Making a match: Exploring the association between 'ethnic match' and program utilization in a home visiting program

A thesis

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Abstract

Culturally competent practice, including “ethnic match” in service provision, is a growing area of interest in this increasingly diverse nation. Ethnic match is often considered a means of ensuring culturally competent practice, based on the assumption that ethnic match represents shared culturally-situated perspectives between the home visitor and participant. The present mixed-methods study, based on data from the Massachusetts Healthy Families Evaluation, explores the association between ethnic match and program utilization among young mothers enrolled in a home visiting program. In addition, a sub-sample of participant interviews is qualitatively analyzed to evaluate perceptions of cultural competence on the part of these mothers’ home visitors.

Results show that ethnic match is not significantly related to core program utilization outcomes (e.g. duration of use, number of home visits, and intensity of use) within the full sample of program participants. Perception of cultural competence was identified in five categories: acknowledging and respecting differences; making necessary connections and referrals; connecting to intrinsic networks; educating participants about goal pursuit strategies; and customizing help. These categories were all referenced in interviews of both matched and non-matched participants; however making necessary connections and education about goal pursuit strategies were discussed more frequently among participants of the matched sample. These differences suggest fruitful avenues for further research.

***Keywords*:** ethnic match, cultural competence, home visiting programs

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Table of Contents

Chapter I: Introduction

In the United States, 37% of the current U.S. population is a member of a minority group; indeed, the U.S. is projected to become a "majority-minority" nation by 2043 (U.S. Census Bureau, 2012). This demographic trend exposes the critical need for culturally responsive practices in human services.

Program directors and policymakers across the country and professional groups across service areas have repeatedly called for infusing practice with a culturally-responsive orientation (American Psychological Association [APA], 2002; Fortier & Bishop, 2003; Sue, Zane, Nagayama Hall, & Berger, 2009). Nonetheless, basic guidelines for understanding culture and appropriate responsiveness to individual and group differences continue to elude the helping professions. In addition, empirical data have yet to provide substantial evidence for efficacious culturally-responsive practices (Perry & Limb, 2004).

At least a dozen terms are used to represent these culturally appropriate approaches—for example cultural competence, (multi)cultural competency, cultural awareness, (multi)cultural sensitivity/responsiveness, and cultural relevance (APA, 2002; Bhui et al., 2007; Gamst, Dana, Der-Karabetian, and Kramer, 2004; Mistry, Jacobs, & Jacobs, 2009; Saha et al., 2011). These terms are sometimes used interchangeably and also may be used to circumscribe particular actions or dispositions. However, the terms are far from synonymous. Some terms are used to describe a set of skills or behaviors, while others emphasize the culture as a lens, or perspective—something not quite so concrete.

The lack of such a comprehensive understanding of terms, definitions, or best practices for culturally sensitive approaches to support services results in differential initial service engagement, appropriate utilization, and achievement of desired outcomes. For example, despite improvements in health status among U.S. residents generally, disparities in access to, and utilization of, health care services, and in health outcomes, remain among ethnic communities when compared to white and more affluent patients (Ferguson, Keller, & Haley, 2003; Geiger, 1996; The Lewin Group, Inc., 2001; Sue & Zane, 2009; Switzer, Scholle, Johnson, and Kelleher, 1998; Wintersteen, Mensinger, & Diamond, 2005).

In response to these disparities, a variety of potential solutions has thus been developed and implemented. Some programs intend to develop generally applicable skills and enhance knowledge among service providers, while others focus more narrowly on the specific cultural beliefs and practices of the particular cultural community being served (Sue et al., 2009; Lakes, Lopez, & Garro, 2006). In other milieus, culturally sensitive practice is expected to develop organically, if the site of practice is physically located within the community of a particular ethnic group. Some professional associations, for their parts, have developed guidelines for practice among their members (American Evaluation Association [AEA], 2011; APA, 2002; Ferguson et al., 2003). These guidelines may vary across disciplines.

There is little agreement about what culturally sensitive practice looks like, and how it may be achieved. For example, there are advocates for cultural match, defined by Gamst et al. (2004) as shared language, understanding of client

culture, and willingness to receive treatment. Others believe in the more distinct practice of ethnic match—matching a client with a provider of the same ethnicity (Maramba & Nagayama Hall, 2002). It is evident that multiple approaches have been implemented as the result of varied conceptions and interpretations of culturally competent practice. Without a consensus for what actually encompasses culturally responsive practice, organizations and programs continue to strive for the most sensitive responses with a vast array of approaches.

This imperative to practice in a culturally appropriate manner is evident in the unique context of home-based service provision. For example, Healthy Families America identifies specific cultural competence standards in its site development guide: “such that the staff understands, acknowledges, and respects cultural differences among participants; and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served” (Frankel, Friedman, Johnson, Thies-Huber, & Zuiderveen, 2000, p. 189).

According to some home visiting implementation research, parents generally intend to enroll, and participate fully, in this programming when it is offered; however a significant percentage of families do not persist to complete the program (Damashek, Bard, & Hecht, 2012). There are high attrition and early termination rates among clients of ethnic minority status as compared to European Americans (Gamst et al., 2004; McCurdy & Daro, 2003). Thus, culturally competent service delivery in home visiting is urgently needed to address these differences in enrollment, retention, and maximization of use among minority

populations (Damashek et al., 2012; Lynch & Hanson, 2004; McCurdy & Daro, 2001; Schouten & Meeuwesen, 2006).

Success in home visiting rests, in part, on the ability of the home visitor to develop the necessary rapport to keep parents invested in program participation (Daro & Harding, 1999). Furthermore, when services are provided within the family's home environment, there is the potential for cross-cultural misalignment, one source of unproductive interactions between the home visitor and the parent(s). This meeting of different cultures has been explored in prior research. For example, Damashek et al. (2012) have found a link across studies between cultural competence and client satisfaction and engagement. Still, investigators also note that cultural competence in home visiting and other service provision remains under-investigated (Kwong, 2009). Thus, it is useful to study the role of cultural interactions and competence between the service provider and program participant, how this facet of the service is acknowledged and understood, and what its relation to program participation appears to be.

Using data from the Massachusetts Healthy Families Evaluation (second cohort study; MHFE-2), a randomized, controlled trial evaluation of the statewide Healthy Families Massachusetts program (HFM; Massachusetts Healthy Families Evaluation Project [MHFE], 2012), I conducted a mixed-methods study first examining the relationship between ethnic matching and program utilization via quantitative analysis. In addition, I explored cross-cultural competence-related relationship characteristics, as delineated by Sue (1998), through qualitative analysis, by answering the following research questions:

1. Within a sample of mothers participating in the Healthy Families Massachusetts program, are "ethnic matches" and "ethnic non-matches" between home visitors (HV) and participants associated with differences in clients' program utilization (i.e., duration of enrollment, number of home visits received, and the intensity of participation)?
2. Considering the sub-sample of mothers who indicated that ethnic match with their home visitors was important, what differences, if any, in the number and types of comments of perceived cultural competence were noted between the group of mothers who were ethnically matched with their HV, and those in non-matched pairs?

This study differs from previous studies of the role of ethnic match in that most previous work focuses solely on the quantitative outcomes of program use in mentoring and mental health services (e.g., duration of enrollment, retention, etc.), or have surveyed participants about their perception of their service providers' cultural competence (Damashek, Doughty, Ware, & Silvosky, 2010; Daro, McCurdy, Falconnier, & Stojanovic, 2003; LaFromboise, Coleman, & Hernandez, 1991). This study sought to gain an understanding of the role of ethnic match in program participation between members of a home visiting dyad through exploring quantitative associations between being in an ethnically matched dyad and program outcomes, and through exploring participants' own perceptions of the cultural competence of their service providers through qualitative analyses of interviews with the participants in matched and non-matched dyads.

This thesis develops as follows: Chapter Two is a review of literature about the varying concepts of culture and cultural competence, and ethnic match, and their use and practice within helping professions. The mixed-methods approach, procedures and justifications is explained in Chapter Three, including sample and data analysis. Chapter Four discusses the quantitative and qualitative findings. Here, I describe the phenomenological analysis of the qualitative data, which was conducted to generate findings related to mothers’ perceptions of cultural competence in their service providers. Finally, Chapter Five provides a summary of the work, offers implications for research and practice, and suggests directions for future research.

Chapter II. Review of the Literature

With the increased focus on providing adequate services to minority groups (Whealin & Ruzek, 2008), cultural competence, its interpretation and implementation have garnered attention in service provision. The term and its corollaries prompt the question: What is cultural competence? This paper delves into ethnic matching, specifically, as one way to practice cultural competence, within the context of home visiting. The following section provides an overview of literature pertinent to cultural competence and its significance in the helping professions (e.g. mental health field, nursing), the practice of ethnic match, and home visiting. The multiple terms and definitions of cultural competence are introduced, as well as the various interpretations of practices and the phenomenology of the participant’s lived experience of a culturally-competent interaction. Ethnic matching, its assumptions and limitations, are introduced in the context of provider-client relationships. Finally, the practice of ethnic matching and the role of client perceptions are reviewed.

Cultural Competence

Discussing culture is central to better understanding cultural competence. Culture is another term that has a range of definitions, especially in the field of psychology (Betancourt & Lopez, 1995). The concept of culture has been oversimplified in traditional definitions, particularly when implying primarily a reference to race and/or ethnicity (Lynch & Hanson, 2004; Lakes et al., 2006). This tendency inappropriately collapses a multitude of cultural factors. Culture, for example, goes beyond race and ethnicity, depicting a more multidimensional

construct that reaches deep into the roots of various aspects of an individual's life (Betancourt & Lopez, 1993).

Culture and cultural experiences are behaviors and motivating attitudes that relate to our institutional and community values and traditions, and those that reflect the collective influence of group identities, shared experiences, values, and norms. Culture is also composed of belief systems, norms, social institutions and organizations. Additionally, culture can be seen as a framework through which every person's daily living activities are filtered, including religious and spiritual traditions (APA, 2002; Lynch & Hanson, 2004; Rogoff, 2003; Saha et al., 2011). The APA (2002) further acknowledges that "all individuals are cultural beings and have a cultural, ethnic, and racial heritage" (p. 8). Thus, culture is not a single factor, nor a specific factor that can be studied as such. It is a composite of dynamic and mutually influencing pieces that must be considered holistically and in the context of various life situations.

The relationship between the individual and culture is also complex. Although groups may share cultural characteristics or practices, not all members of the same group will share the same experiences, history, and background (Lynch & Hanson, 2004; Sue & Zane, 2009; Saha et al., 2011); each individual appropriates culture in a unique manner (Stetsenko & Arievitch, 2004).

When examining race and ethnicity, for example, it is important to be aware that individuals who share the same racial and ethnic background may differ in which cultural traits, values and beliefs they deem to be salient, and adopt or appropriate in their daily lives. As Lynch (2004) explains, "no cultural,

ethnic, linguistic, or racial group is monolithic" (p. 23). Therefore, it is important for providers not to assume that racially similar individuals appropriate culture identically. Otherwise there is danger in trying to force cultural boundaries or norms, which may inadvertently reinforce biases and stereotypes across groups and individuals (Gregg & Saha, 2006).

Cultural competence is a term which has yet to be defined by a consensus in the fields of behavioral and social sciences (Kwong, 2009). For example, Siegel, Haugland, and Chamber (2003) define cultural competence as a set of behaviors, attitudes, policies, skills, and procedures that enable providers to work along cross- or multicultural contexts. Wilson, Ward, and Fischer (2013) define the same term as obtaining and maintaining "culture-specific skills" necessary to navigate novel cultural contexts and/or interact with people from varying backgrounds. Sue (1998), on the other hand, defines the construct as a belief that people should appreciate, recognize, and effectively work with other cultural groups. From these disparate examples, the variety of ways that cultural competence is operationalized is evident.

Hence, in thinking about cultural competence, it is important to consider that an individual's perception of culture may vary within a cultural group. This is particularly relevant in one-on-one service provision among helping professions.

Cultural Competence in Helping Professions

As the APA Practice Organization [APAPO] (2007) indicates, cultural factors shape perceptions of illnesses, help-seeking for any emotional or other

health issues and may even encourage dealing with such issues alone. The Lewin Group (2002)—which prepared a report regarding cultural competence in health care delivery for the DHHS—among others, states that there is a growing collective need for cultural competence in order to facilitate access to healthcare, appropriate response to client needs, and better quality in health care (Gregg & Saha, 2006; McCurdy & Daro, 2001; Saha et al., 2011).

The increase in diversity across the nation is reflected in populations of families and individuals of various backgrounds needing services. In order to provide a maximum impact, these services must be adapted to consider the influence of culture on the client’s experience.

Maramba and Nagayama Hall (2002) explain that cultural competence has been used to health-related issues such as high drop-out rates from psychotherapy, for example. Cultural competence may also alleviate barriers to effective health care for immigrants, refugees and other marginalized populations (Gregg & Saha, 2006). Gamst et al. (2004) argue that recent demographic changes have served as a catalyst to maximize “cultural considerations to foster an applicable, relevant, and credible system of care because it is known that culturally-relevant treatment improves mental health status” (p. 457). Bhui et al. (2007) refer to health and educational policies that prioritize cultural competence in health care provision. It is clear that culture impacts many facets of service provisions, the consensus is that there is a need for culturally competent practices across all the helping professions. To begin moving in that direction, however, it is necessary to

understand what is known about the foundations and understanding about cultural competence, its importance and potential impact.

Theoretical Foundations

The theoretical foundation for the importance of cultural competence as having shared cultural similarities stems from two scholarly domains. From the social psychological perspective, people relate better to others who are more similar to themselves (Wintersteen et al., 2005). Further, the concept implies that clients who perceive providers to be more similar will therefore find the providers more attractive, credible, and thus, perhaps more trustworthy. From the mental health, clinical perspective, the interaction is an interpersonal one, and thus includes cultural and sociopolitical factors. Shared ethnic and cultural backgrounds are thought to imply shared knowledge, skills, communicative patterns, and appropriate provision of treatment. Furthermore, matching historical beliefs would contribute towards positive therapeutic change (Halliday-Boykins et al., 2005). These assumptions, however, are yet to be confirmed in the limited empirical studies that have tried to capture the impact and points of influence of cultural similarities or dissimilarities. Key questions still remain as to what approaches, perspectives, or practices actually constitute cultural competence in any form.

The recommendation that culturally competent services for ethnic minorities be made available has been around for at least four decades and been derived primarily from clinical settings. Some have even advocated that professional ethics mandate its availability through collaboration with ethnic

communities and experts (Sue et al., 2009*).* Culturally sensitive service provision — or demonstrating sensitivity to individual differences — is often assumed to enhance program operations, or process, goal attainment, such as the length of enrollment and retention (American Evaluation Association, 2011; Maramba & Nagayama Hall, 2002; Mistry et al., 2009; Saha et al., 2011). However, the empirical data are often contradictory and fail to disentangle cultural components in order to evaluate program use appropriately (Halliday-Boykins et al., 2005; Daro et al., 2003). The paucity of this genre of research remains and clarification of the effectiveness of these practices continue to elude the field.

In an attempt to expand upon this research, other investigators have explored the phenomenon of cultural competence in helping professions—particularly mental health services and primary health care—and explained cultural competence in numerous ways. McCurdy and Daro (2001) define the ability to possess an awareness, sensitivity, and responsiveness to one’s client’s cultural history and background as cultural competence in service providers. Mistry et al. (2009) suggest the term cultural attentiveness, defined as “deliberate and careful thought about cultural issues, without suggesting the existence of any specific set of best practices” (p.502). The APA (2002) considers multicultural responsiveness to be the psychologists’ consideration that behavior might be shaped by the individuals’ belief systems and value orientations – influencing norms, practices, and social institutions. The common idea posited by these authors is that culturally competent service provision is not based on a set of skills or accumulation of knowledge about cultural groups. Rather, cultural competence

is a mindful perspective and/or stance about approaching each individual and/or family. This approach ultimately influences the relationship between the service provider and client from the style of communication to the attentiveness of the client’s actual versus perceived needs.

Switzer et al. (1998) illustrate the lack of consensus on what cultural competence, and/or similar terms, mean across professions; they describe a range of policies and service practices that include organizations that network with minority communities and clients to those who employ professionals who can “serve” individuals of varying backgrounds. Bhui et al. (2007) describe one perspective that views cultural competence as a representation of a substantive knowledge of beliefs and practices relative to various cultural groups; this reference to distinct “groups”, again, risks overgeneralizations across and within groups. At other times, cultural competency is described as a set of conventions expected to emerge organically from a local community through its workforce. In developing a comprehensive practice-related, inclusive definition of multicultural competence, Hansen, Pepitone-Arreola-Rockwell, and Green (2000) characterize it as:

a. An awareness and knowledge of how age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language and socioeconomic status are crucial dimensions to an informed professional understanding of human behavior; and
b. Clinical skills necessary to work effectively and ethically with culturally diverse individuals, groups, and communities…[and which do

> not]…encompass only the four primary ethnic minority groups in the United States. (p.653).

On the other hand, Switzer et al. (1998) propose a client-based perspective in which clients of diverse cultural and ethnic backgrounds perceive their mental health services as appropriate and respectful to their cultural beliefs and attitudes.

Ultimately, there is no unified conclusion as to what factors comprise cultural competence. Much of the available empirical research derives from clinical practice (LaFromboise et al., 1991; Sue & Zane, 2009; Sue et al., 1982) in the mental health field. With limited exploration of cultural competence in home visiting, however, the understanding and application of what has been posited may be limited in this specific service provision. However, due to the pressing need to continue providing services to culturally diverse populations, programs, interventions and/or providers have had to design and implement practices without the benefit of sufficient empirical data. In programs that seek to provide support to families within the home, for example, the impetus to offer culturally competent services to diverse communities is especially strong.

Cultural Competence in Home Visiting Programs

Home visiting is a method of support service delivery for high-risk families and young children. Overarching goals include providing participants with parenting and developmental information, providing access and making connections to community resources, offering emotional support, and demonstrating best practices for child rearing (Howard & Brooks-Gunn, 2009).

Home visiting is an increasingly popular modality for delivering services to families and complementing clinical-based practice (Olds et al., 2002). The home environment provides a more intimate setting between the service provider and the client, in order to improve the level of support provided by the program—in essence, meeting them “where they are” (Korfmacher et al., 2008, p.172). This personal and individualized context offers an ideal way to understand families’ specific needs, circumstances, and the potential to maximize available resources (Korfmacher et al., 2008). Thus, as Halliday-Boykins et al. (2005) note, it is crucial that both provider and client feel comfortable when engaging in the home; and indeed, the dyad may feel more comfortable with shared experiences, which may reduce barriers to acceptance in the neighborhood and home, as well as facilitate communication, trust, and credibility. At an interpersonal level, respect and trust between one another, despite differences, are also going to bear a great deal of weight in the development of the dyad’s relationship.

Given the numerous goals of home visiting, the home visitor can take on various roles, such as that of a social support, an educator, a role model, and/or an expert. Practices of cultural competence are, thus, not only relevant, but integral, to understanding and conducting home visiting.

Healthy Families America (HFA) is a national, evidence-based service model designed to help young children promote positive child health and development through home visiting and other services to their families. This home visiting program model is strictly voluntary and primarily aims to work with families of young children at-risk for child abuse and neglect. HFA is based

on 12 Critical Elements to ensure program effectiveness, one of which is cultural competence (Healthy Families America, 2013). Critical Element #5 (Frankel et al., 2000) explains the component of cultural competence as follows: “services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; and materials used should reflect the cultural, linguistic, geographic, racial, and ethnic diversity of the population served” (p.189).

The cultural competence element of the HFA program model implementation highlights the importance of cultural context in design and delivery in two ways: 1) the acknowledgement of the diversity of families; and 2) the allowance that a service provider’s culture can differ from that of the participant family. HFA further explicates the need for services to reflect variations of needs, beliefs, coping mechanisms, and child rearing practices. It acknowledges that a failure to do so may present a barrier for the home visitor to establish a quality relationship with her participant families. The lack of a respectable relationship would further interfere with collaboration among everyone involved in the intervention. Showing awareness of the client’s individual cultural practices can enhance the relationship and process of service delivery (Lynch & Hanson, 2004; Maramba & Nagayama Hall, 2002; McCurdy & Daro, 2001; Mistry et al., 2009). Thus, the cross-cultural interaction cannot be ignored when service is being provided and any process and impact is being assessed.

Switzer et al. (1998) assert that cultural competence "exists when clients of diverse ethnic and cultural backgrounds perceive that the mental health care they receive is delivered in ways that respect their cultural beliefs and attitudes" (p. 485). In their study of 151 caregivers in a children's medical evaluation project, they found evidence of a cultural competence model of mental health services that includes the client's perceived ethnic match with the therapist. Ethnic match is the practice of matching a client with a service provider of the same ethnicity. While this model was not developed for home visiting, it suggests an important connection between cultural competence and ethnic match. In light of these findings, ethnic match is explored more thoroughly.

Ethnic Matching

In an attempt to meet cultural adaptations, programs often consider ethnic matching (Maramba & Nagayama Hall, 2002; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Sue & Zane, 2009). Home visiting programs make an effort to use ethnic matching; an analysis of provider attributes in a study of 17 home visiting programs identified the effort of ethnic matching among program workers (McCurdy et al., 2003). The question that arises in home visiting programs, especially in programs using paraprofessionals from the local community, is whether the home visitor should share the client's race or ethnicity (Wasik, 1993). The rationale is that by being provided a service provider of a shared race/ethnicity, the client can build a relationship with someone she can relate to and trust more quickly (Wasik, 1993). Also, Korfmacher (2008) suggests that

mothers may feel more comfortable with home visitors with a shared ethnicity. This shared ethnic similarity has, thus, been studied for its possible benefits on program utilization.

Practice frameworks seeking to achieve cultural competence, often propose ethnic matching as a strategy that will result in longer periods of enrollment, higher commitment to treatment, and increases in the number of sessions received or attended. Daro et al. (2003) suggest that mirroring the racial composition of the served population is one approach that can improve the odds of program retention in home visiting. Gamst et al., (2004) state that "recent research suggests that multicultural…adolescent clients displayed a pattern of service utilization that differed from that of their White peers and corresponded to their adult counterparts" (p. 458). Street Jr. et al. (2008) report evidence that suggests that racial similarity or shared identity has been attributed to higher reports of trust, involvement in decision-making, and use of services.

While there are studies that have found associations between ethnic match and program utilization and outcomes, there is also research that suggests no relation. In a meta-analysis of seven ethnically-matched dyads in psychotherapeutic studies, Maramba and Nagayama Hall (2002) found that ethnic match was not a significant predictor of increase in program use and decrease in likelihood of dropping out. Daro et al. (2003) clarify that despite their findings on the desirability of racial mirroring of the population being served, that particular potential retention factor "may only have an overall modest impact" (p. 1121).

It is pivotal to note that central to this study is the concept of *ethnic* match, or shared ethnic similarities—not *cultural* match. After a meta-analysis of studies pertaining to cultural factors as predictors of program use and effects, Gamst et al. (2004) concluded that ethnic match is a “crude proxy” for cultural match, citing that “cultural match identified as shared language, understanding of client culture, and willingness to receive treatment” (p. 458). Indeed, in their study of multisystemic therapy (MST), Halliday-Boykins, Schoenwald, and Letourneau (2005) found a distinction between the impact of client-therapist cultural similarity and ethnic similarity, whereby the former may yield stronger treatment effects than the latter. Furthermore, Maramba and Nagayama Hall (2002) found that ethnic match was a poor predictor of clinical outcomes, such as dropout and utilization rates; they suggest that measures of cultural match may find that therapists of different ethnicities may be more culturally competent to work with diverse clients. The authors, thus, reinforce what is more recently growing to become a point of consensus: that cultural match differs from ethnic match.

Perception of Relationships Between Home Visitors and Clients

Arguably, the most reasonable approach for researchers to help practitioners better understand perceived cultural competence as suggested by Switzer et al. (1998), then, is to surface patterns among groups that exhibit more cultural competence as perceived by the home visiting client. Daro and Harding (1999) propose that home visiting efforts must engage in strong relationships and mutual reciprocity, between the client, the home visitor, and the community.

Building these robust associations allows room for accommodations and adaptations, because while the demographics are typically fixed, the dynamics of shared cultural commonalities lie primarily in the fluid perception of the client (Street Jr. et al., 2008).

Clients’ perceptions of their service providers are a key component to the relationship. In their study of clients’ perceptions of their therapists’ multicultural competencies, Owen, Leach, Wampold, and Rodolfa (2011) found that the clients’ perception of their providers’ multicultural competencies had a noticeable effect on the clients’ perception of the providers’ general competencies as a therapist. The clients’ cultural perception of the home visitors and their relationship is, thus, the “filter” for the way in which culturally competent service provisions are evaluated, as previously suggested by Lynch and Hanson (2004). This filter can detect differences such as cultural values, communication behavior and diverging cultural values, or the value of individual versus group goals; high or low contexts, or situational cues within conversations; and, perception of self-independence from groups (Schouten, Meeuwesen, & Harmsen, 2005). These client-perception-based factors affect the quality of the relationship and ultimately the success of program delivery and implementation.

Several studies have recommended further research on the relationship between ethnic match and program utilization (Bhui et al., 2007; Damashek et al., 2012; Daro et al., 2003; Gamst et al., 2004; McCurdy & Daro, 2001; McCurdy et al., 2003; Mistry et al., 2009). Future studies should look beyond ethnic subgroup differences and assess factors related to client engagement.

Study Purpose

As reflected in the literature, cultural competence is expected to lead to better relationships with the service provider; this yields, in turn, better program utilization and ultimately, better outcomes. However, too many definitions of cultural competence abound and without consensus, there are no clear guidelines and/or sets of practices to help programs provide the appropriate and necessary responses to their diverse communities. Furthermore, this lack of general agreement has made cultural competence a difficult construct to assess. With no clear guidelines or description it has become hard to measure or assess cultural competence and examine whether it leads to program utilization.

Most often, ethnic match is used as a simple way to ensure the cultural competence of service providers; the practice is considered a proxy for cultural competence. However, previous studies suggest that ethnic match is not associated with program utilization in mental health settings. Hence, this analysis seeks to examine this association among a population of teen mothers, where program utilization is defined as 1) number of home visits, 2) duration of enrollment, 3) intensity of home visit use—number of visits over the duration of enrollment. In addition, it qualitatively explores ways in which participants—both from matched and non-matched dyads—describe behaviors which may be relevant to perceived home visitor cultural competence.

Chapter III: Methods

The chapter begins with a brief introduction to the Healthy Families Massachusetts (HFM) program, the two phases of the Massachusetts Healthy Families Evaluation (MHFE-1 and MHFE-2), and the MHFE data to be used in these analyses. The chapter continues with the description of the research questions, the conceptual frameworks, and the analytical methods used.

Healthy Families Massachusetts

Healthy Families Massachusetts is a comprehensive, voluntary, newborn home visiting program that provides home visiting services to first-time young parents (ages 20 and under), in the state of Massachusetts. The program, which has provided services to more than 27,600 families, is made available to participants prenatally, or until the child’s first birthday, through the child’s third year of age (MHFE-2, 2012). The full, potential enrollment period for a participant is three years, eight months. HFM services include home visits, goal-setting activities, social and educational group activities, secondary contacts, and connections and referrals to other resources. The primary service providers, the home visitors, are paraprofessionals in the sense that they do not have professional post-secondary school training relevant to the field. The majority of the providers have some college education and an average of 2.6 years of experience as a home visitor with either HFM or another home visiting program (Riley et al., 2008).

This program is based on the national Healthy Families America (HFA) model designed to help parents and their newborns by promoting positive

parenting and child development and by providing services to overburdened families (Frankel et al., 2000). HFM, in particular, has set forth five specific goals: (1) to prevent child abuse and neglect; (2) to achieve optimal health and development in infancy and early childhood; (3) to encourage parents' educational attainment, job, and life skills; (4) to prevent repeat teen pregnancies; and (5) to promote parental well-being (Easterbrooks et al., 2012).

The Massachusetts Healthy Families Evaluation (MHFE) Studies

Beginning in 1998, an interdisciplinary research team at Tufts University[1], received a contract from the Massachusetts Children's Trust Fund to initiate an evaluation of the then-new statewide home visiting program, HFM. The Tufts researchers have proceeded since that time to evaluate HFM in two distinct phases, MHFE-1 and MHFE-2.

MHFE-1. From 1998-2005, the Tufts University evaluation team conducted MHFE-1, a quasi-experimentally designed study in which the central sample – 361 young mothers enrolled in HFM (the participants) — was administered standardized questionnaires and a semi-structured research interviews at four time points, over the span of 18 months. The sample was drawn from 22 of the 31 HFM sites in operation in 1999, when data collection began. The information gathered covered demographics, parenting, maternal functioning, and program participation. These data were collected by the programs and also

[1] Co-Principal Investigators: M. Ann Easterbrooks, Ph.D., Francine Jacobs, Ed.D, and Jayanthi Mistry, Ph.D.

accessed through the Participant Database System (PDS). At the second, third, and fourth time points, mother-child interactions were videotaped in two five-minute sessions: a structured teaching session; and a non-structured free play session. Ongoing data collection included ethnographic and process data from HFM clients and staff (Easterbrooks et al., 2012).

The research team identified a few major findings from this phase of the MHFE. They found that mothers were well-satisfied with the program, successful at continuing their education, although reporting "unacceptably" high levels of depression (Jacobs, Easterbrooks, Brady, & Mistry, 2005). In terms of program process outcomes, it was found that families were generally not receiving the prescribed number of home visits, according to HFM standards, and there seemed to be a mismatch between the goals the program had for enrolled mothers, and those of the mothers themselves. However, when the mothers' goals and the program's goals aligned (e.g. increasing knowledge about child development), results reflected that mothers did want what the program provided. Furthermore, the program appeared to have enhanced the mothers' social support and yielded a range of positive intermediate outcomes, such as the increase of coping skills among parents. The children were also found to be developing typically. Finally, particularly relevant to this study, preliminary finding suggested that the home visitor-client connection was critical to keeping mothers involved in the program (Jacobs et al., 2005).

MHFE-2. MHFE-2 is a more ambitious, large-scale, six-year randomized controlled trial (RCT) that began in 2008, with a second cohort of 837

participants. MHFE-2 is comprised of two components: 1) the Impact Study of 837 participants, aimed at documenting HFM's program effects (MHFE-2, 2012), and 2) the Integrative Study of 477 participants, which focuses on a "more in-depth and comprehensive understanding of the contextual factors that influence the participants' trajectories as they transition both to parenthood and adulthood" (Easterbrooks et al., 2012, p.5; MHFE-2, 2012). Following the dictates of a true experiment, random assignment was used to create the program group (home visiting services, HVS; n=420) and the control group (referral and information only, RIO; n=268) (MHFE-2, 2012).

Data were collected, beginning in 2008 and continuing over the span of about three years for each participant, with research interviews (RI) conducted at three time points, roughly a year apart. Prior to the in-person research interview, an intake interview was conducted over the phone, helping to capture data to characterize the participants and their contexts, including demographics, family resources, information about the child's father, residential and financial circumstances, and status of maternal health. Many participants also agreed, as part of their RI, to participate, at the second and third time points, in a video-recorded observation of two five-minute interactions with their children, one structured with a given task, and one free-play. These were later analyzed for Emotional Availability—"the capacity of the dyad to share an emotional connection and to enjoy a mutually fulfilling and healthy relationship" (Biringen & Easterbrooks, 2012).

In addition, MHFE-2 collected extant data from agency data systems, including public agency administrative data systems; the HFM management information system, or PDS (Participant Data System)—which produces and updates participant program utilization; and Geographic Information Systems, or GIS—a computer-based mapping and analytical application that processes data based on geographical reference. A primary component of the second time point of this study was its focus on obtaining information about the mother’s perspective about her relationship with the home visitor (HV) currently working with her at the time of that second interview, or if she had ceased receiving services, the most recent home visitor (MFHE-2, 2012).

Research Questions

The research questions, a brief statement of the conceptual orientation that undergirds each, and my expectations about the results are presented below. The research questions are:

> ***Question #1***: Within a sample of mothers participating in the HFM program, are “ethnic matches” and “ethnic non-matches” between home visitors and participants associated with differences in clients’ program utilization (e.g., duration of enrollment, number of home visits received, and the intensity of participation)?

Question #1 was analyzed using a conceptual framework (as shown in Figure 1) based on the Integrated Theory of Parenting Involvement (ITPI). ITPI is a theory that comprises the integration of factors related to four domains—

individual, program, provider, and neighborhood (McCurdy & Daro, 2001). This theory presents a model that explains parent involvement in voluntary programs, with a focus on enrollment and retention, while considering other factors that may influence involvement. According to this conceptual framework, provider factors, including cultural competency, defined as "an awareness of, sensitivity to, and responsiveness to the parent's cultural background and history" (McCurdy & Daro, 2001, p.116), are seen to enhance program engagement. The theory contends that more culturally competent providers offer services that influence parental engagement, communication style, and presentation of program goals. I did not expect that the analysis would yield results in observed differences in program utilization between the dyads, as moderated by ethnic match.

> ***Question #2***: Considering the sub-sample of mothers who indicated that ethnic match with their home visitors was important, what differences, if any, in the number and types of comments of perceived cultural competence were noted between the group of mothers who were ethnically matched with their HV, and those in non-matched pairs?

Damashek et al. (2012) discuss the need for data on clients' perceptions of their providers' cultural competence. The authors also refer to the ITPI framework highlighting the role of cultural competence as a provider factor on program engagement. In their study, Damashek et al. (2012) used the Client Cultural Competence Inventory-Revised (CCCI-R) to assess whether perceived provider cultural competence would predict greater service utilization. Therefore, I developed a qualitative coding scheme based on the CCCI-R measure.

A factor analysis of the CCCI-R revealed three factors in the measure: Cross-Cultural Counseling Skill; Cultural Sensitivity; and, Socio-Political Awareness (LaFromboise et al., 1991). The analyses presented in this thesis relate only to the items comprising the Cross-Cultural Counseling Skill factor due to the limitations of the data available. However, aspects of the other two factors may be captured since there is some overlap among them. Initially, I identified six items that related to information captured in qualitative transcripts. I then used Sue et al.'s (1982) cross-cultural competencies report to refine the definitions of each item in the data reduction process. Finally, I created a qualitative coding scheme to guide my analysis of the participants' words using the following items as my guide:

1. Counselor values and respects cultural differences;
2. Counselor is comfortable with differences between counselor and client;
3. Counselor accurately sends and receives a variety of verbal and non-verbal messages;
4. Counselor is able to suggest institutional interventional skills that favor the client;
5. Counselor is at ease talking with this client;
6. Counselor acknowledges and is comfortable with cultural differences.

These items were then renamed to reflect the sample and further refined according to the iterative process of data analysis (i.e. Counselor became "HV" for home visitor and client became "P," for participant).

Data Sources and Samples

The present study made use of a number of data sources available through MHFE-2. The demographic and process data used to answer Question #1 (i.e. home visitor demographics, records of services used, frequency of use, and etc.), for the HVS sample of participants was drawn from MHFE-2 data collection and the PDS, for the home visitors, who took part in the study at Time 2. Although the total HVS sample at T2 was 338, this investigation is limited to a smaller sample of mothers (n=150) for whom racial/ethnic self-reported information about their home visitors was available (MHFE-2, 2012). For the actual analysis, there were missing data on the number of home visits received for an additional 49 cases, thus, leaving 101 cases to be analyzed statistically (ie., MANOVA). The number of participants and home visitors in each ethnic group is illustrated in Table 1. Of the full sample, 70 participants (69%) identified as being a member of a minority group. Of the full sample, 73 (72%) home visitors identified as being a member of a minority group.

Question #2 was answered by using a sub-sample (n=25) of participants who endorsed some level of importance in response to the question, "How important is it to you that that your home visitor be of the same race or ethnicity as you?" The participants were asked to respond according to a four-point scale of importance ranging from not at all (1) to very important (4). Only participants who responded with points ≥ 2 (which indicated that ethnic match with their home visitor was of some importance to them) were included in the qualitative

analysis. The number of participants and home visitors in the sub-sample in each ethnic group is illustrated in Table 2.

Establishing ethnic match. To begin my investigation, I used the PDS to identify date of the research interview at the second timepoint (T2) and the participant's race/ethnicity of record, according to four Census categories: (1) White, non-hispanic; (2) Black; non-hispanic; (3) Hispanic/Latino; (4) Other.

The mother's race/ethnicity category was then cross-referenced with state records to find the race/ethnicity of her respective HV, according to the same Census categories. These are the categories by which I divided the overall sample into two groups: ethnically-matched and ethnically non-matched. The distribution of matched versus non-matched dyads was relatively even in the full sample. However, the sub-sample did not have an even distribution, with 22 participants (88%) identifying as a member of a minority group, including 18 as Hispanic/Latino; only 3 participants in the sub-sample identified as White (see Table 3). All the home visitors in the sub-sample identified as being member of a minority group, including 20 as Hispanic/Latino (see Table 4).

Data Analysis

To answer Question #1, a between-groups multivariate analysis of variance (MANOVA) was performed on three dependent variables: duration (in months), number of home visits between T1 and T2, and intensity of use of home visiting services within this time frame—that is, the number of home visits

divided by the duration of enrollment in the program. The independent variable was racial/ethnic match (yes and no).

A MANOVA was chosen as the statistical test to reduce the overall rate of error as compared to running three independent t-tests. Two MANOVAs were conducted: one using the full sample and a second analysis using only participants who identified as an ethnic minority (n=70). Results of the evaluation of assumptions of normality, homogeneity of variance matrices, and linearity were satisfactory.

To answer Question #2, I conducted a qualitative analysis. In deductive qualitative analysis, I applied elements of the phenomenological analytic method with predetermined codes (listed above) to the interview data from the sub-sample of participants who reported that ethnic match with their home visitor was of some importance to them. Phenomenological analysis involves the following stages: reviewing interview transcripts; highlighting "significant statements," or quotes that provide an understanding of the lived experience of the phenomenon (referred to as "horizontalization" by Moustakas, 1994); developing clusters of meaning; writing textural descriptions, or what the participants experienced; describing "imaginative variation," or a description of the context that influenced how the participant experience the phenomenon; and finally, writing a composite description referred to as "the essence" (Creswell, 2007). This study sought to deductively explore elements of critical relationship factors about cultural competence, particularly how cultural differences are handled, and the degree of sensitivity and attentiveness with which participants perceived their home visitors

demonstrating in response to their cultural needs or wants. In the cross-category analyses, the study also looks within and across ethnic matched and non-match group similarities and differences.

Qualitative measure. When developing the CCCI-R, Switzer et al. (1998) had a goal of developing a client-based measure of cultural competence; to the authors, it was important that the form through which cultural competence was measured reflected the clients’ perceived mental health care as “delivered in ways that respect[ed] their cultural beliefs and attitudes” (p.485). LaFromboise, Coleman, and Hernandez (1991) later revised the CCCI-R based on the APA Division 17 report’s description of characteristics of cross-cultural counseling competence (APA, 2002). After an initial development of a measure of 22 items was generated, it was reduced by eliminating overlapping items to an 18-item scale. Each characteristic corresponded to one of Sue et al.’s (1982) cross-cultural counseling’s competence categories of cultural awareness and beliefs, cultural knowledge, and flexibility in counseling skills. Each item is a statement to which the participant responds indicating the extent of agreement with each statement on a 6-point continuum.

After further revisions, two items were added to address general understanding of the counseling process, as this is a tool primarily used for assessing the cultural competence of a mental health service provider. A three-study review of the CCCI-R revealed the tool as a reliable and valid measure for assessing cross-cultural counseling competence (Damashek, Doughty, Ware, & Silovsky, 2011; Damashek et al., 2012; LaFromboise et al., 1991). The scale

yielded an internal consistency reliability of .95. Three factors of cultural competency are built into the tool, including cross-cultural counseling skill; socio-political awareness; and, cultural sensitivity.

For the purposes of this study, I developed qualitative codes for the *etic*, or researcher's views, based on the first factor of: cross-cultural counseling skills—which the authors found to be related to the "counselor's capacity to convey comfort with ethnic and cultural differences" (LaFromboise et al., 1999, p.385). This factor also focuses on the counselor's self-awareness and ability to foster more sensitive communication. Hence, I chose the cross-cultural counseling skills in an attempt to best capture the perceived sensibility of differences in culture. The codes I developed are also in consideration of the information that is available given the questions that were asked in the interview process about the role of the home visitor.

Analytic procedure: A phenomenological method. As described by Moustakas (1994), "perception of the reality of an object is dependent on a subject" (p.28). Moreover, a phenomenological study "describes the meaning for several individuals of their lived experiences of a concept" (Creswell, 2007, p. 57). The purpose of using this analytic approach is to obtain the participants' perceptions of their lived, cross-cultural experiences with their home visitors. The data were analyzed using the phenomenological model: review of interview transcripts; "horizontalization;" clusters of meanings; "imaginative variation," and, finally describing "the essence" (Creswell, 2007).

Phenomenological reduction. The goal of *phenomenological reduction* is to reduce textural and structural meanings, or the “what” and “how” of an experience, to briefly describe the phenomenon for all the participants involved in the study. Since all individuals experience the phenomenon in some form, this is, in essence, trimming the phenomenon of this lived experience to its basic elements. Therefore, the text is approached and labeled with general, open definitions of these constructs. I continued by followed the methodological steps through Moustakas’ phenomenological reduction: bracketing horizontalization.

Horizontalization. Bracketing focuses solely on the topic and the primary research question through quotations. “Horizontalization” involves bracketing off every significant statement made in relation to the experiences cultural competencies and listing them, and giving them all equal value and consideration. Each case had its own document of quotations illustrating each construct, according to the open definitions.

Cluster of meanings. During the phase of “horizontalization,” there is a review of additional literature to help contextual definitions. Some constructs are collapsed due to their overlapping definitions, available data, participant’s responses and ways of responding to questions. Statements irrelevant to the construct, according to the refined definitions, as well as those that are no longer relevant or repetitive are deleted. What stands out as invariant qualities of the phenomenon creates the meanings unit.

Imaginative variation. The next step in this research approach is that of imaginative variation. During this step, one finds possible meanings of the lived

experience that can speak to “how” the experience of phenomenon came to be what it is. The investigator is encouraged to utilize imagination, consider any perspective as a possibility, and approach the phenomenon from various perspectives.

Essence. Finally, the author synthesizes the meanings intuitively and unifies it into a statement called “the essence” of the experience of the phenomenon as a whole. This is to be the universal aspect of the phenomenon, the quality without which the phenomenon could not be.

Chapter IV: Results

The following section discusses the findings of the quantitative and qualitative analyses. It begins by presenting the exploration of the role of ethnic match on program utilization among the full sample. What follows is then the *imaginative variation*, or interpretation of the statements derived from the interviews within the context of the codes deducted from the CCCI and Sue et al. (1982, 1992)’s cultural competencies. Finally, it concludes with a statement of the *essence* of the phenomenon of perceived cultural competence as experienced by the sub-sample of participants in this study.

Ethnic Match and Program Utilization

The first question of this study sought to investigate whether, within a sample of mothers participating in the Healthy Families Massachusetts program, there are differences between “ethnic matches” and “ethnic non-matches” home visitors and participants dyads and their profiles of participation (e.g., duration of enrollment, number of home visits received, and the intensity of participation). With the use of Hotelling’s Trace, the combined DVs were not significantly affected by match, $F(3, 97) = .912$, $p = n.s.$. The results reflect no association between ethnic match and duration, enrollment, or intensity of use.

When considering only matched dyads of participants from ethnic minority groups and their home visitors, the results also reflected no significant association between ethnic match and any of the dependent variables.

The Experience of Perceived Cultural Competence

The second research question explored to what extent, if at all, mothers who indicate that racial/ethnic match is an important characteristic in their relationships with their home visitors, perceive their home visitors’ words and actions as indicators of cultural competence. Further, it sought to compare among the ethnically-matched and non-matched dyads whether there were any differences in presence of comments related to perceived cultural competence between mothers in this subgroup, who endorsed the importance of ethnic match.

Based on selected significant statements, a result of the data reduction process whereby similar quotes are combined into themes (see Table 6), the qualitative analysis suggested some modest differences between the ethnically matched and non-matched groups as it relates to components of perceived cultural competence (see Table 6), as deductively coded. Furthermore, it offered some insight as to how the participants experienced cultural competence in their home visitors.

The following five themes were analyzed in regard to how participants experience cultural competency in their interactions with their home visitors: acknowledging and respecting differences; making necessary connections and referrals; connecting to intrinsic networks; educating of goal pursuit strategies; and, customizing help. Statements, categorized by their respective themes, are presented in Table 7.

Experiencing cultural competence: Acknowledging and respecting differences. According to Sue et al. (1982), “Culturally skilled [providers] have

moved from ethnocentrism to valuing and respecting differences” (p.50); this includes not imposing their own values onto their clients. Cultural differences are respected and valued, not seen as a dividing force between the dyad. The mutual respect contributes to building a solid relationship based on a foundation of trust. The power dynamic of having equal say or feeling equally valued is pivotal in offering a personalized experience, as a participant explained when she openly disagreed with her HV’s recommendation about enrolling in school and his response was, “That it was okay.” Another participant experienced a similar situation regarding the different recommendations she was receiving from her mother and her HV, “So the way she would tell me to raise my daughter or give me advice on something is something that she would have gotten information on, read. And my mother is more like the old fashioned way.” Ultimately, this participant felt it was her decision and felt that whatever she decided to do, “it’s not a big deal.”

Experiencing cultural competence: Making necessary connections and referrals. A key aspect to being an effective service provider is being able to understand one’s limits and provide referrals to the community’s resources (Sue et al., 1992). This occurred frequently, and in various forms. As one participant described, this even included referring the participant to a local wholesale store where she could obtain necessary materials at lower cost: “she was gonna bring me to BJ’s to get a whole bunch of diapers for less price.” This competency also includes the knowledge about resources in the community—knowledge that is especially important when the necessary help exceeds the provider’s professional

capacity. While often home visitors were described as providing more than professional guidance, as shared by one participant, “…she’s also there to support me…,” knowing limits in her expertise is a critical factor for providing culturally competent service provision (Sue et al., 1982). In another dyad, the home visitor knew when his emotional support of the participant required expertise as his participant described, “[The HV] has referred me to psychologists.”

Experiencing cultural competence: Connecting to intrinsic networks. “Culturally skilled [providers]…respect minority community intrinsic help-giving networks…and resources in the family” (Sue et al., 1992, p. 482). As described by the authors, by being able to tap into the intrinsic family network and use that network as a source of support for the participant, the home visitor demonstrates sensitivity to a resource that is readily available to the participant. One participant talked about how she, herself, was blind to this important resource and recognized the home visitor’s ability to see value in what the participant felt she could not:

> One of the goals I didn’t have, I really didn’t want to work with my family, like I kind of just wanted it to be me and my daughter, not my mom and my sisters included. But she kind of wanted to have us have them included so we could build our relationship to make me, as a younger mother, be able to handle things better. Like I knew I had that support and I was kind of pushing them away and she was trying to put back together to make it better. I was happy that someone saw it other than I did.

The value is also found in the ability to identify not only extrinsic, but intrinsic networks that will provide any amount of support for the participant to succeed, including providing that a level of support for others the mother has identified as important. One participant highlighted her experience with her boyfriend and her home visitor and the impact it had, "She allows us to just babble on about our life. Stress reliever."

Experiencing cultural competence: Educating about goal pursuit strategies. An important characteristic described by Sue et al. (1992) refers to developing appropriate intervention strategies and techniques including taking responsibility in educating clients about the processes involved with setting and reaching goals. Identifying goals was consistently present in the review of interviews. However, additional aspects of the process emerged, as did accountability. This education and awareness seemed to be an especially important experience for one participant who explained, "Well she asked me like what are my goals and she puts them on paper and makes me like realize that I even have goals or that those are my plans." The significance of this process at times crossed the boundary of skill development into support as one mother described,

> Even if I told her my goal was to be the president, she would help me get on the right track to figure out how to become the president. Even if she knows it's highly impossible for me to become the president, she would still try to help.

The unconditional support of her home visitor is illustrated in this statement, as is the mother's understanding that her home visitor believes in the mother's capacity to reach beyond whatever boundary she may have previously set for herself. Thus, this responsibility of educating about goal pursuit carries implications of sensitivity to meeting individual needs at various levels.

Experiencing cultural competence: Customizing help. A provider's awareness of her own assumptions, values, and beliefs includes knowing how to accommodate her help to various methods or approaches according to the messages she sends and receives, both verbally and non-verbally (Sue et al., 1992). This particular skill requires the capacity to understand messages appropriately and use that information to customize the necessary help.

Participants described the presence of this competency in various forms. For one participant, it was about obtaining meaningful unsolicited opinions about a school in which to enroll. "She's the one that took me, you know, I told her, her opinions about certain schools, where it's OK which ones were not good." She later went on to admit, "Cause if I would have done it by myself I would have gone to the first school and enrolled myself." One participant shared about her home visitor's immediate response to the parents' need for learning how to install a car seat, "…the next day, she came and showed me how to put the car seat in the car…"

This competency was demonstrated by another home visitor who responded to a family problem the mother was experiencing by helping the mother "do budgeting," to help in a situation involving her aunt. This described

experience demonstrates an example of the ability to respond to the needs of preserving the participant’s intrinsic network and building on her skills. These various types of help adaptations were observed across both groups.

The essence of the experience. Cultural competence is composed of multiple beliefs and attitudes, knowledge, and skills (Sue et al., 1992). There are multiple aspects of an interaction with a service provider that can be attributed as a culturally competent experience. These aspects revolve around providing individualized support to the client that allow for customized help services and goals that connect and preserve the client’s connection to her intrinsic and extrinsic communities. Theoretically, a culturally competent service experience is one full of awareness of the client’s sensitivities and needs. The exchange of information happens in simple and complex life situations, at various points in time, short term and long term, and can involve any numerous level of an individual’s ecological environment. The essence of culturally competent service is ultimately experiencing an attention and response sensitive to one’s individualized, unique needs marked by an acknowledgement of differences, help with connection to necessary resources, connecting to intrinsic networks, education about goal pursuit strategies, and individual customization of help provided.

Analysis of themes. While each theme appeared in the commentary of participants in both the matched and non-matched groups, there were some observable, though modest, differences in how much a theme recurred in one group versus the other. Ethnically-matched dyads had a slight edge in

acknowledging and respecting cultural differences, making necessary connections and referrals, and educating about goal pursuit strategies. The comments related to connecting to intrinsic networks and customizing help were more recurrent in the non-matched group (See Figure 4).

Chapter V: Discussion

The following section reprises the findings of the study and discusses them in the context of previous research and literature. Limitations of the study are discussed, as are implications for practice and research. Finally, a summary of the recommendation for future avenues of study is offered.

The increasing diversity in communities across the United States calls for culturally sensitive practices. As organizations seek to provide the most culturally sensitive and efficacious services for diverse groups, the inquiry into how to best to approach these practices is increasingly relevant. In an effort to be responsive to this need, programs may employ the practice of ethnic matching between service provider and client in order to facilitate an interaction that will foster the most support for families, recipient of home visiting services (Daro et al., 2003). Prior research has not consistently supported the efficacy of ethnic matching in service provision (Maramba & Nagayama Hall, 2002; McCurdy et al., 2003). The present study sought to investigate the role of ethnic match in a statewide home visiting program in two ways. First, by focusing on the relationship between ethnic match and program use indicators (e.g. length of enrollment, number of home visits received, and number of home visits used within the enrollment period); and second by qualitatively analyzing how participants who valued ethnic matching perceived the cultural competence of their service providers.

The quantitative findings of the present study revealed no significant differences in home visiting program utilization between groups of ethnically-

matched and non-matched dyads among this sample. Further tests indicated that this finding held, even among an all-minority sample.

The qualitative findings in the phenomenological study yielded insight into aspects of behaviors that may be perceived as elements of cultural competence. Data were analyzed using a coding scheme informed by the CCCI-R. The qualitative findings suggest that it may be more informative to look at the impact of match in dimensions of a relationship (e.g. making appropriate connections and goal strategizing), rather than looking at cultural competence as a one-dimensional construct. When looking at the dimensions of perceived culturally competent service provision, there are particular aspects which may help to support the needs of the participants in matched pairs—these include *making necessary connections and referrals* and *educating about goal pursuit strategies.*

Making necessary connections and referrals was a more salient theme among the ethnically-matched dyads than among the non-matched ones. Often, with the use of paraprofessionals from shared communities and ethnicity, the provider may be aware of local resources—information that may not be as easily accessible to a service provider from a different community. Places such as cultural centers or organizations that tailor to specific ethnic groups may be known to the paraprofessional simply because she, too, is a member of the community. This ability to capitalize upon shared networks may help to build a reliable support structure for the participant.

On the other hand, there is also a benefit of having a service provider from an outside network to find the best way to customize needed help. While shared community networks may help to bolster a sense of commonality, the availability of additional support services from extrinsic networks can widen the potential for resources. Perhaps a provider from outside the participant's community can supply "bridging" social capital—offering an instant connection to a more expanded network of supports. An additional advantage may be that having a home visitor from the "outer circle" can help to unveil new solutions or resources because of her different practices and norms. This ability to step in from an external position may reveal new possibilities for support and change that may not have otherwise been available to the participant if she worked with someone with shared characteristics.

Educating about goal pursuit strategies was also discussed more frequently among the matched dyads. This may be the result of shared understanding of the concept of goals and how to achieve them. It can be argued that having a cultural understanding of the purpose of goals from similar perspectives may help facilitate how to help a participant identify, plan for, and achieve goals. The shared ethnicity may help the provider know enough to make goal pursuit work through the shared knowledge—and perhaps even a shared "language," or communication and understanding—of how goals can be situated within the participant's circumstances.

However, having a preconceived notion of how to present and develop this and other skills according to shared similarities and understanding can also be

limiting. Making assumptions about another's understanding or approach based on shared similarities may prevent a more specific and detailed process of explaining how to build a skill. Having someone from a different group can not only introduce new "language," but also expands the approaches to teaching a skill.

The working assumption of ethnic matching is that ethnically similar individuals are more culturally similar than are ethnically dissimilar individuals (Halliday-Boykins et al., 2005). While the working theory of shared similarities is important, is it vital to remember differences within groups still exist. Culture accounts for shared practices, values, and experiences among a group—factors that are likely to vary within groups. Assumptions cannot be made within groups, as different individuals have different needs for learning about their local communities, how to strategize goals, and obtaining access to the proper help for themselves. As such, assuming that ethnic matching intuitively tailors to varying needs can be an overestimation. These findings are consistent with previous research where ethnic match was not a good predictor of therapeutic outcomes (Maramba and Nagayama Hall, 2002; Gamst et. al, 2004; Damashek et al., 2010). Furthermore, as Whealin and Ruzek (2008) point out, what we understand to date about culturally competent care is that it requires the ability to understand and accommodate support services to meet the needs of individuals. Ethnic match may theoretically influence the interaction through shared knowledge and communicative patterns; however, it is unclear if and how this translates into engagement in services.

There are various factors, such as individual preferences and experiences, which may serve as moderating factors in a relationship between provider and client. Identifying these elements is pivotal in supporting such crucial interactions in the fields of helping professions, particularly in home visiting. Culture has various facets that may indeed play a role in program use, especially when paraprofessionals from the local community are the service providers. An understanding of the neighborhood, the local customs and practices, and community resources are pieces of what justifies the use of local service providers. However, it can also be argued that a home visitor knowing "too much" personal information can present as a barrier, given the shared space and social environment. Furthermore, assumptions may be made about the participant that perhaps may not hold true for that individual, in particular.

The multidimensional nature of culture suggests that cultural competence should be considered in a broader aspect—well beyond racial/ethnic match. As prior literature and the qualitative data in this study suggest, cultural competence revolves around various aspects of sensitivity to various cultural norms. Therefore, cultural competence should also be considered along these multiple dimensions when implementing program practices. Cultural competence is integral to any relationship, and thus it is important to continue thinking about how it should play out in home visiting. The relationship is important to engaging the parent in the services provided.

Despite the study's possible contribution to understanding how ethnic match may or may not play a role in program use and aspects of perceived

cultural competence, there were some limitations. First, the sample size for the mixed-method analyses was limited. A larger sample size, as initially intended, may have yielded significant results or strengthened the findings of this study. Furthermore, within the sub-sample, the distribution of ethnically-matched match versus the non-matched dyads was uneven, with more matched dyads than non-matched ones. In addition, the majority of the participants in the sub-sample identified as Hispanic/Latina. This may indicate that the qualitative findings may be more specific to this ethnic group. This limited the ability to accurately compare the groups.

Furthermore, there are additional limitations to consider in the qualitative study. The methodology of a phenomenological approach involves collecting data and re-interviewing participants as themes begin to emerge. I was limited to interviews that had occurred previously and could not return to the participants in this iterative wat. This restricted how I could explore the emergent themes for textural description that Mousakas (1994) calls for. Nonetheless, the iterative process of reviewing the transcripts still allowed me to unearth valuable findings about perceived cultural competencies as demonstrated by the home visitors.

As it pertains to the initial conceptual framework, I used the CCCI-R, a quantitative survey, as my starting point for developing qualitative codes, limiting the level of inductive analysis. However, the article's study of its validity introduced Sue et al.'s (1992) characteristics of cultural competency, which helped to inform how I further defined the codes for data reduction. This proved to be a pivotal piece in my qualitative analysis as it provided more literature to

guide my understanding as I unpacked the statements of the participants. Another limitation of the measure, however, is that it is originally intended for clinical settings. Although home visitors are not clinicians, this was as close a measure available for a provider-client relationship.

Finally, it is important to note the limiting nature of using only four racial/ethnic census categories. This fact limited the ability to analyze the dyad matches at a more refined level. More descriptive categories could have provided more detailed information about match and offered within-group distinctions). Still, for an exploratory analysis and for the sample size used in this study, the categories used helped to provide preliminary comparisons between ethnic matched and non-matched groups.

Nevertheless, the findings of this study suggest several promising avenues for future study regarding the practice of ethnic matching and cultural competence. The results of the quantitative study suggest no significant difference in program use according to whether or not a dyad is ethnically matched. It is, therefore, important to consider that other factors may be more relevant to developing a stronger alliance if the provider-client relationship is considered a key agent of change in home visiting programs.

Additionally, the themes that were explored in the qualitative study do suggest the potentially meaningful influences of perceived culturally competent services. It is recommended that these themes be considered as points of connection that can be developed within provider-client relationships. Those key themes are m*aking necessary connections and referrals* and *educating about goal*

pursuit strategies. While some are already teachable, it is important to explore among current practitioners how to build the gap for those characteristics which may not be as teachable, such as being attuned to acknowledging and showing respect for differences and being receptive of verbal and non-verbal messages, such that necessary help is provided whether voiced by the participant or not.

Implications

The present study also has implications for further research looking into what factors most positively impact the relationship between a home visitor and participant, and which practices, in particular, contribute to developing a culturally sensitive relationship.

In order to create a better understanding of the phenomenon of perceived cultural competence in home visiting, more in depth qualitative research interviews should be conducted, iteratively, to flush out further meanings of cultural competencies and how participants experience them. The current research study was only able to use interviews from a prior study, and so was limited to such information. A study in which participants can be revisited and re-interviewed and asked more in depth about emerging themes may be able to produce a more solid picture of the perception of cultural competencies exhibited by home visitors. By asking participants about this concept, specifically, we may be able to garner more evidence to support or refute the theories on cultural competencies as perceived by clients, which is of utmost importance for the success of home visiting and service provision program relationships.

Furthermore, additional types of match were not explored in this research. Language, for example, is of great interest as it can create a barrier or build a bridge between the home visitor and the client, and also the local community and its resources. Other dimensions of shared similarities, such as age, socioeconomic status, and hierarchical differences between the home visitor and client can provide important information about the function of these relationships and their relation to perceived cultural competence.

Finally, although this research identified several themes that have been related to cultural competence in the literature, it is by no means an exhaustive list. The competencies and descriptors proposed by Sue et al. (1992) may remain limited in identifying further variables within culture that should be explored for a need for competency.

Conclusion

In summary, this study may assist the field of home visiting programs in guiding how we continue to mine extant data and/or gather additional data to further understand how to strengthen relationships between provider and client. Ultimately, this will help to meet the home visiting program goals of parental assistance, positive child development, and prevention of child abuse and neglect. Further, if the preliminary findings of this study are confirmed, they will hopefully be able to contribute to better understanding the role of ethnic match in provider-client relationships.

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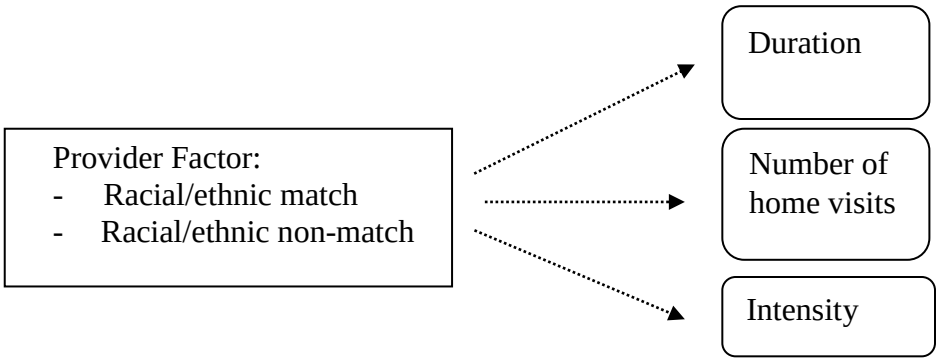
Figures

Figure 1.

Conceptual Model of Role of Racial/Ethnic Match on Program Utilization



Note. Dotted line represents *moderating* role of ethnic match on program outcomes.

Tables

Table 1.

Race/Ethnicity of Participants and Home Visitors in Full Sample

	Participant *n* (%)	Home Visitor *n* (%)
White, non-Hispanic	31 (30.7)	28 (27.7)
Black, non-Hispanic	16 (15.8)	14 (13.9)
Hispanic	44 (43.6)	40 (39.6)
Other	10 (9.9)	19 (18.8)

Table 2.

Race/Ethnicity of Participants and Home Visitors in Sub-Sample

	Participant *n* (%)	Home Visitor *n* (%)
White, non-Hispanic	3 (12)	0 (0)
Black, non-Hispanic	2 (8)	4 (16)
Hispanic	18 (72)	20 (80)
Other	2 (8)	1 (4)

Table 3.

Participant/Home Visitor Dyads by Race/Ethnicity, Full Sample, N=101

Race/Ethnicity	Matched (n=74)		Non Matched (n=76)	
	Number	% Total	Number	% Total
White, non-Hispanic	24	52.2	22	47.8
Black, non-Hispanic	6	26.1	17	73.9
Hispanic	40	59.7	27	40.3
Other	4	28.6	10	28.6
Total		73.2		75.2

Table 4.

Participant/Home Visitor Dyads by Race/Ethnicity, Sub-Sample, N=25

	Matched (n=19)		Non Matched (n=6)	
Participant Race/Ethnicity	Number	% Total	Number	% Total
White, non-Hispanic	0	0	3	100
Black, non-Hispanic	1	50	1	50
Hispanic	18	100	0	0
Other	0	0	2	100
Total		76		24

Note. “Matched” refers to dyads of the same ethnicity. “Non-matched” refers to dyads where participant and home visitor were of different ethnicities.

Table 5.

Selected Significant Statements

- She's the one that took me, you know, I told her, her opinions about certain schools, where it's OK which ones were not good. Cause if I would have done it by myself I would have gone to the first school and enrolled myself. So she helped me a lot with that.

- She always gives me goals. "What do you want to do within the next six….

- She brings my spirits up, she encourages me. "You can do it if you want to."

- Her's is more from raising from her daughter and also being a Healthy Families visitor, so the way she would tell me to raise my daughter or give me advice on something is something that she would have gotten information on, read. And my mother is more like the old fashioned way, you got to do this, babies sleep on their stomach, and all that. So there's a difference…if I choose to take their advice or not, it's not a big deal to them.

- She's really supportive, so it's like a weekly relief.

- Umm, just because she keeps me informed and tells me when she's going to meet with me, and basic information, and if I asked her anything, she checks up on if the baby if the baby was sick or something. So it's helpful.

- With the voucher thing, she got me going with that. She told me where to go, and what to do, and what to bring, so they helped me get daycare for her.

- She keeps me updated of what she should be doing. She's a good influence, you know? She makes me see I can do it, even if I do have a child I can still do whatever.

- She was helping me get a job…If she sees some place where it says "I'm hiring" she would call me and say, "Oh, did you look right here?"

- And she used to help me with the baby. Any question I had with the doctor, if I want to call the doctor, she'll call for me.

- And she used to say, "Oh, I know you could get a better job. I don't see

you working there." And then she would always tell me, "Oh, you need to go back to school. Finish school." She used to be on top of me like, "Did you call this place?" She made me feel like I could do better than what I was doing.

- She's not scared to tell me if I'm doing something wrong. She points me in the direction I'm supposed to be going and she sets up goals for me and makes me want to like get out there. Like I joined a gym because of her and stuff. Not that I'm still there, but I still did it at one point!

- Like she's always full of resources so when I… I have actually called her up on her cell phone and asked her a question.

- It seems like she cares too. It's not just like she comes and she does her job and that's the end of it. I feel like she genuinely does care about her people. Because when I see her at the family parties she's like "oooh, look how big he's getting" and she actually takes care of him for a little while. She sees what he does and then plays with him.

- Well she asked me like what are my goals and she puts them on paper and makes me like realize that I even have goals or that those are my plans. And she asks me about them every time that I come. Like "have you done this, have you done that? Have you gone to the doctors? Have you asked the doctor a specific question about your son" or something, like if I don't know. She kinda reminds me, Oh, well I haven't done it. And she says, "well, you gotta do it!" So she helps me out.

- She would look up stuff for me that I had asked her to. She sent me a card once that said I was a great mother. Just stuff like that.

- He helps me a lot. He's trying to get me to go to school. He's trying to get my partner to get his driver's license. Lots of things

- I: Do you feel that you could tell [HV name] that you're not interested in going to school for /P: I already told him. /I: Oh, ok. How did he respond? / P: That it was okay. But when the baby turned one, I should at least make the effort.

- P: She allows us to just babble on about our life. Stress reliever. I: Who's "us"? P: My boyfriend also babbles a lot with her. / I: Okay, so you guys do the home visits together? / P: Yeah, when he can, when he's home, yeah. He comes and talks to her too.

- She won't tell me what to do, but she'll give me opinions on how I should

handle things or how I should approach things, so she helps me through my problems as well. She's not just there to talk about my son and his development, she's also there to support me as well.

- I remember I was having problems with my voucher, and the woman spoke Spanish, so she talked to her in Spanish.

- She had told me if I ever feel down, how I feel to let her know and to express myself with her. But that if I didn't want my feelings to be showed then I didn't have to talk about it.

- I told her I wanted that because my goal was to finish school and find a job and she said she was going to help me try to put in applications to have my own housing apartment in a couple of few years that it takes.

- Yes, he has referred me to psychologists and things like that.

- He's talked to me about things like that and I've told him, only that, for example, what I want to do is to study and have my GED and a career to be able to work and give my son the best.

- I can call her at any time in regards to my daughter, and she was always concerned and if she didn't know the answer, she would refer me to somebody who would know the answer.

- [HV name] tried and tried and tried to keep my case open, she spoke to her supervisor, her supervisor really wanted to keep it open, but it's procedure that once custody is taken from the parent that, if it happens before the child is one, they can't have the case open until they get custody of the baby, and I have up until she's three year old to be enrolled back.

- She wanted me to get back into school, she said she wanted me to get my license and get my own apartment and take care of the baby, and she helped me - she wanted me to join a support group for moms, and she was just really nice. She supported everything.

- She would just hug me and tell me things are going to be okay.

- Whenever there's something, like when the baby didn't have a swing and I couldn't afford a swing, she brought me a swing for him, and it's like little things that I need and I'll ask her about, like looking for a job, she'll bring me stuff. She just does everything that she should, and above more than what she needs to.

- She helped me cuz I didn't know how to do the car seat, like when we were leaving the hospital, it took us an hour to get the car seat in the car, and the next day, she came and showed me how to put the car seat in the car, and for diapers.

- When I was having issues with the rent with my aunt, she helped me do budgeting, and she was gonna bring me to BJ's to get a whole bunch of diapers for less price, and stuff like that. She did, she brought me and the baby clothes, too.

- Even if I told her my goal was to be the president, she would help me get on the right track to figure out how to become the president. Even if she knows it's highly impossible for me to become the president, she would still try to help.

- She vouches for me. She gives me whatever I need, like whenever I need diapers or something; and they have it in case of emergency, she will get that for me. She also talks to people for me. Like if I am too afraid to talk to an administrator or get my point across, she can get it across for me. She also gives me rides to appointments.

- She tries to help me finish my goals and get through them.

- If I tell her I need information about the baby's teeth, she brings it. She always makes sure his immunizations are up to date.

- One of the goals I didn't have, I really didn't want to work with my family, like I kind of just wanted it to be me and my daughter, not my mom and my sisters included. But she kind of wanted to have us have them included so we could build our relationship to make me, as a younger mother, be able to handle things better. Like I knew I had that support and I was kind of pushing them away and she was trying to put back together to make it better. I was happy that someone saw it other than I did.

Note. P = participant; I: Interviewer. Selected significant statements are similar quotes combined into themes.

Table 6.

Comparison of Frequency (Percent) of Comments Made by Participants between Matched and Non-Matched Dyads, Organized by Theme

Theme	Matched Dyads	Non-Matched Dyads
Acknowledging and respecting cultural differences	3 (16)	1 (12.5)
Making necessary connections and referrals	6 (31.5)	2 (25)
Connecting to intrinsic networks	2 (10.5)	1 (12.5)
Educating about goal pursuit strategies	5 (26)	1 (12.5)
Customizing help	3 (16)	3 (37.5)

Table 7.

Themes or Meaning Units and Evidence, or clusters of meaning

Themes/ Meaning Units	Evidence in Participants' Statements
Acknowledges and respects differences	"so the way she would tell me to raise my daughter or give me advice on something is something that she would have gotten information on, read. And my mother is more like the old fashioned way, you got to do this, babies sleep on their stomach, and all that. So there's a difference…if I choose to take their advice or not, it's not a big deal to them." (*Non-Matched dyad*)
	"She's not scared to tell me if I'm doing something wrong. She points me in the direction I'm supposed to be going and she sets up goals for me and makes me want to like get out there." (*Matched dyad)*
	"I: Do you feel that you could tell [HV name] that you're not interested in going to school for /P: I already told him. /I: Oh, ok. How did he respond? / P: That it was okay." (*Matched dyad*)
	"…if I didn't want my feelings to be showed then I didn't have to talk about it." (*Matched dyad*)
Making necessary community connections and referrals	"With the voucher thing, she got me going with that. She told me where to go, and what to do, and what to bring, so they helped me get daycare for her." (*Matched dyad*)
	"…if she didn't know the answer, she would refer me to somebody who would know the answer." (*Matched dyad*)
	"…and she was gonna bring me to BJ's to get a whole bunch of diapers for less price…" (*Non-matched dyad*)
	"Yes, he has referred me to psychologists and things like that." (*Matched dyad*)
	"She wanted me to get back into school, she said she wanted me to get my license and get my own apartment and take care of the baby, and she helped me - she wanted me to join a support group for moms…" (*Matched dyad*)

	"I remember I was having problems with my voucher, and the woman spoke Spanish, so she talked to her in Spanish." (*Matched dyad*)
	"She said she was going to help me try to put in applications to have my own housing apartment in a couple of few years that it takes." (*Matched dyad*)
	"Whenever there's something, like when the baby didn't have a swing and I couldn't afford a swing, she brought me a swing for him…" (*Non-matched dyad*)
Values and aids in connections to intrinsic network	"He's trying to get my partner to get his driver's license." (*Matched dyad*)
	"P: She allows us to just babble on about our life. Stress reliever. I: Who's "us"? P: My boyfriend also babbles a lot with her. / I: Okay, so you guys do the home visits together? / P: Yeah, when he can, when he's home, yeah. He comes and talks to her too." (*Matched dyad*)
	"…she kind of wanted to have us have them included so we could build our relationship to make me, as a younger mother, be able to handle things better" (*Non-matched dyad*)
Educating about goal pursuit strategies	"She always gives me goals. "What do you want to do within the next six…." (*Matched dyad*)
	"She wanted me to get back into school, she said she wanted me to get my license and get my own apartment…" (*Matched dyad*)
	"Well she asked me like what are my goals and she puts them on paper and makes me like realize that I even have goals or that those are my plans. And she asks me about them every time that I come. Like "have you done this, have you done that?" (*Matched dyad*)
	"Even if I told her my goal was to be the president, she would help me get on the right track to figure out how to become the president. Even if she knows it's highly impossible for me to become the president, she would still

	try to help." (*Non-matched dyad*)
	"She tries to help me finish my goals and get through them." (*Matched dyad*)
	"She brings my spirits up, she encourages me. You can do it if you want to." (*Matched dyad*)
Customizing help	"She's really supportive, so it's like a weekly relief." (*Non-matched dyad*)
	"She's the one that took me, you know, I told her, her opinions about certain schools, where it's OK which ones were not good." (*Matched dyad*)
	"She'll give me opinions on how I should handle things or how I should approach things, so she helps me through my problems as well. She's not just there to talk about my son and his development, she's also there to support me as well." (*Matched dyad*)
	"…the next day, she came and showed me how to put the car seat in the car…" (*Non-matched dyad*)
	"When I was having issues with the rent with my aunt, she helped me do budgeting…" (*Non-matched dyad*)
	"If I tell her I need information about the baby's teeth, she brings it. She always makes sure his immunizations are up to date." (*Matched dyad*)

Appendix: Construct Definitions

Stage 2 Construct Definitions Refined

The constructs and definitions were refined as follows:

1. P feels that HV values and respects, acknowledges and is comfortable with cultural differences (different set of practices, values, and beliefs). P feels that HV is at ease talking with P.
    a. Definition: HV is culturally aware and sensitive to her own cultural heritage and to valuing and respecting differences. HV is comfortable with differences that exist between herself and her client in terms of race, ethnicity, culture, and beliefs. HV values bilingualism and does not view another language as an impediment to provide services.
2. P feels that HV is comfortable with differences between the two.
    a. Definition: HV is willing to contrast her own beliefs and attitudes with those of her culturally different clients in a nonjudgmental fashion.
3. P feels that HV is able to suggest help that favors the HV.
    a. Definition: HV is able to recognize the limits of her competencies and expertise. HV respects minority community intrinsic help-giving networks. HV is aware of institutional barriers that prevent minorities from using…services. HV has knowledge of minority family structures, hierarchies, values,

and beliefs, community characteristics and resources in the community, as well as the family.

4. P feels that HV accurately sends and receives a variety of verbal and non-verbal messages.
    a. Definition: HV possesses knowledge about her social impact upon others. She is knowledgeable about communication style differences, and how to anticipate the impact it may have on others. HV able to engage in a variety of verbal and nonverbal helping responses. HV is able to send/receive verbal and non-verbal messages accurately and appropriately. She is not tied down to one method of approach of helping but recognizes that helping styles and approaches may be culture-bound. HV takes responsibility in educating their clients to the processes of psych interventions such as goals, expectations, legal rights, etc.
5. Quotations about cultural/racial/ethnic relatedness.
    a. Definition: Any statement that P makes about how she and HV relate because of their shared culture, race, or ethnicity.

Stage 3 Theme Definitions

1. Cultural differences are respected
    a. Description: They are valued and acknowledged; HV is still at ease talking with participant despite any cultural differences.
2. Help
    a. HV provides connections to community resources
    b. HV serves as cultural broker
    c. HV helps participant connect to intrinsic networks (i.e. inherent family structures)
3. Verbal and non-verbal messages
    a. HV educates clients on goals, and any processes towards achieving them
    b. HV understands her social impact on others
    c. HV understands communication style differences
    d. HV is able to engage in a variety of verbal and non-verbal helping responses