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Impact of Providers' Cultural Competence on Clients' Satisfaction and Hopefulness in Rural Family Services: A Pilot Study

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Abstract. Cultural competence has been discussed in professional disciplines. However, previous studies focused on ethnic sensitivity in practice, and limited work has addressed the cultural competence of rural social work practitioners. This study examined relationships between families' perceptions of cultural competence, therapeutic alliance, and practice outcomes in rural practice settings. Forty-five youth and their parents receiving intensive in-home family preservation services at Integrated Services of Appalachian Ohio completed a questionnaire regarding their providers' cultural competence in rural settings, and their therapeutic alliance, hopefulness, and satisfaction with services. Families rated their provider as culturally competent in rural practice settings; and provider competence in rural culture was positively associated with practice outcomes – satisfaction and hopefulness. Suggestions for enhancing social work practitioners' cultural competence in rural settings are provided.

***Keywords*:** cultural competence, rural family services, therapeutic alliance, practice outcomes

Cultural diversity is an increasingly important concern among social workers and other behavioral health practitioners in the United States. Racial and ethnic minority populations accounted for 30 percent of the U.S. population in 2000, and are projected to increase to 40 percent by 2015 (U.S. Department of Health and Human Services, 2001). Responding to demographic shifts, cultural competence has been frequently discussed in professional disciplines (Campinha-Bacote, 2003, 2007; Cox, Sullivan, Reiman & Vang, 2009; Musolino et al., 2010). Previous studies regarding cultural competence have focused on ethnic sensitivity and concerns in practice (Fong, 2001; LaVeist, Diala, & Jarrett, 2000; Lum, 2004; Sue & Sue, 1999). The National Association of Social Workers *Code of Ethics (NASW Code)* (NASW, 2008) frequently refers to the importance of cultural competence on the part of practitioners serving diverse client populations; however, cultural competence is rarely defined. Culture includes the ways in which a group of people experience their world, and can include thoughts, actions, communications, customs, beliefs, values, and institutions (NASW, 2001). Citing Sue (1998), Cox et al. (2009) suggest practitioners need to "…avoid drawing premature conclusions about the status of their culturally different clients," and "…avoid stereotypes…" (n.p.). Additionally they suggest practitioners learn to "… appreciate the importance of culture and acquire culture specific expertise" (n.p.) However, few studies have examined practitioners working with rural families to assess providers' cultural competence in the treatment process. This study looked at youth and parents in a rural, impoverished location within the Appalachian region. Because both

service resources and their access are limited, it is important to plan how to use resources wisely to effectively respond to the needs of rural families.

The purpose of this study is to explore families' perceptions of cultural competence and therapeutic alliance in rural family services. This study also examines the relationship between families' perceptions of their provider's competence in rural culture, therapeutic alliance, and practice outcomes: satisfaction and hopefulness with treatment. Additionally, relationships between clients' perceptions and their personal characteristics are examined.

Cultural Competence and Therapeutic Alliance in Social Work Practice

Cultural competence has been identified as an essential part of treatment when social workers and other behavioral health providers work with all people, not just those who are racially or ethnically different from themselves (Black, 2005; Dyche & Zayas, 2001; Pope-Davis, Toporek, Ligiero, Ortega, Bashshur, Brittan Powell, Liu, Codrington, & Liang, 2002). The list of possible differences commonly includes gender, race, ethnic group, nationality, religion, disability, sexual orientation, age, and social class. In many cases, clients and their providers share commonalities, but in some they differ. Both similarities and differences, however, can be tools in relationship building, problem identification, assessment, the development of intervention strategies, and methods of evaluating and terminating clients (Rothman, 2008).

Cultural competence is defined in various ways, sometimes as cultural awareness, cultural sensitivity, or cultural empathy. Additionally, definitions commonly address ethical commitments and social justice as an essential part of social work and behavioral health profession (Hohm & Glynn, 2002; Lum, 2004). A strong commitment to working with vulnerable populations has always been a foundational principle of professions. Particularly, cultural competence in social work practice involves "responding respectfully and effectively" to "people of all cultures, languages, classes, races, ethnic backgrounds, religious, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each" (NASW, 2001).

For the social work profession, cultural competence has been addressed through practice standards and policy statements. For example, the Council on Social Work Education's (2008) Education Policy and Accreditation Standard (EPAS) requires social work schools and programs to provide content related to cultural diversity throughout the curriculum. The EPAS establishes that social workers "recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power; gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups; recognize and communicate their understanding of the importance of difference in shaping life experience; and view themselves as learners and engage those with whom they work as informants" (Educational Policy 2.1.4).

The NASW *Code of Ethics* (2008) provides guidance on multicultural practice. Social workers should understand culture and its function in human behavior, recognize the strengths among all cultures, and be knowledgeable of their clients' cultures to demonstrate competence in the service provision (Standard 1.05). NASW Standards for Cultural Competence in Social Work Practice were also developed and adopted by the NASW Board of Directors in 2001 (NASW,

2001). The Standards charged social workers with ethical responsibility to be culturally competent. As an extension of the Standards, the Cultural Competence Indicators were also published to provide additional guidance on the implementation and realization of culturally competent practice (NASW, 2007).

Cultural competence is as an important factor in treatment (Hancock, 2005; Tseng, 2004). Indeed, cultural competence involves actively seeking advice, consultation, and a commitment to incorporating new knowledge and experience into a wider range of practice (Goode, 2004; Pope-Davis et al., 2002). For example, a culturally sensitive practitioner makes efforts to learn about availability of resources to support clients' cultural identity (Coakley & Orme, 2006). Understanding different cultures is also critical to engaging clients in treatment. In the treatment process, therapeutic alliance represents interactive, collaborative elements of the relationship in the context of an affective bond (Constantino, Castonguay, & Schut, 2002). Being knowledgeable about clients' cultural background improves the therapeutic relationship (Black, 2005; Dyche & Zayas, 2001; Pope-Davis et al., 2002). Engagement between clients and practitioners contributes to persistence in treatment efforts and is extremely relevant in its contribution to positive therapeutic alliance (Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006; Tapia, Schwartz, Prado, Lopez, & Pantin, 2006).

Therapeutic alliance also has been consistently linked with practice outcomes (Hatcher & Gillaspy, 2006; Horvath & Symonds, 1991). For example, a positive alliance provides a safe environment for clients to explore themselves and promotes engagement and mutual agreement on goal setting (Erdur, Rude, Baron, Draper, & Shankar, 2000; Fraser & Solovey, 2007). Goal setting collaboration also can help clients have a more desirable vision that they can achieve their treatment goal (Fraser & Solovey, 2007).

Integrated Services of Appalachian Ohio Family Preservation Programming

Integrated Services of Appalachian Ohio (IS) in Athens, OH is a nonprofit agency that develops, manages, and provides community-based services in southeastern Ohio. Working directly with individuals, families, organizations, governmental entities and private service agencies, central goals of IS are to improve quality, cost efficiency, and access to rural services for individuals and families.

IS provides therapeutic family preservation services for youths, ages 4-17, with emotional disturbances, behavioral disorders, or dual diagnoses. These youth are at risk for significant long-term involvement across public sector systems, particularly in the juvenile justice and/or child protection systems. Though still at home, youth may be at risk of placement, or returning home from out of home placement, including foster care, residential treatment, detention or jail, generally within 30 days. IS centralized intake accepts referrals from the juvenile court or the county public child welfare agency. An assigned coordinator conducts an assessment to determine an appropriate level of service. Like other multisystem providers, family services are typically problem focused and competency based. Interventions are designed to respond to identified needs and may be directed toward individuals, families, family subsystems, peer relationships, school adjustment, academic performance, and any other social system believed to be involved in the problem behavior's etiology. Mental health services including a

community support program, counseling and psychotherapy, diagnostic assessment including psychological testing, and psychiatric services, are provided.

Though IS serves counties and communities throughout southeastern Ohio, the current study focused on one county. In this county, IS provided two models of therapeutic family preservation services: an intensive and a less intensive program. The intensive model was intended for families of youths generally between 14-16 years who were at immediate risk for out-of-home placement. This model sought to empower parents to better manage challenging behaviors while helping youth better cope with friends, school and community life. Though IS family programming evolved from Multisystemic Therapy (MST), much of the current model was based on a family therapy approach that incorporates behavior modification training (Sells, 1998). For example, parents are taught skills to help them regain control of their adolescent and family. Peer intervention strategies and school interventions were also developed to improve the youths' behavior and academic performance. Because each family is unique, practitioners must be flexible in planning services to accommodate individual family needs. Services are provided in the home with continuous staff support. In the less intensive process, a combination of formal and informal services and supports targeting essential life domains was provided, based on a foundation of family strengths. Generally, there was weekly contact between the family and the practitioner in this model.

Based on the literature reviewed, we hypothesized that higher practitioner competence in rural culture and related increases in therapeutic alliance should result in more positive practice outcomes in rural family services. Specifically, youth and their parents who rated their provider more culturally competent in rural practice settings would be more satisfied with as well as more hopeful about treatment. Higher levels of satisfaction and hopefulness would be related to families' willingness to persist in treatment. Additionally, it was hypothesized that some family characteristics would be related to their perception of cultural competence and therapeutic alliance in family services. For example, families who reported lower incomes would rate their provider less culturally competent and would be less positive about the therapeutic alliance with their provider.

Methods

Sampling procedure

The sample was recruited in 2008-2009 from youth and their parents receiving IS services. This study was reviewed and approved by the Institutional Review Board for the Protection of Human Subjects at Ohio University. After we received IRB approval, youth and their parents receiving intensive in-home family preservation services were asked to complete survey questionnaires after two weeks of service. The questionnaire included youth and parents' perceptions of current therapeutic alliance, hopefulness, and satisfaction with services, as well as an assessment of their provider's cultural competence. Other demographic information was collected. Providers also completed the questionnaire measuring therapeutic alliance with youth and parents.

Instruments

Cultural competence. The Client Cultural Competence Inventory (CCCI) (Switzer, Scholle, Johnson, & Kellerher, 1998) was used to assess youth and parent perceptions of providers' cultural competence. The 12-item inventory measured three different areas of provider competence: (a) community and family involvement; (b) respect for ethnic differences; and (c) parent easy access to care. A five-point scale (1 = *never true* to 5 = *always true)* was used to measure constructs. Initially, this instrument was piloted with 7 African American and White parents of severely emotionally disturbed children. Clients reportedly "…experienced no difficulty in understanding the content of the inventory" (Switzer et al., 1998, p. 486). Switzer et al. (1998) also used interviews of families with children ages 5-17 with prior intensive mental health service use in Allegheny County to establish the 3 factor loadings. Of these 151 families, 38 were African American, 61 were White, and 1 was "other," suggesting the CCCI is a valid measure when used with diverse ethnic/cultural groups. The Allegheny County poverty rate in 2011 was 12.4%; and our sample included 33 families (73.2%) with yearly incomes at or below $25,000, with 20 families (48.6%) reporting a yearly income at or below $15,000 (Table 1).

Table 1

Participants' Characteristics

	Characteristics	N	Percent
Parents' Gender	Female	45	100
Parents' Ethnicity	White	45	100
Parents' Education Level	Less than High School	8	16.7
	High School	29	69.0
	Some College/Associate's Degree	4	9.5
	Bachelor's/College Degree	2	4.8
Family Income	Less than $24,999	30	73.2
	$25,000 and over	2	26.8
Months of Parenting Services	0-6	32	80.0
	7 and over	4	20.0
Number of People in Home	2	4	8.9
	3	10	22.2
	4	15	33.3
	5	10	22.2
	6	4	8.9
	7	1	2.2
	8	1	2.2
Children's Gender	Male	19	42.2
	Female	25	56.8
Children's Age (Years)		*M* = 14.00	(*SD* = 3.64)

Though our sample is White and rural, poverty is a characteristic they share with other populations with whom the CCCI has been studied. As Jack and Gill (2012) state: “Whilst each context will be unique in many respects, the majority of families involved with social workers will share the experience of living in impoverished circumstances” (Abstract). Constructs measured by the CCCI share characteristics important to people living in impoverished circumstances (see Table 2), suggesting that the CCCI is a valid measure for use with this Appalachian study sample. The internal consistence was acceptable with an alpha of 0.67.

Table 2

Mean Scores of Cultural Competence, Therapeutic Alliance, and Practice Outcomes (Hopefulness and Satisfaction with Services)

Items	*M*	*SD*
Satisfaction with Treatment	1.79	.73
Hopefulness with Treatment	2.91	.96
Therapeutic Alliance (WAI-SR)	2.83	.24
Cultural Competence (Overall average)	4.35	.38
CCCI Parent Community and Family Involvement		
The caregiver involves other family members in the therapy process whenever possible.	4.27	.78
The caregiver helps to get services we need from other agencies.	4.46	.94
The caregiver accepts our family as important members of a team.	4.66	.56
The caregiver encourages us to meet with other community professionals.	3.37	1.57
The caregiver makes it clear that we as a family are responsible for deciding what is done for our child/family.	4.26	.86
The caregiver encourages us to evaluate child's progress.	4.48	.63
CCCI Caregiver’s Respect for Cultural Differences		
The caregiver respects my family's beliefs, customs, and ways that we do things in our family.	4.42	.78
The caregiver uses everyday languages we can understand.	4.68	.59
The caregiver makes negative judgments about us because we are different (reverse scored).	4.36	1.06
CCCI Parent Easy Access to Care		
My child receives mental health services in a location near (or in) our home.	4.38	1.10
The caregiver's flexible hours make it easy to schedule appointments for my child.	4.55	.75

Therapeutic alliance. Therapeutic alliance was conceptualized as the relationship between clients and their practitioner, and measured with the Working Alliance Inventory-Short Revised (WAI-SR) (Hatcher & Gillaspy, 2006). From the WAI-SR, youth, parents, and

providers rated 12 items of the therapeutic alliance. Items were rated on a 4-point scale (1 = *strongly agree* to 5 = *strongly disagree*). Internal consistencies were at least 0.84 among youth, parents, and providers; the mean score of the WAI-SR was used to measure therapeutic alliance.

Practice outcomes: Satisfaction and hopefulness. Practice outcomes, satisfaction and hopefulness about treatment, were measured using the Ohio Scale (Ogles, Melendez, & Davis, 1998). For treatment satisfaction, youth and parents rated 4 items on a 6-point scale (1 = *extremely satisfied* to 6 = *extremely dissatisfied*). Hopefulness also measured 4 items on a 6-point scale (1 = *a great deal* to 5 = *not at all*). Internal consistencies of satisfaction and hopefulness were excellent with an alpha of 0.84 and 0.90 respectively. Again, mean scores were used to measure these outcomes.

Personal information. Personal information was also collected, including age of parent and children, gender, ethnicity, family income, education level, number of people in home, and length in treatment.

Data Analysis

First, this study calculated mean scores to explore youth and parent perception of providers' cultural competence, therapeutic alliance, hopefulness, and satisfaction with service. It then examined the bivariate relationships between variables and personal characteristics of families. To determine which family characteristics were influencing their perceptions, t-tests and analysis of variance were conducted. Finally, Spearman's correlation was used to determine direct relationships among cultural competence, therapeutic alliance, and the outcome variables of hopefulness and satisfaction with services.

Findings

Participant Characteristics

Forty-five families, including youth and their parents, completed the questionnaire from the IS in-home family preservation program. All parents were White and female. The majority of parents reported an income of $25,000 or below (73.2%, n = 30), and less than high school or a high school education (85.7%, n = 37). A significant percentage (80.0%, n = 32) had been involved with parenting services for 6 months or less. Among the youth, 56.8% were female. Youth's ages ranged from 1 to 20 years with an average of 14.09 years (*SD* = 3.64) (Table 1).

Cultural Competency, Therapeutic Alliance, and Practice Outcomes

Youth and parents reportedly perceived high cultural competency in their provider (*M* = 4.35, *SD* = .38; 5 point scale). However, their responses showed slight differences in the following subcategories: (a) community and family involvement (*M* = 4.22, *SD* = .48); (b) respect for cultural difference (*M* = 4.55, *SD* = .48); and (c) easy access to care (*M* = 4.50, *SD* = .53) (Table 2). Youth and parents also reported moderate therapeutic alliance scores (*M* = 2.83, *SD* = .24). For practice outcomes, youth and parents rated the received treatment as moderately satisfying (*M* = 1.79, *SD* = .73) and reported they were generally hopeful (*M* = 2.91, *SD* = .96). Items were measured on a 6 point scale where lower numbers indicate higher satisfaction and hopefulness.

As we hypothesized, families' perceptions of providers' cultural competence and hopefulness about treatment were significantly related to their personal characteristics. Families whose incomes were less than $25,000 reported less treatment hopefulness (M = 3.03, SD = .91) than families whose incomes were over $25,000 ($M$ = 2.31, SD = .67) (t = 2.36, p < .05). In addition, families with lower incomes rated their provider's cultural competence lower (Mean = 4.25, SD = .35) compared to families with higher incomes (Mean = 4.65, SD = .29) (t = -3.40, p < .01). Families' perception of their provider's cultural competence was also significantly related to the number of people in the home. Larger families perceived lower cultural competence about their therapist (r = -.304, p < .05). Parents' education level was also significantly related to their ratings of therapeutic alliance. Parents with a high school degree (M = 2.68, SD = .27) or less than high school (M = 2.67, SD = .37) rated therapeutic alliance lower than parents with some college or bachelor's degree (M = 2.95, SD = .35) (F = 3.71, p < .05).

Relationships among cultural competence, therapeutic alliance, hopefulness, and satisfaction with services

Spearman's correlations indicated moderate and significant relationships between families' ratings of the cultural competence of their provider and practice outcomes. Overall, youth and their parents who perceived greater cultural competence in their provider rated the treatment as more satisfying (r_s = -.402, p < .01) and more hopeful (r_s = -.417, p < .01). Particularly, provider's cultural competence in community and family involvement was significantly correlated to both practice outcomes – satisfaction with treatment (r_s = -.383, p < .05) and hopefulness about treatment (r_s = -.449, p < .01). However, none of the practice outcomes were associated with the measure of therapeutic alliance (Table 3).

Table 3

Spearman's Correlation among Cultural Competence, Therapeutic Alliance, and Practice Outcomes

	Treatment Satisfaction	Treatment Hopefulness	Therapeutic Alliance
Overall Cultural Competence	-.402**	-.417**	-.056
Cultural Competence: Community/Family Involvement	-.383*	-.449**	.071
Cultural Competence: Respect for Cultural Difference	-.163	-.290*	-.175
Cultural Competence: Access to Care	-.269	-.257	-.147
Therapeutic Alliance	-.198	-.130	

*p <.05; **p <.01

Specifically, youth and their parent's treatment satisfaction was significantly correlated to their provider's following cultural competences: accepting them as important members of a team (r_s = -.585, p < .01), helping to get services from other agencies (r_s = -.473, p < .01), respecting their family's beliefs, customs, and ways (r_s = -.420, p < .01), making families responsible for decisions during treatment (r_s = -.407, p < .01), and encouraging families to evaluate their child's progress (r_s = -.377, p < .05) (Table 4).

Table 4

Spearman's Correlation between Cultural Competence and Ohio Scales: Satisfaction and Hopefulness

Client Cultural Competence Inventory	Satisfaction	Hopefulness
The caregiver involves other family members in the therapy process whenever possible.	-.275	-.159
The caregiver respects my family's beliefs, customs, and ways that we do things in our family.	-.420**	-.402**
The caregiver uses everyday languages that we can understand.	-.261	-.142
My child receives mental health services in a location near (or in) our home.	-.157	-.229
The caregiver's flexible hours make it easy to schedule appointments for my child.	-.247	-.175
The caregiver helps to get services we need from other agencies.	-.473**	-.479**
The caregiver makes negative judgments about us because we are different .	-.148	-.045
The caregiver accepts our family as important members of a team.	-.585**	-.380*
The caregiver encourages us to meet with other community professionals.	-.035	-.102
The caregiver makes it clear that we as a family are responsible for deciding what is done for our child/family.	-.407**	-.465**
The caregiver encourages us to evaluate child's progress.	-.377*	-.303*

*p <.05; **p <.01

In addition, youth and parents' hopefulness about treatment was significantly correlated to the same items in their provider's cultural competences: helping to get services from other agencies (r_s = -.479, p < .01), making families responsible for decision during treatment (r_s = -.465, p < .01), respecting their family's beliefs, customs, and ways (r_s = -.402, p < .01), accepting them as important members of a team (r_s = -.380, p < .05), and encouraging families to evaluate their child's progress (r_s = -.303, p < .05).

Limitations

This study has several limitations that must be considered. First, the results are based on a small sample which limits sample representativeness and generalization. Next, all participants' families and providers were volunteers. It is possible that the respondents who chose to participate were more satisfied with current treatment than those who did not participate, and providers could have been more aware of, or consider, cultural competence a more important factor, compared to those who did not participate. Also, all participants are youth and parents from one location in southeastern Ohio. Therefore, sample representativeness is unknown.

Additionally, this study attempted to identify providers' ability to deliver culturally competent service in rural settings with a use of the standardized instrument. However, the CCCI was initially developed to identify ethnic sensitivity in practice. Thus, this study may have measurement errors between providers' true cultural competence in rural practice settings and the values of cultural competence identified with the instrument.

Finally, this study measured family perception of provider cultural competence in treatment process. There is a risk of social desirability bias in that respondents may tend to report more positive ratings on their practice outcomes and provider cultural competence. At the beginning of treatment process, families may feel concerned if they rated their provider and treatment negatively. Since data were collected at a "point-in-time," we cannot appraise whether these factors and services actually contributed to reduced out-of-home placement for youth. Thus, future research should examine the impact of cultural competence on practice outcomes over the process of treatment. Moreover, with larger samples and more statistical power, future research could use multivariate analyses in a longitudinal study context.

Discussion and Implications

This study indicated that youth and parents generally rated their provider as culturally competent. However, in some instances the perception of cultural competence was related to the family's characteristics. Particularly, the family's socioeconomic status was regarded as an important consideration when the family evaluated their ideas about the provider's cultural competence. The county in which this study was conducted has undergone substantial change in economic opportunity, such as the closing of a paper mill and loss of a television manufacturing facility. Findings revealed that the majority of these rural clients were poor and almost half of families reported their income level was below $15,000. Family income and family size were significantly related to their perception of the provider's cultural competence. Some authors have noted the danger of equalizing the minority and poor population (Javier, Herron & Yanos, 1995). Equalization and stereotype of the minority population do not allow for a more sophisticated discussion on the unique issues. Thus, it will be necessary to develop methods to separate cultural issues linked to socio-economic status from those central to the ethnicity of the client (Switzer et al., 1998). However, the results are consistent with previous studies indicating that poverty is frequently a more serious and entrenched problem in rural areas than urban areas (Fitchen, 1998; Miller & Conway, 2002; Morris, 1995). This study suggests that rural practitioners should develop a high degree of sensitivity to, and skills in relating to, various socioeconomic classes and ethnic groups (Ginsberg, 2005).

As hypothesized, provider cultural competence was associated with positive practice outcomes in rural family services. Youth and parents who perceived their provider as culturally competent reported greater satisfaction and more hopefulness during their treatment. Specifically, youth and parents reported higher levels of satisfaction and hopefulness when the provider respected their family culture, accepted them as important members of a team, and helped them to get services from other agencies.

Achieving cultural competence involves knowledge, skills, practices, and actions. With regard to achieving cultural competence, providers need to receive, understand, and interpret information from clients in a culturally competent and sensitive manner. Lynch and Hansen

(1993) (as discussed in Cox et al., 2009) suggest cultural competence is the ability to "think, feel, and act in ways that acknowledge, respect, and build upon ethnic, sociocultural, and linguistic diversity" (p. 50). Practitioners need to ensure that the presenting problems and issues are understood as the family understands them, and processed in culturally appropriate and relevant ways. Service plans must also be conceptualized and organized with identified cultural values (Simmons, Diaz, Jackson, & Takahashi, 2008).

One of interesting findings in the current study is family's need of services from other agencies. In rural communities, there are fewer formal organizations and resources. Other agencies are likely to be informal and may not be listed in a directory of social services (Jacobson, 2002; Newfield, Pratt, & Locke, 2003; Riebschleger, 2007). For better practice outcomes, providers need to identify and use informal as well as formal resources in order to provide culturally competent services from community collaboration. Culturally competent practice is related to provider's ability to match services that support clients' cultural values and then incorporate the appropriate interventions (Lum, 2010).

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