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Community Integration of Burmese Refugees in the United States

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Community integration is a key to successful resettlement among refugees coming to the United States. Despite the potential benefits of community integration, to date there is no empirical study that examines multifaceted dimensions of community integration among Burmese refugees who are at high risk of physical and mental health problems and social isolation. This pilot study examined the multifaceted dimensions of community integration (physical, social, and psychological integration) and their associated factors among Burmese refugees in the U.S. The study accentuates the importance of health and employment status among Burmese refugees because they were positively associated with physical and social integration. The findings of this study also highlight the ways in which practitioners and policymakers promote the community integration of Burmese refugees, which, in turn, enhances their quality of life.

Keywords: Asian American, Burmese, community integration, quality of life, refugee

Community integration is a primary policy objective related to the resettlement of refugee populations (Ager & Strang, 2008). Successful integration into the community is known to enhance quality of life among refugees by facilitating their utilization of community resources and networks (Aroche, Coello, & Momartin, 2012; Behnia, 2004; Mitschke, Mitschke, Slater, & Teboh, 2011). Current U.S. refugee policy, however, views community integration primarily from an economic perspective, emphasizing economic self-sufficiency (Dwyer, 2010). Although economic security is essential for refugee resettlement in the U.S., focusing only on the economic benefits of integration falls short of providing a comprehensive understanding of refugee populations in the U.S, who represent a social group at high risk of physical and mental health problems (World Health Organization, 2012; Yun et al., 2012).

Wong and Solomon (2002) proposed that as a multidimensional concept, *community integration* encompasses the following: (a) physical integration: the use of community resources and participation in community activities (Segal, Baumohl, & Moyles, 1980); (b) social integration: engagement and interaction with other community members (Wolfensberger & Thomas, 1983); and (c) psychological integration: the development of a sense of belonging in relation to neighbors and the neighborhood (Solomon, Lee, Chatterjee, & McClaine, 2010). These three components of community integration among refugees are crucial to understanding their quality of life. For example, new refugees often experience limited access to community resources and hesitate to participate in community activities because of language barriers and the unfamiliarity of a new environment (i.e., physical integration). Although advanced technology may help refugees to maintain distant social networks in their home countries, refugees nonetheless need to develop new social networks in the host country, a process which requires a great deal of time and effort for newcomers. Finally, it is expected that enhancing psychological integration (e.g., sense of belonging to the community) would help refugees to feel accepted in the host country.

To date there is no empirical study that examines how Burmese refugees have physically, socially, and psychologically integrated into the community. Thus, to fill the gap in the literature, this study aimed to examine community integration of Burmese refugees using a multidimensional perspective. Building a comprehensive understanding of the Burmese refugee population is today more important than ever because the number of Burmese refugees has sharply increased in the past several years (Office of Refugee Resettlement, 2007). The United States began keeping records of refugee resettlement in 1983. Between 1983 and 2006, only 0.3% of all refugees who resettled in the U.S. were from Burma (6,298 of the total 2,112,984 refugees resettled in that time period; Office of Refugee Resettlement, 2006). The number of Burmese refugees has substantially increased since 2007, when 9,776 Burmese refugees resettled in the U.S. in just one year (Office of Refugee Resettlement, 2007). In 2007, Burmese refugees became the second largest group of refugees resettled in the U.S. (Office of Refugee Resettlement, 2007), and since 2008, more than 12,000 Burmese refugees have been resettled in the U.S. each year (12,852 in 2008, 18,275 in 2009, 16,665 in 2010, 16,901 in 2011, and 14,020 in

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2012; Office of Refugee Resettlement, 2012). The 2010 U.S. Census Bureau indicates that 100,200 Burmese individuals resided in the U.S. (U.S. Census Bureau, 2014).

Along with the substantial growth of the Burmese refugee population in the U.S., their physical and mental health issues deserve further attention from practitioners and policymakers (Behnia, 2004; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011; van Wyk, Schweitzer, Brough, Vromans, & Murray, 2012). Previous studies demonstrated that some refugee ethnic groups, including the Burmese, are at a high risk of suicide (Negash, 2012), and more than 50% of refugees are struggling with debilitating psychiatric conditions (World Health Organization, 2012). This might be related to the language barriers, cultural differences, and acculturation stress that refugees experience during the resettlement process (Kirmayer et al., 2011; Tribe, 2002). In addition, considering Burmese refugees' protracted stays in refugee camps before they are admitted to the U.S. (Gilbert, Hein, & Losby, 2010), they are likely to be more susceptible to poor physical and mental health conditions than U.S.-born and other foreign-born individuals who voluntarily immigrated to the U.S.

Particularly among Burmese refugees, Schweitzer and colleagues (2011) found that many newly arrived Burmese refugees in Australia experienced multiple and severe premigration traumas that were likely to be associated with the high prevalence of PTSD (9%), anxiety (20%), depression (36%), and somatization (37%). Another study by Akiyama and colleagues (2013) also found that Burmese adolescents experienced a great number of traumatic events and suffered from poor mental health status.

History of Burmese Refugee Resettlement in the U.S.

Refugees originating from the country of Burma (also known as Myanmar), consist of several different ethnic groups including Karen, Karenni, Burman, Kachin, Shan, Mon, and Chin. According to Cheah (2008), Burmese individuals have come to the U.S. in three waves. The small first wave consisted primarily of Burmese individuals of Chinese decent and occurred in the 1960s in response to the passage of the 1965 Immigration and Nationality Act in the U.S. along with political and socioeconomic oppression in Burma. They were offered economic and political incentives in the U.S. After undergoing oppression and forced assimilation to Burmese culture/identity, Burmese individuals of Chinese decent "re-ethnicized themselves" in the U.S., identifying with their Chineseness upon their migration (Cheah, 2008, p. 201). The second wave coincided with military action in Burma in the late 1980s and included several thousand people from several Burmese ethnic groups, including Chinese-Burmese, Karen, Kachin, Burmans, and others. Many of these individuals in the second wave migrated to Fort Wayne, Indiana and have since remained undocumented.

Finally, the third and current wave of Burmese individuals to come to the U.S. began in 2006 to 2007. In the early 2000s, as a result of the September 11 attacks, restrictive U.S. laws were implemented to prevent thousands of Burmese individuals from qualifying for resettlement in the U.S. (Barkdull, Weber, Swart, & Phillips, 2012). However, these bans were waived for certain Burmese individuals in 2006, creating a broader pathway for Burmese refugees to come to the U.S. (Morse, 2006). Accordingly, the number of Burmese refugees has grown continuously over the past several years, resulting in the largest wave to date. Many Burmese newcomers in this wave are admitted to the U.S. as refugees and are likely to be dispersed across the county (Cheah, 2008).

In terms of geographic distribution, the largest Burmese population is located in the South, followed by the West, Northeast, and Midwest (Asian & Pacific Islander American Scholarship Fund [APIASF], 2014). More specifically, Texas, New York, and Indiana have been identified as the top three states for Burmese immigrant resettlement (Centers for Disease Control, 2012). Although there are no empirical studies that solely focus on Burmese refugee settlement preference, the overall refugee settlement trends indicate that refugees are more likely to be resettled in large metropolitan areas with significant foreign-born populations because of the greater opportunities to build social networks (social integration) and access community resources (physical integration; Singer & Wilson, 2006).

Cultural Differences Among Burmese Refugee Groups

As noted above, Burmese refugees in the U.S. consist of several different ethnic groups including Karen, Karenni, Burman, Kachin, Shan, Mon and Chin. The term 'Burmese' in the modern context refers to the language of the Burman ethnic group, the largest ethnic group that makes up about two thirds of the population and controls the military and government (Ditton, 2012). According to the Burmese government, the total population of Burma is 56 million with more than 135 national ethnicities, although there are no reliable census data available (Ekeh & Smith, 2007). Other than Burman, the largest minority groups include Shan (9%) and Karen (7%). The remaining minority groups (such as Mon, Chin, Kachin, Karenni, Chinese, and Indian) make up five percent or less of the entire population (Ekeh & Smith, 2007).

These ethnic groups may include further subethnic groups with different linguistic, cultural, and religious backgrounds (Ekeh & Smith, 2007). For example, ethnic groups originating from the Tibetan-Central Asian region are considered 'Karen' though these subethnic groups speak different but related languages (Karenic language; Ekeh & Smith, 2007). Regarding religion, whereas the majority of the Karenni, Kachin, and Chin groups are Christians, a majority of the Karen population is Buddhist. In addition to these differences, Burmese refugees in the U.S. are likely to migrate from different parts of the country. For example, whereas the Karens mainly live in the southern parts of Burma, the Chin live in the mountainous region of western Burma and the Kachin live in northern Burma close to the border with China and India. Diversity within the country, coupled with the Burmese government's oppression of and discrimination against minority groups, has inspired ethnic resistance movements such as the Kachin Independence Organization (KIO) to fight against the state.

Community Integration of Burmese Refugees

Despite the importance of connectedness in the community among refugees during the resettlement process (Aroche et al., 2012), in the process of transition, refugees often lose the social support and community ties they had previously in their native country. Thus, they must often rebuild their social networks and support system in the U.S. to achieve a fulfilling life. Burmese refugees are particularly vulnerable during the resettlement pro-

cess because they tend to go through a very long waiting period in refugee camps (usually in Thailand) before their final destination is decided. Their vulnerability to harsh premigration experiences may also be compounded by limited English proficiency, unfamiliarity with the U.S. social service systems, and a lack of connection to proper resources in the community after they resettle in the U.S.

A recent study conducted by Nawyn and colleagues (2012) identified limited English proficiency as a barrier to the integration of Burmese refugees into the community and emphasized the capacity of a local church as a facilitator of social capital development. Previous studies have demonstrated that support from both the community and other Burmese individuals is a protective factor for Burmese refugees during and after initial resettlement (Banki, 2006; Harkins, 2012; Mitschke et al., 2011). Without such support, refugees may remain socially excluded even if they integrate well economically (Ives, 2007; Korac, 2003).

Previous studies, however, are limited by the use of a single dimension of community integration. For instance, individual refugees who experience a high level of social integration (e.g., social interactions with others) may at the same time experience a low level of psychological integration (e.g., sense of belonging) and vice versa. To provide a more comprehensive understanding of the integration of Burmese refugees into the community, this pilot study employed multifaceted dimensions of community integration (i.e., physical, social, and psychological integration) to explore the level of community integration of Burmese refugees. Using a quantitative survey of Burmese refugees, the study identified facilitators and barriers to the integration of Burmese refugees into the community. Furthermore, to explore service providers' perceptions about Burmese refugees' community integration and its associated factors and resource needs, data were collected through semistructured interviews with service providers (including both focus group and face-to-face interview formats). Identifying factors associated with community integration would facilitate the formation of informed and tailored policies and interventions to improve the well-being of this vulnerable population. From the data collected from Burmese refugees, this study addressed the following research questions: (a) what is the level of community integration among Burmese refugees; and (b) what are the factors that are associated with community integration of Burmese refugees? Furthermore, using the data collected from service providers, we explored (a) service providers' perceptions about Burmese refugees' community integration, (b) its barriers and facilitators, and (c) the resources needed to facilitate the community integration of Burmese refugees.

Method

Data From Burmese Refugees: Quantitative Survey

Participants. Recruitment was conducted through collaboration with a local agency that works with Burmese refugees in the community. Located in a city a population of approximately 180,000, it was the only agency in the area that received federal funding to help Burmese refugees resettlement. All adult Burmese refugees (18 years and older) who settled in the community during the period of 2008 through 2012 were invited to participate in the survey. The agency case manager identified all eligible Burmese refugees ($N = 37$), who were mostly Chin, and asked them whether they wanted to participate in the study. Two individuals refused to participate. Accordingly, the survey was distributed to 35 Burmese individuals. Among them, 24 Burmese refugees returned the survey (i.e., response rate = 68.6%). All survey respondents were paid $10 for their participation.

Measures. Data were collected through in-person group and mailed individual surveys of Burmese refugees to assess community integration as well as sociodemographic, clinical, and migration-related characteristics of Burmese refugees. The survey questionnaire was in the Burmese language and was developed using back-translation methods. Two independent translators, who are bilingual, were hired to develop the Burmese version of the survey.

Community integration. (a) Physical integration: An adapted version of Segal and Aviram's (1978) external integration scale was employed to measure the level of physical integration. The scale is composed of 16 items assessing the participant's frequency of involvement in different activities outside their household in the past month, related to both leisure and work (e.g., "how often did you visit a grocery store?"). The questions were measured on a 5-point Likert scale, ranging from *never* to *very often* (0–4). The Cronbach's alpha for this measure was 0.75. (b) Social integration: A 12-item scale developed by Aubry and his colleagues (1995) was used to measure how often respondents had different types of social contact with neighbors, including individuals from different ethnic groups (e.g., "how often have you said hello or waved to a neighbor when seeing them on the street?"). The questions were measured on a 5-point Likert scale, ranging from *never* to *frequently* (1–5). The Cronbach's alpha for this measure was 0.89. (c) Psychological integration: An 8-item scale of the Sense of Acceptance in Community Activities (SACA) developed by Solomon and colleagues (2010) was used to examine the level of psychological integration experienced by Burmese refugees (e.g., "when attending activities in the community, I feel like I belong"). The questions were measured on a 4-point Likert scale, ranging from *never* to *often* (1–4). The Cronbach's alpha for this measure was 0.75.

Sociodemographic characteristics. Age (in years), gender (female = 1, male = 0), marital status (married = 1, not married = 0), education level (high school = 1, no high school diploma = 0), employment status (employed = 1, unemployed = 0), and income (monthly income, $) were assessed.

Clinical characteristics. A series of dichotomous questions (yes/no) were asked to assess the presence of 19 physical health conditions (e.g., arthritis, diabetes, and cancer). The number of physical conditions marked for each individual was counted. Perceived general health status was initially assessed on a 5-point Likert scale and was then used as a dichotomous variable (*excellent/very good/good* = 1, *fair/poor* = 0) to achieve parsimony (Wolinsky & Arnold, 1988).

Immigration-related characteristics. Current immigration status (*refugee* = 1, *permanent resident/naturalized citizen* = 0), English proficiency (*good* = 1, *not good* = 0), and length of stay in the U.S. (in years) were assessed.

Data analysis. Univariate statistics were computed to present sample characteristics. To examine the factors associated with each dimension of community integration, a correlation matrix comprising intercorrelations among study variables was analyzed. In addition to a correlation matrix, sensitivity analyses were con-

ducted with a series of independent samples *t* tests between integration variables and categorical variables such as sex, marital status, and English proficiency to confirm the associated factors. The results were similar to the results from correlational analyses. Thus, only a correlation matrix was presented. SAS version 9.3 was used to analyze quantitative data.

Data From Service Providers: Semistructured Interviews

Participants. Four service providers participated in the semistructured interviews; three in a focus group and one in an individual interview. Because there are only a few service providers who are involved with providing services to Burmese refugees given the small size of the community, we conducted one focus group and one face-to-face individual interview using a purposive sampling method to collect data from service providers. The focus group was cofacilitated by the second and third author. The second author had extensive experience with facilitating focus groups and the third author had had previous working relationships with the participating service providers. Among four providers selected, one provider's schedule could not be accommodated and the personal interview was conducted by the third author.

Three service providers were female and one provider was male. Two service providers came to the U.S. as a refugee and among them one was a Burmese refugee. The other two providers were U.S.-born. The role of service providers in the Burmese community ranged from a direct service worker to an agency administrator. Some exclusively worked for the Burmese population, whereas others also worked for groups of diverse ethnic and legal status. All of the service providers have worked with refugee populations in this community for several years. Only English-speaking service providers were recruited because of resource constraints. The focus group participants were paid $20.

Measures. Both the focus group and the interview were semistructured and the guiding questions used included, "how would you assess the level of community integration of the Burmese refugee families in the area?" and "What do you think are the facilitators/barriers of community integration among the Burmese refugee families in the area?" The questions are presented in the Appendix. The focus group lasted approximately 50 minutes, and the interview was conducted for approximately 30 minutes.

Data analysis. Both the focus group and interviews with service providers were tape-recorded and transcribed for data analysis. Line by line open coding using the NVivo 10 software was first conducted by the first author until no new codes emerged to describe patterns in the data and to develop codes (Padgett, 2008). Then, codes and in vivo quotes were independently reevaluated by all four authors before the research team met in a group to discuss and resolve differences and to reach the final codes (Bradley, Curry, & Devers, 2007).

Results

Findings From Burmese Refugees

Table 1 shows sample characteristics. The mean age of the sample was 32.5 years old ($SD = 7.2$). The majority of the subjects were married (75%), employed (69.6%), and had no high school diploma (88.5%) and no health insurance (59.1%). Approximately 30% of the sample reported that they suffered from one or more health conditions, and more than half perceived their health status as not good (52.2%). In terms of immigration-related characteristics, the majority of the sample remained as refugees (60.9%), and the mean length of stay in the U.S. was 1.8 years ($SD = 1.4$). Approximately 87% of the sample reported that their English proficiency was not good.

Table 2 shows correlations among study variables. Physical integration was positively associated with both employment status ($r = .44$, $p < .05$) and perceived general health status ($r = .49$, $p < .05$), whereas it was negatively associated with the number of reported health conditions ($r = -.54$, $p < .01$). Social integration was positively associated with perceived general health status only ($r = .74$, $p < .001$). None of the study variables were associated with psychological integration ($p > .05$). Within three domains of integration, we found a positive relationship between physical integration and social integration ($r = .58$, $p < .001$).

Findings From Service Providers

Overall, service providers perceived that Burmese refugees had low degrees of social and physical integration in their community (e.g., "because of I think language problems, they don't have outside friends and other facilities [they use]"). Service providers in general demonstrate that even though there is some variation in English proficiency and age at migration, overall Burmese refugees' social interactions are limited to people from their own culture (e.g., "They [the Burmese refugees] stay within their group mostly . . . especially the adults"). However, providers indicated that compared with other refugee groups, Burmese refugees have shown much higher levels of adaptability to the community. One respondent states, "they [Burmese] feel more like they are connected, this is our home, we are Americans", pointing out that Burmese individuals are very open to accepting new cultural values and display relatively higher levels of psychological integration (i.e., sense of belonging). Although limited, their physical integration into the community is mainly through employment (consistent with quantitative findings), school, and church.

The following important themes were identified from data related to the facilitators of and barriers to Burmese refugees' physical, social, and psychological integration into their community: (a) value system, (b) church community, and (c) capacity building. Some of these themes are related to each other, working both as facilitator and barrier to community integration among Burmese refugees. Furthermore, each theme tends to simultaneously include more than one aspect of community integration. Finally, providers also identified a number of resources needed to facilitate community integration and the wellbeing of Burmese refugees in the community.

Value system. Providers indicate that Burmese refugees as a group share major values related to their native culture and migration history. Most of all, Burmese refugees maintain a very strong social tie with other Burmese refugees in the community. One respondent states, "they are a more connected community they help each other . . . they just like to help each other . . . that is something really unique" Another respondent also states, "they help each other with employment which is something amazing." Additionally, Burmese refugees tend to accept anybody regardless

Table 1
Sample Characteristics (N = 24)

Characteristic	Frequency (%)	Mean (*SD*)	Min–Max
Socio-demographic characteristics			
Age		32.5 (7.2)	19–45
Sex			
Female	12 (50.0)		
Male	12 (50.0)		
Marital status (currently married)			
Yes	18 (75.0)		
No	6 (25.0)		
Education (high school diploma)			
Yes	3 (12.5)		
No	21 (88.5)		
Employment status			
Employed	16 (69.6)		
Unemployed	8 (31.4)		
Insurance status			
Insured	9 (40.9)		
Uninsured	15 (59.1)		
Income (monthly)		983.5 (674.1)	0–2070
Clinical characteristics			
Number of health conditions		0.4 (0.8)	0–3
None	16 (69.6)		
1 or more	7 (30.4)		
Perceived health status			
Good	11 (47.8)		
Not good	13 (52.2)		
Immigration-related characteristics			
Current immigration status			
Refugee	14 (60.9)		
Non-refugee (permanent resident or naturalized citizen)	9 (39.1)		
Length of stay in the U.S. (years)		1.8 (1.4)	0.4–5.0
English proficiency			
Good	3 (13.0)		
Not good	21 (87.0)		
Community integration			
Physical integration		15.6 (7.7)	4–29
Social integration		27.3 (10.4)	5–59
Psychological integration		24.6 (3.8)	12–28

of their religion or dialect as long as the person is Burmese. Within the group, Burmese people trust each other and readily provide information and instrumental help to other members in regard to getting a job, using health services, providing transportation, and so on. For example, one respondent states, "I think within the Burmese community, there is an understood sense of trust."

However, providers also note the flip side of this strong collectivity within the Burmese refugee group. One participant states, "the group is so supportive of one another, they don't often ask for help," even in cases such as severe domestic violence situations. In addition, this strong coethnic social network is observed as a factor that decreases Burmese refugees' physical and social integration beyond their ethnic group.

Additionally, in terms of their fast adaptation to the U.S., providers state that Burmese refugees tend to accept "whatever is available" in the U.S., whether it is related to jobs, health services, or living arrangements. For example, one respondent states, "they are easy to open and accept the new culture and try to live with it." This attitude may be related to their cultural values of being appreciative of their surroundings and seems to facilitate their psychological integration into the community. However, it can also be understood through the lens of their premigration experiences in refugee camps and in Burma, where their living situations were crowded and unsecure. Another characteristic of the Burmese refugees' value system that assists in their integration to the community is that they have strong work ethic and place high values on supporting their families and being self-sufficient. One participant states, "they are very hard working and they want to take care of their families and become self-sufficient very quickly." This trait is the same with young Burmese students. They are described as "hard working" students who tend to remain in school.

Church community. The meaning of church among Burmese refugees goes beyond the Christian religion. The Burmese group in this study borrows a space in an American church and it was stated that "every Burmese family in this community goes to church." Another quote says, "the Burmese community sees themselves as Burmese . . . they don't see themselves as Christian, or Muslim, or Buddhist . . . they blend just perfect." In connection with their strong social ties as described above, church in the Burmese community serves as a place for social gathering and mutual support (e.g., women's groups) and as a channel for social integration beyond the Burmese community because a number of refugees also attend services at the American church. Frequent use

Table 2
Correlations (N = 24)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Physical integration	—														
2. Social integration	.58**														
3. Psychological integration	.13	.21													
4. Age	−.24	−.34	.20												
5. Sex	−.15	.27	−.11	−.09											
6. Marital status	−.35	−.15	−.21	.34	.19										
7. Education	.03	−.25	−.10	.12	.13	.07									
8. Employment status	.44*	.20	−.01	.39	−.44*	−.18	.13								
9. Insurance status	−.16	−.09	−.03	−.02	.28	.01	−.06	−.23							
10. Income	.29	.16	−.04	.23	−.10	−.04	.13	.62**	−.37						
11. Current immigration status	.27	.01	−.22	−.03	−.12	−.21	.48*	.30	−.33	.34					
12. English proficiency	.07	−.04	.33	−.01	−.37	−.11	−.62**	−.12	.38	−.29	−.22				
13. Length of stay in the U.S.	.12	.13	.27	−.14	.05	−.07	−.13	−.16	−.17	.14	−.28	−.07			
14. Perceived general health status	.49*	.74***	−.41	−.32	.03	−.17	−.36	.20	−.09	.24	.17	.06	.35		
15. Number of health conditions	−.54**	−.31	.32	.49*	−.09	.16	−.28	.04	.19	−.19	−.47*	.28	−.29	−.53**	

* $p < .05$. ** $p < .01$. *** $p < .001$.

of the church building itself also increased the level of physical integration among Burmese refugees by increasing physical activities and resource use in the community.

Capacity building. As the number of Burmese refugees to this community grows, group capacity increases. Because of their strong work ethic and tendency to abide by the rules, refugees have gained a good reputation in the community, a reputation that can potentially help them with better social and physical integration into the community and self-sufficiency. For example,

> landlords . . . actually waive the deposit fee most of the time . . . the Burmese have better housekeeping when they take care of their apartments. . . . When they move out, everything will be as it is. They don't break things and I think that is something landlords appreciate.

As a group, Burmese refugees now have better English proficiency compared with that of the earlier waves of refugees, even though it is still regarded as one of the major barriers to community integration among Burmese refugees. Some new refugees had English classes in the camps before they migrated to the U.S. Earlier waves of refugees who remained in the community now have better English proficiency and, as described above, they have accumulated a significant amount of collective knowledge and networks that can help newcomers to settle in the community. For example, job seekers may be connected to a vacant position within days. This capacity indicates a great potential for better physical and social integration among Burmese refugees in the future through increased physical activities and social interactions in the community.

Resources needed. When asked what resources would help Burmese refugees to better integrate into the community, providers indicated the following resources: extended federal benefits, better access to medical services (e.g., medical translators, knowledge about the health care system), housing, transportation, skills education for adults, better employment opportunities, higher quality of English Language Learner (ELL) classes, and dental care.

As indicated above and supported by survey results from Burmese refugees, the majority of Burmese individuals work full-time. However, with limited vocational skills and limited postmigration education and English proficiency, their jobs are often limited to low-paying, physical jobs at hotels and supermarkets that require longer working hours that are often extended into weekends. This limitation affects their economic well-being, especially when they have to send money back home to family members left behind in Burma. At the same time, however, long work hours act as a barrier to community integration among this population. One respondent states, "the parents work all the time. They typically work on the weekends when most social events are held." Accordingly, the respondent describes how Burmese refugees have little time to spend with their children, to attend school events and to interact with the larger community. In addition, because Burmese refugees often work with other Burmese colleagues, they have limited opportunities to interact with non-Burmese individuals through their employment. These situations lead providers and Burmese refugees to believe that they need more educational opportunities to learn new skills and to improve their English proficiency to seek better career opportunities.

Another area where needs were heavily identified was in medical and dental care in relation to community resource use and physical integration. One respondent states, "the dentist is very expensive and every Burmese person has bad teeth or something . . . [they] didn't go there in Burma." This issue was associated with a limited period of federal benefit coverage for refugees, but was also related to a lack of knowledge about the health care system itself (e.g., which health care provider is covered). In addition, Burmese individuals experience difficulties in using medical services because of limited English proficiency and heterogeneity within the Burmese group in terms of their ethnicity and language (e.g., "there are so many different dialects too"). Many doctor's offices do not offer translators, and translation is often provided by online or phone services which have greater communication limitations than face-to-face translation. Lastly, providers indicate that dental coverage is lacking and that there is a large coverage gap (e.g., "the refugee health program does not cover dental at all and that's one of the big challenges").

Discussion

This pilot study explored community integration and associated factors among Burmese refugees in the U.S. As a vulnerable population in terms of service accessibility, assessing their levels of integration and identifying the factors associated with community integration of Burmese refugees is imperative because of its potential positive association with quality of life in the community. The findings from both Burmese refugees and service providers indicate that low English proficiency is a major barrier to social and physical integration among Burmese refugees (e.g., 87% indicated their English proficiency was not good). Limited English proficiency has been identified as a major issue in access to health and social services among immigrants and refugees (Derose & Baker, 2000; Wilson, Chen, Grumbach, Wang, & Fernandez, 2005), a factor closely related to refugees' physical integration in the community. However, results indicate that Burmese refugees have great potentials for higher community integration especially if adequate supports are provided to help them overcome barriers.

Both sources of data indicate a high employment rate (69.6%) among Burmese refugees. Considering the fact that employment was positively associated with physical integration ($r = .44$), employment can be identified as an important source of community integration among Burmese refugees. However, it is worthwhile to note that employment was not associated with Burmese refugees' social integration. For a plausible reason, the providers suggest that because of a lack of proper vocational education after resettlement and also because of their low English proficiency, Burmese refugees' employment is limited to certain low-paying jobs with a high density of coethnic coworkers. Limited employment opportunities for refugees are associated with their low monthly income ($M = \$983.5$) and limited opportunities to socialize with individuals from other ethnic groups. Thus, as service providers suggested, and as is implied in refugee survey data, supporting educational opportunities in this group (vocational, English, and GED classes) would enhance Burmese refugees' social and physical integration through better employment prospects. It is important to note that only 12.5% of Burmese refugees in this study had a high school diploma, which is often associated with better employment opportunities and greater income (Carter, Polevychok, Friesen, & Osborne, 2008). This limitation could be a result of their lengthy stays in camps before migration, which might hinder Burmese refugees from obtaining formal education (Carter & Osborne, 2009).

Despite these barriers, data from the service providers indicate a higher level of psychological integration among Burmese refugees. In addition, refugees' strong within-group social ties provide emotional and instrumental supports that work as a basis for further community integration after their resettlement in the U.S. Many foreign-born individuals, including immigrants and refugees, often have limited social networks that may work as a barrier to physical integration to the community because of limited information regarding how to access health and social services in the community, for example. However, our findings from service providers indicate that the Burmese refugee group is one of a few refugee groups that maintain very strong internal cohesion. Obviously, this strong tie has worked to compensate for a limited social network outside of their ethnic group, and they used their inner network to help new Burmese refugees to successfully resettle in the community. However, along with the strong tie within the Burmese ethnic group, enlarging their social network may also be needed for this group, as connecting with individuals who are not in the same ethnic group often works as a facilitator to getting high-paying jobs and using broader community resources (Granovetter, 1983). Thus, practitioners should make an effort to create a balance between strong and weak ties among refugee groups.

Although we found a positive relationship between physical integration and employment status, the direction of causality is uncertain because of the cross-sectional design of this study. In other words, it may be that employed individuals tend to become more involved in community activities than the unemployed, or that physical integration may increase employment opportunities among Burmese refugees. Either way, this finding demonstrates the importance of interventions that increase employment and/or physical integration of Burmese refugees. Further studies should examine the causality of this relationship by utilizing a longitudinal study design.

Our study findings also demonstrate that the perceived general health status of an individual was associated with the level of physical and social integration. This result is consistent with previous findings indicating that an individual's health is associated with social integration (Berkman & Glass, 2000). Considering the fact that more than half of our sample reported their health as not good and that approximately 30% of the participants had at least one physical health condition despite their relatively young ages (age range: 19–45 years old), it is important to incorporate health promotion elements into the intervention to facilitate community integration. In spite of the importance of adequately accessing health care, service providers also listed many systematic and individual level barriers to health and dental services among Burmese refugees. In particular, a lack of culturally competent health care providers has been reported as a top priority. To provide appropriate and adequate services, professionals should act as interorganizational coordinators in the community by establishing strong structural relationships among health and social service organizations (Dhooper, 2003).

Several limitations of this study should be noted. First, this pilot study was conducted in one local community in the U.S. where a small number of Burmese refugees reside, and most of them were Chin. The Karen and Karenni are the two largest new refugee groups in the U.S., whereas Chin refugees constitute a relatively small group. The small number of study participants was another limitation in this study. Thus, there are limitations in generalizing our study findings to all Burmese refugees. Further research with a larger sample in more diverse geographic locations would be helpful in better understanding Burmese refugees' community integration. Second, this project was a cross-sectional study and therefore does not allow us to examine causality. Considering potential changes in the level of community integration over time, replication of the study with a longitudinal study design is recommended. Third, measures of community integration might be a limitation of the study because they have not yet been validated with refugee populations. Currently, there are no existing measures of community integration employing a multifaceted approach designed exclusively for refugee populations (i.e., physical, social, and psychological integration). Although this pilot study has provided reliability of the measures of community integration among refugee population, further research should test the psychometrics

of the measures of community integration with a large refugee sample. Fourth, our current study did not account for neighborhood characteristics where refugees live. Given that community resources may greatly influence residents' levels of community integration, further studies are recommended to examine the effects of neighborhood characteristics on community integration (e.g., rural vs. urban, % of foreign-born individuals, % of ethnic minority groups, and availability of health care resources). Finally, although this study converged both qualitative and quantitative data to better understand the Burmese refugee population, because of resource constraints related to language differences, data collected from Burmese refugees were constrained by survey methods, whereas qualitative data were collected only from English-speaking service providers. Therefore, the current study could be considered as multimethod research, instead of mixed methods research (Creswell & Plano Clark, 2007). In the future, to verify the agreement in perception between Burmese refugees and their service providers, further studies are recommended to fully mix quantitative and qualitative approaches for refugees. This approach will also facilitate clearer explanations of the relationships between associated factors and each domain of community integration (e.g., employment status and physical integration).

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Appendix

Questions for Semi-Structured Interview With Service Providers

1. In general, how would you assess the level of community integration of the Burmese refugee families in the Knoxville area? Specific examples would be helpful if you want to share.

a. How would you compare their community integration with that of other refugee populations in the community? Are they any unique aspects?

2. What do you think are the facilitators of community integration among Burmese refugees? In other words, what factors help them to achieve better community integration?

3. What do you think are the barriers to community integration among Burmese refugees? (individual or community-level barriers)

4. What resources or supports are needed to facilitate Burmese refugees' community integration?

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