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SPECIAL ISSUE

Stress, Mental Health, and Self-Care Among Refugee Teachers in Malaysia

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The mental health of postconflict refugees stuck in limbo in neighboring countries, often hostile to refugees, is critically important, given the current refugee crisis. Currently, more than 70 million people have been displaced, with nearly 1 million forcibly displaced from Myanmar. This pair of studies sought to highlight the importance of a culturally sensitive assessment prior to the implementation of an intervention; they rely on an Ecological Developmental approach and mixed-method model to both examine and explore stress, mental health (i.e., depression and anxiety), and self-care among refugee teachers from Myanmar who are living in Kuala Lumpur, Malaysia. For Study 1, participants included 97 primarily Burmese refugee teachers and 26 nonrefugee teachers living in Malaysia. Study 1 used quantitative measures, was cross sectional, and data were collected in 2013, including Depression, Anxiety, and Stress Scales and a self-care questionnaire. Study 1 results suggested that refugee teachers reported significantly higher rates of mental health and stress, but lower rates of self-care, compared with nonrefugee teachers. In addition, higher rates of self-care were associated with lower rates of stress and mental health symptoms, and the association was moderated by age. For Study 2, in 2018, qualitative interviews explored conceptualizations of stress, mental health, and coping among refugee teachers who were from Myanmar ($n = 11$). Study 2's 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 related to being a refugee in a country hostile to refugees. The discussion connects results to previous literature and addresses implications of this culturally sensitive assessment for future intervention development.

What is the public significance of this article?
This mixed-method, cross-sectional paper suggests that teachers who are refugees experience more stress, depression, and anxiety than teachers who are not refugees in Malaysia, and age plays a moderating, protective role in mitigating the relation between self-care and mental health. A predominant theme voiced by Myanmar refugees, who were refugee teachers, was that macrolevel factors associated with their refugee status (e.g., discrimination) impact microlevel, individual lived experiences (i.e., stress and mental health) of Asian teachers who are refugees; at the same time, refugee teachers described their coping strategies as strengths, including religious practices, in addition to refugee school and community support. This paper's mixed-method results hold implications for the development of future culturally relevant interventions focused on refugee teachers' mental health, self-care, and healing.

Keywords: refugee, teacher, stress, mental health, self-care

Postconflict refugee education is both a challenge to access and underfunded in the face of the current global refugee crisis, which has forcibly displaced more than 70 million people, half of whom are children, who are refugees, asylum seekers, and internally displaced in need of postconflict education (United Nations High Commissioner for Refugees [UNHCR], 2019a, 2019b). We define postconflict as an adjective that describes both a limbo experience and location of refugees immediately after they flee their home country to a neighboring country; refugees typically want to be resettled from a postconflict country to a safer, more welcoming country where they can plan their future as citizens because they would have access to opportunities like legal jobs, careers, and a formal education for their children (O'Neal, Atapattu, et al., 2018). Approximately 50% of refugees are school-aged children, with only 63% of those receiving an informal, typically half-day primary school education and 24% receiving an informal secondary school education (UNHCR, 2019a, 2019b). Refugee children are often prohibited by postconflict governments from receiving formal education or working legally, so some refugee communities have offered an informal education to their own refugee children. Despite refugee education being in crisis worldwide (UNHCR, 2019a, 2019b), such postconflict refugee schools have acted as a refugee community base and symbol of hope—hope of preparing their children

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for work and resettlement in another country, for instance, by teaching them English (O'Neal, Atapattu, et al., 2018). Refugees face macrolevel challenges, like just existing as refugees (i.e., refugee status). In 2019, only 63,726 refugees were resettled to safe countries by UNHCR; more than 99% of the world's refugees have not been resettled and live in a postconflict setting (UNHCR, 2019b). Such macrolevel postconflict challenges of living in a neighboring country, which is often hostile to refugees, can result in individual refugee stress and mental health struggles, exacerbated by little hope of either citizenship in the postconflict country or resettlement to a safer country with real potential of citizenship (Low et al., 2014). Postconflict refugees, in particular, have high rates of mental health symptoms and trauma (e.g., Kroll et al., 2011).

In Study 1 and Study 2, refugee teachers were operationalized as refugees who teach refugee children, given that the majority of teachers of refugee children in postconflict education, and Malaysia, are refugees (O'Neal, Atapattu, et al., 2018). Refugees were defined as displaced people with or without a UNHCR refugee card who fled their home countries in which they were oppressed and persecuted; we define a nonrefugee as a citizen who has not fled their home country. Postconflict refugee teachers are essential because informal refugee education offered by their small refugee communities is often the only positive, engaging, stimulating experience that refugee children have when living in a postconflict country that does not allow them access to public education (O'Neal, Atapattu, et al., 2018). The stress of teaching in under-resourced, challenging school environments may further impact refugee teachers' mental health (Low et al., 2014; O'Neal, Gosnell, et al., 2018). The potential relations among stress, mental health, and self-care among postconflict refugee teachers have not received attention. The goal of the two current studies was to conduct a culture-specific, mixed-method assessment to inform the development of a future intervention in Malaysia by examining stress, mental health (i.e., depression), and self-care among refugee teachers in the context of macrolevel factors unique to the refugee experience in Malaysia. Study 1 participants included teachers who were refugees, largely from Asia, including a majority from Southeast Asia (Myanmar), but also a minority from Southern and Western Asia, in addition to a few North African participants from Sudan. Study 2 was designed to be an in-depth follow up to Study 1, with a qualitative focus on participants from Myanmar.

Theoretical Framework

Study 1 and Study 2 utilized an Ecological Developmental model proposed by Suárez-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, microsystem, and individual level). The Ecological Development model provides a framework to conceptualize and understand relations of macrolevel factors, like refugee status, with individual-level factors like mental health. The framework considers a multitude of risk and resilience factors, which interact with the individual's characteristics and may affect individual outcomes (Suárez-Orozco et al., 2011). Study 1 examined the relations among these individual-level constructs and how these constructs were moderated by age, gender, and refugee status, which we view as a macrolevel contextual factor. Qualitatively, Study 2 explored macrolevel factors unique to the postconflict refugee experience and how they may impact refugees' experiences and definitions of individual-level mental health, stress, and self-care. Examples of potential macrolevel factors include public policies (e.g., detention), 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). Refugee status is a macrolevel factor because refugee status is determined by immigration and UNHCR policies, and an individual's refugee status impacts how they are viewed by Malaysian and global societies; in addition, refugee status has a whole constellation of other macrolevel factors associated with it (e.g., postconflict societies' discrimination).

This pair of studies also relied on the Participatory Culture-Specific Consultation Model (PCSC). PCSC underscores the necessity for culture-specific, mixed-methods studies to inform the development of interventions. Prior to intervention development, participant voices need to inform the intervention. PCSC is relevant to the current studies because they collected participant voices using mixed methods to inform the development of a refugee intervention. Both PCSC and the Ecological Developmental models underscore the importance of examining not only risk factors, at a variety of ecological levels, but also protective factors. The models' rationale for valuing the study of protective factors is a strength-focus, rather than solely a deficit-focus. In designing our studies, we prioritize a protective factor-focus by including self-care as a protective factor, with further rationale for self-care as a protective factor reviewed below.

Postconflict Refugees

Often, postconflict countries are unwilling to host refugees, and these postconflict countries do not view refugees as refugees but, rather, view them as illegal immigrants who are a threat to their economy and education systems, like in Malaysia (Nathan, 2012). Unlike a refugee who is resettled to a safe country via safe travel, a postconflict refugee endures dangerous travel to a new, postconflict country without support. During their flight, they must remain hidden while trekking through regions where officials are typically actively attempting to capture them (O'Neal, Gosnell, et al., 2018). Many refugees also face persecution and oppression in postconflict countries, like those in Southeast Asia (Low et al., 2014; Nathan, 2012). Postconflict refugees' experiences are very different from resettled refugees who are typically resettled to Western countries and receive better, legal financial opportunities, job support, education, and the opportunity for citizenship (United Nations High Commissioner for Refugees, 2017). Overall, postconflict refugees have faced multiple unique macrolevel stressors, including sociopolitical conflict, traumatic and/or difficult flights from their home countries, challenging living conditions, and hostility from their new postconflict country (Fazel & Stein, 2002).

Postconflict Refugees in Malaysia

The refugee teachers who participated in Study 1 were mostly Burmese refugees living in Malaysia. All refugee teachers who participated in Study 2 were Burmese refugees who were originally from Myanmar and were currently living in Malaysia. As of February 2020, there were 178,990 refugees and asylum-seekers registered with UNHCR in Malaysia. About 154,080 refugees living in Malaysia are persecuted ethnic groups from Myanmar; indeed, over 1 million refugees have fled Myanmar (UNHCR, 2020a, 2020b). Given the current military coup and state-sanctioned violence in Myanmar, even more refugees will soon be fleeing Myanmar into surrounding Asian countries, including Malaysia,

hoping for eventual resettlement with family in the U.S. or other countries. In our paper, the Rohingya and Chin ethnic groups fled their home country of Myanmar to Malaysia due to their experience of religious persecution and oppression back in Myanmar. Many refugees from Myanmar choose to flee to Malaysia, perhaps, because the Malaysian government does not require them to live in refugee camps, unlike the Thai Government. In addition, there are under-the-table, illegal work opportunities in restaurants and tea plantations in Malaysia; Rohingya and Chin refugee family and friends already living in Malaysia; and easy, although dangerous and costly, access to the human smuggling route from Myanmar to Malaysia. The Malaysian government is not a signatory to the 1951 UN convention or its 1967 protocol. Therefore, there are no legislative or administrative provisions in place for dealing with the situation of postconflict refugees and asylum-seekers in Malaysia (UNHCR, 2019a, 2019b), and UNHCR-Malaysia is in a weak advocacy position, with the threat of being expelled due to its unofficial status. 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, 1959/1963; Nathan, 2012). On top of the stress of both marginalization and persecution back in Myanmar, refugees who have fled to Malaysia live in fear, have no access to legal employment, and face extreme poverty, discrimination, psychological turmoil, fines, detention, whipping with a cane for illegal entry, and deportation (Low et al., 2014; Nathan, 2012). The government does not offer resources to support refugees. Non-governmental organizations (NGOs) (i.e., nonprofit organizations that operate independently of the government) in Malaysia are, however, able to offer very limited mental and physical health services to refugees, with long waiting lists and inconvenient locations; no specialty health services are offered to refugees either, like neuropsychological services.

Postconflict Urban Refugee Schools in Malaysia

As of February 2020, 46,520 child refugees and asylum-seekers under the age of 18 were registered with UNHCR in Malaysia (UNHCR, 2020a, 2020b); this is a significant underestimate of the number of refugee children, given how many are speculated to be out of UNHCR-Malaysia's radar. Given the number of children in need of a postconflict education and the laws prohibiting refugee children from attending Malaysian public schools, refugee communities have created hidden "informal learning centers" for refugee children. These hidden schools operate on minimal funding from student fees and a handful get limited funding from nonprofit organizations. Although they 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. Only 44% of refugee children aged 6–13 and 16% of secondary school-aged refugee children attend these informal learning centers, which we call schools in this paper.

Refugee Teacher Stress and Mental Health

The postconflict refugee education context provides unique challenges and opportunities for refugee teachers. 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. Only a small number of studies have examined stress among teachers who are refugees, who teach refugee children (e.g., Kirk, 2010).

In contrast, numerous studies have examined stress and mental health of typical teachers. In general, stress is associated with negative mental health symptoms and psychiatric disorders among adults (Avison & Turner, 1988). 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 (e.g., Ballou, 2012). Teachers who work in urban settings, like the teachers in our sample, may be especially affected by stress (Abel & Sewell, 1999).

Although there is only limited research on mental health among refugee teacher populations, there are many studies of mental health among adult refugees. Adult refugees experience higher rates of mental health disorders than nonrefugees. For instance, a 2009 meta-analysis by Steel, Chey, Silove, Marnane, Bryant, and Ommeren revealed that the prevalence of Post Traumatic Stress Disorder (PTSD) was 30.6% and depression was 30.8% among refugees and other conflict-affected adults. When compared with nonrefugees, refugees have higher PTSD and depressive symptoms (e.g., Kroll et al., 2011). Some research indicates that mental health problems persist or worsen over time among refugee adults (Mollica et al., 2001). Refugee status can be considered a risk factor for developing mental health problems given that refugee adults experience more negative mental health symptoms than their nonrefugee peers. Most existing research is on nonrefugee versus resettled refugee mental health, and most resettled refugee/nonrefugee mental health comparison studies were conducted in Western countries, like the U.S. and England. In sum, refugee status (refugee vs. nonrefugee) is an important factor to study using culturally sensitive assessments; in addition, the current studies offer a novel approach of studying postconflict, rather than resettled, refugees.

Refugee Teacher Stress and Mental Health

Many stressors are experienced by refugee teachers, above and beyond stressors associated with general teaching, including refugee student–teacher ratios, refugee student mental health and behavior, lack of resources, and sociopolitical challenges (O'Neal, Gosnell, et al., 2018). A handful of 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 (e.g., Kirk, 2010). These additional stressors, coupled with their refugee status, may put teachers of refugee children (who are also refugees, themselves) at a greater risk for experiencing negative mental health symptoms as compared with teachers in general. For example, a small-scale qualitative study in Malaysia by Low et al. (2014) found that the stress of living in an urban environment within a country hostile to refugees creates additional stressors (e.g., intense discrimination) for refugee teachers that go beyond classroom demands and structural challenges (e.g., classroom setting) and impacts their overall well-being.

Self-Care to Manage Mental Health Problems and Stress

Put simply, self-care has been defined as "engagement in behaviors that maintain and promote physical and emotional well-being" (Myers et al., 2012, p. 56). It is a broad concept which can include lifestyle (e.g., sporting activities, leisure), environmental factors

(e.g., living conditions), and socioeconomic factors (e.g., income level; World Health Organization, Regional Office for South-East Asia, 2014). 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). Self-care casts a wide umbrella of healthy routines and practices that include coping skills; coping skills can be used in moments of stress (Braime, 2016). 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). Research has established that gender and age differences exist in mental health symptoms and self-care (e.g., Folkman et al., 1987; Kessler et al., 2005; Matud, 2004).

As reviewed in the theoretical model section above, PCSC and Ecological Developmental approaches underscore the importance of identifying and defining culture-specific protective factors. Self-care may be a potential culture-specific protective factor for refugee teachers. Based on the theoretical models, and the following literature, we give a rationale for our testing if self-care mitigates the relation between stress and mental health among refugee teachers. 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; Newsome et al., 2006). Given that refugee teachers experience unique stressors beyond that of the average teacher (e.g., Kirk, 2010), self-care may be especially useful; however, no self-care research, that we know of, has been done with refugee teachers. Self-care may help refugee teachers manage stress in the classroom and with their own experiences as a refugee. Self-care may mitigate the impact of stress on refugee mental health, but it is unclear how refugees, who are teachers, in Southeast Asia define self-care, stress, and mental health.

Previous research has examined cultural differences in the conceptualization of self-care, largely in the field of medicine around self-care of chronic illnesses like diabetes and heart disease, with some studies finding cultural differences and some not (e.g., De Maria et al., 2019). A recent integrative review found that in African American and South Asian groups, the cultural factors of collectivism, kinship, and gender norms influenced the self-care practice of dietary adherence around cardiovascular disease (Osokpo & Riegel, 2019). Given the reliance of the field of psychology on the term self-care, especially around practitioner self-care, it was surprising that, to our knowledge, there has been such limited cross-cultural research on self-care of mental health and stress. In addition, there was a surprising lack of qualitative research on cultural differences in the conceptualization of self-care. Since the constructs of mental health, stress, and self-care are Western concepts, it is important to establish culture-specific definitions of these constructs via qualitative research to inform further quantitative assessment and psychosocial interventions.

In sum, teachers who are refugees may be at increased risk for developing mental health problems due to the unique stressors they experience. Therefore, it is important to study stress, mental health, and self-care among a refugee teacher population. Further, self-care may be a protective factor of the relation between stress and mental health, yet there is little-to-no research on self-care and its effects among refugee teachers. Culture-specific definitions of stress, mental health, and self-care and how refugee teachers' lived experiences inform our understanding of how refugee status may impact the individual experience of stress, mental health, and self-care among refugee teachers.

The current mixed-methods paper has two parts. Study 1 used our 2013 quantitative dataset to test stress and mental health differences between refugee and nonrefugee teachers in Malaysia, in addition to how the relation between stress and mental health may be dependent on self-care. Study 1 participants were refugees from Asia and were largely Southeast Asian (from Myanmar), but a minority were from Southern and Western Asia; a few participants were from Sudan. Study 2 built on Study 1, 5 years later, with the goal of following up on Study 1 with more culturally nuanced ways of gaining refugee teachers' perspectives on mental health and self-care via qualitative data. Study 2 included only refugees from Myanmar, with an exploration of their culture-specific definitions of stress, mental health, and self-care, in addition to how refugee status may impact the individual lived experiences of stress, mental health, and self-care among teachers who were refugees from Myanmar. Our mixed-methods approach is similar to the sequential structure (Quantitative Study 1 then Qualitative Study 2), expansion process (Study 2 expands on research questions raised by Study 1), and the "connect" process (Study 2 builds on Study 1 by in-depth sampling of one refugee ethnic minority group and deep qualitative analysis of their lived experiences) in the taxonomy of mixed-method designs detailed by Palinkas et al. (2011).

Hypotheses and Questions

This mixed-method paper includes quantitative hypotheses (Study 1) and an exploratory qualitative question (Study 2):

1. Study 1:
    a. We expected individual rates of negative mental health symptoms, stress, and self-care to differ by the macrolevel factor of refugee status.
    b. We expected there to be a positive relation between stress and mental health and for self-care to moderate the relation. We predicted that self-care would weaken the relation between stress and mental health, as a protective factor in the face of stress. In addition, we explored age and gender as potential moderators.
2. Study 2:
    a. Qualitatively, we explored how Burmese refugee teachers conceptualized the individual factors of stress, mental health, and self-care in the context of the macrolevel refugee experience.

Study 1

Study 1 Method

Participants

The quantitative data for Study 1 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

Table 1
Study 1 Participant Demographics

Variable	Refugee status	
	Refugee (n = 97)	Nonrefugee (n = 27)
Age (in years)	30.22 (9.85)	48.42 (11.18)
Malaysian Citizenship (%)		
Yes	1.0	50.0
No	99.0	50.0
Sex (%)		
Female	57.1	73.1
Male	42.9	26.9
Country of origin (%)		
Myanmar	77.6	
Sudan	3.1	
Pakistan	7.1	
Afghanistan	3.1	
Malaysia		50.0
Western European Countries		23.1
Other Asian Countries (Syria, Iran, Iraq, Palestine, and others)	9.2	26.9
Ethnicity (%)		
Chin	58.8	
Arabic, Persian, Hazara, Elassher	15.5	8.7
Zomi	8.2	
Pakistani	7.2	
Mizo	3.1	
Kachin	3.1	
Chinese		43.5
White		26.1
Other Asian		17.4
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
Years living in Malaysia (%)		
<1 year	14.4	24.0
1–5 years	74.3	24.0
>5 years	11.3	52.0

living in Malaysia, (b) teacher of refugee children (aged under 18), and (c) conversational English-speaking ability. It was difficult to estimate the total number of schools from which we originally recruited given that recruitment occurred via a snowball procedure (Flick, 2009) including word of mouth, in-person meetings, and emails sent by refugee service organizations and UNHCR to the refugee schools with whom they were in contact. Of the 124 teachers, 97 teachers were refugees, themselves. Study 1 participants include refugees from Asia, including largely Southeast Asia (Myanmar), but also a minority from Southern and Western Asia; however, there were a few participants who were refugees from Sudan, a North African country. Refugee participants were primarily from the country of origin of Myanmar (77.6%) (Mage = 30.22, 57.1% female). The participants were from 30 informal refugee schools; most refugees had only lived in Malaysia between 1 and 5 years. The other 27 teachers of refugee students were not refugees, were primarily from Malaysia (50%) or Western countries (e.g., U.S., Australia; Mage = 48.42, 73.1% female), and were from seven refugee schools.

Data Collection

The quantitative data utilized in Study 1 were collected in Kuala Lumpur, Malaysia, in 2013 as part of a larger study (O'Neal, Gosnell, et al., 2018). Data collection was through self-report surveys of stress, anxiety, depression, and self-care. No qualitative data were collected from these participants.

Study 1 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.

Depression Anxiety Stress Scales-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. It is a reliable and valid measure for use with both clinical and nonclinical populations (Henry & Crawford, 2005). Each state includes a seven-item scale, rated on a 4-point Likert scale (0 = *Does not apply to me* to 3 = *Applies to me very much or most of the time*). 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. A score above 11 on the depression scale, greater than 8 on the anxiety scale, and greater than 13 on the stress scale, indicates clinically severe symptoms. Previous research suggests that the DASS-21 has convergent and discriminant reliability in a normative sample (as reviewed in Henry & Crawford, 2005). The DASS questionnaire had an α of .90. The stress scale had an α of .71, the anxiety α was .82, and the depression α was .72.

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 consisted of 10 statements about self-care strategies (e.g., "I occasionally give myself something nice like a present or treat"). Participants then rated each statement according to whether it was representative of them over the past week on a 4-point Likert scale (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 and the likelihood of engaging in the strategy. This questionnaire had an α of .77 in Study 1.

Study 1 Results

Analyses were run by refugee status. Given that the nonrefugee sample size was so small, full sample results were only reported if they differed from the refugee-only sample.

Descriptive Statistics

Rates of mental health symptoms and stress among refugee teachers ($n = 97$) were high, and they were significantly higher than their nonrefugee peer teachers ($n = 19$). For example, 8.3% of refugee teachers reported stress levels in the severe or extremely severe clinical ranges (i.e., a total score of 13 or higher), while none of the nonrefugee 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 in the severe or extremely severe clinical ranges (i.e., a total score of 11 or higher), while none of nonrefugees 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, but only 10.5% of nonrefugees reported levels in the severe or extremely severe range (Tables 2 and 3). It should be noted that there were missing data as only 19 of the 27 nonrefugee teachers completed both DASS-21 and self-care questionnaires.

Use of self-care strategies also differed significantly based on refugee status, as nonrefugee teachers used self-care practices more often than refugee teachers. There were also differences in stress, mental health, and use of self-care strategies by gender and age. Women practiced significantly less self-care than men, and among refugee teachers, women were significantly more stressed than men (see Table 3). Age was negatively correlated with depression, anxiety, and stress—younger teachers experienced higher rates of depression, anxiety, and stress than older teachers.

Results relied on Welch's *t*-test, with equal variances not assumed due to unbalanced sample sizes for the refugee and nonrefugee groups and for the male and female groups.

Correlations and Regressions

Correlation analyses revealed that stress, anxiety, and depression were all positively correlated with one another among the refugee sample. Of the mental health symptoms, however, self-care was only correlated with stress in the refugee sample (Table 4). Among the full sample, higher self-care was associated with lower anxiety, depression, and stress.

Regression results indicated that self-care was a significant predictor of anxiety, depression, and stress among the full sample. In the refugee sample, self-care explained a significant proportion of variance in stress, but not anxiety and depression (Tables 5–7).

Moderation

Moderation analyses were conducted utilizing Andrew Hayes' PROCESS macro for SPSS. We expected that self-care would weaken the relation between stress and mental health, but the hypothesized moderation model was not significant. However, additional moderation analyses were conducted to explore how mental health and self-care differed by gender and age. For the refugee sample, age was a significant moderator of the relation between self-care and anxiety; self-care and depression; and self-care and stress. For younger teachers, the more self-care they reported, the less mental health problems they reported. For older refugee teachers, in contrast, there was a weak positive association between self-care and mental health symptoms and self-care and stress (see Table 8 and Figures 1–3). Moderation analyses by gender were not significant.

Study 2

Study 2 Method

Participants

We recruited teachers who were refugees from Myanmar and taught in refugee schools in Malaysia. Interview participants were recruited in 2018 through purposeful snowball sampling (Flick, 2009) via flyers and emails distributed by various refugee community connections the second author made from 2010 to 2013. 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. All 11 teachers were originally from Myanmar. Four teachers had college degrees or some college prior to arriving in Malaysia, but none had teaching experience in Myanmar. Nine teachers had UNHCR refugee cards at the time of the interview, but two did not have refugee cards. Interview participants did not participate in any of the previous rounds of data collection (2013).

Data Collection

In addition to quantitative data collected in 2013, qualitative data were collected via individual interviews in Malaysia in the

Table 2
Descriptive Statistics

Participant group	Variable	*N*	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

Table 3
Independent Samples t-Tests by Refugee Status and Gender

Participant Group	Variable	*t*	*df*	*p*	Mean	Mean difference	Effect size
Refugee status	Stress	2.571*	29.009	.016	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	−3.236*	35.648	.003	26.77 (r) 29.63 (nr)	−2.86	0.71
Gender	Stress (refugee only)	−2.173*	94.853	.032	12.15 (m) 15.29 (f)	3.14	0.44
	Self-care (full sample)	2.191*	112.521	.031	28.33 (m) 26.55 (f)	1.78	0.40

Note. r = refugee; nr = nonrefugee; m = male; f = female.
* $p < .05$.

summer of 2018. All interviews were individual interviews which occurred in a private, quiet space. Each participant was interviewed only once. At the beginning of the interview, the first author introduced herself as a researcher, emphasizing that she was not affiliated with UNHCR or any related organization. It is important to note that the first and second author are White, female, U.S. citizens. The second author was not present for all interviews; her presence was random, dependent on availability. The interview began after the consent process and a brief demographics questionnaire was completed. Interviews lasted between 30 min and 1 hr. Some teachers ($n = 2$) 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.

Interview questions were open ended and focused on establishing culture-specific definitions/perceptions of and drawing connections among the individual-level constructs of stress, mental health, and self-care in the macrolevel context of being a refugee living in a postconflict country. The interview consisted of questions regarding stressors, stress, mental health, and self-care. At the end of the interview, each participant was compensated with 40 ringgit, which is equivalent to about ten U.S. dollars.

Table 4
Correlations Among Mental Health, Stress, Self-Care

Participant Group	Variable	Self-care	Stress	Anxiety
Refugee	Self-care	—	—	—
	Stress	−.214*	—	—
	Anxiety	−.148	.760**	—
	Depression	−.185	.742**	.708**
Nonrefugee	Self-care	—	—	—
	Stress	−.109	—	—
	Anxiety	−.235	.603**	—
	Depression	−.155	.414	.315
Full sample	Self-care	—	—	—
	Stress	−.242**	—	—
	Anxiety	−.201*	.756**	—
	Depression	−.237*	.722**	.699**

* $p < .05$. ** $p < .01$.

Study 2 Qualitative Analyses

An Interpretive Phenomenological Approach (IPA) as described by Creswell (2013) was utilized to analyze the qualitative interview data with a focus on individual themes and variation through lived experiences; code and theme development were also informed by constant comparative analysis, which is a systemic procedure for developing codes and themes, balancing deductive and inductive approaches (e.g., Percy et al., 2015). Although not a pure IPA approach, we did largely rely on an inductive approach consistent with IPA in our use of a "bottom-up" interpretation of themes based on individual participants' own words. We characterize our approach also as deductive due to our reliance on ecological theories and mental health literature to develop the codes and interpret the themes. Data analysis procedures moved from narrow units of analysis (codes) to broader units (themes) that summarized the "how" and "what" of the experience, with an end goal of capturing the essence of the experience. After an immersive review of all transcripts, a preliminary codebook was created (Creswell, 2013). Codes were first developed via in-depth interpretive thematic content analyses of two cases. 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 final codebook with a list of nonrepetitive codes. Next, codes were grouped into larger units of information known as "meaning units" or "themes" (Creswell, 2013, p. 193). The theme development process involved synthesizing and interpreting the various parts of the interview transcript which were coded under a particular topic (e.g., Percy et al., 2015).

Credibility of our coding system was established via reliability dyads (Merriam & Grenier, 2019), and interrater reliability via percent agreement was adequate (73%). The first author was the primary member of the reliability dyads, and she led the final round of consensual coding (Hill et al., 2005). Credibility was aspired to via transparency by writing with as much detail as possible in the constraints of an article about the sample, the context, the process, and using key quotes to illustrate themes. Triangulation was attempted via a mixed-methods approach with quantitative results to inform the qualitative results, and vice-versa. As recommended

Table 5
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									
Nonrefugee	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									

by Flick (2009), we maintained an audit trail during data collection and processing by (a) documenting how we collected the data, (b) making theoretical notes, and (c) detailing how and the rationale for creating specific codes.

Reflexivity

One's identities can influence the qualitative research process, including personal and methodological processes (e.g., Palaganas et al., 2017). The authors are white, cisgender, female school psychology researchers from the U.S. The authors are also neither teachers nor refugees, and we are not from Myanmar, compared with the participants' identities which were ethnic minority, refugee teachers from Myanmar. Such transcultural differences in our identities were likely to have mutual influences between us and the refugee teachers; however, like us, most of the participants were female and seemed to value talking about school psychology-related issues, like student and teacher coping. We noticed that some of our interviewees initially seemed reticent. Perhaps they were uncomfortable with the transnational, transcultural nature of our largely dyadic interviews. At the same time, some seemed to open up to us in ways that they said they did not feel comfortable opening up to their refugee teacher colleagues, especially not to colleagues who were teachers that were not refugees. We made a decision before the research started to only do interviews and not do focus groups. In retrospect, we think that was a wise decision because the refugee teachers seemed much more comfortable with the confidential intimacy of a one-on-one interview compared with a focus group, and, indeed, a couple teachers said that they would not feel comfortable discussing these mental health and coping issues in a group with other refugee or nonrefugee teachers.

We were influenced by this research in many ways. The first author was a doctoral student collecting this data for her dissertation. It was her first time in Malaysia and her first time in refugee schools; she found it to be a powerful field-based research experience. She was also deeply impacted, and often distressed, by the refugee-related difficulties and emotions expressed by the interviewees; she experienced feelings guilt when some of the refugee interviewees cried, at points, during the interviews. The second author is a school psychology professor who had conducted over a decade of research with refugee teachers in Malaysia. She was impacted by these interviews by understanding the systemic influences, mental health, and coping of refugee teachers in more depth, which not only affected her emotionally but also informed the next iteration of her collaborative, refugee teacher consultation intervention.

Study 2 Results

Qualitatively, we explored how refugee teachers experience stress, mental health, and self-care in the context of macrolevel factors related to being a refugee. Coding yielded seven common themes. (a) Fear and human rights violations in the postconflict country; (b) Refugee teaching was meaningful, but demanding; (c) Stress was described in terms of cognitive, emotion, and somatic elements; (d) Mental health was described in terms of symptoms and tied to the family; (e) Emotion expression was reported as ranging from avoidance to explicit identification; (f) Stress and mental health were distinct, but related; and (g) Self-care was contingent on resources. These themes shed light on refugee teachers' experiences and conceptualizations of

Table 6
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									
Nonrefugee	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 7
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									
Nonrefugee	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									

individual 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. All names used below are pseudonyms.

Theme 1: Fear and Human Rights Violations in the Postconflict Country of Malaysia

Refugee teachers explained that once they made it to Malaysia, they experienced fear of discovery and human rights violations, not unlike in their home countries. But, with nowhere left to flee, they were stuck awaiting resettlement, often for years. Fear of discovery in Malaysia was even more intense for refugees who did not possess a UNHCR refugee card, which offers them limited refugee protections (limited given that Malaysia does not recognize the 1951 UN convention protecting refugees).

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 stress related to feeling imprisoned in their homes because it was too dangerous to be in the community without a refugee card. It was not uncommon for police to extort those without refugee cards by demanding money or goods. Huang explained, "when we met the police, they took everything. It's very, very painful for us because we work 1 month, and it's 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 were arrested, it impacted their community. Ya Zin explained, "they arrest two or three Chin people and ask for 10,000–15,000 ringgit [approximately $2,300–3,600 USD to release the detained refugees]."

Human Rights Violations and Discrimination. In Malaysia, refugees reported experiencing a lack of protection/rights, and they faced intense discrimination; again, the situation was amplified for those without a refugee card. Citizens abused refugees verbally, physically assaulted them, stole from them, and demanded money. Refugees reported feeling publicly shamed. The culture of citizen abuses against refugees was perpetuated because Malaysian citizens knew the police would not protect refugees from citizens. Further, Malaysian children were reported to bully refugee children in the community. Refugees described various types of discrimination including housing, employment, education, and healthcare discrimination. 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 for Malaysian citizens. Kywa said, "I see the Malaysians, if they go to the government clinic, they pay one [ringgit] only, but we pay like 100 [ringgit]." Refugees also pay more for rent and have difficulty finding landlords who will rent to them.

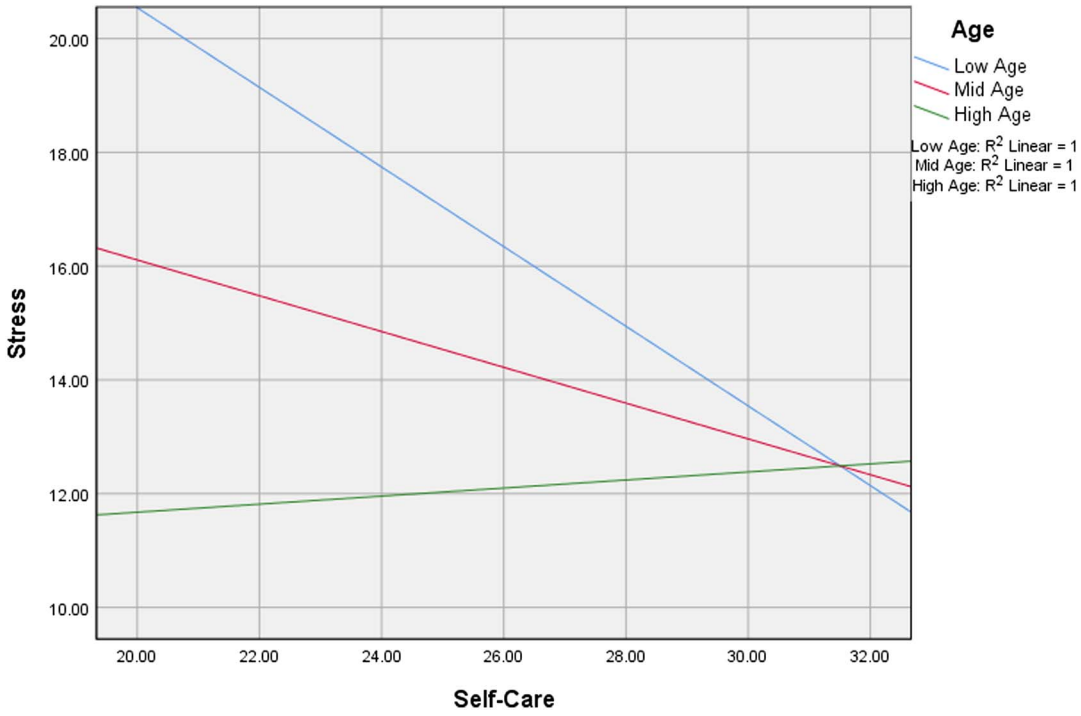
Several refugees spoke about how their college degrees earned in Myanmar were not recognized in Malaysia. It was also difficult for refugees to continue their studies in Malaysia because the limited programs they were permitted to attend were unaffordable. In Malaysia, it is technically illegal for refugees 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 were not 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

Table 8
Age as a Moderator of the Relation of Self-Care With the Outcomes of Anxiety, Depression, and Stress

Outcome	Coefficients	*B*	Std. error	β	*t*	*p*	Effect size
Anxiety	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	
Depression	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	
Stress	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	

Figure 1

Age as a Moderator of Self-Care and Stress (Refugee Sample)



Note. See the online article for the color version of this figure.

to poverty and food insecurity. 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 face the macrolevel factors of serious human rights abuses and a lack of protection under Malaysian law, which may impact their individual (micro) stress, mental health, and self-care.

Theme 2: 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 stressors made teaching mentally, emotionally, and physically demanding.

Teaching as a Meaningful Occupation. Refugee teachers expressed a desire to help children and shared that teaching was gratifying. They noted that refugee schools created a sense of community, safety, and an opportunity to learn. Generally, they found relative happiness in teaching compared with 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 tried hard and learned as they taught. There is a sense of community in some hidden refugee schools. May Lin Kha described her experience of feeling responsible for helping refugee children in hopes of securing them a better future:

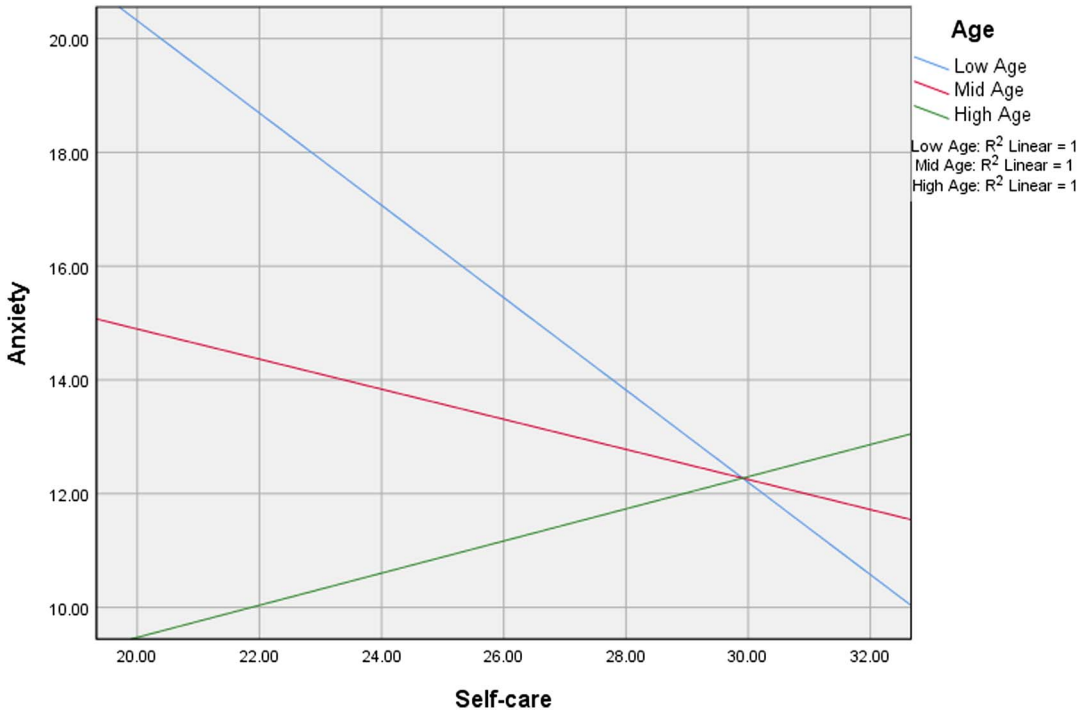
> I feel very blessed to become a teacher as I'm a refugee and I see many of our students here are from my own country and I feel very responsible in their life so by giving them knowledge we can change their future right so I want to try my best I want to try harder so I can give them a better future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

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

Mental, Emotional, and Physical Demands. Although 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. Several teachers spoke about the challenge of dealing with parent complaints, cultural differences, and managing student behavior. At one school, parents complained via a public chatroom; parents called teachers out by name, which made them feel ashamed. Teachers noted that teaching in Malaysia was different than their experience of education in Myanmar, for example, Bawi described her experience of 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

Figure 2

Age as a Moderator of Self-Care and Anxiety (Refugee Sample)



Note. See the online article for the color version of this figure.

homework will not be finished]." Some refugee teachers explained their belief that the use of the cane (as corporal punishment) was the only way to manage children because nothing else worked.

Language and pace of learning created additional challenges. Many teachers struggled with speaking English as they had just started speaking it after arriving in Malaysia, yet they were expected to instruct students in English. Teachers also explained that their students struggled to learn concepts, and they learned at different paces. 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 in the hidden, unregulated refugee schools. Some commented that they were 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 that poor treatment and long days had on her well-being: "I cry. Why [citizen] 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." 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 on the basis of their English-speaking ability and refugee status:

> ... she [the Malaysian citizen teacher colleague] 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 comes with administrative challenges for teachers including staff shortages, crowded schools, and unmanageable expenses. Bills accumulate quickly and schools cannot afford necessary resources (e.g., food for students at lunchtime). Similarly, refugee teachers have 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 creates intense mental, physical, and emotional demands for teachers.

Theme 3: Stress Was Described in Terms of Cognitive, Emotion, and Somatic Elements

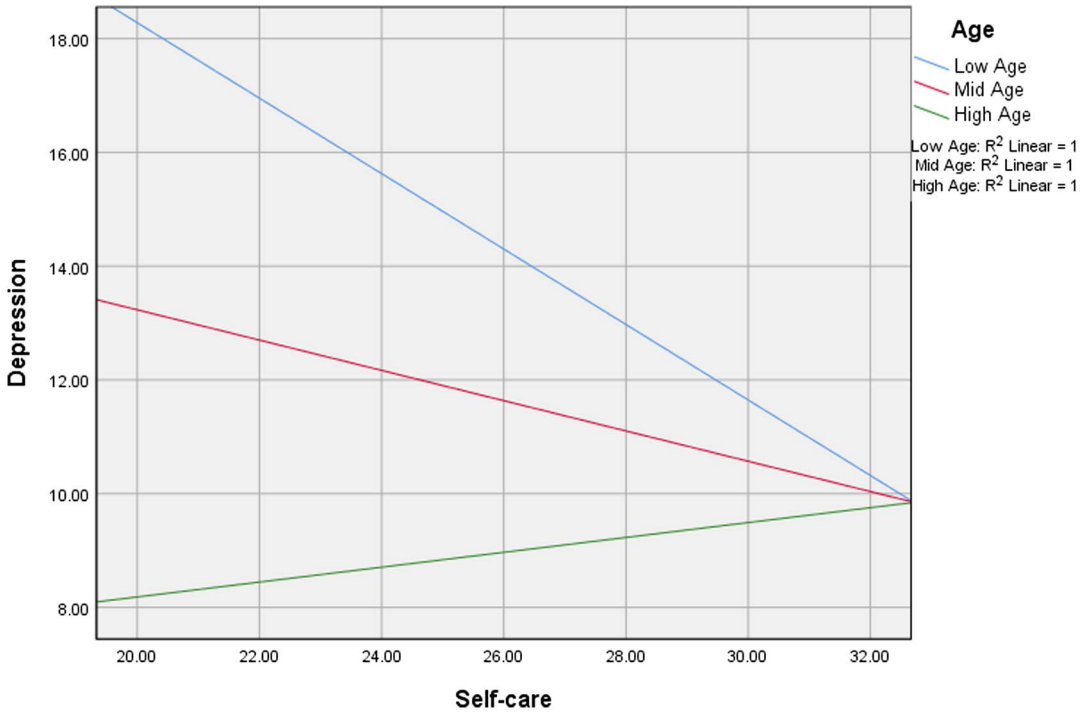
Stress seemed to be conceptualized in terms of a cognitive, emotion, and somatic body-based experience and in terms of the stressor, itself. Stress was largely described as being experienced in the body.

Stress as Cognition. Refugees described stress as a cognitive process: Feeling too busy, feeling overwhelmed, having racing thoughts, rumination, being unable to relax, and trouble sleeping. Nyinyi said, "Yeah, think so much, can't sleep, and today ... I can't relax again, but ... always you feel stress—thinking, thinking."

Stress as Emotion. Teachers also defined stress as an emotion: anger, irritability, crying, and worry. Several participants noted that they felt angry or irritable when they experienced 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

Figure 3

Age as a Moderator of Self-Care and Depression (Refugee Sample)



Note. See the online article for the color version of this figure.

pray, I cry in front of God." Teachers most commonly defined stress as feeling worried, and they discussed worry 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 Physical. Refugee teachers also viewed stress as a somatic body-based experience characterized by a racing heart, appetite changes, shaking, trouble breathing, and feeling tired or achy in the body. 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 or eating too much.

Stress Defined 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, or chronic stress, for example, Mya said, "stress mean we have so many problems."

Theme 4: Mental Health Was Described in Terms of Symptoms and Tied to Family

Mental health was defined by refugee teachers as symptoms, felt in the body, and dependent on more than individual well-being; instead, mental health was dependent on the well-being of the entire family unit. Participants expressed some hesitance as they responded to questions about mental health. Refugee teachers were willing to endorse mental health symptoms, but, overall, they were not as willing to endorse the diagnostic label (e.g., mental health, anxiety, depression).

Mental Health Symptomology. Refugee teachers described 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 a diagnostic label (which may also be related to linguistic variables, for example, difficulty translating the diagnostic label). Some refugee teachers made references to psychosis and lack of remorse in others when asked how they defined mental health. Several teachers discussed hopelessness and sadness. 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 it relates to a hostile attribution bias, "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." Although teachers commented on how they express their sadness, usually expressing sadness 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."

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 feel like I have no energy, headache, I feel pain [in] the whole body."

Mental Health as Family. Several teachers described mental health in terms of the family, which took 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, another teacher noted hearing about husbands who were 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.

Theme 5: Emotion Expression Ranged From Avoidance to Explicit Identification

Discussion of emotions ranged from avoidance of verbal emotion identification to explicit emotion identification; emotionality was also experienced physically. During the interview, given the nature of the interview questions, participants frequently expressed nonverbal displays of emotion (e.g., crying), as they discussed their experiences.

Avoidance of Emotion Identification. Some refugee 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, "we separate [from family in Myanmar], 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 naming it.

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 of feeling bad more often than feeling happy. Fear and sadness were named most frequently in the teachers' interviews. May Lin Kha described feelings of sadness around being unable to continue her education—"I feel sad like I'm not satisfied with myself."

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. 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]."

Overall, although some of the refugees were somewhat uncomfortable discussing emotions, they displayed nonverbal signs of emotionality and discussed the physical experience of emotions.

Theme 6: Stress and Mental Health Were Distinct, but Related

Teachers described mental illness as being more serious than stress; they described stress as something that can go away or be "fixed" more easily than mental illness and classified mental illness as "a bigger problem." May Lin Kha reflected on this difference, saying " . . . we can relieve stress or get rid of it by doing something. We can change our [stress], but I think it would take more time . . . to cure that [mental health]." They also pointed to differences in how they experience each construct, for example, within the body. Nyinyi noted, "stress, it's in your head, but sad it always come in your heart." Sann commented on how the constructs can cause or influence one another, "if we are sad, also the stress follows."

Theme 7: Self-Care Was Contingent on Resources

For refugee teachers, self-care was contingent on resources: refugees did not have access to more demanding or costly forms of self-care. The primary way refugees coped was through prayer and religion, but their family and work-related demands did not leave much room for self-care.

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 their 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. Kywa said, "I pray to God because, us, we cannot do anything [else]." An overall lack of control may have led refugees to rely on God as their primary form of self-care.

Other Forms of Self-Care. The refugee teachers we spoke with did not have access to more "lavish" Western forms of self-care (e.g., spas). Their self-care strategies made use of their limited resources within the context of a postconflict environment. Music, small rewards, sewing, window-shopping, and quiet environments were other ways refugee teachers coped. 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 rely 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." Ya Zin explained, "just went to the shopping mall for eye shopping [i.e., window 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.

Self-Care Was Not the Highest Priority. The simplicity of the refugee teachers' self-care strategies may be explained by the inequity of refugee conditions, resulting in a lack of time and resources for caring for one's self. 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."

Discussion

Resettlement is not a reality for most refugees—more than 99% of the world's displaced persons await resettlement in a postconflict setting (UNHCR, 2019a, 2019b). This paper makes the contribution of finding that refugees, namely refugee teachers, living in a postconflict setting experience lower rates of self-care and higher rates of stress and mental health problems compared with nonrefugees, but the association of self-care with stress and mental health may be mitigated by age (Study 1); refugee teacher stress and mental health are impacted by being a refugee and living in a country hostile to refugees, with refugee teachers offering unique definitions of stress and protective factors (Study 2). Our studies relied on an Ecological Developmental Model, which focuses on the relation between macrolevel factors (e.g., refugee status) and individual/microlevel factors (e.g., individual mental health; Suárez-Orozco et al., 2011), in addition to protective factors. Consistent with the Ecological Developmental model, the macrolevel factor of being a refugee was associated with worse individual stress, mental health, and self-care. The unique stressors of being a refugee teacher included the behaviors and mental health of their refugee students and parents; harsh, discriminatory treatment of refugees by Malaysian authorities and many civilians; and the instability and threat of being stuck in limbo for years (Low et al., 2014; O'Neal, Gosnell, et al., 2018). Religious community and prayer served as protective, coping factors in the face of stress for refugee teachers. This discussion reviews Study 1 and Study 2 findings, links the results with previous research and theory, integrates the findings from the two studies, and addresses implications and translation of results into future intervention development.

Study 1 Quantitative Findings

Quantitative results indicated high rates of mental health problems and stress, and low rates of self-care among refugee teachers, compared with nonrefugee teachers, consistent with high rates of mental health problems reported in previous studies of teachers and adult refugees (e.g., Ballou, 2012). This finding is also consistent with the Ecological Developmental Model, as individual mental health, stress, and self-care differed by macrolevel refugee status. Across all participants, women practiced less self-care than men; among refugee teachers, women were more stressed than men, which is in agreement with existing literature on gender differences in self-care and stress (e.g., Matud, 2004). Self-care was negatively associated with stress, anxiety, and depression in the full sample. These findings are congruous with research, suggesting that self-care may improve mental health outcomes, particularly for teachers and those in other caregiver professions (e.g., Newsome et al., 2006).

The Ecological Developmental framework highlights the importance of macro- and microlevel protective factors, which mitigate negative impacts on individual (microlevel) outcomes. In our study, the protective factor of age significantly moderated the relation between self-care and mental health, and the relation between self-care and stress, which is consistent with literature on age differences in mental health symptoms (e.g., Kessler et al., 2005). Previous self-care research has also found associations between self-care and mental health, in addition to self-care and stress, among younger teachers (Newsome et al., 2006; Shapiro et al., 2007). However, the weak positive association of self-care with mental health symptoms for older teachers contradicted the 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 in this sample. Further, we expected self-care to moderate the relation between stress and mental health, but the moderation was not significant. For whom, and how, self-care is related to refugee mental health merits further research.

Study 2 Qualitative Findings

Qualitative analyses explored individual interviews with refugees who fled from their native Myanmar to Kuala Lumpur where they lived and worked as teachers in hidden refugee schools. Notably, refugee experiences were colored by their refugee status (e.g., lacking a refugee card), which is consistent with the Ecological Developmental Model.

Lived Experiences in a Postconflict Country Hostile to Refugees

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 of ethnic minority groups like those in Study 2—the Chin and Rohingya (O'Neal, Atapattu, et al., 2018). Upon arrival 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 in Malaysia, after fleeing human rights abuses in Myanmar. Refugees felt trapped in Malaysia, separated from their families, without much hope of resettlement to a safer country, 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 created intense mental, physical, and emotional demands for teachers. Low et al. (2014) also found that the lived experiences of refugee teachers in Malaysia were dominated by the stress of living in a country hostile to refugees. Consistent with the Ecological Developmental Model, the lived experience of refugees living in a hostile, postconflict country was defined by their refugee status.

Defining Stress, Mental Health, and Self-Care

Refugee teachers defined stress as cognitive, emotional, and physical. When defining mental health, refugee teachers were more likely to endorse specific symptoms (e.g., sadness) than labels (e.g., depression). Some were more likely to describe a situation as "very difficult" than reflect on specific emotions. They conceptualized mental health as experienced in the body and dependent on the well-being of not only the individual, but also the family unit. Although some seemed reluctant to discuss underlying emotions, some participants often displayed nonverbal displays of emotion (e.g., crying).

Self-care was most often expressed as prayer and religion for refugee teachers. For our sample and other refugee groups, prayer and religious community support have been described as powerful tools for coping with the stress of being a refugee (e.g., King et al., 2017). Indeed, religion can be both an individual and a collective, communal coping strategy. Research suggests that refugees place a heavy emphasis on religion when dealing with stressful situations, especially given that many fled their home countries due to religious persecution (e.g., Adedoyin et al., 2016; Gladden, 2012). Our sample discussed the self-care strategies, like prayer, they had access to, valued, and could afford. Refugee teachers did not have enough time to devote to self-care, even to attend prayer and religious meetings as they would like. In the Ecological Developmental framework, religious community and rituals, like prayer, represent macrolevel supports for refugees. In many ways, religious community, prayer circles, and, even the school community may represent a sense of home, supports, and identity that act as cultural strengths (e.g., Eastmond, 1998).

These qualitative findings are consistent with both quantitative and qualitative research on the experiences of postconflict refugees (Fazel & Stein, 2002; Low et al., 2014). A related qualitative study by Low et al. (2014) suggested that refugee teachers living in Malaysia experience discrimination and stress from many sociopolitical factors outside the classroom due to living in a country hostile to refugees with consequences for their well-being. The authors also relied on an ecological model to inform their work (Low et al., 2014). Our Study 2's qualitative results regarding stressors unique to the refugee experience and their impact on mental health and stress map on to the Ecological Developmental Model in that macrolevel refugee status has effects across ecosystems and is associated with various risk and protective factors that may impact individual outcomes (Suárez-Orozco et al., 2011).

Integration of Study 1 Quantitative and Study 2 Qualitative Results

As reviewed in the introduction, this paper used a sequential structure with Study 2's qualitative research building, on Study 1's quantitative results, with a process of connecting Study 2 with Study 1. Study 2 was connected with Study 1 due to Study 2's more in-depth sampling of only refugees from Myanmar, and Study 2 offered a deeper understanding of their lived experiences to illuminate stress, mental health, self-care, and connections to refugee status, which were initially addressed in Study 1 (Palinkas et al., 2011). Qualitative analyses allowed us to understand the full range of how refugee teachers experienced individual stress and mental health (e.g., how they worried), as well as what acted as potential protective, self-care factors (e.g., religious practices), which went beyond what could be assessed on the related quantitative measures of stress, mental health, and self-care. In detailing refugee teachers' stressful and 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 accessing time and resources for self-care, but feeling better when they do engage in self-care strategies, supported the quantitative negative relation between self-care and mental health. Qualitative results offered a more detailed explanation of how refugees conceptualized stress, mental health, and self-care that went beyond what was reflected in quantitative questionnaires (e.g., where somatic symptoms were located in their bodies). The refugee teachers were also able to give voice to the meaning and stress of their unique refugee educational context, further illustrating the macrolevel impact of their refugee status on individual-level factors, as posited by the Ecological Developmental Model.

Limitations

Data collection for Study 1 and Study 2 was led by white American researchers who could only spend a limited amount of time in Malaysia, thus leading to a biased lens. Although we did our best to establish rapport and had established a solid reputation after 8 years of refugee research in Malaysia, having interviews led by white American researchers may have influenced how the refugee teachers presented their stories and what information they chose to share. Another limitation was the small size of the nonrefugee sample in Study 1. Finally, Study 1 and Study 2 would have benefited from longitudinal assessment and member check-ins over time to better capture consistency of conceptualizations and experiences over time.

Conclusions and Implications for Intervention Development

These studies were designed to inform a future culture-specific intervention based on Developmental Ecological and Participatory Culture-Specific Consultation frameworks. High rates of stress and mental health symptoms among Burmese refugee teachers support the need for a culture-specific intervention to target individual stress and mental health, while taking into account the macrolevel sociopolitical and educational context in addition to related risk and protective factors associated with refugee status and community. Based on an Ecological Developmental framework, understanding the shared experiences of refugee teachers defined by macrolevel refugee status is crucial to developing and implementing a culture-specific intervention designed to target their high levels of individual stress and mental health symptoms. A unique contribution of this study is the emergence of self-care as a protective factor (consistent with the Ecological Developmental model's conceptualization of protective factors as related to individual outcomes) coupled with establishing a culture-specific definition of self-care among this refugee teacher population.

Refugee healing and empowerment has the potential to crystallize through empowering refugee teachers, who are typically refugees themselves, to support their fellow refugee teachers. Our results could be translated into intervention in Malaysia, or elsewhere, by having empowerment take the shape of refugee teachers providing individual peer consultation and emotional support to other refugee teachers (e.g., O'Neal, Gosnell, et al., 2018). In turn, their fellow refugee teachers could then create healing classrooms by implementing classroom-based interventions with their refugee students. Indeed, a call has been made for more empowerment of refugee teachers to support their refugee students' emotional and engagement needs in class (Mendenhall et al., 2017). We recommend that future refugee interventions develop healing-focused classrooms. A healing-focused classroom is different from a trauma-focused classroom in that the school heals the relationship of authority figures with and instruction/support of students in culturally responsive ways, resulting in more student engagement (Morris, 2019).

Culture-specific, self-care practices merit inclusion in future interventions targeting refugee teacher stress and mental health. This research can help guide further research as it is the first of its kind to, based on the Ecological Developmental model, quantitatively examine stress, mental health, and self-care among a population of postconflict Burmese refugee teachers, paired with qualitative interview data. It is an important step to understanding how stress, mental health, and self-care are defined, experienced, and conceptualized in a specific population before developing a treatment or intervention, similar to a PCSC process (Nastasi & Jayasena, 2014).

Given the more than 70 million displaced peoples around the world, almost half of whom are children in need of a postconflict education, this paper sought to highlight the importance of a culturally sensitive assessment of mental health, stress, and self-care prior to the implementation of a future psychosocial intervention for refugee teachers who educate refugee children in Malaysia. Consistent with the Ecological Developmental framework, results suggested that macrolevel factors can influence individual stress, mental health, and self-care among refugee teachers. With the goal of understanding stressors that may cause mental health challenges, and self-care as a possible protective factor for future interventions with Asian refugees, this novel research answered a call from the American Psychological Association task force on refugees (Porterfield et al., 2010). This research focused on understanding the lived experiences and needs of refugee teachers to inform the future design and implementation of a targeted, culture-specific intervention to address the mental health and well-being of refugee teachers.

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