of teachers (both Turkish and adult Syrian refugees) of Syrian refugee children in Turkey, Arabaci, Basar, Akan, and Goksoy (2014) identified educational problems teachers face. Teachers discussed physical problems in the classroom such as overcrowding and inadequate physical structures (e.g., tents as classrooms) and also a lack of resources. Teachers expressed concerns about management incompetence, which is amplified as more qualified teachers leave the camps to work elsewhere. In addition, since neither teachers nor managers are paid, they are not concerned with risking their livelihood so they are unmotivated to cooperate with one another. Additionally, since no salary can be provided to teachers, qualified teachers leave the camps and remaining unpaid teachers have little formal training or motivation to take their job seriously. Teachers also indicated that the trauma their students had witnessed translated to violent behavior in the classroom and an inability to adapt to classroom structure. Teachers saw the effects of trauma on parents as they were reluctant to cooperate with the schools and be involved in their child's education.

Although a few other studies have explored structural, educational, and student-related stressors faced by refugee teachers, one study by Low, Kok, and Lee (2014) is quite related to the proposed current study as it qualitatively explored discrimination and psychological distress experienced by Burmese refugees who were living in Malaysia and teaching refugee students. The study also used Bronfenbrenner's ecological theory as the theoretical basis for examining the participant's psychological distress within their social

context, which is the same theoretical framework this dissertation relies upon. Low et al. (2014) utilized a narrative inquiry approach and conducted in depth interviews with six teachers who were refugees. Findings suggest that refugee teachers in Malaysia experience social, economic, and psychological discrimination as they await resettlement. The authors found that refugee teachers experienced stress from many sociopolitical factors outside the classroom due to living in a country hostile to refugees: discrimination by neighbors who were citizens, identity threat, fear of arrest/detention, government prohibitions against refugees' legal employment, lack of employment, insufficient pay, and fear for their refugee students' and their own futures. This study suggests that the stress of living in an urban environment within in a country hostile to refugees, like Kuala Lumpur, Malaysia, (where the participants in the current study also reside) creates additional stressors for refugee teachers that go beyond classroom demands and structural challenges (e.g., classroom setting) and impact their overall well-being. In addition, the authors discuss findings regarding refugees coping with distress and discrimination, such that refugee teachers "opted to cope 'safely' by avoidance and acceptance so as to preserve themselves and salvage a minimal degree of self esteem and self worth." The macrolevel factors identified in (Low et al., 2014) warrant additional research to examine how such macrolevel factors such as social, economic, and psychological discrimination on the basis of refugee status may impact the relationship between stress and mental health in addition to how protective factors like self-care and coping strategies may offset the impact of these macrolevel risk factors. The current study sought to address this gap as it examines microlevel stress, mental health, and self-care in the context of unique macrolevel stressors experienced by refugees. In addition, the current study explored

how refugee teachers experience stress, mental health, and self-care, and how the experience of macrolevel stressors shapes refugee teachers' definition of constructs of stress, mental health, and self-care.

Adult refugee mental health. There is only limited research among refugee teacher populations, but there are many studies of mental health among adult refugees. Refugee status can be considered a risk factor for developing mental health problems as refugee adults experience more negative mental health symptoms than their non-refugee peers. Thus, given the limited research on refugee teachers, it is useful to examine the literature on adult refugee mental health overall. As illustrated above, members of the teaching profession are highly stressed and experience high rates of mental health problems related to the unique stressors they face as teachers (Ballou, 2012; Bauer et al., 2007; Kovess-Masfety, Rios-Seidel, Sevilla-Dedieu, 2007). Thus, it is likely that *refugee* teachers face even more challenges that may impact their mental health as compared to non-teacher refugee peers. It is important to first understand mental health trends among refugee adults before adding the additional level of risk of being a teacher (reviewed above).

In general, research suggests that when compared to non-refugees, refugees have higher incidences of both Post Traumatic Stress Disorder (Fazel, Wheeler, & Danesh, 2005; Nickerson, Liddell, Maccallum, Steel, Silove & Bryant, 2014; Steel, Chey, Silove, Marnane, Bryant, & Ommeren, 2009; Teodorescu, Heir, Hauff, Wentzel-Larsen & Lien, 2012), and Depressive Symptoms (Lindert, von Ehrenstein, Priebe, Mielck, & Brahler, 2009; Kroll, Yusef, & Fujiwara, 2011; Schewitzer, Brough, Vromans, & Asic-Kobe, 2011). For example, results of a 2009 meta-analysis by Steel, Chey, Silove, Marnane,

Bryant, and Ommeren suggest there are high rates of mental health problems among refugee adults. According to the meta-analysis, the prevalence of PTSD was 30.6% and the prevalence of depression was 30.8% among refugees and other conflict-affected adults. Worldwide the prevalence of PTSD is 1.1%, depression is 4.4% and anxiety is 3.6 (Karam et al., 2014; World Health Organization, 2017). In Southeast Asia, the prevalence of depression is 4.5% and anxiety is 3.1% (World Health Organization, 2017).

More specifically, Berthold, Kong, Mollica, Kuoch, Scully, Franke (2014) examined rates of mental health problems among Cambodian refugees resettled in the US via a self-report survey created by the Harvard Program in Refugee Trauma. Of the sample, 73% report being diagnosed with depression, PTSD, or both. Further, participants with comorbid PTSD and depression symptoms had nearly twice as many physical health problems (Berthold, 2014). Many refugees in the sample were survivors of the Khmer Rouge genocide which resulted in exposure to combat, bombings, starvation, slave labor, kidnapping, and separation from family. Similarly, among a sample of Somali refugees resettled in the US (recruited from a university-community mental health clinic), Kroll, Yusef, and Fujiwara (2011) found that rates of PTSD and depression were higher for all Somali refugees in comparison to a non-Somali, non-refugee control across age and gender groups except for males over 30 years old. As measured by a DSM diagnosis via clinical interview, rates of PTSD and depression were highest among older male and Somali female (regardless of age) patients. Notably, 80% of Somali males under the age of 30 experienced symptoms of psychosis (for the purpose of this research, psychosis included all patients with schizophrenia, mania, drug-induced psychosis, and psychosis not otherwise specified [DSM-IV codes 295, 297, 298, 293,

296.4 and 296.6]), a significant difference compared to the 13.7% people who experience psychosis among the non-Somali control group (Kroll et al., 2011). The results of this study are surprising and it is important to consider them in the context of study limitations such as use of Western measures on a non-Western population and language barriers.

In addition, some research indicates that mental health problems persist or worsen over time among refugee adults. For example, in a longitudinal study, Mollica, Sarajlic, Chernoff, Lavelle, Sarajlic Vukovic, and Massagli (2001) examined rates of mental health problems among Croatian and Bosnian refugees using the Hopkins Checklist and Harvard Trauma questionnaire. Forty-five percent of respondents who had met the DSM-IV criteria for depression, PTSD, or both at time 1 in 1996 still met criteria for the disorders at time 2 in 1999, thus initially measured negative mental health symptoms persisted from time 1 to time 2 for these individuals. In addition, a portion of participants, 16%, who were asymptomatic in 1996 developed one or both disorders in 1999, suggesting that some participants who did not present with mental health symptoms at time 1 developed negative mental health symptoms by the second time point (Mollica et al., 2001).

Research also suggests that rates of mental health problems may differ based on the country of resettlement. For example, D'Avanzo and Barab (1998) measured rates of depression and anxiety among Cambodian women refugees resettled in the US and France using the Hopkins Symptom Checklist. They found four major differences: (a) rates of depression among refugee women resettled in France were higher than women resettled in America; (b) the sample of refugees resettled to America was older on

average than those in France; (c) women in France experienced three times more depression symptoms than refugee women resettled in America; and (d) women in France reported more anxiety symptoms (D'Avanzo & Barab, 1998). These differences may be due to women in France being more socially isolated and having children (younger sample), in contrast to the older US sample (D'Avanzo & Barab, 1998). Thus, it is important to consider these mental health results in the context of potential confounding variables (e.g., age, location). In sum, refugee adults have high rates of mental health problems, significantly higher than those of an average citizen. Additionally, mental health symptoms may differ by country of origin, and by country of resettlement. This finding may be particularly relevant for the participants in this study who have not been officially resettled, but have fled to Malaysia, a country hostile to refugees.

Refugee student mental health. As mentioned above, a major risk factor that can impact teacher mental health is the behavior of their students. Refugee students present with unique behavioral challenges which may impact teacher mental health. For example, trauma witnessed by students can translate to violent behavior in school and an inability to adapt to classroom structure (Arabaci et al., 2014). Since refugee child experiences and mental health are likely to impact classroom behavior, it is important to understand child mental health as it relates to refugee teacher stress. Refugee status may be a risk factor affecting refugee children's mental health, on top of other variables like being an ethnic minority, low-income, and living in an urban area. Therefore, it is important to understand how unique experiences as a refugee child influence mental health. Given that most refugee mental health research has been done in the US (and other Western countries), but not in post-conflict refugee locations/countries, it is

important to identify unique post-conflict refugee macrolevel risk factors, like stressful events caused by experiences of discrimination and persecution in the post-conflict country (e.g., being unable to attend Malaysian public schools, native citizens' views of refugees, and refugees' experiences with detention, fines, and physical punishment which may be linked to mental health issues.

Meta-analysis results suggest that child refugees suffer from exposure to significant conflict-related situations (e.g., war, violence, trauma, human rights violations, and persecution) (Lustig et al., 2004). In addition, there has been ample research establishing that post-conflict refugee children have high rates of Post-Traumatic Stress Disorder, anxiety, and depression symptoms (Bronstein & Montgomery, 2011; Hepinstall et al., 2004; Lustig et al., 2004). Refugee children are at great risk of developing mental health problems, as they are exposed to many parent, child, and environmental risk factors (Fazel & Stein, 2002). Among refugee children in exile, there is a high prevalence of emotional and behavioral disorders, most commonly PTSD, anxiety, and depression (Fazel & Stein, 2002). Fazel Reed, Panter-Brick, and Stein (2012) found that exosystem level exposure to violence prior to fleeing the home country was highly predictive of microlevel mental health problems. In addition, at the microlevel, refugee children may experience extreme sadness, not only due to loss of friends or family members, but also due to loss of their culture (Eisenbruch, 1988). Overall, the literature suggests that the experience of migration may have a significant impact on refugee child mental health outcomes.

Self-care to Manage Mental Health Problems and Stress

Put simply, the dictionary definition of self-care is care for oneself (Merriam-Webster, 2019). According to the World Health Organization “Self-Care is what people do for themselves to establish and maintain health [including psychological health], and to prevent and deal with illness. It is a broad concept encompassing hygiene (general and personal), nutrition (type and quality of food eaten), lifestyle (sporting activities, leisure etc), environmental factors (living conditions, social habits, etc.) socio-economic factors (income level, cultural beliefs, etc.) and self-medication” (World Health Organization, 1998). Self-care has also been described by Orem (1995) as “action of persons who have developed capabilities to use appropriate, reliable and valid measures to regulate their own functioning and development in stable or changing environments” (p. 43). The International Self-Care Foundation has developed a framework for self-care around seven domains of self-care: health literacy, mental well-being, physical activity, healthy eating, risk avoidance, good hygiene, and rational use of products/services) International Self-Care Foundation, 2019). Self-care practice is dependent on the individual; what may function as self-care for one person, may be a trigger for another person (e.g., visiting family). Some ways people practice self-care in the US include: spending time on a hobby, spending time in nature, spending time with family or friends, getting a massage, exercising, going on vacation, going shopping, meditating, eating healthy, and having a sleep routine. Self-care promotes well-being and health, (Baumann, & Dang, 2012) it is possible that engaging in self-care may reduce stress and mental health challenges among teachers in refugee schools. Although self-care has not been studied previously in relation to stress and mental health among refugee teachers, research suggests that self-

care (including stress management techniques) may improve mental health outcomes for teachers and those in other caregiver professions (e.g., therapists and counselors) (Newsome, Christopher, Dahlen, & Christopher, 2006; Shapiro, Brown, & Biegel, 2007). Teaching is similar to counseling in that individuals in these roles are expected to enrich and improve the lives of others (Naisbitt & Cracknell, 1984). These caregiving occupations often involve a high degree of empathy, attachment, and personal investment, which is also accompanied by a high risk for burnout, making self-care highly necessary for these individuals (Skovholt, Grier, & Hanson, 2001). Further, self-care may be even more necessary for teachers of refugee children, due to the unique stressors refugee teachers and their students face. Overall, literature suggests that self-care can be viewed as a tool to manage negative mental health and stress. For example, a large meta-analysis of over 200 studies suggests that self-care is related to improved health outcomes and more appropriate use of health and social services (Department of Health, 2007).

The ways in which we take care of ourselves vary by individual, but there may be some common factors in how we define self-care. For example, a meta-analysis examining the nature of self-care (Lucock et al., 2011) identified a wide range of self-care strategies across studies including: employment, education, creative activity, physical exercise, health living, structured routine, and spirituality. Additionally, control arose as a common feature across studies, including control over one's life, treatment, and future (Lucock et al., 2011). It is also important to note that there may be gender differences in self-care practices. For example, women are more likely to rely on social

supports, communicate emotions, and ask for help when they need it, in comparison to men (Maris, Berman, & Silverman, 2000).

As discussed above, teaching is a high stress occupation, but self-care strategies (e.g., emotion and stress management) may help teachers manage their stress. Refugee teachers experience unique stressors beyond that of the average teacher (Arabaci, Basar, Akan, and Goksoy, 2014; Kirk, 2010; Kirk and Winthrop, 2007), thus self-care practice may be especially useful, however, no self-care or stress-management research has been done with refugee teachers. Stress management and self-care may help refugee teachers cope with stress in the classroom and with their own experiences as a refugee (e.g., living in a country hostile to refugees). Although no self-care research has been done with refugee teachers (with exception of our research team's work [see O'Neal, Gosnell, Ng, & Ong, 2018b for intervention effects on self-care use]), it has been studied among other teacher populations, for example, in a study by Dicke, Elling, Schmeck, and Leutner (2015) beginning German teachers (N = 97) underwent a classroom management and stress management training (which included group discussion, group work, roleplays, and questionnaires). Post-intervention results suggest improved teacher well-being and classroom-management self-efficacy, as indicated by teacher self-report (Dicke et al., 2015). Similarly, Neves de Jesus, Miguel-Tobal, Rus, Viseu, and Gamboa (2014), in a meta-analysis, evaluated the effects of an evidence-based stress management training program (which combines different person-focused interventions like relaxation and cognitive-behavioral skills training to help participants acquire coping skills [Neves de Jesus & Conboy, 2001]) on stress-related outcomes among teachers and physicians. The program was implemented among groups of physicians and teachers (N = 144) in Portugal

and Brazil. Across subsamples, there was a decrease in stress-related outcomes (emotional exhaustion, work distress, and irrational beliefs), with the greatest impact on irrational beliefs.

In a related study, Leung, Mak, Chui, Chiang, and Lee (2009) explored job-related stress, mental health, and self-care among a sample of 89 teachers working in secondary schools in Hong Kong. The authors sought to compare teachers who engaged in techniques for stress management (self-care) and those who did not actively engage in such techniques. Measures included three self-report surveys: Occupational Stress Inventory (OSI-R), Depression Anxiety Stress Scale (DASS-21), and Health-Promoting Lifestyle Profile (HPLP) II. Results indicated that 75% of the sample experienced fair to low satisfaction with their chosen career in teaching and 82% experienced burn-out related symptoms (e.g. exhaustion) (Leung, Mak, Chui, Chiang, & Lee, 2009). A third of the sample experienced significant stress and a third anxiety; 12% experienced severe depression. Results of the stress-management assessment suggested that the teachers in this sample often ignored their own health and stress levels. Further, teachers who engaged in more stress-management practices showed less physical symptoms, greater satisfaction with their profession, and less job stress.

As mentioned previously, in addition to teachers, self-care is often studied among mental health professionals, for example, Newsome, Christopher, Dahlen, and Christopher (2006) evaluated a self-care for stress reduction course among counselors in training. The course was mindfulness-based (mindfulness can be viewed as a form of self-care) and lasted for fifteen weeks. Data were collected over the span of four years during which the course was offered via qualitative analysis of journal entries,

quantitative course evaluations, and focus group (only in the fourth year). Results suggest positive changes for students in terms of stress management and improving their counseling practice. After completing the course, students also reported positive changes across physical, emotional, mental, spiritual, and interpersonal levels as well as improvement in their counseling skills. Similarly, Richards, Campenni, and Muse-Burke (2010) examined the effects of mindfulness on the relationship between self-care and well-being. The sample included 148 mental health professionals with a bachelor's degree or higher in the northeastern US. All measures were self-report and included a self-care survey (which measured types of self-care, rate of self-care, and importance of self-care), the Self-Reflection and Insight Scale (SRIS), the Mindful Attention Awareness Scale (MAAS), and Schwartz Outcomes Scale-10 (SOS-10) (a measure of well-being). Results suggest that self-awareness and mindfulness were significantly, positively correlated. Mindfulness, among this sample of mental health professionals mediated the relationship between self-care and well-being. However, this study only included one timepoint, a weakness for a mediation study.

Research suggests that self-care is also particularly useful among patients with existing mental health issues. Examining self-care among individuals with existing mental health problems is relevant given that refugee adults are more likely to have mental health problems (e.g., depression) than non-refugees (Schewitzer, Brough, Vromans, & Asic-Kobe, 2011; Lindert, von Ehrenstein, Priebe, Mielck, & Brahler, 2009; Kroll, Yusef, & Fujiwara, 2011). Among adults with depression and anxiety, Lucock, Kirby, and Wainright (2011) sought to examine the effectiveness of a guided self-help intervention. The intervention was two sessions in length and was provided by graduate-

level mental health care professionals in a primary care clinic. The authors utilized a randomized trial design with a waitlist control group. At intake, patients presenting with significant anxiety and depression symptoms were randomly assigned to one of two groups (immediate or delayed treatment after eight weeks). The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) was the primary outcome measure. Analysis of covariance showed a significant treatment effect, and there was a significant difference in means comparing the immediate and delayed treatment groups. Across groups, CORE-OM scores for patients who completed the intervention decreased between screening and the review session; 47% of participants showed a significant improvement after participating in a guided self-help intervention.

In a related study, McCusker et al. (2015) sought to compare outcomes among depressed patients who utilized a depression self-care toolkit with and without lay coaching via phone. The sample included patients with depression and comorbid physical conditions who were aged 40 years or older. Participants were randomized to receive the self-care toolkit intervention with (intervention) or without (control) telephone coaching provided by trained coaches. The primary outcome of depression was measured via the Patient Health Questionnaire (PHQ-9) after six months. Additional variables were self-efficacy, satisfaction, and use of health services. The mean for the intervention group was significantly higher at three months, but there were no significant differences between groups at three months. Patients who had a moderate level of depression symptoms and high self-efficacy were the most likely to benefit from the intervention. Based on the literature reviewed in this section, self-care may improve mental health outcomes for those in caregiver professions (e.g., teachers and counselors)

and also among those with existing mental health concerns. Self-care could potentially be especially beneficial for refugee teachers as they occupy two of these categories, they are employed in a caregiver profession and, given their refugee status, they are likely to experience higher than average rates of mental health symptoms.

Current Study

Using a mixed method design, this study aims to examine stress, mental health (i.e., depression and anxiety), and self-care among refugee teachers in hidden refugee schools in Kuala Lumpur, Malaysia. This study utilized existing quantitative and limited pilot qualitative data collected in Malaysia in 2012-2013 as well as additional qualitative data that I collected in Malaysia in June 2018 (see Figure 2). See list of questions and hypotheses above (page 7).

Figure 2. Description of data collection timeline.

Chapter 3: Method

Relationship-building

Relationship-building is an essential first step in a research process (Nastasi & Schensul, 2005). Since there is often mistrust of outsiders by refugee communities living in countries that are hostile to refugees, Dr. O’Neal first established relationships with refugee schools with help from World Vision-Malaysia, HELP University-Malaysia, UNHCR–Malaysia, Muslim and Christian groups, and other local community refugee school leaders beginning in 2010. World Vision-Malaysia is a Christian philanthropic organization, and the most respected nonprofit in Malaysia for their work in marginalized students’ education; they fund the largest refugee school. The World Vision–Malaysia leader introduced Dr. O’Neal and her colleagues to the leader of the largest center refugee school. Then, that refugee school leader introduced Dr. O’Neal to UNHCR-Education officials and many of the community refugee school leaders at a training organized by the center refugee school and UNHCR, where Dr. O’Neal and colleagues gave a brief overview of their interest in developing collaborations with the goal of future interventions and research. The involvement of UNHCR–Malaysia was limited but essential. UNHCR is hardly welcomed into Malaysia by the government, since the government is not a signatory to the U.N. convention protecting refugees. Thus, UNHCR’s lobbying efforts on behalf of refugees are restricted. HELP University, a private higher education institution with one of the strongest psychology undergraduate and graduate programs in Malaysia, was another partner. Dr. O’Neal was a Fulbright teacher/research scholar based at HELP University from 2010–2011. This research was

made possible by collaboration with the partners described above who helped guide and inform the decisions made during this research process.

Context for the Study

After Dr. O’Neal completed her Fulbright in 2011, she received an award from the Fulbright New Leaders Group to collaborate with another HELP University professor and graduate students to continue refugee student education research through student mental health assessments and brief therapy, in addition to preliminary teacher training. Then, from 2012 to 2013, Dr. O’Neal and a professor at HELP University received funding from the Fulbright Alumni Engagement Innovation Fund to conduct three focus groups. The focus group with Burmese community refugee teachers is reported, in part, in this dissertation. Next, Dr. O’Neal and her collaborators developed a community refugee-teacher-train-refugee-teacher initiative; data (mental health and self-care) from which is reported in this dissertation, while intervention effects data are reported in a separate published article (O’Neal et al., 2018b). In 2016, Dr. O’Neal received private funding from an alumnus of the College of Education at University of Maryland to collect additional qualitative data on refugee teachers to inform future interventions and related work. In June 2018, Dr. O’Neal and I traveled to Malaysia to collect this data, which served as the additional qualitative data (in the form of individual interviews) in this dissertation (see figure 2).

Participants

Quantitative study participants. The quantitative data for this study were collected in Kuala Lumpur, Malaysia in 2013. Quantitative participants included 124

teachers recruited from 400 total teachers working in informal refugee schools in Malaysia (see Table 1 for participants' demographic information). Eligibility criteria included: (a) currently living in Malaysia, (b) teacher of refugee children (aged under 18), and (c) conversational English-speaking ability. Note that it was difficult to estimate the total number of schools from which we originally recruited given that recruitment occurred via a snowball procedure including word of mouth, in-person meetings, and e-mails sent by refugee service organizations and UNHCR to the refugee schools with whom they were in contact. Of the 124 teachers, there were 97 teachers who were refugees themselves, were primarily from the country of origin of Burma (77.6%) (M age = 30.22, 57.1% female), and were from 30 schools. The other 26 teachers of refugee students were not refugees themselves, were primarily from Malaysia (50%) or Western countries (e.g., U.S., Australia) (M age = 48.42, 73.1% female), and were from 7 schools. Among the teachers who were refugee themselves, 15.3% were in a head teacher position in comparison to 3.8% among non-refugee teachers. The majority of both refugee (76.5%) and non-refugee (68%) were Christian and had been teaching in Malaysia for less than five years (refugee: 99%, non-refugee: 91.6%). The majority of refugee teachers (88.7%) had been living in Malaysia for less than five years while more than half of the non-refugee teachers (52%) had been living there for more than five years.

Hidden refugee schools. In Malaysia, refugee children are prohibited from attending Malaysian public schools, thus, informal learning centers were created in refugee communities to educate refugee children. These schools operate on minimal funding from non-profit organizations; about ten of them get funding from UNHCR, and the other schools get minimal resources from UNHCR or other foundations. Most

teachers are refugees themselves, but some schools also employ citizen teachers. In general, schools that receive funding from UNCHR employ more citizen teachers than schools who do not receive UNHCR funding. Often the school director is a Malaysian citizen. Citizens of other countries (e.g., US, Australia) may also work or volunteer, typically part-time or on short stints, at refugee schools. Refugee teachers are paid a small salary, citizen teachers may earn more depending on the school. While the schools are hidden in the sense that they do not display signs or have an official address, they could be found if officials wanted to find them. Education for refugee children typically ends by age 12. Refugee students do not have a recognized graduation certificate or curriculum from these schools. There are, however, a handful of refugee schools that have recently starting secondary school programs due to the recent influx of Syrian refugees who were typically well-educated back in Syria and expect more education. The problem is that in order to go to these refugee secondary schools, run by NGO's, it usually costs enough in tuition that it is prohibitive to the majority of refugee students.

Table 1

Quantitative Participant Demographics

Variables	Refugee Status	
	<i>Refugee (n=97)</i>	<i>Non-Refugee (n=27)</i>
Teacher Position		
Head Teacher	15.3	3.8
Supervisor	2.0	
Teacher	82.7	96.2
Age (<i>in years</i>)	30.22 (9.85)	48.42 (11.18)
Malaysian Citizenship (%)		
Yes	1.0	50.0
No	99.0	50.0

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Sex (%)		
Female	57.1	73.1
Male	42.9	26.9
Country of Origin (%)		
Myanmar	77.6	
Middle East	9.2	7.7
Countries (Syria, Iraq, Iran, Palestine)		
Sudan	3.1	
Pakistan	7.1	
Afghanistan	3.1	
Malaysia		50.0
Western/European		23.1
Countries (Australia, UK, Germany, France, USA)		
Other Asian		19.2
Countries (Korea, Philippines, Singapore)		
Ethnicity (%)		
Chin	58.8	
Arabic, Persian, Hazara, Ellassher	15.5	8.7
Zomi	8.2	
Pakistani	7.2	
Mizo	3.1	
Kachin	3.1	
Chinese		43.5
Western/European		26.1
Countries		
Other Asian		17.4
Countries		
Indian		4.3
Other	4.1	
Religion (%)		
Christian	76.5	68.0
Muslim	18.4	20.0
Buddhist	4.1	
Agnostic	1.0	12.0
Time in Malaysia (%)		
<1 year	14.4	24.0
1-5 years	74.3	24.0
>5 years	11.3	52.0
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Time teaching in Malaysia (%)		
<1 year	39.2	37.5
1-5 years	59.8	54.1
>5 years	1.0	8.4
Time teaching in current school (%)		
<1 years	45.4	36.0
1-5 years	53.6	60.0
>5 years	1.0	4.0

Pilot focus group participants. This research also relied on a small amount pilot qualitative data regarding refugee teacher self-care collected via focus group in Kuala Lumpur, Malaysia in 2012. Although three focus groups were conducted as part of another study from 2011-13 (O’Neal et al., 2016), the small self-care portion of one focus group which included questions regarding classroom management and teacher self-care conducted with teachers who are Burmese refugees working at community refugee schools, informed the additional qualitative data (collected June 2018). Of the three focus groups, only one included a question related to self-care, which is why it was utilized to inform this study. The focus group data (with the exception of the self-care data) have been reported on in another publication (O’Neal et al., 2016). Exploring the small amount of qualitative self-care data, which have not yet been reported on, sparked my interest in collecting qualitative data on stress, mental health, and self-care among teachers who are Burmese refugees. The pilot community focus group included nine Burmese refugee teachers from nine different community refugee schools that served approximately 1,100 refugee students. Of their students, the majority were in elementary school. The focus group was conducted at one of the nine schools. Questions focused on challenges working with refugee students, use of classroom management strategies,

relationships with and respect for authority among students, and stresses teachers are feeling (see Appendix A).

The Burmese refugee teacher pilot focus group participants were six male and three female teachers aged 24 to 35 years ($M = 30$ years of age). Most were Christian ethnic minority refugees, a marginalized group in Burma. All teachers were Burmese refugees who identified with the following Burmese ethnic groups: 2 Chin, 2 Shan, 1 Arakanese, 1 Mon, 1 Kachin, 1 Karenni, and 1 Karen. It is important to note that in the context of Burma, these different groups are referred to as ethnic groups, groups with which individuals self-identify based on historical, religious, or geographical identities. Two of the nine reported they had not yet obtained a UNHCR refugee card; often, it can take years before a refugee receives a card. Seven of the nine teachers reported that they had had some teacher experience in their country of origin. In terms of education one teacher has less than high school, four had completed high school, and four had some college or had completed college. The teachers had taught for a couple years, on average, at their community refugee schools, ranging from 1 month to 4 years of teaching at their community school. They had lived in Malaysia for three years, on average, ranging from less than 1 year to 7 years.

The participating focus group teachers reported their students' Burmese ethnicities as: 716 Chin, 20 Kachin, 87 Karen, 19 Shan, 3 Karenni, 50 Mon, and 56 Arakenese. The Chin majority in this group reflected the Burmese refugee population in Malaysia as a whole. Each of the community refugee schools these teachers worked at were largely monoethnic (e.g., Chin only), and the teachers were from the same Burmese ethnic group as their students. While refugee cards provide only very limited protection in Malaysia,

at the time of this 2012 focus group, refugee adults reported that refugee cards were looked upon as a gateway to resettlement, may provide limited resources such as housing for unaccompanied refugees, and, in some rare cases, were a way to get UNHCR's attention if placed in detention (O'Neal et al., 2018a). Thus, the lack of refugee cards among this population of students and teachers could put them in a more vulnerable position than those with cards.

Individual interview participants. Pilot qualitative data on self-care practices among refugee teachers collected via focus group in 2012 informed the additional interview data collected in June 2018. I recruited teachers who are refugees from Burma and who currently teach in refugee schools in Malaysia. UNHCR has given the term "Informal Learning Centres" to identify these informal refugee schools. The majority of these schools service the Burmese student community, but there are also schools focused on other, smaller refugee populations in Malaysia (i.e., Somali, Afghan, and Iraqi students). Almost all of the refugee students at these centers range from ages 5-12 because the schools do not have enough funding to educate older students, and older students often have to work to support their families instead of attending school. Interview participants were recruited via flyers and emails distributed by various connections within the community that Dr. O'Neal made during her time in Malaysia in 2011- 2013. My goal was to recruit at least five interview participants as recommended for phenomenological qualitative research (Polkinghorne, 1989). Eligibility criteria for the individual interview included: (a) refugee status, (b) currently living in Malaysia, (c) fled from Myanmar to Malaysia, (d) teacher of refugee children (aged under 18), and (e) conversational English-speaking ability. Eleven (9 female, 2 male) Burmese refugee

teachers participated in individual interviews. Most were Christians from the Chin ethnic group, but two women were Muslims from the Rohingya ethnic group. Four teachers had college degrees or some college prior to arriving in Malaysia, but none had teaching experience in Burma. Nine teachers had UNHCR refugee cards at the time of the interview, but 2 did not (see Table 2). It is important to note, that these eleven interview participants did not participate in any of the previous rounds of data collection (2012-2013). They did not complete the quantitative measures collected in 2013.

Table 2

Qualitative Participant Demographics

Pseudonym	Gender	Religion	Ethnicity	Education Level	Refugee card?
Bawi	Female	Christian	Chin	High School	Yes
Chit	Male	Christian	Chin	Some College	Yes
Kywa	Female	Christian	Chin	High School	Yes
Linn	Female	Christian	Chin	High School	Yes
May Lin Kha	Female	Christian	Chin	High School	Yes
Mya	Female	Muslim	Rohingya	College Degree	Yes
Nyinyi	Female	Muslim	Rohingya	College Degree	No
Sann	Female	Christian	Chin	High School	Yes
Huang	Male	Christian	Chin	Some College	Yes
Thura	Female	Christian	Chin	High School	No
Ya Zin	Female	Christian	Chin	High School	Yes

Reporting potential bias. According to Hill and Colleagues (2005) as part of a Consensual Qualitative Research (CQR) approach, it is recommended that researchers report potential sources of bias in qualitative work in the participants section. Potential bias includes researcher demographics and researcher feelings or reactions to the topic of study. I conducted this research under the supervision of Dr. Colleen O’Neal. In terms of researcher demographics, both Dr. O’Neal and I identify as white, highly educated women. We were born in and remain citizens of the United States of America. We have different backgrounds and lived experiences as compared to the Burmese refugee teachers we interviewed. In this case, demographics are an unavoidable source of potential bias that I have been cognizant of throughout this research process. In terms of my own feelings and reactions to the topic, I was surprised at my own intense emotionality while conducting and reflecting upon the interviews. There were moments when I felt as though I was feeling with a participant as they spoke, which made it difficult for me to respond objectively to the data at all times. I also reflected a great deal on my feelings about doing this work in the first place. Refugees living in Malaysia are a severely exploited population. At times, I felt like I was adding to that degree of exploitation without being able to provide any tangible benefits. My personal reactions and feelings which were intense at times are another potential source of bias in this study (see my detailed reflection on the process in the discussion section). Hill et al., (2005) also recommend that qualitative researchers report their expectations or “beliefs that researchers have formed based on reading the literature and thinking about and developing research questions.” I have written a master’s thesis and coauthored two papers on Burmese refugees living Malaysia. Thus, I have read a great deal of literature

and developed several research questions on this topic over the past several years. I want to acknowledge that I did have well-formed expectations as I began this work, however, nothing could have prepared me for what it was like to actually travel to Malaysia and conduct these interviews. The experience of being in the room, of analyzing the data, and reporting results has offered many surprises and successfully defied my expectations. Overall, I recognize that bias is a natural part of the qualitative research process; it will also be discussed in the discussion section of this dissertation.

Quantitative Data Collection

This study involves no direct interaction with refugee students and only targets the teachers of refugee students, who are refugees themselves. As mentioned previously, the quantitative data utilized in this study were collected in Kuala Lumpur, Malaysia in 2013 as part of a larger intervention study which evaluated a training program for refugee teachers (O'Neal et al., 2018b). Teachers were trained over 2 days on the following topics: refugee student mental health; empathy for refugee students; teaching in a refugee classroom; rules, transitions; positive teacher-child relationships; praise; rewards; and star charts. The training also focused in depth on teacher self-care, including stress, anxiety, and anger-management strategies. On the third and final day of training, peer trainers were offered information and practice on how to effectively train their peers, with a focus on general presentation and discussion facilitation skills in addition to practice in delivering the specific training content. This study uses pre-intervention survey data which have not yet been reported on in this way. The procedure included immediate pre- and post-intervention assessment of confidence in classroom management strategies, knowledge of classroom management strategies, stress, anxiety, depression, and self-care

in addition to daily training satisfaction ratings. A demographics questionnaire was administered pre-intervention. No qualitative data were collected from these participants.

Qualitative Data Collection

The study also relied on a small amount of pilot qualitative data that were collected in Malaysia in 2012-2013 via focus group. The pilot focus included open-ended questions addressed (a) unique socioemotional needs and strengths of refugee students, focused on student behavior, attention, and emotions, and (b) teacher classroom management of student behavior, attention, and emotions (see questions in Appendix A). The three-hour focus group started with the consent process, was audio recorded, was held on-site at one of the schools, and provided dinner and a dinner break. Questions were asked one at a time, with follow-up questions for more depth. No quantitative data were collected from these participants.

In addition to the existing qualitative and pilot quantitative data, additional qualitative data were collected via individual interviews in Malaysia in the summer of 2018. This qualitative data were collected to enhance and expand upon the existing qualitative data. New qualitative data were necessary to achieve goals not addressed in our previously collected qualitative data. The additional data focused on establishing culture-specific definitions and connecting the constructs of stress, mental health, and self-care. It elicited information regarding stressors both inside and outside the classroom which contribute to teachers' current stress and mental health as well as the overall impact of being a refugee teacher on mental health (in addition to the impact of their stress and mental health on their functioning as an instructor). Further, the new data

shed light on teachers' perceived importance of self-care and the specific coping strategies and ways of caring for oneself that refugee teachers employ.

Individual interview participants were recruited via purposeful snowball sampling through Dr. O'Neal's connections from relationships built through previous research while on a Fulbright Scholar Award in Kuala Lumpur, Malaysia and when conducting refugee teacher intervention research in 2013. As mentioned above, the 2018 interview participants did not participate in any of the previous rounds of quantitative or qualitative data collection (2012-2013). The interview along with a brief demographics questionnaire were the only data collected from these participants. All interviews were individual interviews (sometimes with a participant-selected peer teacher acting as a translator) which occurred in a private, quiet space. Each participant was interviewed only once. At the beginning of the interview, I introduced myself as a researcher, emphasizing the fact that I was a doctoral student at an American university and that I was not affiliated with UNHCR or any related organization. I explained that the purpose of my study was to learn about the experience of refugees, specifically refugee teachers. The interview began after the consent process and a brief demographics questionnaire was completed. Interviews lasted between thirty minutes and one hour. Most interviews with female teachers lasted closer to an hour. One female teacher and the two male teachers had shorter interviews. I conducted all interviews; some were conducted with Dr. O'Neal present. Dr. O'Neal's presence was solely dependent on her availability. Some teachers elected to have a trusted peer teacher help translate if they did not feel completely confident in their English, however, all participants had at least conversational English-speaking ability. Use of a peer translator was a decision made by

the participant and they chose which of their peers would help translate. If participants did elect to use a peer to help translate, the consent form was also translated.

Interview questions were open-ended and focused on establishing culture-specific definitions/perceptions of and drawing connections among the constructs of stress, mental health, and self-care (see Table 5). The interview consisted of questions regarding stressors refugee teachers face both inside and outside the classroom. In addition, questions addressed how these various stressors contribute to teachers' current stress levels and mental health, the overall impact of being a refugee teacher on mental health, and the impact of stress and mental health on their functioning as an instructor. Interview questions explored how teachers take care of themselves, including perceived importance of self-care and specific coping strategies. At the end of the interview, each participant was compensated with forty ringgits, which is equivalent to about ten U.S. dollars. This amount was decided based on communication with community stakeholders. After all interviews were completed, I transcribed the electronic audio files with the assistance of three other doctoral students in Dr. O'Neal's lab. The recording device malfunctioned causing the deletion of one participant's audio file. I realized this at the conclusion of the interview and immediately wrote down everything the participant said as I remembered it. My notes were utilized in lieu of a transcript for this one participant.

Table 5

Qualitative Measure: Interview Prompts and Questions

Prompt/Question
<ol style="list-style-type: none"> 1. Tell me about your experience as a refugee. <ol style="list-style-type: none"> a. in your country of origin b. during flight c. in Malaysia 2. Tell me about being a teacher of refugee children. <ol style="list-style-type: none"> a. Positive aspects? b. Challenges? 3. What does stress mean to you? <ol style="list-style-type: none"> a. When you feel stressed, what do you feel inside? b. What are some of the stressors you face? 4. What does mental health mean to you? <ol style="list-style-type: none"> a. When you feel mental health strong, what do you feel inside? b. Can you give examples of mental health problems? <ol style="list-style-type: none"> i. Can you think of examples you have seen in other refugee teachers? c. When you feel mental health problems, what do you feel inside? 5. What do you see as the difference between stress and mental health? 6. What do you do to make yourself feel better (take care of yourself) when you feel stressed? <ol style="list-style-type: none"> a. How often do you take of yourself? b. How important is taking care of yourself to you?

Note: All sub-prompts (a, b, c levels) will only be asked if I could not gain enough necessary information from the main prompt/question (numbered 1-6).

An Inductive Phenomenological Approach. My qualitative methodology was based on an Inductive Phenomenological Approach. Phenomenological qualitative research involves exploring a specific phenomenon among a group of individuals who have all experienced the phenomenon (Creswell, 2013). Typically, data are collected through interviews, but may take other forms (e.g., poems, observations). To analyze data using a phenomenological approach, there are systematic procedures that move from narrow units of analysis (codes) to broader units of analysis (themes) (Creswell, 2013). The overall goal of a phenomenological approach to qualitative research is to capture the essence of participants' experience of the phenomenon. I determined that my qualitative

question would be best answered using a phenomenological approach, given that it was important to understand several individuals' common or shared experiences of a phenomenon to inform practice or policies and develop a deeper understanding of the phenomenon (Creswell, 2013). A phenomenological approach requires in-depth interviews of at least five participants who have all experienced a phenomenon. For the purpose of this dissertation, I identified *what it means to be post-conflict refugee teacher* as the phenomenon of interest. Consistent with this approach interview participants were asked broad questions regarding their experience of a phenomenon and what contexts or situations have affected their experiences of the phenomenon in order to gain an understanding of their common experiences (Creswell, 2013). Next, after all interviews were transcribed, myself, Dr. O'Neal, and two other doctoral students went through the transcripts to highlight significant statements (this process is referred to as horizontalization) (Creswell, 2013). A list of codes was generated from the horizontalization process and I coded all transcripts. Dr. O'Neal acted as a second coder on two interviews for reliability purposes. Inter-rater reliability was conducted using percent agreement. See additional details in analytic section below.

Quantitative Measures

Demographics. Demographic information gathered from participants included variables such as sex, age, ethnicity, country of origin, religion, number of years living in Malaysia, number of years teaching, and name of school. It was obtained through a paper and pencil demographic survey.

DASS-21 Inventory. The Depression Anxiety Stress Scales-21 (DASS-21) (Lovibond & Lovibond, 1995) is a 21-item self-report which measures three emotional

states: depression, anxiety, and stress (see table 3). It is a reliable and valid measure for use with both clinical and nonclinical populations (Henry and Crawford, 2005). It is a shorter version of the Depression Anxiety Stress Scales-42. Each state is covered by a 7-item scale, each of which is rated on a 4-point Likert scale which ranges from (0 = “Does not apply to me,” to “3 = Applies to me very much or most of the time”). The Depression Anxiety Stress Scales-Depression (DASS-D) Scale contains items which measure symptoms typically associated with low mood (e.g., feelings of sadness) (Antony, Bieling, Cox, Enns, & Swinson, 1998). A depression scale sample item is: “I couldn’t seem to experience any positive feeling at all.” The Depression Anxiety Stress Scales-Anxiety (DASS-A) Scale contains items that measure symptoms associated with fear, physical arousal, and panic. A sample item on the anxiety scale is: “I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat).” In contrast, items on the Depression Anxiety Stress Scales-Stress (DASS-S) Scale measure symptoms of tension, irritability, and a tendency to overreact to stressful events. A stress item is: “I found it hard to wind down.” These stress-related symptoms are unique to the construct of stress in that they are not assessed on typical measure of anxiety (e.g., Beck Anxiety Inventory). The summary scores for each subscale are calculated by averages across all items in each subscale.

The maximum score on the DASS-21 is 42 (each scale is multiplied by 2 to make scores comparable to the DASS-42). There are clinical ranges for each scale that specify level of severity of the symptoms. A score above eleven on the depression scale indicates clinically severe symptoms. A score greater than eight on the anxiety scale suggests clinically severe anxiety and a score over 13 on the stress scale indicates severe stress

(see Figure 3). Previous research suggests that the DASS-21 has convergent and discriminant reliability in a normative sample (as reviewed in Henry and Crawford, 2005) and that doubled score means on the DASS-21 are nearly the same as scores on the longer DASS (which contains 42 questions; Henry & Crawford, 2005). Based on existing factor analytic studies with both nonclinical (Lovibond & Lovibond, 1995) and clinical samples (Brown, Chorpita, Korotitsch, & Barlow, 1997), items on the DASS can be reliably grouped into three scales measuring three separate constructs: (a) Depression (DASS-D), (b) Anxiety (DASS-A), and (c) Stress (DASS-S). Although scores on measures aimed at assessing these constructs individually (e.g., State-Trait Anxiety Inventory [STAI-T; Spielberger, 1983]) tend to be highly intercorrelated and have a great deal of overlap in content (Clark, 1989; Clark & Watson, 1991; Moras, Di Nardo, & Barlow, 1992), factor analytic results have suggested that the DASS actually measures stress, anxiety, and depression as separate constructs (Brown, Chorpita, Korotitsch, & Barlow, 1997; Lovibond & Lovibond, 1995). The DASS questionnaire in this study had an alpha of .90. The stress scale had an alpha of .71, the anxiety scale .82, and the depression scale .72. It should be noted that the DASS has never been validated on a population of Southeast Asian refugees; there are obvious limitations when using measures that were not normed on the specific population of study. These limitations are discussed in more detail in Chapter 5 (Discussion).

Table 3

Quantitative Measure 1: DASS-21 Items

Scale, Question
<i>Stress</i>
1. I found it hard to wind down
2. I tended to over-react to situations
3. I felt that I was using a lot of nervous energy
4. I found myself getting agitated
5. I found it difficult to relax
6. I was intolerant of anything that kept me from getting on with what I was doing
7. I felt that I was rather touchy
<i>Anxiety</i>
1. I was aware of dryness of my mouth
2. I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)
3. I experienced trembling (e.g., in the hands)
4. I was worried about situations in which I might panic and make a fool of myself
5. I felt I was close to panic
6. I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)
7. I felt scared without any good reason
<i>Depression</i>
1. I couldn't seem to experience any positive feeling at all
2. I found it difficult to work up the initiative to do things
3. I felt that I had nothing to look forward to
4. I felt down-hearted and blue
5. I was unable to become enthusiastic about anything
6. I felt I wasn't worth much as a person
7. I felt that life was meaningless

	Depression	Anxiety	Stress
Normal	0 - 4	0 - 3	0 - 7
Mild	5 - 6	4 - 5	8 - 9
Moderate	7 - 10	6 - 7	10 - 12
Severe	11 - 13	8 - 9	13 - 16
Extremely Severe	14 +	10 +	17 +

Figure 3. DASS clinical cut-off ranges.

Self-care strategies. This self-care strategy questionnaire was adapted from a self-care scale in the Mental Health Handbook (Powell, 2000) and used to measure participants' use of self-care strategies. It consists of 10 statements about self-care strategies (e.g., "I occasionally give myself something nice like a present or treat" and "I make time to do relaxing activities") (see table 4). Participants then rated each statement according to whether it was representative of them over the past week on a 4-point Likert scale which ranges from 1 ("Very unlike me") to 4 ("Very like me"). The total score on this measure reflects both the number of different self-care activities the participant endorses as well as the likelihood of engaging in the strategy, thus high scores suggest a participant is likely to engage in a variety of self-care strategies. This questionnaire had an alpha of .77 in this study.

Table 4

Quantitative Measure 2: Self-care Questionnaire Items

Item
1. I occasionally give myself something nice like a present or treat
2. I make time to do relaxing activities.
3. I believe it is necessary to be selfish at times.
4. I plan events in my life that I can look forward to, such as holidays or outings.
5. Every day I make sure I have some time to do something pleasurable for myself.
6. I make a point of looking after my appearance and health.
7. I can praise myself if I think I have done a good job.
8. I make time to take part in absorbing, meaningful hobbies and activities.
9. Sometimes I have to put my own needs first.
10. I can say 'no' when other people make demands on me.

Analyses

First, summary scores were created for each of the DASS-21 scales (Stress, Anxiety, and Depression) and the self-care measure. DASS-21 summary scores were multiplied by two to create clinical scores comparable to the DASS-42 as outlined in the scoring instructions for the DASS-21. Question 1: *What are the rates of depression, anxiety, stress, and use of self-care strategies among Southeast Asian refugee teachers teaching in refugee schools in Malaysia and how do these rates compare to non-refugee teachers teaching in refugee schools in Malaysia?* was answered by conducting descriptive statistics. Question 2: *Is more frequent use of self-care strategies associated with fewer negative mental health symptoms (i.e., depression and anxiety) among Southeast Asian refugee teachers and non-refugee teachers teaching in refugee schools in Malaysia?* was answered by conducting simple regression analyses which included self-care as the independent variable and depression and anxiety as dependent variables. There were two separate models, one included anxiety as the dependent variable, the other, depression. Note that simple regressions were carried out in addition to correlations based on the usage of regression. Regression analyses describe how an independent variable is numerically related to the dependent variable (i.e., regression predicts the value of the dependent variable based on the known value of the independent variable), while correlation analyses only determine the co-relationship or association of two variables. Question 3: *Does self-care moderate the association between stress and negative mental health symptoms among Southeast Asian refugee teachers and non-refugee teachers teaching in refugee schools in Malaysia?* was answered by conducting separate moderation analyses for each mental health outcome (i.e., depression and

anxiety) (see Figures 4 and 5) via Andrew Hayes' PROCESS macro for SPSS. Using the PROCESS macro, self-care was entered as the moderator variable, stress was entered as the X variable, and mental health was entered as the Y variable (anxiety in one model and depression in the other). The significance and amount of variance each model accounted for was assessed. Based on a priori power analyses with one predictor of an outcome and with three predictors of an outcome, I determined that I had sufficient power (.80 or greater) for detecting small to large effect sizes when employing the traditional .05 criterion of statistical significance.

Figure 4. Hypothesized moderation model. Stress as a predictor of anxiety moderated by self-care.

Figure 5. Hypothesized moderation model. Stress as a predictor of depression moderated by self-care.

Question 4, the qualitative question: *How do Southeast Asian refugee teachers living in Malaysia and working in hidden refugee schools experience stress, mental health, and self-care in the context of macrolevel factors related to the experience of being a refugee?* was answered by using an Inductive Phenomenological Approach to code refugee teacher interviews. Through their interviews, I gained an understanding of how refugee teachers experience stress, mental health, and self-care. All interviews were transcribed in order to analyze the qualitative data. An Interpretive Phenomenological Approach as described by Creswell (2013) was utilized to analyze the qualitative data based on the qualitative methods of a previously published study (O’Neal et al., 2016). Phenomenological qualitative research involves exploring a phenomenon with a group of individuals, typically via interview. Data analysis using a phenomenological approach follows systematic procedures that move from narrow units of analysis (codes) to broader units (themes) that summarize the “how” and “what” of the experience, with an end goal of capturing the essence of the experience. To code the data, I employed an inductive approach to develop codes. No a priori codes from the pilot data were used. After an immersive review of all transcripts by myself, Dr. O’Neal, and two other graduate students, we highlighted significant statements and I created a preliminary codebook (horizontalization of the data) (Creswell, 2013). Later, I detailed in further depth an interpretive thematic content analyses of two cases to develop codes for unique refugee teacher experiences regarding stress, mental health, and self-care. Throughout the coding process, additional codes were added if they were mentioned in more than one interview, and the previously-coded interviews were re-examined for these codes. The goal was to

create a list of non-repetitive, overlapping codes, a final codebook (Creswell, 2013).

Qualitative themes were devised by first coding the interviews for broader topics (codes) as described above. Next, codes were grouped into larger units of information known as “meaning units” or “themes” (Creswell, 2013, p. 193). The process involved synthesizing and interpreting the parts of the interview transcript which were coded under a particular topic in order to develop a deeper qualitative theme that was representative of how the participants addressed the topic. The purpose of the qualitative theme is to draw an overall inference and reach a deeper meaning based on the participants’ discussion of a common topic. The final step in the process of inductive phenomenological analysis the “what” and “how” in regard to the participants’ experience of the phenomenon (see qualitative results section below).

To ensure trustworthiness in my qualitative work (Lincoln & Guba, 1985; Nastasi & Schensul, 2005) Dr. O’Neal served as a secondary coder for two interviews in order to calculate inter-rater reliability. I discussed my codebook at length with her and thoroughly explained to her the codes and the purpose of the coding. Dr. O’Neal independently coded two interviews. I sought to ensure triangulation in my qualitative work through the procedures described above. Triangulation in qualitative research is defined as “the use of multiple sources, methods, theories, and investigators in the process of data collection and transformation” (Nastasi & Schensul, 2005).

Chapter 4: Results

Quantitative Results

Quantitative results are organized by research question. For each research question, analyses are run by refugee status (i.e., analyses are run separately, splitting the file by refugee teachers and non-refugee teachers). Splitting analyses by refugee status is congruent with this dissertation's theoretical framework, (Suarez-Orozco and colleagues [2011]; Developmental Ecological Model) as I examined microlevel constructs (i.e., depression, anxiety, and stress) in the context of a macrolevel factor (i.e., refugee status). Given that the non-refugee sample size was so small, full sample results were only reported if they differed from the refugee only sample. In addition to refugee status, I am also interested in how mental health, stress, and self-care rates differ across age and gender; analyses will be explored further in the context of these demographic variables.

Descriptive Statistics. First, descriptive statistics were carried out to answer question 1, *What are the rates of depression, anxiety, stress, and use of self-care strategies among Southeast Asian refugee teachers teaching in refugee schools in Malaysia, and how do these rates compare to non-refugee teachers teaching in refugee schools in Malaysia?* Rates of mental health symptoms and stress among refugee teachers were high; significantly higher than their non-refugee peer teachers. For example, 8.3% of refugee teachers reported stress levels that fell in the severe or extremely severe clinical ranges (i.e., a total score of 13 or higher), while 0% of non-refugee teachers reported levels in the severe or extremely severe range. Depression scores also followed this pattern as 14.4% of refugee teachers reported depression scores that fell in the severe or extremely severe clinical ranges (i.e., a total score of 11 or higher), while 0% of non-

refugees reported levels in the severe or extremely severe range. Anxiety rates were especially high among refugees; 41.2% of refugee teachers reported anxiety levels that fell in the severe or extremely severe clinical ranges (i.e., a total score of 8 or higher), but only 10.5% of non-refugees reported levels in the severe or extremely severe range (see Table 6 and Figures 6-8). It should be noted that there are missing data as only 19 of the 27 non-refugee teachers completed DASS-21 forms. Consistent with the Developmental Ecological Model, rates of microlevel mental health and stress differed by the macrolevel factor of refugee status. The unique risk factors associated with refugee status (e.g., flight from country of origin) may have impacted microlevel outcomes (i.e., stress and mental health) among the refugee teacher sample.

Table 6

Descriptive Statistics

		<i>N</i>	Range	Minimum	Maximum	Mean	Std. Deviation
Refugee	Self-Care	97	26.00	11.00	37.00	26.77	4.78
	Stress	97	36.00	.00	36.00	13.96	7.46
	Anxiety	97	36.00	.00	36.00	13.09	8.93
	Depression	97	30.00	.00	30.00	11.36	7.44
Non-Refugee	Self-Care	19	11.00	24.00	35.00	29.63	3.21
	Stress	19	20.00	.00	20.00	9.79	6.25
	Anxiety	19	16.00	2.00	18.00	7.37	5.04
	Depression	19	22.00	.00	22.00	5.37	5.62

Figure 6. Stress levels (refugee vs. non-refugee).

Figure 7. Anxiety symptom rates (refugee vs. non-refugee).

Figure 8. Depression symptom rates (refugee vs. non-refugee).

Use of self-care strategies also differed significantly based on refugee status, as non-refugee teachers engaged in self-care practices more often than refugee teachers. Thus, self-care (a microlevel protective factor) differs based on refugee status. There were also differences in stress, mental health, and use of self-care strategies by gender and age. Across the refugee sample and the full sample, women practiced significantly less self-care than men, and among refugee teachers specifically, women were significantly more stressed than men (see table 7). Among the refugee only sample and the full sample, age was negatively correlated with depression, anxiety, and stress; in other words, younger teachers experienced higher rates of depression, anxiety, and stress

than older teachers. Age functioned as a risk and protective factor via its influence on microlevel mental stress mental health outcomes.

Table 7

Independent Samples t-Tests by Refugee Status and Gender

Grouping Variable		<i>t</i>	<i>df</i>	<i>p</i>	Mean	Mean Difference	Effect Size
Refugee Status	Stress	2.283*	114	.024	13.96(r) 9.79(nr)	4.17	0.61
	Anxiety	3.898*	43.887	.000	13.09 (r) 7.37 (nr)	5.72	0.79
	Depression	4.009*	31.809	.000	11.36 (r) 5.37 (nr)	5.99	0.91
	Self-Care	-2.495*	114	.014	26.77 (r) 29.63 (nr)	-2.86	0.71
Gender	Stress (refugee only)	-2.084*	95	.040	12.15 (m) 15.29 (f)	3.14	0.44
	Self-Care (full sample)	2.032*	114	.044	28.33 (m) 26.55 (f)	1.78	0.40

Correlation analyses revealed that stress, anxiety, and depression were all positively correlated with one another among the refugee only sample. However, of the mental health symptoms, only self-care was negatively correlated with stress among the refugee only sample (see Table 8).

Table 8

Correlations between Mental Health, Stress, Self-Care

		Self-Care	Stress	Anxiety
Refugee	Self-Care	-	-	-
	Stress	-.214*	-	-
	Anxiety	-.148	.760**	-
	Depression	-.185	.742**	.708**
Non-Refugee	Self-Care	-	-	-
	Stress	-.109	-	-
	Anxiety	-.235	.603**	-
	Depression	-.155	.414	.315
Full-Sample	Self-Care	-	-	-
	Stress	-.242**	-	-
	Anxiety	-.201*	.756**	-
	Depression	-.237*	.722**	.699**

* $p < 0.05$, ** $p < 0.01$

Simple regression analyses were carried out to answer question 2: *Is more frequent of use of self-care strategies associated with fewer negative mental health symptoms (i.e., depression and anxiety) among Southeast Asian refugee teachers and non-refugee teachers teaching in refugee schools in Malaysia?* Among the full sample, higher self-care was associated with lower rates anxiety, depression, and stress. Self-care explained a significant proportion of variance of anxiety, depression, and stress scores among the full sample. However, self-care only explained a significant proportion of variance in stress among the refugee-only sample; self-care did not significantly explain variance in anxiety or depression among the refugee only sample. Self-care also did not significantly explain the variance of anxiety, depression, or stress scores among the non-refugee only sample (see Tables 9-11 and Figures 9-11). These findings are also in

agreement with the Developmental Ecological model as the relations between microlevel constructs differed by the macrolevel factor of refugee status.

Table 9

Regression Models: Self-Care as a Predictor of Anxiety

Model	Sum of Squares	df	Mean Square	F	R ²	B	Std. Error	β	t	p	Effect Size
Refugee	168.70	1	168.70	2.140	.02	-.277	.190	-.148	-1.463	.147	-
	7487.47	95	78.82								
	7656.17	96									
Non-Refugee	25.11	1	25.11	.990	.05	-.367	.369	-.235	-.995	.334	-
	431.31	17	25.37								
	456.42	18									
Full Sample	349.68	1	349.68	4.812	.04	-.373	.170	-.201	-2.194	.030	.04
	8283.52	114	72.67								
	8633.21	115									

Table 10

Regression Models: Self-Care as a Predictor of Depression

Model	Sum of Squares	df	Mean Square	F	R ²	B	Std. Error	β	t	p	Effect Size
Refugee	182.34	1	182.337	3.369	.03	-.288	.157	-.185	-1.835	.070	-
	5142.03	95	54.127								
	5324.37	96									
Non-Refugee	13.64	1	13.637	.418	.02	-.270	.418	-.155	-.646	.527	-
	554.78	17	32.634								
	568.42	18									
Full Sample	363.47	1	363.467	6.793	.06	-.381	.146	-.237	-2.606	.010	.06
	6099.84	114	53.507								
	6463.31	115									

Table 11

Regression Models: Self-Care as a predictor of Stress

Model	Sum of Squares	df	Mean Square	F	R ²	B	Std. Error	β	t	p	Effect Size
Refugee	245.16	1	245.16	3.37	.04	-.335	.156	-.214	-2.139	.035	.04
	5090.67	95	53.57								
	5335.84	96									
Non-Refugee	8.36	1	8.36	.42	.01	-.212	.468	-.109	-.452	.657	-
	694.80	17	40.87								
	703.16	18									
Full Sample	368.90	1	368.90	7.07	.06	-.384	.144	-.242	-2.659	.009	.06
	5946.28	114	52.16								
	6315.17	115

Figure 9. Self-care and stress.

Figure 10. Self-care and anxiety.

Figure 11. Self-care and depression.

Moderation analyses were conducted to answer question 3: *Does self-care moderate the association between stress and negative mental health symptoms among Southeast Asian refugee teachers and non-refugee teachers teaching in refugee schools in Malaysia?* Moderation analyses were conducted utilizing Andrew Hayes' PROCESS macro for SPSS. The hypothesized moderation analyses were not significant. However, additional moderation analyses were conducted to explore how mental health and self-care differ by gender and age. Additional analyses revealed that moderations by age were significant for the refugee only sample, however, moderations by age were not significant among the non-refugee sample. Among the refugee only sample, age significantly moderated the relationship between self-care and anxiety, self-care and depression, and self-care and stress; multiple regression models that included age, self-care, and the interaction term (ageXself-care) were significant and accounted for more variance than models that included both predictors without the interaction term. The negative associations (between self-care and anxiety, self-care and depression, and self-care and stress) were strongest among younger teachers across both the refugee only sample. However, for older teachers, there was a weak positive association between self-care and mental health, and self-care and stress among the refugee only sample (see Tables 12-14 and Figures 12-14). Although the positive association for older teachers was weak, it is an unexpected finding. Moderation analyses by gender were not significant.

Table 12

Moderation: Age as Moderator of the Relation between Self-care and Anxiety

Model	Coefficients	<i>B</i>	Std. Error	β	<i>t</i>	<i>p</i>	Effect size
Refugee	Interaction	.056	.021	1.909	2.703	.008	.06
	Self-care	-1.953	.653	-1.049	-2.993	.004	
	Age	-1.665	.554	-1.822	-3.004	.003	
Non-Refugee	Interaction	.039	.034	3.004	1.147	.269	-
	Self-care	-2.360	1.810	-1.508	-1.303	.212	
	Age	-1.245	.973	-2.897	-1.279	.220	

Table 13

Moderation: Age as Moderator of the Relation between Self-care and Depression

Model	Coefficients	<i>B</i>	Std. Error	β	<i>t</i>	<i>p</i>	Effect size
Refugee	Interaction	.040	.016	1.671	2.454	.016	.04
	Self-care	-1.491	.522	-.966	-2.859	.005	
	Age	-1.321	.443	-1.744	-2.982	.004	
Non-Refugee	Interaction	.013	.042	.925	.318	.755	-
	Self-care	-.960	2.248	-.550	-.427	.675	
	Age	-.414	1.208	-.863	-.343	.737	

Table 14

Moderation: Age as Moderator of the Relation between Self-care and Stress

Model	Coefficients	<i>B</i>	Std. Error	β	<i>t</i>	<i>p</i>	Effect size
Refugee	Interaction	.039	.017	1.614	2.320	.023	.04
	Self-care	-1.504	.536	-.969	-2.807	.006	
	Age	-1.235	.455	-1.622	-2.715	.008	
Non-Refugee	Interaction	.017	.046	1.065	.373	.715	-
	Self-care	-1.069	2.451	-.550	-.436	.669	
	Age	-.611	1.318	-1.145	-.463	.650

Figure 12. Age as a moderator of self-care and stress (refugee sample)

Figure 13. Age as a moderator of self-care and anxiety (refugee sample)

Figure 14. Age as a moderator of self-care and depression (refugee sample)

In sum, refugee teachers had significantly higher rates of mental health and stress, but lower rates of self-care as compared to their non-refugee peer teachers. Mental health, stress, and self-care also differed by gender and age. For example, women practiced less self-care than men, and refugee women were more stressed than refugee men. Younger teachers had higher rates of mental health symptoms and more stress than their older peers. Higher levels of self-care were associated with lower rates of mental health symptoms and stress among the full sample, but only predicted stress among the refugee only sample. For refugees and the full sample, age was a significant moderator of the relation between self-care and mental health and the relation between self-care and stress. Moderation results suggested that for younger teachers there was a strong negative

association between self-care and mental health, and self-care and stress; however, for older teachers there was a weak positive association between self-care and mental health and self-care and stress.

Qualitative Results

Qualitatively, I have explored macrolevel factors unique to the post-conflict refugee experience and how they may impact refugees' experience and definitions of microlevel mental health, stress, and self-care. More specifically, qualitative analyses were carried out by coding interviews using Interpretative Phenomenological Analysis in order to generate themes and answer the question: *How do Southeast Asian refugee teachers living in Malaysia and working in hidden refugee schools experience stress, mental health, and self-care in the context of macrolevel factors related to the experience of being a refugee?* Coding yielded nine common themes across the eleven interviews which will be discussed in detail below. Qualitative themes were (a) Religious oppression led to flight; (b) Inhumane conditions and fear during flight; (c) Fear and human rights violations; (d) teaching was meaningful, but demanding; (e) Stress was cognition, emotion, and somatic; (f) Mental health was symptoms and tied to the family; (g) Emotion avoidance to emotion identification; (h) Stress and mental health were distinct, but related; (i) Self-care was simple (see table 15). These themes shed light on experiences, and conceptualizations of microlevel factors including mental health (i.e., depression and anxiety), stress levels, and use of self-care strategies in the context of macrolevel factors unique to the refugee experience consistent with the Developmental Ecological Model. Given that the qualitative interview questions and prompts were created based on the study's research questions, many of the themes are parallel to the

interview questions, which reflect the research questions. However, several novel themes and subthemes (e.g., emotion expression) emerged from the interpretative phenomenological analysis that do not coincide directly with the interview questions and prompts. Direct quotes from interview participants are utilized throughout this section. Inter-rater reliability (73%) was calculated via percent agreement.

Table 15

List of Interpretive Thematic Statements

<i>Interpretive Thematic Statement</i>
1. Oppression by a military controlled government on the basis of religion and ethnicity led to severe human rights violations against minority groups and ultimately forced them to flee Myanmar.
2. En route from Myanmar to Malaysia, refugees endured moments of intense fear interspersed among their experience of consistently inhumane conditions.
3. In Malaysia, refugees continued to experience fear of discovery and human rights violations, but with nowhere left to flee, they were stuck.
4. For refugees, being a teacher was seen as the most meaningful and personally satisfying of their employment options; although teaching made refugees feel fulfilled, unique teaching stressors made teaching mentally, emotionally, and physically demanding.
5. Stress was not only experienced as thoughts for the refugee teachers, it was also experienced in the body; stress was cognition, emotion, a somatic body-based experience, and the stressor itself.
6. Mental health was defined as symptoms, it was felt in the body, and it was dependent on more than individual well-being; instead, mental health was dependent on the well-being of the entire family.
7. Discussion of emotions ranged from avoidance of verbal emotion identification to explicit emotion identification; emotionality can also be experienced physically.
8. Stress and mental health were viewed as distinct, but related constructs.

Interpretive Thematic Statement

9. The primary way refugees cope was through prayer and religion, but their family and work-related demands do not leave much room for self-care; self-care took on a more simplistic form, as refugees did not have access to more demanding or costly forms of self-care.
-

Pilot qualitative results. The pilot qualitative focus group data have been reported in another paper (O’Neal et al., 2016), with exception of a small amount of data related to self-care. The initial qualitative self-care data both sparked my interest in and informed my collection of additional qualitative data in 2018. O’Neal and colleagues (2016) used a Participatory Culture-Specific Consultation (PCSC) approach to examine the perspectives of Burmese refugee teachers on Burmese refugee student socioemotional issues and classroom management via a refugee teacher focus group. A thematic content analysis suggested four overarching themes: (a) societal pressures have an effect on the classroom environment; (b) refugee student behavior and emotions ranged from externalizing to internalizing; (c) refugee teachers relied on traditional Burmese methods for managing serious misbehavior; and (d) with mild misbehaviors, teachers employed more “modern,” student-centered methods. Although not reported in the 2016 publication, a small amount of self-care data were also collected as part of pilot data collection through one open-ended question: “how do you take care of yourselves as teachers?” Initial findings related to self-care laid the groundwork and informed the in-depth qualitative analysis of self-care using additional data I collected in 2018.

The section of pilot data on self-care was coded using the same qualitative codebook used for qualitative coding of the interviews conducted in 2018. Refugee teachers, who participated in the pilot focus group, primarily conceptualized self-care as religion and prayer. For example, when asked how they take care of themselves, one

teacher responded, “God is good: we pray.” Most teachers agreed and provided similar responses. Other teachers described the meaningfulness of their work and their commitment to the community as factors that motivated them and made the stress of teaching “worth it.” Teachers mentioned that talking to others about their problems was often a helpful strategy. They also explained that they do not have the luxury of time to devote to self-care as there are higher priorities. An initial informal content analysis of self-care based on pilot qualitative data, especially the differences in self-care conceptualizations among refugee teachers as compared to Western perceptions, motivated my deeper investigation of self-care, stress, and mental health. Pilot self-care data laid the basis for and partly informed the current dissertation study questions as I wondered how a unique conceptualization of self-care might relate to rates, experiences, and conceptualizations of microlevel factors (i.e., mental health, stress, self-care) in the context of macrolevel factors unique to the refugee experience. The unique conceptualizations of self-care among this population led to my curiosity about establishing culture-specific definitions of stress, mental health, and self-care in the context of macrolevel factors uniquely experienced by these Burmese refugee teachers. I utilized the pilot data to inform my codebook for the eleven individual interviews, and once the codebook was created, I used it to code the pilot data as well as the 2018 interview data. After coding the pilot data using the same codebook I used for the 2018 interviews, there was consistency between the pilot focus group data (especially regarding the definition of self-care) and the eleven individual interviews (described below).

Thematic analysis of eleven interviews. Through qualitative data I collected in June 2018, I sought to explore how Southeast Asian refugee teachers living in Malaysia and working in hidden refugee schools experience stress, mental health, and self-care in the context of macrolevel factors related to the experience of being a refugee. Qualitative themes encompassed several general topics including: the experience in Myanmar, the route from Myanmar to Malaysia, life in Malaysia, being a refugee teacher of refugee children, discussion of emotions, and definitions of stress, mental health, and self-care. As mentioned above, these themes highlight experiences and conceptualizations of microlevel factors (i.e., mental health, stress, self-care) in the context of unique macrolevel factors (e.g., government oppression, human rights violations against refugees) informed a Developmental Ecological Framework. The nine common themes across the eleven interviews which I found in my current dissertation will be discussed in detail below.

In-depth description of a select case. Like many others, May Lin Kha fled Myanmar because she feared for her safety. In her village, soldiers were “taking advantage” of women. She was especially vulnerable since her father was not living with her and her mother at the time. Her mother felt she had no choice but to send May Lin Kha away to keep her safe. A member of her church in Myanmar put her in touch with an agent to facilitate her journey. She traveled to Malaysia by bus, car, and on foot; at times, there were more than twenty people in one car. There was limited food, typically one small meal per day. Even if one had money to buy food, there was no food available for purchase. Upon arriving in Malaysia, she stayed with a relative for a couple months. She found a job and married another refugee from Myanmar who worked with her. As

refugees, she said Malaysian citizens “look down on us” and there is not enough protection. Even with a refugee card, she fears the police, who have knocked on her door in the middle of the night checking for paperwork. Before she had a refugee card, she did not feel safe leaving the house and would just stay at home. She reported that even with a refugee card, the police can still detain refugees and question them. May Lin Kha also described being discriminated against by her boss at work based on her refugee status. She felt blessed to become a teacher and she feels responsible for her refugee student’s futures. She heard that she could attend HELP University in Malaysia to take a small set of classes with a refugee card and secured her previous transcripts from her parents, but when she went to apply, she realized the fees were too high and she could not afford it. May Lin Kha lives with her husband and her daughter. She works as a teacher in a refugee school.

Theme 1: Religious oppression led to flight. Oppression by a military controlled government on the basis of religion and ethnicity led to severe human rights violations against minority groups and ultimately forced them to flee Myanmar. Burmese refugees fled Myanmar because they felt they had no other choice due to government brutality fueled by religious oppression which led to a variety of human rights abuses and other related factors including detainment, poverty, unemployment, and lack of education.

Religious and ethnic minorities. Religion is a driving factor that underlies many of the human rights violations experienced by interview participants who were religious and ethnic minorities in Myanmar. Myanmar is a predominantly Buddhist country whose government is controlled largely by a Buddhist army (89% of the general population identify as Buddhist) (Department of Population Ministry of Labour, Immigration and

Population MYANMAR, 2016). Christian and Muslim minorities, who are also ethnic minorities face severe oppression on the basis of their religious and ethnic status. Generally, participants described the situation in Myanmar as “difficult for my religion” and of Myanmar said “religion [other than Buddhism] is not allowed.” They referenced the “fighting” over religion, being unable to access basic human rights because of their religion, and religious slurs (e.g., Kala). It is important to understand that religious minorities are also ethnic minorities in Myanmar. According to Human Rights Watch, as of August 2017, over 671,000 Rohingya Muslims have fled Myanmar’s Rakhine State to “escape the military’s large-scale campaign of ethnic cleansing.” The Rohingya ethnic group in particular has experienced severe abuse for decades, since they were first denied citizenship in 1982, making them one of the largest stateless populations in the world. Mya, a Muslim Rohingya woman, described her experience of religious oppression in Myanmar.

“They have many problems in my country, basically in our religion, that's why we cannot wear the stuff like this (gestures to her hijab)...I haven't worn it. One of my friends, she told me, she's Buddhist, and she told me...one day I said I want to wear the scarf because of my religion if a lady becomes a lady she needs to wear [it] and then she [my friend] say if you wear that scarf I will take it off you in front of many people and then she left me in front of many people and I feel very shame. I cry as well.”

Overall, religion drove the government oppression of ethnic and religious minority groups in Myanmar.

Government oppression led to human rights violations and related effects.

Myanmar has experienced internal conflict for much of its history. The country has experienced military rule and government instability for decades. Government officials, the army, and police have committed serious human rights violations against religious and ethnic minorities in Myanmar (Human Rights Watch, n.d.). Participants referenced the military control of the government and the invasion of their villages. Several participants described the situation as a civil war, Chit said, “the government is trying to destroy our people.” Ya Zin described the prime minister, Aung San Suu Kyi’s position in the context of military influence, “the prime minister is powerless because of army influence, she is prime minister in name only. She is okay, but she cannot do anything. It’s under the army. Just the name... so she cannot do anything. She is good but she cannot do anything.”

Religious and ethnic minority groups, and especially women, have experienced brutality at the hand of the government, including: sexual assault, abduction, forced labor, forced marriage, and forced army service. There was a risk of being taken (and possibly detained etc.) if you did not give the officials food or obey demands. For example, officials sent a woman’s friend to jail because the woman fled her home when the government was looking for her. When they could not find her they took her friend instead. Sann said: “the army, they will just take whoever they want.” A few women, like Kywa, experienced abduction and forced marriage (or the threat of): “two police they're waiting [for] me and they just told me come you must marry me I said I don't want [to].” Several women described soldiers “taking advantage” and the threat of sexual assault: “like once a week they would come to our village. They just, if they saw a girl they want

to slip, we have to run, run, run and it's not they're going to marry them. Just want [what] they want and get them to go back." Sann described her experiences of forced labor:

"It's a forced labor. They asked us to clean the road for 3 days. Three days and we have to bring our own food and after 2 days, the army let all my friends go back and the leader of the army, he asked me to help at home for one week because their maid was not coming. So, I don't want [to]. I have to go. I go there, after one week, they don't want me to go back and if at their house, actually, if they pay, no problem [but, they don't]. They don't even give proper food. After they eat, they will give whatever left over and we can eat. And the wife also very naughty. Whatever we do wrong, she will get angry and beat us and after one week, I cannot think. I run away."

Participants also described the interconnectedness of their Myanmar identification cards being revoked, being unable to work, and the poverty that ensued. At the time of their flight, religious and ethnic minorities could not obtain identification cards, their existing identification cards were revoked, and they were no longer officially recognized as citizens. The Myanmar government was treating ethnic and religious minorities as foreigners, even though their families had lived in Myanmar for generations and held high-status occupations, Mya said, "we [were] not born in other country... my mom, my grandma, my great-grandfather, also they are born in Myanmar and then my grandfather is a lawyer my grandfather also is an immigration officer but just now we cannot get the ID card, however my grandfather is officer." Religious and ethnic minorities could not get jobs without an identification card (even if they were highly educated). For example,

Bawi said “they have very good study. Even university, even sometime doctor line, but they are going to training then after because it is uh Burmese government... Sometime even they are training the doctor but don’t know they couldn’t work.” Poverty was inevitable for all interviewees, for example, Bawi said, “I could not do anything after high school and we are very poor.” Similarly, Kywa said, “no business very difficult no money.” Further, education for ethnic and religious minorities became severely lacking as children cannot attend schools and can’t learn the Burmese language. Participants noted that there were no longer any schools in their villages. From their interviews, one can infer that oppression by a military-controlled government on the basis of religion led to severe human rights violations. These macrolevel factors of oppression and human rights abuses that are unique to the refugee experience likely impact microlevel stress, mental health, and self-care.

Theme 2: Inhumane conditions and fear during flight. En route from Myanmar to Malaysia, refugees endured moments of intense fear scattered interspersed in their experience of consistently inhumane conditions. Refugees understood the consequences of being discovered. They experienced inhumane conditions in order to keep moving forward while reducing the risk of discovery. Even with these precautions, such as only traveling at night, they recalled moments during which they feared for their lives, moments they thought might be their last.

Inhumane conditions. Refugees traveled long distances by foot, in cramped vehicles, and in small boats. In describing traveling on foot, Nyinyi said, “basically for 24 hours we climb the mountain” and “the hardest part [was] when we are walking. They will ask very rash and have to run and very tired.” Traveling by boat was no better, Ya

Zin reported, “then at night the small boats, like 40 or 50 people so we have to sleep there.” Cars were also very cramped, Bawi explained, “the small car is around maybe, for a 4 person, but actually they would put into maybe 10 or 15 person in the car” “it is very difficult to breathe.” Refugees went for days with limited to no food and poor sanitation (e.g., no access to clean clothes, unable to bathe). Some were only given one small meal per day, others went for a day or longer completely without food, Thura said, “cannot bring any clothes. No shower. No food. No water. one day, two to three days.” Upon reaching Malaysia, many refugees had to wait at the Thailand-Malaysia border, sometimes for several days.

Moments of intense fear. En route to Malaysia refugees grappled with consistent uncertainty of safe arrival; while paying an agent may have helped, it was expensive and did not guarantee safety. While refugees were always cognizant of the dangers of being discovered, participants described specific moments in time characterized by intense fear. It was “safer” to travel at night, thus refugees often hid and waited out the daylight in the jungle and on farms. Thura said, “some 7 days, just daytime, have to wait [in] the jungle. At night only, they move. Sometimes have to sleep one, two, three nights in one place, maybe until the road is clear enough to go.” Specific moments stand out as particularly intense, one woman recalled hiding from immigration officers in a chicken coop, another teacher, Sann, said, “very scared all the police will catch us, so we have to run, run, run, run.” Several participants described specific instances during which they feared for their life, moments they assumed would be their last. In such moments, they recalled thinking: maybe I will die here. Ya Zin said, “we don’t know we maybe die or we don’t know but sometimes very scary.” In sum, the dangers were ever-present, but moments of intense

fear stand out for refugees on the journey from Myanmar to Malaysia. Macrolevel factors fueled a constant fear of imminent danger unique to the refugee experience, with likely consequences for microlevel stress, mental health, and self-care.

Theme 3: Fear and human rights violations in Malaysia. In Malaysia, refugees continued to experience fear of discovery and human rights violations, but with nowhere left to flee, they were stuck awaiting resettlement. In Malaysia, refugees continued to fear discovery by Malaysian authorities. This fear was even more intense for refugees who did not possess a UNHCR refugee card. The human rights abuses also continued, as refugees living in Malaysia faced government oppression, detainment, theft and abuse by citizens, lack of access to healthcare and education, poverty, unemployment, food insecurity, language barriers, discrimination, and family separation. They felt stuck in Malaysia, separated from their families, and uncertain of their future.

Fear of discovery. Consistent with their experience en route to Malaysia, refugees lived in constant fear of discovery in Malaysia. This fear was amplified for those without refugee cards. Several participants described feeling imprisoned in their houses because it was too dangerous to be in the community without a refugee card, refugees without UNHCR cards have “more fear of the police and cannot go out anywhere,” said Thura. Refugees described the intense fear of or their actual experience with police and government official brutality. It was not uncommon for police to demand money or goods. Huang explained, “sometimes the police will start. I work in the restaurant, but the day we came out from our restaurant. We went home, but on the way we met a police. So, because we got the money in our pocket, when we met the police, they took everything. Its very, very painful for us because we work one month and its gone.” If refugees could

not pay the police they were detained, Nyinyi said, “when police kept me, my baby stay with my friend so I in the jail. [Then], I asked my friend please carry my baby in the jail me and my baby stay together in the jail.” When refugees are arrested it can impact their whole community, for example, Ya Zin explained, “they arrest two or three Chin people and ask for 10,000- 15,000 ringgit [approximately 2300-3600 USD] so they collect the money from all the Chin.” For refugees, fear of discovery is a consistent experience.

Human rights violations and discrimination. In Malaysia, refugees experienced a lack of protection/rights and they face intense discrimination; the situation was amplified for those without a refugee card. As described above refugees are left unprotected by police, rather they are in constant fear of the police. To make matters worse, citizens abused refugees verbally, physically assaulted them, stole from them, and demanded money. Refugees were humiliated publicly. The culture of citizen abuses against refugees is perpetuated because Malaysian citizens know the police will not help refugees. Further, Malaysian children bullied refugee children in the community, Ya Zin explained, “so even the [refugee] students they got... slap or like punched from the, the... citizen students.” Refugees face various types of discrimination including housing, employment, education, and healthcare. Several participants discussed their lack of access to healthcare as healthcare is far more expensive for refugees (even more so without a refugee card) than Malaysian citizens, for example, Kywa said, “I see the Malaysians, if they go to the government clinic, they pay one [ringgit] only, but we pay like 100 [ringgit]. Refugee also pay more for rent and have difficulty finding landlords who will rent to them. Several refugees spoke about how their college degrees earned in Burma were not recognized in Malaysia. It was also difficult for refugees to continue

their studies in Malaysia because the limited programs they were permitted to attend were unaffordable. May Lin Kha described her experience in trying to further her studies in Malaysia:

“I really want to complete my study and get a really good job so I was so happy that I can apply and I went with one of my friends to [X] University and they asked us [for] our certificate [high school diploma] and all. I asked my parents, through my friends help, [if] they could send me the certificate. [They sent it] so I went there to apply and I could, but the fee is very high. When the fee is too high, I couldn't join it [the university] so I feel very sad.”

In Malaysia, it is technically illegal for refugees to work, thus, refugees faced unemployment, low wages, and unfair practices within employment settings. Even if they had relevant experience, refugees could not get jobs because they weren't Malaysian citizens. Thura said, “at our workplace, they treat us so different. [We're] the one who work very hard, we get paid very low and if we say something they don't want, they just say: ‘out.’” Employment challenges led to poverty and food insecurity. Refugees in Malaysia also struggled with a language barrier, as they don't speak Malay. Sann described her experience of poverty in Malaysia:

“[My husband] have to find again another job. Take him like one month, two months. My salary only cover our rent so everything we get, very difficult when he don't have any job. The one, two month we have to borrow. He got a job again, we pay again. Cannot stop. Cannot, uh - how to say - cover anymore if one month, he working every month is just cover

our expense and when he don't have a job for one or two months, we borrow from people. Cannot cover anymore. Every month gone.”

In sum, refugees living in Malaysia faced the macrolevel factors of serious human rights abuses and a lack of protection under Malaysian law which may have impacted their microlevel stress, mental health, and self-care.

Theme 4: Teaching is meaningful, but demanding. For refugees, being a teacher was the most meaningful and personally satisfying of their employment options; although teaching made refugees feel fulfilled, unique teaching stressors made teaching mentally, emotionally, and physically demanding. Since it is illegal for refugees to work in Malaysia, their employment options were limited, and their work environments were less than ideal. Being a teacher was a meaningful experience among many less desirable employment situations, however, it was also intensely draining on the individual. While this theme is specific to teaching, it is important to interpret it in the context of the previous themes which describe stressors that may make teacher burnout even more likely and exacerbate the stress of teaching.

Teaching as a meaningful occupation. Refugee teachers expressed a desire to help children and shared that teaching was gratifying. They noted that refugee schools create a sense of community and an opportunity to learn. Teachers reported feeling safe while working in hidden refugee schools and felt that the schools they were in were a safe place for their own children. Generally, they found happiness in teaching and are far happier in a teaching position as compared to other jobs, May Lin Kha explained, “when we see them grow it makes us really, really happy.” All of the teachers expressed a similar sentiment, for example, Chit said, “I enjoy [teaching] them because they [the

children] are feeling so happy and trusting.” Refugee teachers enjoyed gaining teaching experience; they try hard and learn as they go. Refugee teachers felt responsible for the students they served and had a strong desire to help these children. They believed school is good for refugee children and their parents (provides childcare so parents can work and may provide the children with a better future). There was a sense of community in hidden refugee schools. May Lin Kha described her experience of feeling responsible for helping refugee children in hopes of securing them a better future:

“I feel very blessed to become a teacher as I'm a refugee and I see many of our students here are from my own country and I feel very responsible in their life so by giving them knowledge we can change their future right so I want to try my best I want to try harder so I can give them a better future when they get educated their future will be much, much better than ours.”

Overall, refugee teachers felt that teaching refugee children in hidden schools was a meaningful and rewarding experience that far surpassed their other limited employment options.

Mental, emotional, and physical demands. While there are many positive aspects of being a refugee teacher, teaching in a hidden refugee school was a mentally, emotionally, and even physically demanding occupation. Teaching refugee children resulted in the experience of unique stressors including managing, student behavior, academically struggling students, parent complaints, cultural differences, unfair employment practices, long days, low wages, staff shortages, language barriers, lack of resources (school and school families), and crowded schools. These stressors were exacerbated by the fact that refugee teachers don't feel qualified to teach since most don't

have any formal teacher education or training. While these stressors may also be experienced by teachers in Western countries like the US, they were exacerbated for refugee teachers in the context of the macrolevel stressors described in the themes above.

Several teachers spoke about the challenge of dealing with parent complaints, cultural differences, and managing student behavior. Parents complained about how the teachers teach, and how the children are grouped into classes. At one school parents could complain via a public chatroom; parents would call teachers out by name, making them feel ashamed, Sann explained, “the mother will complain at the parent chat group and all the parents also can see so it’s quite difficult.” Teachers noted that teaching in Malaysia is different than their experience of education in Burma, for example, Bawi said, “Myanmar culture and [the] culture now here is totally different.” Managing student behavior was a big difference across the cultures. Although hidden refugee schools are not controlled by the Malaysian government, the school director is typically a Malaysian citizen, thus, disciplinary policies are dictated by Malaysian culture. Refugee teachers grappled with the urge to inflict physical punishment, and felt helpless as they managed children who were “acting out.” Bawi described her experience going to school in Myanmar as a child where physical punishment was part of the culture, “If they holding the stick and they will hit us then we listen to them. And they say, Ok, tonight you have to do this homework. Then we will do everything finished, but without stick no [all of our homework will not be finished].” Teachers explained feeling like use of the cane was the only way to manage children because nothing else worked. Huang described the lack of effectiveness of verbal warnings and the related cultural differences:

“a refugee teacher is different. Not like our own country. Here we have to be patient and understand the kids because some of them are very, very naughty. We shout, but they will not listen. Very, very difficult. In our own country, if they don't listen, we can force. But here, we don't like to force. It is different, you know.”

Language and pace of learning created additional challenges. Most teachers struggled with speaking English as they had just started speaking it since arriving in Malaysia and they also did not speak the Malaysian language. Refugee teachers were expected to speak to lead teachers and instruct students in English, which was not their native language. This made communication with supervisors and instruction difficult. Another challenge related to instructing children in English is that children were not learning the Burmese language, thus, teachers worried they were missing out on learning about their own culture. As students learn English, teachers explained that their students struggled to learn concepts and learn at different paces, for example, Sann said, “children, they don't learn the same. Some they will very slow. Even 6 months, they cannot even write A, B, C. So you have to be very patient with them and they are so different.”

Refugee teachers also faced challenges related to unfair employment practices and running hidden refugee schools. They commented that they are treated poorly by citizen teachers and paid low wages for very long work days. Mya described her experience of being treated unfairly by citizen teachers and the impact poor treatment and long days had on her wellbeing: “I cry. Why teachers [treat] me like that? I feel sick cause I can't do [it]. I need to leave my home at 6:15 and then only [late at night] I can come back and I feel sick.” As discussed under the previous theme, public humiliation and shaming

emerged as a novel subtheme, for example, Thura described unfair treatment by a citizen teacher who frequently humiliated, mocked, and belittled refugee teachers based on their English-speaking ability and refugee status:

“she won't come and say directly, but she will talk to the children – ‘I'm Malaysian. I'm Malaysian, you all know that. We are not the same. I am not a refugee. I am not a refugee like you are.’ To answer back, it's not directly to us, but she is talking. She is talking. We know that she is talking about us, but it is not directly at us, so we cannot talk back. But it's very hard for us.”

Running a hidden refugee school also came with administrative challenges for teachers including staff shortages, crowded schools, and unmanageable expenses. Bills piled up and schools could not afford necessary resources (e.g., food for lunchtime). Similarly, refugee teachers had to manage the financial insecurity of their students and families. In sum, the combination of stressors unique to being a refugee teacher teaching in a hidden refugee school created intense mental, physical, and emotional demands for teachers.

Theme 5: Stress was cognition, emotion, and somatic. Stress was not only experienced as thoughts for the refugee teachers, it was also experienced in the body; stress was cognition, emotion, a somatic body-based experience, and the stressor itself. Refugee teachers defined stress quite broadly. Their conceptualization of stress can be divided in terms of cognitive, emotional, and physical aspects. Some teachers also defined their stress in terms of the stressor itself (e.g., finances).

Stress as cognition. Refugee teachers defined stress as cognition: being too busy, feeling overwhelmed, having racing thoughts, rumination, being unable to relax, and

trouble sleeping. For some teachers, stress was being too busy, having too much to do, and feeling overwhelmed. May Lin Kha explained, “I’m a housewife and I’m working here for [a] full day and then I go back home [and] I got things to do I have to take care of my daughter and sometimes it makes me really stressed.” Others described stress in terms of racing thoughts or rumination which makes it difficult to relax or sleep, for example, Nyinyi said, “yeah think so much, can’t sleep and today either I can’t relax again, but stress how to say always you feel stress, thinking, thinking.” Refugees described stress as a cognitive process.

Stress as emotion. Teachers also defined stress as an emotion: anger, irritability, crying, and worry. Several participants noted that they feel angry or irritable when they experience stress and “hard stuff.” May Lin Kha said, “I get very angry when I’m stressed. Short temper when I’m stressed.” Other teachers reported that they cry when they feel stressed, Nyinyi said, “when I’m really stressed just I pray I cry in front of God.” Teachers most commonly defined stress as feeling worry and they discussed worrying as a consistent experience, Sann said, “worry, when we worry, cannot just take out. Worrying takes so many hours. It’s very long.”

Stress as a physical experience. Refugee teachers also view stress as a somatic body-based experience characterized by a racing heart, appetite changes, shaking, trouble breathing, feeling tired or achy in the body. When defining stress, teachers frequently described how they feel in their bodies when they are stressed. They experience a racing heartbeat, shaking, and trouble breathing, Sann explained, “my heart beats very fast and I tired of breathing.” The most common physical experience of stress was described as the

body feeling tired, sick, or achy. Some teachers reported not being able to eat when they are stressed, while May Lin Kha said, “I eat to relieve my stress.”

Stress as the stressor. Several teachers also defined stress in terms of the stressor itself which included: safety, the future, refugee status, resettlement, finances, and detainment. They explained that stress is the result of having too many stressors to deal with, Mya said, “stress mean, how to say, we have so many problems as you know now as I’m talking to you so many problems, sometimes we feel yeah we have stress because of that.”

In sum, refugees’ stress was cognitive, emotional, and physical, but was also closely connected to (or even defined as) the stressor itself. Like stress, mental health was equally complex in nature.

Theme 6: Mental health was symptoms and tied to family. Mental health was defined as symptoms, it was felt in the body, and it was dependent on more than individual well-being; instead, mental health was dependent on the well-being of the entire family. Participants expressed some hesitance as they responded to questions about mental health, as they seemed to be checking if their answers fit with what I was looking for. Refugees were willing to endorse mental health symptoms, but, overall, they were not as willing to endorse the label (e.g., mental health, anxiety, depression). Refugees defined mental health as body-based experience and measure their mental health in terms of the well-being of their whole family, not just their own well-being. While mental health was mostly defined as the experience of negative mental health and related symptoms, a few participants defined good mental health or wellbeing as happiness and being appreciated.

Mental health symptomology. Refugee teachers endorsed symptoms related to mental health diagnoses including: hopelessness, trouble sleeping, crying, sadness, negative attribution bias, lack of motivation, emotion expression, emotion suppression, and “something wrong inside.” They seemed to define mental health as a collection of symptoms rather than labeling diagnoses (which may also be related to linguistic variables). Some refugee teachers made references to psychosis and lack of remorse in others as they defined mental health. Teachers described a lack of motivation, May Lin Kha said, “sometimes it makes me really want to give up on everything” and feeling hopeless about their future, Huang said, “sometimes we feel like we are wasting our time in Malaysia.” Hopelessness was related to the experience of sadness and expressing sadness by crying, Nyinyi explained, “I’m sad yeah, because I’m thinking about my future and my baby future because we don’t have any future how I can continue my life how I can choose which way is best, but I can’t think, so I just cry.” May Lin Kha described mental health as sadness as it relates to a hostile attribution bias:

“being unhappy, it’s you’re just sad inside, you don’t want to talk to anyone, just want to be alone, unhappy. Everything around us we take everything as a negative way, people even though they might not think that, even though it’s not like they are doing bad to us when we are unhappy, we feel that they are bad to us.”

While teachers commented on how they express their sadness, usually in private, they also reflected on the need to suppress it, Ya Zin said, “just keep [to] our self too many things so it’s really hard.” Overall, it was more common for refugee teachers to reference mental health symptoms instead of labels (diagnoses).

Mental health as a physical experience. Like stress, it was common for refugee teachers to conceptualize mental health as a body-based experience, as they defined mental health in terms of being unable to sleep, feeling ill, headache, feeling tired in your body and heart, trouble breathing, and changes in menstruation. Several teachers noted feeling tired and ill as related to their mental health, May Lin Kha said, “I just I feel like I have no energy, headache, I feel pain [in] the whole body.” Bawi described tiredness in her heart as well as her body, “I’m really tired in my body, in my heart—everything.” Mya explained how sadness caused sleep difficulties, “I feel very tired sometimes I think I not enough sleep yeah for example yesterday suddenly we got the sadness like Saturday we got my brother caught in front of me and then the feeling also the whole day we not well” Sann described the relationship between being unable to sleep and the tiredness she felt everyday as she defined mental health, “Very, very tired. So, everything I have to go to the clinic. They give medicine, but for sleep, I never take.” Teachers also explained the physical sensations around breathing as part of their conceptualization of mental health, Sann said, “tight feeling (gestured to her chest) and difficult to breathe.” Similar to stress, refugee teachers experience mental health in the body.

Mental health as family. Another important trend in the way refugees defined mental health was through its connectedness with family. Several teachers emphasized that mental health was tied to the family in the form of relational issues, alcoholism, and domestic violence. Bawi explained her definition of mental health as:

“really the mental [health] is all the problems also maybe the family. The family happy, everybody’s happy. Actually, the mental health is uh...I feel that it’s the family that is the problem. Now it’s I will tell sometime my

husband is drunk too. Of course, he's drunk then keep what it is like. I'm really sad, never happy. When my husband is not drunk and he's working I come back really happy. Of course, I'm really happy that time. My feeling is very better."

She explained that her mental health was dependent on the happiness of her family and that her husband's drinking problem also directly impacts her mental health. Similarly, when asked what mental health meant to her, a teacher noted hearing about husbands who are in prison while their wives raise the children and support them, then, when these husbands return from prison, they hit their wives and "drown in wine." Teachers also commented on how individual mental health impacts familial relationships, May Lin Kha said, "our husband and wife family and friends our relationship is much better when mental health is good." Kywa described her experience of secondary trauma based on an injury her husband sustained at work and how it continues to affect her, "he working at shop, then he accident [gestures to her hand] so sometimes if I see my husband's hand not happy." Family is crucial to the conceptualization of mental health for refugee teachers.

Through their interviews, it was clear refugee teachers were attempting to fit the Western term: "mental health" with their lived experience. They were more likely to endorse mental health symptoms than labels. They conceptualized mental health as connected to the body and to the well-being of not only the individual, but the family.

Theme 7: Emotion avoidance to emotion identification. Discussion of emotions ranged from avoidance of verbal emotion identification to explicit emotion identification; emotionality could also be experienced physically. It should be noted that

this is a novel theme which emerged solely from the interpretative phenomenological analysis of the interview transcripts, such analysis allowed me to capture the subtlety of participants' expression of intense emotions. In thinking about the way themes might map onto my interview questions, I was unaware of the nuances of emotional expression to be captured until I immersed myself in an interpretative phenomenological analysis of the interviews. These patterns of emotionality that emerged are crucial to the exploration of stress, mental health, and self-care in the context of the refugee experience. It is also important to note that the interviewee's emotionality had a large impact on me as the interviewer. For me, it created an experience of feeling with them.

Overall, refugees seemed more reluctant to discuss underlying emotions throughout their interviews than we might expect if this study was conducted with a sample of Western teachers. During the interview, given the nature of the interview questions, participants frequently displayed non-verbal displays of emotion (e.g., crying), as they discussed their experiences.

Avoidance of emotion identification. Some teachers seemed to avoid verbally naming underlying emotions. Instead teachers often used the words “hard” or “difficult” as a proxy for emotional difficulties, Huang explained:

And, my father is not there. He already passed away. My mother and two of my younger sisters are in Myanmar. So, sometimes I understand because it's been so long. 8 years, 7 years already. So, especially at Christmas or anything. When I think about my family, I used to miss my family mostly. But we cannot go back [laughs]. We don't have enough money to send them. But it's very hard for us, I want to try and call our

family to be here. Wherever we are, if we stay with our family, it is sad for me also and very happy. When we separate, we cannot send the money. We cannot send as much as they want. We are also feeling difficult, so it is very difficult for us.

Several participants conveyed an implicit sense of discouragement through their stories, without actually naming it. May Lin Kha said:

“when you're like actually in my mind I want to do something I want to achieve something then when in reality I cannot do anything about it I know I cannot do but I know inside my heart I still want to get that thing but I can't do anything it makes me really stressed about sometime when I see my colleagues my friends they study they're graduating.”

Overall, it was not uncommon for refugee teachers to avoid verbal identification of emotions in their interviews, instead using “difficult” as a proxy for specific emotions or implying emotionality without stating it explicitly.

Explicit emotion identification. Other teachers explicitly identified emotions in their interviews including fear, sadness, happiness, loneliness, hopelessness, anger, frustration, irritability, and shame. They also commented on the experience feeling bad more often than feeling happy. Fear and sadness were named most frequently in the teachers’ interviews. Fear typically referred to fear of discovery in Myanmar, en route to Malaysia, and in Malaysia. Ya Zin described the consistent fear experienced by a refugee living in Malaysia, “even when we want to go to church also its very scary because sometimes we see police also even the simple police also we are really scared sometimes ... just stay at home.” Sadness was another commonly named emotion, for example, May

Lin Kha described feelings of sadness around being unable to continue her education and a dissatisfaction with herself:

“I feel like sad like I'm not satisfied with myself I wanted to study more I wanted to complete my studies so that I can give them I want to what I want to do I cannot do I'm not satisfied with this and I want to complete everything I want to study more so I can give them my best sometimes I feel sad that I couldn't finish my studies.”

Although this was not the case for all teachers, several teachers did verbally and explicitly identify emotions in their interviews.

Emotions as a physical experience. Like stress and mental health, refugee teachers described emotions as being felt in the body. Several teachers described feeling emotions like anger and sadness in their hearts. Others described the toll emotions take on their bodies, for example, Nyinyi reflected on changes in her menstrual cycle, “yes when I get very sad and become very sad my periods also change ... feeling sad periods come [early].” Refugee teachers view emotions as a body-based experience. Overall, while refugees were somewhat resistant to discussing emotions, they displayed non-verbal signs of emotionality and discussed the physical experience of emotions.

Theme 8: Stress and mental health were distinct, but related. Stress and mental health were viewed as distinct, but related constructs. This is another novel theme that partially emerged during the interview process and was fleshed out during the analysis phase. It does not directly parallel one of the original interview questions. The idea of how mental health and stress might be viewed in relation to one another had not occurred to me before I began the interview process, but it came up in most of the

interviews as teachers discussed the constructs. It seemed that for some teachers, in order to define the constructs individually, they needed to express how they were related or different from one another. A comparison of the constructs of mental health and stress was part of the process of defining them. To define one, was also to discuss what the other was or was not. The emergence of this theme was surprising to me and was crucial as I attempted draw conclusions about how refugee teachers made sense of Western constructs on an individual level. In conceptualizing the constructs, refugee teachers felt that stress and mental health have similarities and differences. Teachers described mental illness as being more serious than stress, describing stress as something that can go away or be “fixed” more easily than mental illness, and calling mental illness “a bigger problem.” May Lin Kha reflected on this difference, “stress actually stress we can relieve stress or get rid of it by doing something, we can change our [stress], but mental health I think it would take more time I guess it would take more time to cure that [mental health].” On a similar note, Nyinyi explained, “[mental health is] more serious yeah, stressful they just have stress, not like... but for the mental, they already have something wrong inside.” They also pointed to differences in how they experience each construct, for example, within the body. Nyinyi noted where she felt stress and sadness, “stress it’s in your head, but sad it always come in your heart.” While refugee teachers see the constructs as distinct, stress and mental health are related according to participants. Sann commented on how the constructs can cause or influence one another, “if we are sad also the stress follows.” Overall, refugee teachers conceptualize and speak about stress and mental health as distinct constructs that share common aspects.

Theme 9: Self-care was simple. The primary way refugees cope was through prayer and religion, but their family and work-related demands did not leave much room for self-care; self-care took on a more simplistic form, as refugees did not have access to more demanding or costly forms of self-care. Self-care was most often expressed as prayer and religion. Since refugees did not have access to many “Western” forms of self-care, their self-care strategies may have shown up in the form of music, small rewards, a quiet space, support from loved ones, food, meditation, sewing, breathing, window shopping, and basic healthcare. In discussing self-care, a common issue arose: refugee teachers could not spend enough time on self-care because there were too many other things to do and/or an overall lack of resources.

Self-care as prayer and religion. In defining self-care, refugee teachers pointed to religion most frequently. In times of greatest difficulty and with a realistic assessment of limited control over numerous factors (e.g., refugee status), the only thing refugees felt they had control over (or the only thing they really could do) was turn to God, for example, Kywa said, “just I pray to God I pray to God because us we cannot do anything [else].” Huang also reflected on self-care through prayer as he viewed faith in God as his only hope, “I pray and read the bible. That only encourage me because from other people, I don't have any expectation, you know. My hope is from God.” Refugees may have relied on God as their primary form of self-care because their locus of control was so narrow.

Other forms of self-care. Refugees did not have access to more “lavish” Western forms of self-care (e.g., spas, vacations, shopping, going to the gym, fancy dinners). Their self-care strategies were simpler. Several refugee teachers noted music helped them

feel better including singing, listening to music, or playing an instrument, Huang said, “I play guitar. Singing. Makes me happy.” Others relied on small rewards such as a special food or buying a treat for one’s self, “I go out once and eat what I want.” Quiet environments (napping, going for a walk, being alone, going to sleep after a long day, and short rests) and meditation were other ways refugee teachers coped, for example, May Lin Kha said, “I can spend some time alone, it makes me feel better.” Talking to or visiting with friends and family was also helpful, Kywa said, “if we've got problems sometimes it's very difficult like when we're sad, sometimes we call [our] mother.” Refugees mentioned activities such as sewing and window-shopping (“eye-shopping”) as they defined self-care, Ya Zin explained, “just went to the shopping mall for eye shopping I didn’t buy something... then I go home and I’ll be okay.” Self-care was also defined in terms of basic needs such as eating a meal, drinking water, and medical checkups, Mya said, “at least one year one time we go and check like with doctor we take the medicine or check-up take care of myself once every year.” Overall, refugees may have conceptualized self-care differently because they did not have access to many forms of self-care that many affluent Westerners take for granted.

Self-care was not the highest priority. The way refugee teachers defined self-care and the simplicity of their self-care strategies existed within a context of lack of time and resources for caring for one’s self. Without time or access to more lavish forms of self-care, refugee teachers worked with what they had. Generally, teachers explained that they did not spend a lot of time focusing on themselves because they had too many other things to worry about, Mya said, “I cannot remember so many things means I can't take care of myself as well.” Some teachers struggled to come up with things they did to take

care of themselves, saying that they did not really do anything “special.” It seemed difficult for refugees to prioritize caring for one’s self when they lacked resources and time. Overall, refugees utilized relatively simple forms of self-care, most often prayer and religion, given their lack of access to most Western forms of self-care.

Summary. An inductive phenomenological analysis of the eleven individual interviews explored how Southeast Asian refugee teachers living in Malaysia and working in hidden refugee schools experience stress, mental health, and self-care. Nine common themes emerged from an analysis of the interviews. In addition, the quantitative results shed light on the various macrolevel factors that refugee teachers raise as being related to their stress, mental health, and self-care in the context of their experience as refugees.

Chapter 5: Discussion

Resettlement is not a reality for most refugees, as the majority (86%), like those who participated in this study, still live in post-conflict settings and resettlement rates have dropped significantly. Consistent with existing literature (described in more detail below) this dissertation found that living in a post-conflict setting results in the experience of unique stressors; in addition, refugees have experienced past stressors in the country of origin and during flight. Macrolevel factors unique to the refugee experience (e.g., persecution in country of origin, flight from country of origin) impact microlevel stress, mental health, and self-care among refugee teachers. Specifically, refugees who have fled their native Myanmar to Kuala Lumpur experience unique stressors which impact their mental health, such as the behaviors and mental health of their refugee students, the larger discrimination and lack of support by the post-conflict country's government, and their own at-risk status as refugees (Gosnell, 2017; Low et al., 2014; O'Neal, et al., 2018a). Quantitative results indicated that refugee teachers are more stressed, experience higher rates of mental health symptoms, and engage in self-care less frequently than their non-refugee peer teachers. Additionally, lower engagement in self-care strategies significantly predicted higher levels of stress and mental health. Qualitative results suggested that for refugee teachers, macrolevel factors (e.g., refugee status) affected their experience of stress, mental health, and self-care in addition to how they conceptualize the constructs. The discussion that follows will revisit the Developmental-Ecological model, summarize key quantitative and qualitative findings, integrate qualitative and quantitative results, and address study limitations and implications for further research and practice.

Theoretical Framework: The Developmental Ecological Model

This study utilized a Developmental Ecological model proposed by Suarez-Orozco et al. (2011); the model examines how undocumented immigrant students were affected at each level of the ecological system (i.e., chronosystem, macrosystem, exosystem, mesosystem, and microsystem). The framework considers a multitude of risk and resilience factors which interact with the individual's characteristics and may affect individual outcomes and responses (Suarez-Orozco et al., 2011). I have adapted Suarez-Orozco et al.'s (2011) model for undocumented students to my model of refugee teacher mental health as this study has explored various macrolevel risk factors which likely impact the microlevel outcomes: stress and mental health, of refugee teachers (e.g., discrimination in Malaysia on the basis of refugee status). Quantitatively, this study has measured microlevel rates of mental health, stress, and self-care. Qualitatively, I have explored macrolevel factors (and their associated risk factors) unique to the post-conflict refugee experience and how they may impact refugees' experience and definitions of microlevel mental health, stress, and self-care. Quantitative data also examined these microlevel constructs in the context of macrolevel refugee status; refugee status can be viewed as a macrolevel factor because refugees are impacted by immigration policy and an individual's refugee status impacts how they are viewed within Malaysian society and Malaysian culture. Both quantitative and qualitative results suggest that macrolevel factors such as refugee status and public policies (e.g., refugee schools being hidden, lack of resources for refugee teachers, detention, caning), societal norms against refugees, and shared negative attitudes toward refugees (e.g., a "snitch culture" in which Malaysian citizens threaten to report refugees to deportation authorities) affect rates of microlevel

stress, mental health, and self-care (and the way these constructs are defined) among refugee teachers.

Quantitative Findings

Quantitative results indicated high rates of mental health problems and low rates of self-care among refugee teachers. More specifically, rates of mental health symptoms and stress among refugee teachers were significantly higher than their non-refugee peer teachers. In addition, refugee teachers engaged in self-care practices less often than non-refugee teachers. This finding is consistent with current trends of high rates of mental health problems among adult refugees (e.g., Schewitzer, Brough, Vromans, & Asic-Kobe, 2011; Lindert, von Ehrenstein, Priebe, Mielck, & Brahler, 2009; Kroll, Yusef, & Fujiwara, 2011). It also corresponds with existing literature suggesting that teaching is a high-stress profession, that teachers are at risk for developing mental health problems, and that teacher stress is associated with teacher mental health problems (e.g., Ballou, 2012; Bauer et al., 2007; Kovess-Masfety, Rios-Seidel, Sevilla-Dedieu, 2007; Kyriacou, 2000). High rates of mental health symptoms and stress among refugees in comparison to a non-refugee group is consistent with this dissertation's theoretical framework, Suarez-Orozco and Colleagues' (2011) Developmental Ecological Model. The Developmental Ecological Model posits that immigration status (in this case refugee status) has effects across ecological systems (e.g., acculturation, laws, forced migration) and comes with varying levels of risk and protective factors. Given the differences between refugee versus non-refugee mental health and stress rates, it is possible that refugee status (and risk factors related to status) impacts microlevel stress and mental health which is consistent with the Developmental Ecological Framework. Rates of stress, mental health,

and use of self-care strategies differed significantly by gender and age as well. Across all participants, women practice significantly less self-care than men, while among refugee teachers, women are significantly more stressed than men; which is agreement with existing literature on gender differences in self-care and stress (e.g., Maris, Berman, & Silverman, 2000; Matud 2004). Age was negatively correlated with depression, anxiety, and stress; younger teachers experience higher rates of depression, anxiety, and stress than older teachers, which is consistent with existing research on the relation between age and mental health problems among the general population (e.g., Kessler, Berglund, Demler, Jin, Merikangas, & Walters 2005). This finding also parallels the Developmental Ecological Framework as age may also have effects across ecological systems above and beyond refugee status; age may also be associated with unique risk and protective factors (e.g., level of acculturation) that may be related or unrelated to refugee status and impact potential responses and outcomes (e.g., mental health and stress).

Stress, anxiety, and depression were all inter-correlated among the refugee and full samples. Self-care was negatively associated with stress, anxiety, and depression among the full sample. Among the refugee only sample, of the mental health symptoms, self-care was only correlated with stress. Based on regression analyses, self-care was associated with anxiety, depression, and stress among the full sample. These findings are congruous with existing research suggesting that self-care may improve mental health outcomes, particularly for teachers and those in other caregiver professions (e.g., therapists and counselors) (e.g., Newsome, Christopher, Dahlen, & Christopher, 2006; Shapiro, Brown, & Biegel, 2007). These findings are also consistent with the Developmental Ecological Model as it posits that varying levels of risk and

protective factors can impact adaptation and outcomes. Based on the regression results, self-care may be functioning as a protective factor which impacts outcomes such as mental health and stress.

Age was a significant moderator for the refugee only and full samples, but not for the non-refugee only sample. Age significantly moderated the relationship between self-care and mental health (i.e., depression and anxiety), and self-care and stress; among younger teachers there was a strong negative association between self-care and mental health, and between self-care and stress. However, among older teachers there was a weak positive association between self-care and mental health, and between self-care and stress. The association between self-care and mental health and self-care and stress among younger teachers is consistent with the self-care literature cited above (Newsome, Christopher, Dahlen, & Christopher, 2006; Shapiro, Brown, & Biegel, 2007). Age functioning as a moderator is also consistent with existing literature on age differences in mental health symptoms (e.g., Kessler, Berglund, Demler, Jin, Merikangas, & Walters 2005). However, the weak positive association for older teachers is contradictory to the existing self-care literature; it is likely that this finding was impacted by the trend of older teachers experiencing lower rates of mental health symptoms and stress (which is consistent with the literature). Age functioning as a moderator among the refugee sample, but not among the non-refugee sample, maps on to the Developmental Ecological model in that age is functioning as a risk factor (on top of macrolevel refugee status) that influences the relationship between a microlevel protective factor (self-care) and microlevel outcomes (stress and mental health).

Qualitative Findings

Qualitative analyses explored unique individual interviews with refugees who traveled from their native Burma to Kuala Lumpur, Malaysia where they currently live and work as teachers of refugee children in hidden refugee schools. Through eleven individual interviews, each refugee teacher shared their experience of flight from their country of origin to a new life as a teacher of refugee children in a country hostile to refugees. Qualitative thematic phenomenological analyses revealed nine themes which emerged from the individual interviews: were (a) Religious oppression led to flight; (b) Inhumane conditions and fear during flight; (c) Fear and human rights violations; (d) teaching was meaningful, but demanding; (e) Stress was cognition, emotion, and somatic; (f) Mental health was symptoms and tied to the family; (g) Emotion avoidance to emotion identification; (h) Stress and mental health were distinct, but related; (i) Self-care was simple. It is important to note that refugee experiences were colored by their type of refugee status. For example, some refugees are living in a post-conflict country and do not have refugee cards, others are living in a post-conflict country with a refugee card, and the luckiest are formally resettled to a third country (a country willing to grant them protection as asylum seekers). Based on the qualitative results, post-conflict refugees who do not yet have a refugee card, need the most support.

In context of the refugee experience: From country of origin to post-conflict setting. Burmese refugees fled Myanmar because it was their only option given their experience of government brutality fueled by religious oppression which led to severe human rights violations. En route from Myanmar to Malaysia refugees experienced ever-present dangers and inhumane conditions, but moments of intense fear stand out in

particular. Upon arriving in Malaysia, refugees continued to fear discovery by Malaysian authorities, a fear amplified for those who did not possess a UNHCR refugee card. The human rights abuses also continued. Refugees felt trapped in Malaysia, separated from their families, and uncertain of their future. Laws prohibiting refugees from working in Malaysia greatly limited their employment options, thus being a teacher was a meaningful experience among other less desirable employment options. However, the combination of stressors unique to being a refugee teacher teaching in a hidden refugee school created intense mental, physical, and emotional demands for teachers. These qualitative findings are consistent with both quantitative and qualitative research on the experiences of post-conflict refugees (Almqvist & Broberg, 1999; Fazel & Stein, 2002; Low et al., 2014). More specifically, the findings of this dissertation expand upon and are consistent with a closely related study by Low and Colleagues (2014) which also explored the experience of refugee teachers living in Kuala Lumpur Malaysia through qualitative methodology. The Low et al., (2014) study suggested that refugee teachers living in Malaysia experience social, economic, and psychological discrimination and stress from many sociopolitical factors outside the classroom due to living in a country hostile to refugees (i.e., discrimination by neighbors who were citizens, identity threat, fear of arrest/detention, government prohibitions against refugees' legal employment, lack of employment, insufficient pay, and fear for their refugee students' and their own futures). Low et al., (2014) argued that the stress of living in an environment within in a country hostile to refugees, like Kuala Lumpur, Malaysia, (where the participants in the current study resided) creates additional stressors for refugee teachers that go beyond classroom demands and impact their overall well-being. Low et al., (2014) also utilized

an ecological framework. Stressors unique to the experience of being a refugee teacher teaching in a hidden refugee school which create intense mental, physical, and emotional demands for teachers (a main qualitative finding of this dissertation) is consistent not only with the related literature, but also with the Developmental Ecological Framework. The qualitative results regarding stressors unique to the refugee experience and their impact on mental health and stress maps on to Developmental Ecological Model in that refugee status has effects across ecosystems and is associated with various risk factors that may impact individual outcomes.

Defining stress, mental health, and self-care. Refugee teachers defined stress as cognitive, emotional, and physical, but also closely connected to (or defined as) the stressor itself. When defining mental health, refugee teachers attempted to fit the Western term with their lived experience. Refugee teachers were more likely to endorse specific symptoms (e.g., sadness) than labels (e.g., depression). They were also more likely to describe a situation as “very difficult” than reflect on specific emotions. It seemed some participants had a preconceived notion of what felt more “acceptable” when conceptualizing mental health. They conceptualized mental health as experienced in the body and dependent on the well-being of not only the individual, but the family unit. Refugees seemed more reluctant to discuss underlying emotions throughout their interviews, but, given the nature of the interview questions, participants often displayed non-verbal displays of emotion (e.g., crying). Refugee teachers conceptualized stress and mental health as distinct constructs that share commonalities. Self-care was most often expressed as prayer and religion for refugee teachers. Since they don’t have access to many Western forms of self-care, they discussed self-care strategies in the form of music,

small rewards, a quiet space, support from loved ones, food, meditation, sewing, breathing, window shopping, and basic healthcare. A common issue arose around self-care: refugee teachers did not have enough time or resources to devote to self-care. While, to my knowledge, this is the only work of this nature with Burmese refugee teachers, qualitative findings regarding emotionality and self-care correspond with pilot results and my previous work with Burmese refugee students (Gosnell, 2017). They also closely align with the Low et al., (2014) study's findings related to coping among refugee teachers. Low et al., (2014) found that refugee teachers cope with the distress and discrimination "safely by avoidance and acceptance so as to preserve themselves" which maps on to my qualitative themes around engaging in simplistic forms of self-care (e.g., prayer) and avoidance of emotion identification (in the interviews). Participants' unique definitions of microlevel factors of mental health, stress, and self-care are consistent with the Developmental Ecological Model as these definitions are likely shaped by the experience of macrolevel factors (e.g., refugee status) and associated risk factors.

The process of interviewing and analyzing the qualitative results. In

summarizing the qualitative results, I believe it is also important to discuss my experience of the qualitative process. I proposed this dissertation based on ideas from existing literature and my previous work exploring mental health and emotion regulation among refugee children and the experience of being a refugee teacher. It is work I feel passionate about. Traveling to Malaysia, being welcomed into hidden refugee communities, hearing stories first-hand, and experiencing deep human connection takes the experience of dissertation research to a new and unexpected height. My previous work prepared me for the types of experiences I would discuss with the refugee teachers who shared their

stories with me. However, I was struck by the emotionality of the experience. Most interviews were wrought with raw emotion (especially when discussing discrimination, humiliation, family, the future, and safety), more so than I had expected and prepared for. I entered communities as a stranger, yet I felt so instantly connected. I was most surprised by the impact the emotionality of the interviews had on me. I felt with them. There were moments of sadness, anger, helplessness, and most frequently powerlessness. I consistently grappled with the feeling that nothing I could do, none of my work, would help. I felt guilty that our conversations were emotionally intense, that so much was brought the surface, and yet I was utterly powerless when it came to actually *helping* the teachers I spoke with. I was concerned that my interviews were only exploiting them further. While the emotionality of the interview process was deeply impactful for me personally, it also translated into an important novel theme of emotion expression in the context of the refugee experience. The theme emerged unrelated to any interview question. The patterns of emotionality were gleaned purely from the interview process.

In addition to defying my expectations at the experiential level, there was also content that was striking. Similar to the novel theme of emotionality, another novel theme emerged through the process of defining stress and mental health. My goal was to shed light on culture-specific definitions of these Western constructs which are often explored through Western quantitative measures that are not always be the best fit for every population. In conversations around defining these constructs individually, the theme of how stress and mental health are related to one another emerged. For most of the refugee teachers with whom I spoke, part of defining stress and mental health as individual constructs included a conceptualization of how the constructs are similar and different to

one another. It seemed comparing and contrasting the two was a pillar of making sense of the constructs. This theme was unexpected for me, a part of the process of defining the constructs that I had overlooked when creating the interview.

As a whole, the content of the interviews was intense. Refugee teachers described experiences that would be unimaginable for most U.S. citizens. For me, some content was particularly striking, evoking emotionality in both the interviewee and me. For example, back in Myanmar, in addition to having most of their basic rights stripped away, the intense fear women expressed of being abducted by government officials to be used for domestic labor and/or sex really struck me. The feeling in the room was tangible when they described it, likely because of the connection to my own gender identity. Of their experience in Malaysia, I was particularly affected by the issue of access to healthcare, which is relatively low-cost in Malaysia except when you are a refugee. Teachers described the experience of watching citizens pay a small fee for medical care and then being charged hundreds, or even thousands for the same service, simply because they are refugees. One teacher described a hospital turning a seriously ill refugee infant away. This same issue also pertains to housing. Refugees are trapped in a vicious cycle of the Malaysian laws that make it illegal for them to work, forcing them to get low-paying unregulated jobs, and then being grossly overcharged for basic needs. While I was expecting it, hearing themes around persistent discrimination, lack of basic human rights, humiliation, and constant fear for safety still left me emotional. I was also struck by subthemes that I wasn't expecting. For example, the way refugee teachers are treated by parents of their students (parents who are also refugees). They described situations of parents slandering and belittling them (mentioning them by name) on the school's online

forum and also in person. In addition, at one school, teachers described a Malaysian citizen teacher who worked at the school; she treated the refugee teachers with hostility and disrespect, demeaning and mocking them in front of the students. While much of this section relates to emotionality and hardships, perhaps what has affected me most is the refugee teachers' resilience, spirit, and willingness to connect with me. I feel incredibly grateful that they were willing to share their stories with me.

Integration of Quantitative and Qualitative Results

The purpose of the qualitative data gained from eleven individual interviews with Burmese refugee teachers was to shed light on some of the risk factors and refugee experiences that could impact quantitative stress, mental health, and self-care. The purpose for collecting qualitative data are consistent with the Developmental Ecological Model which posits that macrolevel factors (e.g., refugee status) are associated with unique risk factors (e.g., detainment) which may create effects across ecosystem levels and impact microlevel outcomes (e.g., stress and mental health); however, protective factors (e.g., self-care) may help to offset the effect of risk factors on outcomes. The qualitative data were separated into themes in order to understand the various risk and protective factors within the refugee experience which may influence stress, mental health, and self-care based on a Developmental Ecological Framework. In addition, qualitative data were utilized to establish culture-specific definitions for the variables of interest (i.e., stress, mental health, and self-care) as they are Western constructs. As indicated by the pilot results, refugees primarily defined self-care as prayer and religion which, in some ways, contrasts the Western conceptualization of the construct. Thus, it was important to continue exploring refugee teachers' conceptualizations of the Western

constructs qualitatively to contextualize the quantitative measurement of the constructs. The qualitative interview questions and prompts were designed with these specific goals in mind. I view the qualitative data (which sheds light on the risk factors associated with macrolevel refugee status) as a possible means of explaining the quantitative stress, mental health, and self-care microlevel outcomes. While rating scales provide valuable quantitative stress, mental health, and self-care data, qualitative data better capture and contextualize the experiences and risk factors that may lead to stress and negative mental health outcomes, in addition to how self-care may act as a protective factor.

Qualitative results provided a more detailed understanding of individual refugee interviews regarding flight from country of origin and integration into a second country where they work as refugee teachers. Both quantitative and qualitative findings suggested that refugee teachers struggle with high rates of stress and mental health symptoms, which are likely impacted by low rates of self-care and risk factors unique to the refugee experience. In detailing the refugee teachers' traumatic experiences, qualitative findings offered an explanation and context for the quantitative high incidence of stress and mental health symptoms. In addition, qualitative details regarding difficulties around prioritizing self-care, but feeling better when they do engage in self-care strategies, supported the quantitative negative relation between self-care and mental health. The combined methods design led to greater depth than separate methods. For example, the qualitative interviews suggested that a lack of resources and time make it difficult for refugees to prioritize self-care especially as it is conceptualized in the Western world, which is supported by low rates of self-care as evidenced by quantitative findings. In addition, qualitative results offer a more detail explanation of how refugees

conceptualize stress, mental health, and self-care that goes beyond what was reflected in quantitative questionnaires. The link between the qualitative and quantitative results and their ability to serve complementary purposes within this mixed methods design is congruous to existing research on the utility of mixed methods designs (e.g., Kelle, 2006). Overall, the integration of qualitative and quantitative results cemented the link between refugee experiences, risk factors, emotions, stress, self-care, and mental health, which is consistent with existing literature cited throughout this section and the Developmental Ecological Framework.

Limitations

Several limitations should be taken into account when considering the results of this study. First and foremost, issues surrounding culture created several barriers and obstacles. The data collection was led by white American researchers, who could only spend a limited amount of time in Malaysia. Furthermore, I write this paper through my own cultural lens of a white, college-educated, American female. These facts about our backgrounds and our cultural lenses are highly important. This research was conducted and written through a Western lens. This is even more noteworthy in reference to the qualitative work. Although I did my best to establish rapport, having interviews led by a White American researcher may have influenced how the refugee teachers presented their stories and what information they chose to share. Given my skin color, country of origin, and first language, there was a power differential among the interviewer, the interviewees, and in some cases the translator (another refugee teacher who was more confident in her English), which may have impacted the information that was expressed and the way it was presented by both the interviewees and translator. As an educated,

White, American, the interviewer may have been viewed as an authority figure by the refugee teachers, despite making clear that she was unaffiliated with UNHCR. The way the interviewer was perceived by participants likely impacted how they shared their experiences. Participants may have been willing to share more during the interview if the interviewer was trusted and familiar, rather than an unknown interviewer from the US. However, it is also possible that the refugee teachers were more open with the unknown interviewer, as compared to talking with another refugee or a community member. Another refugee teacher acting as a translator (on a voluntary basis on the part of the interviewee and the translator) may have also impacted the integrity of the data. Further, the English-speaking ability of the participants may have been a factor that distinguished study participants from the general population. Similarly, my research on refugee teachers is limited based on my lack of belonging within hidden, vulnerable refugee communities and my lack of a shared identity. As I am not an ethnic-minority, refugee living in a country which is hostile to refugees and teaching in a hidden refugee school, I will never be able to fully capture the experience of this population, nor do I claim to. My intention with this work is simply to share the story of refugee teachers in the best way that I can and give a voice to the often overlooked refugee experience. It is also to raise awareness not only about their experiences and the challenges they face as refugees and teachers of refugee children, but about the relation of such macrolevel factors with their stress, mental health, and self-care, which is consistent with existing literature.

Overall, it should be understood that language barriers and the use of Western measures could affect the integrity of the data. For example, the English terms we asked refugees to define may not translate or have the same meaning in Burmese. Additional

limitations are the relatively small quantitative and qualitative sample sizes, especially the non-refugee sample. It is important to acknowledge that differences between the refugee and non-refugee samples could be attributed to differences in power. It is also possible that differences between the refugee and non-refugee samples may be attributed to ethnicity and related variables, as half of the non-refugee participants were from Western countries (e.g., U.S., Australia). Moreover, while the measures were well-validated, I relied on two self-report measures to obtain stress, mental health, and self-care data. These Western measures have not been specifically validated on a Burmese refugee sample. While it was determined that participants were proficient enough in English to complete the measure, there is still a possible disconnect when a measure that was normed on a Western population is interpreted through a different cultural lens. Future research is needed to establish more culturally sensitive measures to more accurately measure the constructs of mental health, stress, and self-care among refugee populations. The measures are also limited given that they are self-report and there are stronger methods to measure mental health symptoms (diagnostic interview). Another limitation is the use of archival quantitative data for this study. Future research, as discussed later in more detail, should utilize a larger sample sizes and focus on linking experiences with emotion and well-being. This research might be viewed as a preliminary study to guide future research. Future research should include longitudinal analyses with larger quantitative and qualitative samples to study changes over time and increase power. Additional measures and a more diverse refugee sample may also be useful.

Implications

Implications for school psychologists and other professionals. This research is meant to raise awareness around refugee trauma, for school professionals who will work with refugees since it is easy as an American, to become numb to migrant trauma given the recent overwhelming media attention to refugees and migration (Erbentraut, 2015). This work has implications for practitioners and educators worldwide, but particularly in those countries with large populations of resettled refugees, especially refugee children. For example, in the U.S. over a third of the resettled refugees are children (BRYCS, 2016) who are now attending American schools. There is an overwhelming necessity for the professionals who serve refugee children in countries of resettlement to understand their experiences before they were resettled and to also understand how serving these children may impact them. The refugee interviews analyzed in this research illuminate the traumatic experience of being a refugee, but also the experience of teaching refugee children. Such experiences are unimaginable for most children and adults in the Western world and are often unfamiliar to Western practitioners and educators. Although every story is different and the results of this dissertation are not generalizable to all refugees, these results have implications for the practice of trauma-informed care. Having some knowledge of what a refugee might have faced in their past and insight into the experience of teaching refugee children, may give professionals a better sense of the whole individual. Even when refugees are resettled to Western countries like the U.S., it is important for practitioners and educators to understand the traumatic experiences and the complete lack of regard for human rights that these individuals faced prior to their arrival. These findings may also inform work with undocumented individuals, for

example, those seeking asylum in the U.S. after fleeing countries in Central and South America. Further, it will shed light on the experience of teaching refugee children; this work will help those professionals to understand how past (and current) experiences may impact stress and mental health for refugees; and how working with refugee children may impact them. It also provides insight into possible protective factors like self-care, which raises practitioner awareness of the benefits of self-care for the migrant populations they serve, but also for themselves as service providers. Understanding refugee stress, mental health, and experiences (specific to the refugee experience, but also to the refugee teacher experience) will help school psychologists, professional psychologists, and school staff to better serve refugee children.

This work also has a broader impact as it relates to issues in the U.S. The current immigration crisis, which has resulted from decisions made by the Trump administration, has created a crisis situation for those seeking asylum in the U.S. This dissertation sheds light on the impact of experiencing migration-related trauma on negative mental health symptoms. The U.S. is currently violating human rights and inflicting migration-related trauma on asylum seekers who are fleeing countries in Central and South America. When considering the findings from this dissertation and previous research, it is likely the mental health of asylum seekers will suffer at the hand of the U.S. government as it leaves them stateless.

Implications for future research. This research can help guide further research as it is the first study of its kind to quantitatively examine stress, mental health, and self-care among a population of post-conflict Burmese refugee teachers, paired with qualitative interview data. It is an important step to first understanding how stress,

mental health, and self-care are defined, experienced, and conceptualized among a specific population before developing a treatment or intervention (Nastasi & Jayasena, 2014; Nastasi, Varjas, Bernstein, & Jayasena, 2000). One of the most important contributions of this research is that it can inform future research on treatment or intervention development for similar post-conflict refugee populations. The link between self-care and stress among refugee teachers working in hidden refuge schools may encourage researchers to examine this link in other refugee populations, in a larger sample, and at more than one time-point. The interesting illumination of the quantitative results via the qualitative analyses may encourage further research to replicate this work using a true mixed methods design that really expands upon the role and possibilities of the qualitative portion of this work. Further research might consider a much larger qualitative and quantitative sample from multiple countries of origin. For future qualitative research on refugee stress, mental health, and self-care, researchers should ensure the interviewer is not viewed as an authority figure by the interviewees. Researchers may also consider preliminary activities to help participants feel more comfortable discussing emotions. Perhaps one of the most important implications of this work is the need for additional measures. For example, the qualitative results around defining self-care suggest that the current self-care measure may be inappropriate for use with this population. Since macrolevel factors like refugee status impact the way refugee teachers define and practice self-care, and the current measure does not actually capture self-care practice among this population. Thus, there is a need for development of a culture-specific self-care measure. In addition, the Western constructs of mental health, stress, and self-care were measured using quantitative Western measures which may not

translate precisely. In establishing culture-specific measures, it will be important to understand how these constructs translate into concepts within the native language of the population of study.

Conclusion

Given the more than 70 million displaced peoples around the world, half of whom are children in need of a post-conflict education, this study sought to examine the nature of stress, mental health, self-care, and experiences in a subset post-conflict population of mostly Burmese refugee teachers who teach refugee children in hidden refugee schools in Malaysia. In this paper I have argued that macrolevel factors can influence microlevel stress, mental health, and self-care among refugee teachers. With the goal of understanding the stressors that may cause mental health challenges and self-care as a possible protective factor, this work explored themes raised by Burmese refugee teachers in qualitative interviews addressing persecution and related stressors faced in Burma, their flight to Malaysia, life as a refugee teacher in Malaysia, and culture-specific conceptualizations around stress, mental health, and self-care. Quantitative results indicated that refugee experience high rates of stress and mental health symptoms which are negatively correlated with their use of self-care strategies. Additionally, qualitative interviews supported the overall argument that macrolevel factors have an impact on refugee teachers' stress, mental health, and self-care. This and future research may raise awareness about the experiences of refugees, and even more specifically, refugees who work as teachers in hidden refugee schools, an understudied population. If nothing else, such research gives their hidden stories a voice, so that hearing their stories is a call to action.

Appendices

Appendix A

Pilot Refugee Teacher Focus Group Questions (2012)

1. What is your experience as a refugee teacher in Malaysia?
2. What is the best thing about being a teacher?
3. What is the most stressful thing about being a teacher?
4. How do you feel as teachers when parents challenge you?
5. How do you take care of yourselves as teachers?
6. What is the worst behavior of students?
7. How do you punish your children who do not behave?
8. Does this physical punishment result in a change in behavior?
9. How do you decide which children need beating?
10. Do you think the methods that you have shared work?
11. How do children feel as refugees and does it affect their studies?
12. How do students show when they are angry/frustrated/sad?
13. How do you get your children to be excited about coming to school?
14. Any problems where children cannot focus in class?
15. What are the children's strengths?

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